

Indiana Family and Social Services Administration
HCBS Statewide Transition Plan



Division of Aging | Division of Disability and Rehabilitative Services | Division of Mental Health and Addiction | Office of Medicaid Policy and Planning



Statewide Transition Plan for Compliance with Home and Community-Based Services Final Rule

State of Indiana

March 2017
Version 6



TABLE OF CONTENTS

PURPOSE.....	4
FSSA PROGRAMMATIC IMPACT	5
Division of Aging (DA).....	7
SECTION 1: SETTINGS INCLUDED IN THE STP.....	7
SECTION 2: SYSTEMIC ASSESSMENT	8
SECTION 3: SITE SPECIFIC ASSESSMENT.....	42
SECTION 4: KEY STAKEHOLDERS AND OUTREACH.....	64
DIVISION OF DISABILITY AND REHABILITATIVE SERVICES (DDRS).....	65
SECTION 1: SETTINGS INCLUDED IN THE STP.....	65
SECTION 2: SYSTEMIC ASSESSMENT	65
SECTION 3: SITE SPECIFIC ASSESSMENT.....	82
SECTION 4: KEY STAKEHOLDERS AND OUTREACH.....	96
Division of Mental Health and Addiction - Youth (DMHA-Y)	97
SECTION 1: SETTINGS INCLUDED IN THE STP.....	97
SECTION 2: SYSTEMIC ASSESSMENT	98
SECTION 3: SITE SPECIFIC ASSESSMENT.....	110
SECTION 4: KEY STAKEHOLDERS AND OUTREACH.....	119
Division of Mental Health and Addiction – Adult (DMHA-A).....	120
SECTION 1: SETTINGS INCLUDED IN THE STP.....	121
SECTION 2: SYSTEMIC ASSESSMENT	122
SECTION 3: SITE SPECIFIC ASSESSMENT.....	140
SECTION 4: KEY STAKEHOLDERS AND OUTREACH.....	151
Public Input.....	153
Division of Aging (DA).....	155
Division of Disability and Rehabilitative Services (DDRS).....	158
Division of Mental Health and Addiction - Youth (DMHA-Y)	169
Division of Mental Health and Addiction – Adult (DMHA-A).....	170
Table of Acronyms	173

References

CMS Home and Community-Based Services: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html>

Division of Aging: <http://www.in.gov/fssa/2329.htm>

Division of Disability and Rehabilitative Services: <http://www.in.gov/fssa/2328.htm>

Division of Mental Health and Addiction: <http://www.in.gov/fssa/dmha/index.htm>

Family and Social Services Administration Calendar:

<http://www.in.gov/activecalendar/CalendarNOW.aspx?fromdate=10/1/2014&todate=10/31/2014&display=Month&display=Month>

Indiana Home and Community-Based Services Final Rule: <http://www.in.gov/fssa/4917.htm>

Public Comment E-mail: HCBSrulecomments@fssa.in.gov

PURPOSE

On March 17, 2014, the Centers for Medicare & Medicaid Services (CMS) issued regulations that define the settings in which it is permissible for states to pay for Medicaid Home and Community-Based Services (HCBS) known as the HCBS Settings Final Rule. The purpose of these regulations is to ensure that individuals receive Medicaid HCBS in settings that are integrated and that support full access to the greater community. This includes opportunities to seek employment and work in competitive and integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree as individuals who do not receive HCBS. These changes will maximize the opportunities for participants in HCBS programs to have access to the benefits of community living and to receive services in the most integrated setting.

States must ensure all HCBS settings comply with the new requirements by completing an assessment of existing state standards including rules, regulations, standards, policies, licensing requirements, and other provider requirements to ensure settings comport with the HCBS settings requirements. States must submit a transition plan to CMS that includes timelines and deliverables for compliance with 42 CFR 441.301(c) (4) (5), and Section 441.710(a) (1) (2). States must be in full compliance with the federal requirements by the time frame approved in the transition plan but no later than March 17, 2019. More information on the rules can be found on the CMS website at: [CMS Home and Community-Based Services](#).

The Indiana Family and Social Services Administration (FSSA) has created a Statewide Transition Plan (STP) to assess compliance with the HCBS Final Rule and identify strategies and timelines for coming into compliance with it as it relates to all FSSA HCBS programs. Indiana's initial STP (version 1) was submitted to CMS for review and approval in December 2014. In October 2015, CMS responded to Indiana's STP with a request for supplemental information, noting it was not approved by CMS at that time. Through guidance from CMS, Indiana submitted a modified STP (version 2) in April 2016 that provided additional detail from systemic assessments and incorporated changes related to October 2015 guidance from CMS. In September 2016 and per CMS requirement, Indiana submitted an amended STP (version 3) with the results of its site-specific assessments along with detailed plans for remediation, heightened scrutiny, ongoing monitoring, and relocation processes. During that time, CMS requested technical corrections for Indiana's STP systemic assessments in order to receive initial approval. CMS did not require this version to be submitted for public comment. Indiana submitted a technical corrections revision of the STP (version 4) in October 2016. In November 2016, CMS requested a few additional technical corrections. Indiana submitted version 5 of the STP on November 4, 2016. On November 8, 2016, CMS granted initial approval to Indiana's STP for the systemic portion of the plan. CMS requested additional edits for the site-specific assessment portion of the STP. Indiana will submit version 6 of the STP in March 2017 with additional updates and details for remediation, heightened scrutiny, ongoing monitoring, and relocation processes.

Overview of the Settings Provision

The HCBS Final Rule requires that all home and community-based settings meet certain criteria. These include:

- The setting is integrated in and supports full access to the greater community;
- The setting is selected by the individual from among setting options;
- Each individual has a right to privacy, is treated with dignity and respect, and is free from coercion and restraint;
- Provides individuals independence in making life choices; and
- The individual is given choice regarding services and who provides them.

In residential settings owned or controlled by a service provider, additional requirements must be met:

- The individual has a lease or other legally enforceable agreement providing similar protections;
- Each individual must have privacy in their living unit including lockable doors;
- Individuals sharing a living unit must have choice of roommates;
- Individuals must be allowed to furnish or decorate their own sleeping and living areas;
- The individual controls his/her own schedule including access to food at any time;
- The individual can have visitors at any time; and
- The setting is physically accessible.

Any modification to these additional requirements for provider-owned home and community-based residential settings must be supported by a specific assessed need and justified in the person-centered service plan.

The HCBS Final Rule clarifies settings in which home and community-based services cannot be provided. These settings include: nursing facilities, institutions for mental disease, intermediate care facilities for individuals with intellectual disabilities, and hospitals.

It is not the intention of CMS or FSSA to take away any residential options or to remove access to services and supports. The intent of the federal regulation and the Indiana transition plan is to ensure that individuals receive Medicaid HCBS in settings that are integrated in and support full access to the greater community.

FSSA PROGRAMMATIC IMPACT

FSSA as the single state Medicaid agency is comprised of five divisions, all of which play a role in the operation, administration, and reimbursement of HCBS. The Division of Family Resources determines Medicaid eligibility. The Office of Medicaid Policy and Planning (OMPP) develops medical policy, ensures proper reimbursement of Medicaid services, and acts as the administrative authority for all HCBS programs. The remaining three divisions, listed below, operate multiple programs including Medicaid HCBS programs. The programs currently under review include 1915(c) HCBS Waivers and 1915(i) State Plan benefits operated by the following divisions within the FSSA:

Division of Aging (DA)

- Aged & Disabled (A&D) Waiver – IN.210
- Traumatic Brain Injury (TBI) Waiver – IN.4197

Division of Disability and Rehabilitative Services (DDRS)

- Community Integration and Habilitation (CIH) Waiver – IN.378
- Family Supports Waiver (FSW) – IN.387

Division of Mental Health and Addiction (DMHA)

Youth Services

- Psychiatric Residential Treatment Facility (PRTF) Transition Waiver – IN.03
- Child Mental Health Wraparound Services (CMHW) – TN No. 12-013

Adult Services

- Behavioral and Primary Healthcare Coordination (BPHC) – TN No. 13-013
- Adult Mental Health Habilitation (AMHH) – TN No. 12-003

The following pages include plans presented by each of the three FSSA divisions that operate Indiana's HCBS programs. Each division is presenting a customized plan, including methods and timelines that best suit their operations as well as their members and stakeholder groups.

Although each plan is unique, they each include the following fundamental steps of the process necessary to comply with the HCBS Final Rule:

- A systemic assessment of HCBS programs, service definitions, rules and policies addressing all settings including both residential and non-residential.
- Site-specific assessment plans to determine whether the setting complies with the HCBS Final Rule.
- Remediation plans for issues discovered in systemic and site-specific assessments including plans for heightened scrutiny and relocation of members.
- Description of data collection to validate assumptions.
- Quality assurance processes to ensure ongoing compliance.
- Involvement of key stakeholders, associations, advocacy groups and members throughout the process of transition plan development through public comment.

Individuals who are enrolled in and receiving services from one of the HCBS programs may also be referred to in this STP as participants, members, beneficiaries, consumers, individuals, or clients.

DIVISION OF AGING (DA)
HCBS Programs
Aged and Disabled (A&D) Waiver – 1915(c)
Traumatic Brain Injury (TBI) Waiver – 1915(c)

SECTION 1: SETTINGS INCLUDED IN THE STP

The Division of Aging’s analysis of settings where HCBS are provided has included:

- A crosswalk of Indiana Statute, Indiana Administrative Code (IAC), HCBS policy;
- A self-survey of residential providers to assess operating practices, waiver participation levels and general adherence to HCBS rule principles;
- Review of licensing rules and regulations, recently noted statute governing housing with services establishment (IC 12-10) still to be added to this analysis; and
- Site surveys of all assisted living (AL), adult day service (ADS), and adult family care (AFC)

The DA has determined the following waiver services can be presumed to fully comply with the regulatory requirements because they are individualized services provided in a residential setting that is not provider owned or controlled.

- **Attendant Care (A&D, TBI):** Assistance with activities of daily living
- **Behavior Management/Behavior Program and Counseling (TBI):** Specialized therapies to address behavioral needs
- **Case Management (A&D, TBI):** Coordination of other waiver services, assuring freedom of choice and person-centered planning
- **Community Transition (A&D, TBI):** Funds to purchase household needs for participants transitioning into their own home
- **Environmental Modification Assessment (A&D, TBI):** Support to assure that home modifications are effective and efficient
- **Environmental Modifications (A&D, TBI):** Home modifications to meet the participant’s disability-related needs
- **Healthcare Coordination (A&D, TBI):** Specialized medical support for participants with complex medical needs
- **Home Delivered Meals (A&D, TBI):** Nutritional meals for participants who are unable to prepare them
- **Homemaker (A&D, TBI):** Assistance with cleaning and routine household tasks
- **Nutritional Supplements (A&D, TBI):** Liquid supplements such as “Boost” or “Ensure”
- **Personal Emergency Response System (A&D, TBI):** Medical emergency alert systems for participants who spend time alone
- **Pest Control (A&D, TBI):** Pest extermination services when health and safety is compromised
- **Residential Based Habilitation (TBI):** Specialized therapies in the home setting
- **Respite Home Health Aide/ Respite Nursing (A&D, TBI):** Respite services are services that are provided temporarily or periodically in the absence of the usual caregiver. Service may be provided in the following locations: in an individual’s home or in the private home of the caregiver
- **Specialized Medical Equipment and Supplies (A&D, TBI):** Adaptive equipment and supplies to help participants live more independently
- **Structured Family Caregiving (A&D):** a living arrangement in which a participant lives in his or her private home or the private home of a principal caregiver who may be a related or unrelated individual who is not the participant’s spouse, the parent of the participant who is a minor, or the legal guardian of the participant; support services are provided by the principal caregiver (family caregiver) as part of structured family caregiving; only agencies may be structured family caregiving providers, with the structured family caregiving settings being approved, supervised, trained, and paid by the approved agency provider. This is not a provider owned or controlled setting as long as the caregiver is a related individual. DA will evaluate each situation individually to determine if the caregiver is an unrelated individual and if the participant resides in that caregiver’s home. DA believes that few, if any, situations will prove to be provider owned or controlled but any that are will be assessed and remediated individually for compliance with the HCBS settings requirements. SFC will be included in regulatory language to cover any situations that do involve services in the home of an unrelated paid caregiver.
- **Transportation (A&D, TBI):** Rides to assist participants in accessing community services, activities, and resources identified in the service plan

- **Vehicle Modifications (A&D, TBI):** Modifications to vehicles to meet a participant’s disability-related need

It is not the intention of CMS or DA of Indiana to take away any residential options, or to remove access to services and supports. The intent of the federal regulation and the Indiana transition plan is to ensure that individuals receive Medicaid HCBS in settings that are integrated in and support full access to the greater community. The DA has identified five services which are provided in provider owned settings:

- **Adult Family Care (A&D, TBI):** Residential services provided in a family-like setting; the AFC homes are approved to serve not more than four participants in a home-like setting in a residential community with a live-in caregiver.
- **Adult Day Services (A&D, TBI):** Activities provided in a group setting, outside the home
- **Assisted Living (A&D, TBI):** Residential services offering an increased level of support in a home or apartment-like setting.
- **Structured Day Program (TBI):** Activities and rehabilitative services provided in a group setting outside the home.
- **Supported Employment (TBI):** Supported employment includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training. Supported employment is conducted in a variety of settings, particularly worksites where persons without disabilities are employed. Can be provided one on one or in a group setting.

SECTION 2: SYSTEMIC ASSESSMENT

DA’s systemic assessment process included a thorough review of all applicable regulations in Indiana:

- [455 IAC 2](#) – DA administrative code currently covering all HCBS service providers and settings
- [455 IAC 3](#) – DA administrative code currently covering assisted living providers under DA Medicaid waivers
- [410 IAC 16.2](#) – Indiana State Department of Health (ISDH) residential care facility licensure rules (all Medicaid waiver assisted living providers are required to be licensed by ISDH)
- DA Medicaid Waiver Provider Reference Module – provider manual for DA’s Medicaid waiver programs
- [IC 12-10-15](#) – Indiana code on housing with services establishments which requires a registration process and imposes other requirements on both licensed and unlicensed assisted living communities in Indiana

DA completed a preliminary review in 2015 followed by a more thorough legal review in early 2016. Following the completion of part of the site surveys, DA revisited the systemic assessment related to assisted living providers in particular. At that time, IC 12-10-15 was added to the review. Significant conflicts with 410 IAC 16.2 were noted. The extent of this conflicted was highlighted as the site survey process was underway. DA’s final systemic review and crosswalk is now complete.

Systemic Assessment Crosswalk

Federal Requirement: Settings are integrated in and support full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.			
Applicable Indiana Regulation	Compliance with HCBS Settings Final Rule:	Remediation Activity	Timeline
Current DA Provider Rule 455 IAC 2	Silent No reference is made to community integration activities or employment in the current provider rule.	455 IAC 2 is already open for review and is applicable to residential and non-residential settings; language to be added includes: 455 IAC 2.1-3-27 "Home and community-based services" or "HCBS" means supportive services provided in the home or a community setting that meets the requirements of 42 CFR 441.301."	455 IAC 2.1 public comment period – February 2017 455 IAC 2.1 goes

		<p>In 455 IAC 2.1, DA will add additional language to specify required characteristics of HCBS settings to include that settings are integrated in and support full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.</p> <p>455 IAC 2.1-6-5 (c) (6), (7) and (10) Adult Family Care services include: “transportation for community activities that are therapeutic in nature or assist with maintaining natural supports; participant-focused activities appropriate to the needs, preferences, age, and condition of the individual participant; ... and therapeutic social and recreational programming.”</p> <p>455 IAC 2.1-6-5(d) Adult Family Care providers must ensure that a participant has the ability to: come and go in and out of the home when they choose; have guests when they choose; control their own schedule and choose to participate in activities or not; and participate in activities outside the adult family care.</p> <p>455 IAC 2.1-6-6 (b) Assisted living facilities are required to ensure that a participant has the ability to: come and go from the facility when they chose, have guests when they choose; control own schedule and choose whether to participate in activities; participate in activities outside the facility; and receive services in the community</p> <p>455 IAC 2.1-6-6 (c) Assisted living services include transportation for community activities that are therapeutic in nature or assist with maintaining natural supports; are participant focused and appropriate to the needs, preferences, age and condition of the individual; and therapeutic social and recreational programming.</p>	<p>into effect – November 2017</p>
<p>Current DA AL Rule 455 IAC 3 - 455 IAC 3-1-6 (g) The provider shall provide services in a manner that: (1) makes the services available in a homelike environment for recipients with a range of needs and preferences; (2) facilitates aging in place by providing flexible services in an environment that accommodates and supports the recipient's individuality; and</p>	<p>Partially complies</p> <p>Does not specifically address employment opportunity.</p>	<p>455 IAC 3 will be rolled into the updated 455 IAC 2 which will be entitled 455 IAC 2.1</p>	<p>455 IAC 2.1 public comment period – February 2017</p> <p>455 IAC 2.1 goes into effect –</p>

<p>(3) Supports negotiated risk, which includes the recipient's right to take responsibility for the risks associated with decision making.</p> <p>455 IAC 3-1-2 (18) "Homelike" means 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, which promotes the dignity, security, and comfort of recipients through the provision of personalized care and services to encourage independence, choice, and decision making by the recipients. A homelike environment also provides recipients with an opportunity for self-expression and encourages interaction with the community, family, and friends.</p>			<p>November 2017</p> <p>455 IAC 3 repealed – November 2017</p>
<p>Current ISDH Health Facilities Rule 410 IAC 16.2-5-1.2 410 IAC 16.2(b) "Residents have a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. Residents have the right to exercise their rights as a resident of the facility and as a citizen or resident of the United States."</p> <p>410 IAC 16.2-5-1.2(t) Residents have the right to manage their personal affairs and funds. When the facility manages these services, a resident may, by written request, allow the facility to execute all or part of their financial affairs.</p> <p>410 IAC 16.2(z) Residents have the right to: (1) refuse to perform services for the facility; (2) perform services for the facility, if he or she chooses, when: (A) the facility has documented the need or desire for work in the service plan; (B) the service plan specifies the nature of the duties performed and whether the duties are voluntary or paid; (C) compensation for paid duties is at or above the prevailing rates; and (D) The resident agrees to the work arrangement described in the service plan. (s) "Residents have the right to manage their personal affairs and funds. When the facility manages these services, a resident may, by written request, allow</p>	<p>Partially complies</p> <p>This addresses need for activities but is silent on community integration. References to employment rights is more focused on protecting the individual</p>	<p>410 IAC 16 contains licensing requirements for residential care facility (RCF); currently Medicaid waiver assisted living providers are required to be licensed as an RCF.</p> <p>DA will establish an MOU with ISDH to waive certain provisions of the RCF license for Medicaid waiver providers and/or participants as permitted by IC 16-28-1-10.</p> <p>DA will design, submit to CMS, and upon approval, implement a new Medicaid HCBS program. This program will include a congregate, residential option for consumers. It may or may not be called assisted living. DA will work with stakeholders and obtain technical assistance to evaluate the appropriate vehicle for this new program, possibly a Community First Choice or 1915(i) state plan service. DA will also engage with stakeholders to redefine the service definitions and requirements for the new program. A residential care facility license will not be required to participate in the new program. Standards will be developed to support a new certification system for these providers that will be administered through DA and not ISDH.</p>	<p>MOU between ISDH and FSSA/DA – February 2017</p> <p>New HCBS program submitted to CMS – January 2018</p> <p>Start of new HCBS program – July 2018</p>

<p>the facility to execute all or part of their financial affairs. Management does not include the safekeeping of personal items...”</p> <p>(dd) “The facility shall provide reasonable access to any resident, consistent with facility policy, by any entity or individual that provides health, social legal, and other services to any resident, subject to the resident’s right to deny or withdraw consent at any time.”</p> <p>(ff) “Residents have the right to participate in social, religious, community services, and other activities of their choice that do not interfere with the rights of other residents at the facility.”</p> <p>410 IAC 16.2-5-7.1 Activities programs Sec. 7.1. (a) The facility shall provide activities programs appropriate to the abilities and interests of the residents being served. (b) The facility shall provide and/or coordinate scheduled transportation to community-based activities.</p>			
<p>DA Medicaid Waiver Provider Reference Module</p>	<p>Silent</p> <p>No reference is made to community integration activities or employment in the current provider manual, i.e. reference module.</p>	<p>DA will add additional language to specify required characteristics of HCBS settings to include that settings are integrated in and support full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.</p> <p>Waiver services must comply with HCBS Settings Rule. Requirements to be addressed primarily in 455 IAC 2.1 revisions.</p> <p>Reference Module to be updated to reflect any changes made to HCBS waiver services or programs when they occur.</p> <p>Reference Module will be reviewed for inclusion of language supporting HCBS settings requirements during semi-annual updates.</p>	<p>Reference Module reviewed for inclusion of HCBS settings language – November 2016 and May 2017</p> <p>Reference Module updated to reflect any changes to waiver services or programs – ongoing</p>
<p>Housing with Services IC 12-10-15 IC 12-10-15-9(c)(2) the ability of a resident to engage in activities away from the establishment regardless of the time, duration, and distance of the activities may not be restricted;</p>	<p>Partially complies</p> <p>Language supports integration in the greater community and control of personal resources. Does not specifically address employment.</p>	<p>Additions to the new rule 455 IAC 2.1 will draw authority from IC 12-10-15 when referencing services, like assisted living, provided in housing with services establishments.</p>	<p>455 IAC 2.1 public comment period – February 2017</p> <p>455 IAC 2.1 goes into effect</p>

			– November 2017
<p>Federal Requirement: Settings are selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.</p>			
Applicable Indiana Regulation	Compliance with HCBS Settings Final Rule:	Remediation Activity	Timeline
<p>Current DA Provider Rule 455 IAC 2 455 IAC 2-17-1 A provider of case management services shall have the following information about an individual receiving case management services: (1) The needs and wants of an individual, including the following: (A) Health. (B) Welfare. (C) Wishes for self-directed care. (2) The array of services available to an individual whether the services are available under this article or are otherwise available.</p>	Partially compliant	<p>455 IAC 2 is already open for review; language to be added includes: 455 IAC 2.1-3-27 "Home and community-based services" or "HCBS" means supportive services provided in the home or a community setting that meets the requirements of 42 CFR 441.301.”</p> <p>455 IAC 2.1-3-16(2) - Case Management defined – “Case management means a comprehensive service including, but not limited to, the following, assisting participants in the establishment of a person centered service plan.”</p> <p>455 IAC 2.1-3-39 - Person centered service planning process defined: “Person centered service planning process has the meaning set forth in 42 CFR 441.301 (c) (1).</p> <p>455 IAC 2.1-3-40 - Person centered service plan defined as “Person centered service plan has the meaning set forth in 42 CFR 441.301(c) (2).”</p> <p>In 455 IAC 2.1, DA will add additional language to specify required characteristics of HCBS settings to include that settings are selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.</p> <p>455 IAC 2-1-7-2 (b)-(d) – Person Centered Service Plan; Service Coordination - (b) At a minimum of every ninety (90) days, the case manager, using the ninety (90) day monitoring tool, will review service deliverables as determined by the person-centered plan, to determine if participant’s assessed needs are</p>	<p>455 IAC 2.1 public comment period – February 2017</p> <p>455 IAC 2.1 goes into effect – November 2017</p>

		<p>being addressed and assess whether the participant is satisfied that the services meet their needs and goals. As necessary, the case manager will assist the participant with updating the person-centered service plan. The case manager must conduct the first face-to-face assessment with the participant in the home. The case manager must conduct at least two of the four required assessments in the home.</p> <p>(c) All case managers must:</p> <p>(5) Coordinate services;</p> <p>(6) Share information on the participant's well-being as required by the participant's person-centered plan;</p> <p>(7) Collaborate with the participant's other providers; and</p> <p>(8) Collaborate with other authorized entities.</p> <p>(d) The participant or their legal representative and any persons chosen by the participant are the only individuals that may assist with the development of the participant's person centered service plan</p> <p>455 IAC 2.1-6-4 - General Direct Care Service Standards: A provider shall:</p> <p>(1) Develop person-centered service plan specific to participants' assessed needs;</p> <p>(2) Allow decision-making and self-determination to the fullest extent possible;</p> <p>(3) Provide services that maintain or enhance a participant's quality of life and promotes participant:</p> <p>(A) privacy;</p> <p>(B) dignity;</p> <p>(C) choice;</p> <p>(D) independence; and</p> <p>(E) Individuality.</p> <p>(b) SFC, AFC, and AL providers shall maintain a safe, clean, and comfortable living environment.</p> <p>455 IAC 2.1 -6-4 (a)(4) - Assisted living facilities shall:</p> <p>"Provide living units that include access to the following in accordance with the participant's person-centered service plan:</p> <p>(A) A bedroom;</p> <p>(B) A private bath;</p> <p>(C) A living area;</p> <p>(D) A kitchenette that contains:</p> <p>(i) a refrigerator;</p> <p>(ii) a food preparation area;</p> <p>(iii) a microwave or stovetop for hot food preparation; and</p> <p>(E) Individual thermostat."</p> <p>455 IAC 2.1-6-7(b)(1) Assisted Living Service Plan – "The provider shall provide the intensity and level of services as outlined in the participant's person centered service plan."</p>	
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<p>Current DA AL Rule 455 IAC 3 455 IAC 3-1-8(d) “The provider shall ensure the service plan: (1) includes recognition of the recipient’s capabilities and choices and defines the division of responsibility in the implementation of services; (2) addresses, at a minimum, the following elements: (A) assessed health care needs; (B) social needs and preferences; (C) personal care tasks; and (D) limited nursing and medication services, if applicable, including frequency of service and level of assistance; (3) is signed and approved by: (A) the recipient; (B) the provider; (C) the licensed nurse; (D) the case manager; and (4) Includes the date the plan was approved.”</p>	<p>Partially complies</p> <p>Language supports recognition of personal preferences but does not address all elements person centered planning nor does it reference offering setting options to individuals.</p>	<p>455 IAC 3 will be rolled into the updated 455 IAC 2 which will be entitled 455 IAC 2.1</p>	<p>455 IAC 2.1 public comment period – February 2017</p> <p>455 IAC 2.1 goes into effect – November 2017</p> <p>455 IAC 3 repealed – November 2017</p>
<p>Current ISDH Health Facilities Rule 410 IAC 16.2-5-1.2</p>	<p>Silent</p> <p>Not applicable to this requirement. Case management would be responsible for assuring that the individual is provided with setting options and the person centered planning process.</p>	<p>Not applicable</p>	<p>Not applicable</p>
<p>DA Medicaid Waiver Provider Reference Module</p> <p>Page 23 - Medicaid waiver case managers coordinate and integrate all services required in a participant’s person centered service plan, link participants to needed services, and ensure that participants continue to receive and benefit from services. Waiver case managers enable participants to receive a full range of services needed due to a medical condition in a planned, coordinated, efficient, effective manner.</p> <p>Page 26, 16. Case managers will ensure that person centered planning is occurring on an ongoing basis.... 18. Case managers will base the service plan upon the individual’s needs, strengths, and preferences.</p>	<p>Partially complies</p> <p>Language does support person centered planning but does not specifically reference documentation of the need to offer setting options.</p>	<p>DA will add additional language to specify required characteristics of HCBS settings to include that settings are selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual’s needs, preferences, and, for residential settings, resources available for room and board.</p> <p>Waiver services must comply with HCBS Settings Rule. Requirements to be addressed primarily in 455 IAC 2.1 revisions.</p> <p>Reference Module to be updated to reflect any changes made to HCBS waiver services or programs when they occur.</p> <p>Reference Module will be reviewed for inclusion of language supporting HCBS settings requirements during semi-annual updates.</p>	<p>Reference Module reviewed for inclusion of HCBS settings language – November 2016 and May 2017</p> <p>Reference Module updated to reflect any changes to waiver services or programs - ongoing</p>
<p>Housing with Services IC 12-10-15</p>	<p>Silent</p>	<p>Not applicable</p>	<p>Not applicable</p>

	Not applicable to this requirement. Case management would be responsible for assuring that the individual is provided with setting options and the person centered planning process.		
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Federal Requirement: Settings ensure an individual’s rights of privacy, dignity, respect, and freedom from coercion and restraint.

Applicable Indiana Regulation	Compliance with HCBS Settings Final Rule:	Remediation Activity	Timeline
<p>Current DA Provider Rule 455 IAC 2 455 IAC 2-8-1 “Each provider will inform individuals of their right to exercise any or all guaranteed rights without: (1) restraint; (2) interference; (3) coercion; (4) discrimination; or (5) threat of reprisal”</p>	<p>Partially complies</p> <p>Language is silent on rights of privacy, dignity, and respect but does address freedom from coercion and restraint.</p>	<p>455 IAC 2 is already open for review; language to be added includes: 455 IAC 2.1-3-27 "Home and community-based services" or "HCBS" means supportive services provided in the home or a community setting that meets the requirements of 42 CFR 441.301.”</p> <p>In 455 IAC 2.1, DA will add additional language to specify required characteristics of HCBS settings to include that settings ensure an individual’s rights of privacy, dignity, respect, and freedom from coercion and restraint.</p> <p>455 IAC 2.1-8-1 Providers must inform participants, or participants’ legal representative of their right to be free from: (1) restraint; (2) interference; (3) coercion; (4) discrimination; and (5) threat of reprisal; by the provider and its employees 455 IAC 2.1-6-6 (b) (11) The assisted living facility must assure that the participant has freedom from coercion, restraint and seclusion.</p> <p>455 IAC 2.1-6-7(d) (5) The assisted living services provider shall provide services that assure “freedom from coercion and from chemical or physical restraint of the participant.” 455 IAC 2.1 -6-5 (d) (10) The adult family care provider must assure that the participant has freedom from coercion and restraint.</p>	<p>455 IAC 2.1 public comment period – February 2017</p> <p>455 IAC 2.1 goes into effect – November 2017</p>
<p>Current DA AL Rule 455 IAC 3</p>		<p>455 IAC 3 will be rolled into the updated 455 IAC 2 which will be entitled 455 IAC 2.1</p>	<p>455 IAC 2.1 public comment period – February 2017</p>

			<p>455 IAC 2.1 goes into effect – November 2017</p> <p>455 IAC 3 repealed – November 2017</p>
<p>Current ISDH Health Facilities Rule 410 IAC 16.2-5-1.2 410 IAC 16.2-5-1.2 (c) “Resident have the right to exercise any or all of the enumerated rights without: (1) restraint; (2) interference; (3) coercion; (4) discrimination; or (5) threat of reprisal by the facility. These rights shall not be abrogated or changed in any instance, except that, when the resident has been adjudicated incompetent, the rights devolve to the resident’s legal representative. When a resident is found by his or her physician to be medically incapable of understanding or exercising his or her rights, the rights may be exercised by the resident’s legal representative.”</p> <p>(d) Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality.</p> <p>410 IAC 16.2-5-1.2(u) “Residents have the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident’s medical symptoms.”</p> <p>410 IAC 16.2-5-1.2(v)(6) – “Residents have the right to be free from ...involuntary seclusion.”</p>	<p>Does not comply</p> <p>Restraints are permitted as part of treatment for medical symptoms.</p>	<p>410 IAC 16 contains licensing requirements for residential care facility (RCF); currently Medicaid waiver assisted living providers are required to be licensed as an RCF.</p> <p>DA will establish an MOU with ISDH to waive certain provisions of the RCF license for Medicaid waiver providers and/or participants as permitted by IC 16-28-1-10.</p> <p>DA will design, submit to CMS, and upon approval, implement a new Medicaid HCBS program. This program will include a congregate, residential option for consumers. It may or may not be called assisted living. DA will work with stakeholders and obtain technical assistance to evaluate the appropriate vehicle for this new program, possibly a Community First Choice or 1915(i) state plan service. DA will also engage with stakeholders to redefine the service definitions and requirements for the new program. A residential care facility license will not be required to participate in the new program. Standards will be developed to support a new certification system for these providers that will be administered through DA and not ISDH.</p>	<p>MOU between ISDH and FSSA/DA – February 2017</p> <p>New HCBS program submitted to CMS – January 2018</p> <p>Start of new HCBS program – July 2018</p>
<p>DA Medicaid Waiver Provider Reference Module</p> <p>AFC service definition, page 32: “...goal is to preserve the dignity, self-respect, and privacy of the participant by ensuring high-quality care in a non-institutional setting.”</p> <p>AL service definition, page 36: “...Care must be furnished in a way that fosters the independence of each individual to facilitate aging in place. Routines of care and service delivery must be individual-driven to the</p>	<p>Partially complies</p> <p>Does reference privacy, dignity, and respect in assisted living and adult family care settings but not in the broader spectrum of all HCBS.</p>	<p>DA will add additional language to specify required characteristics of HCBS settings to include that settings ensure an individual’s rights of privacy, dignity, respect, and freedom from coercion and restraint.</p> <p>Waiver services must comply with HCBS Settings Rule. Requirements to be addressed primarily in 455 IAC 2.1 revisions.</p> <p>Reference Module to be updated to reflect any changes made to HCBS waiver services or programs when they occur.</p> <p>Reference Module will be reviewed for inclusion of language supporting HCBS</p>	<p>Reference Module reviewed for inclusion of HCBS settings language – November 2016 and May 2017</p> <p>Reference Module updated to reflect any</p>

maximum extent possible and must treat each person with dignity and respect.”		settings requirements during semi-annual updates.	changes to waiver services or programs - ongoing
Housing with Services IC 12-10-15	Silent Code does not mention specifically respect, dignity, or privacy protections or freedom from coercion or restraints.	Additions to the new rule 455 IAC 2.1 will draw authority from IC 12-10-15 when referencing services, like assisted living, provided in housing with services establishments.	455 IAC 2.1 public comment period – February 2017 455 IAC 2.1 goes into effect – November 2017

Federal Requirement: Settings optimize, but do not regiment, individual initiative, autonomy, and independence in making life choices including but not limited to, daily activities, physical environment, and with whom to interact.

Applicable Indiana Regulation	Compliance with HCBS Settings Final Rule:	Remediation Activity	Timeline
Current DA Provider Rule 455 IAC 2	Silent Current rule does not reference individual initiative, autonomy, or independence in life choices with respect to their daily activities.	455 IAC 2 is already open for review; language to be added includes: 455 IAC 2.1-3-27 "Home and community-based services" or "HCBS" means supportive services provided in the home or a community setting that meets the requirements of 42 CFR 441.301.” In 455 IAC 2.1, DA will add additional language to specify required characteristics of HCBS settings to include that settings optimize, but do not regiment, individual initiative, autonomy, and independence in making life choices including but not limited to, daily activities, physical environment, and with whom to interact. 455 IAC 2.1-6-4 (2) – (3) Under the general direct care services standards, provider shall “allow decision-making and self-determination to the fullest extent possible; and “provide services that maintain or enhance a participant’s quality of life and promotes participant: (A) privacy; (B) dignity; (C) choice; (D) independence; and (E) individuality.” 455 IAC 2.1-6-7(d) (4) An assisted living services provider shall provider services in a manner that “support negotiated risk, which includes the participant’s right to take responsibility for the risks associated with decision making.”	455 IAC 2.1 public comment period – February 2017 455 IAC 2.1 goes into effect – November 2017

<p>Current DA AL Rule 455 IAC 3 455 IAC 3-1-2 (11) "Choice" means a recipient has viable options that enable him or her to exercise greater control over his or her life. Choice is supported by the provision of sufficient private and common space within the facility to provide opportunities for recipients to select where and how to spend time and receive personal assistance. (18) "Homelike" means 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, which promotes the dignity, security, and comfort of recipients through the provision of personalized care and services to encourage independence, choice, and decision making by the recipients. A homelike environment also provides recipients with an opportunity for self-expression and encourages interaction with the community, family, and friends. (20) "Independence" means being free from the control of others and being able to assert one's own will, personality, and preferences within the parameters of the house rules or residency agreement.</p> <p>455 IAC 3-1-5 (3) Contain individual thermostats.</p> <p>455 IAC 3-1-6 (g) The physical environment and the delivery of assisted living Medicaid waiver services shall be designed to enhance autonomy in ways which reflect personal and social values of dignity, privacy, independence, individuality, choice, and decision making of recipients. The provider shall provide services in a manner that: (1) makes the services available in a homelike environment for recipients with a range of needs and preferences; (2) facilitates aging in place by providing flexible services in an environment that accommodates and supports the recipient's individuality; and (3) supports negotiated risk, which includes the recipient's right to take responsibility for the risks associated with decision making.</p>	<p>Partially complies</p> <p>Language is nearly compliant but is not clear on choice to interact with whom the individual choses.</p>	<p>455 IAC 3 will be rolled into the updated 455 IAC 2 which will be entitled 455 IAC 2.1</p>	<p>455 IAC 2.1 public comment period – February 2017</p> <p>455 IAC 2.1 goes into effect – November 2017</p> <p>455 IAC 3 repealed – November 2017</p>
<p>Current ISDH Health Facilities Rule 410 IAC 16.2-5-1.2 410 IAC 16.2(b)</p>	<p>Partially complies</p>	<p>410 IAC 16 contains licensing requirements for residential care facility (RCF); currently</p>	<p>MOU between ISDH and</p>

<p>“Residents have a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility.”</p>	<p>Rule does not specifically address individual control of schedule in daily activities.</p>	<p>Medicaid waiver assisted living providers are required to be licensed as an RCF.</p> <p>DA will establish an MOU with ISDH to waive certain provisions of the RCF license for Medicaid waiver providers and/or participants as permitted by IC 16-28-1-10.</p> <p>DA will design, submit to CMS, and upon approval, implement a new Medicaid HCBS program. This program will include a congregate, residential option for consumers. It may or may not be called assisted living. DA will work with stakeholders and obtain technical assistance to evaluate the appropriate vehicle for this new program, possibly a Community First Choice or 1915(i) state plan service. DA will also engage with stakeholders to redefine the service definitions and requirements for the new program. A residential care facility license will not be required to participate in the new program. Standards will be developed to support a new certification system for these providers that will be administered through DA and not ISDH.</p>	<p>FSSA/DA – February 2017</p> <p>New HCBS program submitted to CMS – January 2018</p> <p>Start of new HCBS program – July 2018</p>
<p>DA Medicaid Waiver Provider Reference Module AFC service definition, page 32: “...goal is to preserve the dignity, self-respect, and privacy of the participant by ensuring high-quality care in a non-institutional setting.” AL service definition, page 36: “...Care must be furnished in a way that fosters the independence of each individual to facilitate aging in place. Routines of care and service delivery must be individual-driven to the maximum extent possible and must treat each person with dignity and respect.”</p>	<p>Partially complies</p> <p>Does reference independence in care routines in assisted living and adult family care settings but not in the broader spectrum of all HCBS.</p>	<p>DA will add additional language to specify required characteristics of HCBS settings to include that settings optimize, but do not regiment, individual initiative, autonomy, and independence in making life choices including but not limited to, daily activities, physical environment, and with whom to interact.</p> <p>Waiver services must comply with HCBS Settings Rule. Requirements to be addressed primarily in 455 IAC 2.1 revisions.</p> <p>Reference Module to be updated to reflect any changes made to HCBS waiver services or programs when they occur.</p> <p>Reference Module will be reviewed for inclusion of language supporting HCBS settings requirements during semi-annual updates.</p>	<p>Reference Module reviewed for inclusion of HCBS settings language where possible – November 2016 and May 2017</p> <p>Reference Module updated to reflect any changes to waiver services or programs - ongoing</p>
<p>Housing with Services IC 12-10-15 IC 12-10-15-9(c)(2) the ability of a resident to engage in activities away from the establishment regardless of the time, duration, and distance of the activities may not be restricted; (3) except to protect the rights and activities of other residents, the housing with services establishment may not restrict the ability of the resident to have visitors and to receive family members and guests;</p>	<p>Partial complies</p> <p>While language is supportive of individual choice and autonomy in activities away from the setting and in the ability to have visitors, it is not strong enough to insure that individuals will autonomy, and independence in making life choices including but not limited to,</p>	<p>Additions to the new rule 455 IAC 2.1 will draw authority from IC 12-10-15 when referencing services, like assisted living, provided in housing with services establishments.</p>	<p>455 IAC 2.1 public comment period – February 2017</p> <p>455 IAC 2.1 goes into effect – November 2017</p>

	daily activities, and physical environment.		
Federal Requirement: Settings facilitate individual choice regarding services and supports, and who provides them.			
Applicable Indiana Regulation	Compliance with HCBS Settings Final Rule:	Remediation Activity	Timeline
Current DA Provider Rule 455 IAC 2	<p>Silent</p> <p>While there are references to individual choice and the provider selection process, the manual fails to specifically note individual choice regarding services and supports, and who provides them.</p>	<p>455 IAC 2 is already open for review; language to be added includes: 455 IAC 2.1-3-27 "Home and community-based services" or "HCBS" means supportive services provided in the home or a community setting that meets the requirements of 42 CFR 441.301."</p> <p>In 455 IAC 2.1, DA will add additional language to specify required characteristics of HCBS settings to include that settings facilitate individual choice regarding services and supports, and who provides them.</p>	<p>455 IAC 2.1 public comment period – February 2017</p> <p>455 IAC 2.1 goes into effect – November 2017</p>
Current DA AL Rule 455 IAC 3 455 IAC 3-1-6(h) If requested by a recipient, the provider will assist a recipient and a recipient's case manager in obtaining, arranging, and coordinating services outlined in a recipient's plan of care that are not assisted living Medicaid waiver services.	<p>Partially complies</p> <p>Additional language is need to specify choice of providers.</p>	<p>455 IAC 3 will be rolled into the updated 455 IAC 2 which will be entitled 455 IAC 2.1</p>	<p>455 IAC 2.1 public comment period – February 2017</p> <p>455 IAC 2.1 goes into effect – November 2017</p> <p>455 IAC 3 repealed – November 2017</p>
Current ISDH Health Facilities Rule 410 IAC 16.2-5-1.2 410 IAC 16.2-5-0.5(c) ...The provision by a licensed home health agency of medication administration or residential nursing care in a facility which provides room, meals, a laundry, activities, housekeeping, and limited assistance in activities of daily living does not require the facility to be licensed, regardless of whether the facility and the home health agency have common ownership, provided, however, that the resident is	<p>Partially complies</p> <p>Language provides for choice of providers but does not require the setting to facilitate that choice.</p>	<p>410 IAC 16 contains licensing requirements for residential care facility (RCF); currently Medicaid waiver assisted living providers are required to be licensed as an RCF.</p> <p>DA will establish an MOU with ISDH to waive certain provisions of the RCF license for Medicaid waiver providers and/or participants as permitted by IC 16-28-1-10.</p> <p>DA will design, submit to CMS, and upon approval, implement a new Medicaid HCBS program. This program will include a congregate, residential option for consumers. It may or may not be called assisted living.</p>	<p>MOU between ISDH and FSSA/DA – February 2017</p> <p>New HCBS program submitted to CMS – January 2018</p>

<p>given the opportunity to contract with other home health agencies at any time during the resident's stay at the facility.</p> <p>(d) Notwithstanding subsection (f), a resident is not required to be discharged if receiving hospice services through an appropriately licensed provider of the resident's choice.</p> <p>(j) Residents have the right to the following:</p> <p>(1) Participate in the development of his or her service plan and in any updates of that service plan.</p> <p>(2) Choose the attending physician and other providers of services, including arranging for on-site health care services unless contrary to facility policy. Any limitation on the resident's right to choose the attending physician or service provider, or both, shall be clearly stated in the admission agreement. Other providers of services, within the content of this subsection, may include home health care agencies, hospice care services, or hired individuals.</p>		<p>DA will work with stakeholders and obtain technical assistance to evaluate the appropriate vehicle for this new program, possibly a Community First Choice or 1915(i) state plan service. DA will also engage with stakeholders to redefine the service definitions and requirements for the new program. A residential care facility license will not be required to participate in the new program. Standards will be developed to support a new certification system for these providers that will be administered through DA and not ISDH.</p>	<p>Start of new HCBS program – July 2018</p>
<p>DA Medicaid Waiver Provider Reference Module</p>	<p>Silent</p> <p>While there are references to individual choice and the provider selection process, the manual fails to specifically note individual choice regarding services and supports, and who provides them.</p>	<p>DA will add additional language to specify required characteristics of HCBS settings to include that settings facilitate individual choice regarding services and supports, and who provides them.</p> <p>Waiver services must comply with HCBS Settings Rule. Requirements to be addressed primarily in 455 IAC 2.1 revisions.</p> <p>Reference Module to be updated to reflect any changes made to HCBS waiver services or programs when they occur.</p> <p>Reference Module will be reviewed for inclusion of language supporting HCBS settings requirements during semi-annual updates.</p>	<p>Reference Module reviewed for inclusion of HCBS settings language – November 2016 and May 2017</p> <p>Reference Module updated to reflect any changes to waiver services or programs - ongoing</p>
<p>Housing with Services IC 12-10-15</p> <p>IC 12-10-15-9(c) (4) except as stated in the contract and identified in the disclosure document, an operator may not:</p> <p>(A) restrict the ability of a resident to use a home health agency, home health provider, or case management service of the resident's choice; or</p> <p>(B) Require a resident to use home health services.</p>	<p>Partially complies</p> <p>Language provides for choice of providers but does not require the setting to facilitate that choice.</p>	<p>Additions to the new rule 455 IAC 2.1 will draw authority from IC 12-10-15 when referencing services, like assisted living, provided in housing with services establishments.</p>	<p>455 IAC 2.1 public comment period – February 2017</p> <p>455 IAC 2.1 goes into effect – November 2017</p>

Applicable Indiana Regulation	Compliance with HCBS Settings Final Rule:	Remediation Activity	Timeline
<p>Federal Requirement: In provider-owned or controlled residential settings, the setting is a specific physical place that is owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has the same responsibilities and protections from eviction as all tenants under landlord/tenant law of the State, county, city or other designated entity. In settings where tenant laws do not apply, a lease, residency agreement or other written agreement is in place providing protections to address eviction processes and appeals comparable to those provided under the jurisdiction’s landlord tenant law.</p>			
<p>Current DA Provider Rule 455 IAC 2</p>	<p>Silent</p> <p>Current rule language does not reference requirement agreement or lease.</p>	<p>455 IAC 2 is already open for review; language to be added includes: 455 IAC 2.1-3-27 "Home and community-based services" or "HCBS" means supportive services provided in the home or a community setting that meets the requirements of 42 CFR 441.301.”</p> <p>In 455 IAC 2.1, DA will add additional language to specify required characteristics of HCBS settings to include that, in provider-owned or controlled residential settings, the setting is a specific physical place that is owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has the same responsibilities and protections from eviction as all tenants under landlord/tenant law of the State, county, city or other designated entity. In settings where tenant laws do not apply, a lease, residency agreement or other written agreement is in place providing protections to address eviction processes and appeals comparable to those provided under the jurisdiction’s landlord tenant law.</p> <p>455 IAC 2.1-6-5 The adult family care provider must assure that the participant has a “lease or other legally enforceable agreement that address eviction procedures and is consistent with or comparable to applicable State and local landlord tenant laws.”</p> <p>455 IAC 2.1-6-6 The assistant living service provides must assure that the participant has a “lease or other legally enforceable agreement that address eviction procedures and is consistent with or comparable to applicable State and local landlord tenant laws.”</p>	<p>455 IAC 2.1 public comment period – February 2017</p> <p>455 IAC 2.1 goes into effect – November 2017</p>
<p>Current DA AL Rule 455 IAC 3 455 IAC 3-1-6 (2) Should a recipient require more intense assisted living Medicaid waiver services (a higher level of services) than the provider is approved to provide, or require services more intense than level 3, the provider shall assist the recipient in transferring to a more appropriate setting and shall observe all discharge requirements of 410 IAC 16.2-5.</p>	<p>Does not comply</p> <p>Language forces compliance with 410 IAC 16.2-5 discharge requirements which conflict with landlord/tenant agreement requirements.</p>	<p>455 IAC 3 will be rolled into the updated 455 IAC 2 which will be entitled 455 IAC 2.1</p>	<p>455 IAC 2.1 public comment period – February 2017</p> <p>455 IAC 2.1 goes into effect –</p>

			November 2017 455 IAC 3 repealed – November 2017
<p><u>Current ISDH Health Facilities Rule 410 IAC 16.2-5-1.2</u> 410 IAC 16.2-5-1.2(e) Residents have the right to be provided, at the time of admission to the facility, the following: (1) A copy of his or her admission agreement... (5) The facility's policy on voluntary termination of the admission agreement by the resident, including the disposition of any entrance fees or deposits paid on admission. The admission agreement shall include at least those items provided for in IC 12-10-15-9.</p> <p>410 IAC 16.2-5-0.5(e) (f) The resident must be discharged if the resident: (1) is a danger to the resident or others; (2) requires twenty-four (24) hour per day comprehensive nursing care or comprehensive nursing oversight; (3) requires less than twenty-four (24) hour per day comprehensive nursing care, comprehensive nursing oversight, or rehabilitative therapies and has not entered into a contract with an appropriately licensed provider of the resident's choice to provide those services; (4) is not medically stable; or (5) meets at least two (2) of the following three (3) criteria unless the resident is medically stable and the health facility can meet the resident's needs: (A) Requires total assistance with eating. (B) Requires total assistance with toileting. (C) Requires total assistance with transferring.</p> <p>410 IAC 16.2-5-1.2(r) (4) Health facilities must permit each resident to remain in the facility and not transfer or discharge the resident from the facility unless: (A) the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) the transfer or discharge is appropriate because the resident's health has improved sufficiently so that the</p>	<p>Does not comply</p> <p>Language is not comparable to landlord/tenant protections. Repeated references to “discharge” and “transfer” do not reflect appropriate tenant/participant rights. Requirements for allowable discharge or transfer inside or outside of the setting do not offer protections comparable to landlord/tenant agreements.</p>	<p>410 IAC 16 contains licensing requirements for residential care facility (RCF); currently Medicaid waiver assisted living providers are required to be licensed as an RCF.</p> <p>DA will establish an MOU with ISDH to waive certain provisions of the RCF license for Medicaid waiver providers and/or participants as permitted by IC 16-28-1-10.</p> <p>DA will design, submit to CMS, and upon approval, implement a new Medicaid HCBS program. This program will include a congregate, residential option for consumers. It may or may not be called assisted living. DA will work with stakeholders and obtain technical assistance to evaluate the appropriate vehicle for this new program, possibly a Community First Choice or 1915(i) state plan service. DA will also engage with stakeholders to redefine the service definitions and requirements for the new program. A residential care facility license will not be required to participate in the new program. Standards will be developed to support a new certification system for these providers that will be administered through DA and not ISDH.</p>	<p>MOU between ISDH and FSSA/DA – February 2017</p> <p>New HCBS program submitted to CMS – January 2018</p> <p>Start of new HCBS program – July 2018</p>

<p>resident no longer needs the services provided by the facility; (C) the safety of individuals in the facility is endangered; (D) the health of individuals in the facility would otherwise be endangered; (E) the resident has failed, after reasonable and appropriate notice, to pay for a stay at the facility; or (F) the facility ceases to operate.</p>			
<p>DA Medicaid Waiver Provider Reference Module</p>	<p>Silent</p> <p>Current rule language does not reference requirement agreement or lease.</p>	<p>DA will add additional language to specify required characteristics of HCBS settings to include that, in provider-owned or controlled residential settings, the setting is a specific physical place that is owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has the same responsibilities and protections from eviction as all tenants under landlord/tenant law of the State, county, city or other designated entity. In settings where tenant laws do not apply, a lease, residency agreement or other written agreement is in place providing protections to address eviction processes and appeals comparable to those provided under the jurisdiction’s landlord tenant law.</p> <p>Waiver services must comply with HCBS Settings Rule. Requirements to be addressed primarily in 455 IAC 2.1 revisions.</p> <p>Reference Module to be updated to reflect any changes made to HCBS waiver services or programs when they occur.</p> <p>Reference Module will be reviewed for inclusion of language supporting HCBS settings requirements during semi-annual updates.</p>	<p>Reference Module reviewed for inclusion of HCBS settings language – November 2016 and May 2017</p> <p>Reference Module updated to reflect any changes to waiver services or programs - ongoing</p>
<p>Housing with Services IC 12-10-15 IC 12-10-15-9 Sec. 9. (a) Each resident or the resident's representative must be given a complete copy of the contract between the establishment and the resident or the resident's representative and all supporting documents and attachments and any changes whenever changes are made. (b) A housing with services establishment contract must include the following elements in the contract or through supporting documents or attachments in clear and understandable language: (4) Supportive services under arrangement with the operator. (5) The term of the contract.....</p>	<p>Partially complies</p> <p>It is unclear that the level of protection is comparable to landlord/tenant arrangements. That can be clarified in administrative rule.</p>	<p>Additions to the new rule 455 IAC 2.1 will draw authority from IC 12-10-15 when referencing services, like assisted living, provided in housing with services establishments.</p>	<p>455 IAC 2.1 public comment period – February 2017</p> <p>455 IAC 2.1 goes into effect – November 2017</p>

<p>(9) A description of the process through which the contract may be modified, amended, or terminated.</p> <p>(10) A description of the housing with services establishment’s complaint resolution process available to the residents....</p> <p>(15) The billing and payment procedures and requirements....</p> <p>(c) The housing with services establishment contract must state that:</p> <p>(1) except as stated in the contract, residency in the housing with services establishment may not be terminated due to a change in a resident’s health or care needs...</p> <p>(d) Except where the resident's health or safety or the health or safety of others are endangered, an operator shall provide at least thirty (30) days’ notice to the resident or the resident’s designated representative before terminating the resident's residency.</p>			
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Federal Requirement: In provider-owned or controlled residential settings, each individual has privacy in their sleeping or living unit.

Applicable Indiana Regulation	Compliance with HCBS Settings Final Rule:	Remediation Activity	Timeline
<p>Current DA Provider Rule 455 IAC 2</p>	<p>Silent</p> <p>Current rule does not reference privacy in individual’s sleeping or living unit.</p>	<p>455 IAC 2 is already open for review; language to be added includes: 455 IAC 2.1-3-27 "Home and community-based services" or "HCBS" means supportive services provided in the home or a community setting that meets the requirements of 42 CFR 441.301.”</p> <p>In 455 IAC 2.1, DA will add additional language to specify required characteristics of HCBS settings to include that, in provider-owned or controlled residential settings, each individual has privacy in their sleeping or living unit.</p> <p>455 IAC 2.1-6-5 Adult family care allows an individual to choose to reside with a full-time caregiver in a home owned, rented or managed by the adult family care provider. The provider must assure that the participant has a private room.</p> <p>455 IAC 2.1-6-6(b)(2) The assisted living facility must assure that the participant has a private room.</p>	<p>455 IAC 2.1 public comment period – February 2017</p> <p>455 IAC 2.1 goes into effect – November 2017</p>

<p>Current DA AL Rule 455 IAC 3 455 IAC 3-1-5 (e) “Residential units provided to recipients must be single units unless the recipient chooses to live in dual-occupied unit and the recipient and other occupant consent to the arrangement.”</p> <p>(g) The physical environment and the delivery of assisted living Medicaid waiver services shall be designed to enhance autonomy in ways which reflect personal and social values of dignity, privacy, independence, individuality, choice, and decision making of recipients.</p> <p>(f) Residential units provided to recipients shall be able to be locked at the discretion of the recipient, unless a physician or a mental health professional certifies in writing that the recipient is cognitively impaired so as to be a danger to self or others if given the opportunity to lock the door.</p>	<p>Partially complies</p> <p>Rule has several references to privacy and requires single units unless otherwise requested by the individual. However, privacy references are generally in relation to the provision of services and not specifically in relation to living or sleeping areas.</p>	<p>455 IAC 3 will be rolled into the updated 455 IAC 2 which will be entitled 455 IAC 2.1</p>	<p>455 IAC 2.1 public comment period – February 2017</p> <p>455 IAC 2.1 goes into effect – November 2017</p> <p>455 IAC 3 repealed – November 2017</p>
<p>Current ISDH Health Facilities Rule 410 IAC 16.2-5-1.2 410 IAC 16.2-5-1.2(y) Residents have the right to be treated as individuals with consideration and respect for their privacy. Privacy shall be afforded for at least the following:</p> <ol style="list-style-type: none"> (1) Bathing. (2) Personal care. (3) Physical examinations and treatments. (4) Visitations. <p>410 IAC 16.2-5-1.6 (z) A comfortably furnished resident living and lounge area shall be provided on each resident occupied floor of a multistory building. This lounge may be furnished and maintained to accommodate activity and dining functions.</p> <p>410 IAC 16.2-5-1.6 (5) Equip each resident unit with a door that swings into the room and opens directly into the corridor or common living area.</p> <p>(6) Not house a resident in such a manner as to require passage through the room of another resident. Bedrooms shall not be used as a thoroughfare.</p>	<p>Does not comply</p> <p>Rule has several references to privacy. However, privacy references are generally in relation to the provision of services and not specifically in relation to living or sleeping areas. In fact, this rule references common living areas as shared spaces.</p>	<p>410 IAC 16 contains licensing requirements for residential care facility (RCF); currently Medicaid waiver assisted living providers are required to be licensed as an RCF.</p> <p>DA will establish an MOU with ISDH to waive certain provisions of the RCF license for Medicaid waiver providers and/or participants as permitted by IC 16-28-1-10.</p> <p>DA will design, submit to CMS, and upon approval, implement a new Medicaid HCBS program. This program will include a congregate, residential option for consumers. It may or may not be called assisted living. DA will work with stakeholders and obtain technical assistance to evaluate the appropriate vehicle for this new program, possibly a Community First Choice or 1915(i) state plan service. DA will also engage with stakeholders to redefine the service definitions and requirements for the new program. A residential care facility license will not be required to participate in the new program. Standards will be developed to support a new certification system for these providers that will be administered through DA and not ISDH.</p>	<p>MOU between ISDH and FSSA/DA – February 2017</p> <p>New HCBS program submitted to CMS – January 2018</p> <p>Start of new HCBS program – July 2018</p>
<p>DA Medicaid Waiver Provider Reference Module</p>	<p>Silent</p> <p>Manual, i.e. Reference Module, does not reference privacy in individual’s sleeping or living unit.</p>	<p>DA will add additional language to specify required characteristics of HCBS settings to include that, in provider-owned or controlled residential settings, each individual has privacy in their sleeping or living unit.</p>	<p>Reference Module reviewed for inclusion of HCBS</p>

		<p>Waiver services must comply with HCBS Settings Rule. Requirements to be addressed primarily in 455 IAC 2.1 revisions.</p> <p>Reference Module to be updated to reflect any changes made to HCBS waiver services or programs when they occur.</p> <p>Reference Module will be reviewed for inclusion of language supporting HCBS settings requirements during semi-annual updates.</p>	<p>settings language – November 2016 and May 2017</p> <p>Reference Module updated to reflect any changes to waiver services or programs - ongoing</p>
<p>Housing with Services IC 12-10-15 IC 12-10-15-9</p>	<p>Silent</p> <p>Statute does not reference privacy in individual's sleeping or living unit.</p>	<p>Additions to the new rule 455 IAC 2.1 will draw authority from IC 12-10-15 when referencing services, like assisted living, provided in housing with services establishments.</p>	<p>455 IAC 2.1 public comment period – February 2017</p> <p>455 IAC 2.1 goes into effect – November 2017</p>

Federal Requirement: In provider-owned or controlled residential settings, units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.

Applicable Indiana Regulation	Compliance with HCBS Settings Final Rule:	Remediation Activity	Timeline
<p>Current DA Provider Rule 455 IAC 2</p>	<p>Silent</p> <p>Current rule does not reference lockable doors in provider owned or controlled residential settings.</p>	<p>455 IAC 2 is already open for review; language to be added includes: 455 IAC 2.1-3-27 "Home and community-based services" or "HCBS" means supportive services provided in the home or a community setting that meets the requirements of 42 CFR 441.301."</p> <p>In 455 IAC 2.1, DA will add additional language to specify required characteristics of HCBS settings to include that, in provider-owned or controlled residential settings, units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.</p> <p>455 IAC 2.1-6-5 (d) (1) The adult family care provider must assure that participants have the ability to lock their room.</p> <p>455 IAC 2.1-6-6 (b) (1) The assisted living facility must assure that participants have the ability to lock their room.</p>	<p>455 IAC 2.1 public comment period – February 2017</p> <p>455 IAC 2.1 goes into effect – November 2017</p>
<p>Current DA AL Rule 455 IAC 3 455 IAC 3-1-5 (f) "Residential units provided to recipients shall be able to be</p>	<p>Not compliant</p>	<p>455 IAC 3 will be rolled into the updated 455 IAC 2 which will be entitled 455 IAC 2.1 –</p>	<p>455 IAC 2.1 public comment</p>

<p>locked at the discretion of the recipient, unless a physician or mental health professional certifies in writing that the recipient is cognitively impaired so as to be a danger to self or others if given the opportunity to lock the door. This section does not apply if this requirement conflicts with applicable fire codes.”</p>	<p>While the current rule does reference the need for units that can be locked at the discretion of the resident, no reference is made to only appropriate staff having access to keys.</p> <p>Additionally, the current rule implies a modification can be made based on a certification from a physician or mental health provider that a recipient has a cognitive impairment that could pose danger to self or others if given the opportunity to lock the door.</p>	<p>non-compliant language from 455 IAC 3 will be omitted in any merged language.</p>	<p>period – February 2017</p> <p>455 IAC 2.1 goes into effect – November 2017</p> <p>455 IAC 3 repealed – November 2017</p>
<p>Current ISDH Health Facilities Rule 410 IAC 16.2-5-1.2</p>	<p>Silent</p> <p>Current rule does not reference lockable doors in provider owned or controlled residential settings.</p>	<p>410 IAC 16 contains licensing requirements for residential care facility (RCF); currently Medicaid waiver assisted living providers are required to be licensed as an RCF.</p> <p>DA will establish an MOU with ISDH to waive certain provisions of the RCF license for Medicaid waiver providers and/or participants as permitted by IC 16-28-1-10.</p> <p>DA will design, submit to CMS, and upon approval, implement a new Medicaid HCBS program. This program will include a congregate, residential option for consumers. It may or may not be called assisted living. DA will work with stakeholders and obtain technical assistance to evaluate the appropriate vehicle for this new program, possibly a Community First Choice or 1915(i) state plan service. DA will also engage with stakeholders to redefine the service definitions and requirements for the new program. A residential care facility license will not be required to participate in the new program. Standards will be developed to support a new certification system for these providers that will be administered through DA and not ISDH.</p>	<p>MOU between ISDH and FSSA/DA – February 2017</p> <p>New HCBS program submitted to CMS – January 2018</p> <p>Start of new HCBS program – July 2018</p>
<p>DA Medicaid Waiver Provider Reference Module</p>	<p>Silent</p> <p>Current manual, i.e. reference module, does not reference lockable doors in provider owned or controlled residential settings.</p>	<p>DA will add additional language to specify required characteristics of HCBS settings to include that, in provider-owned or controlled residential settings, units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.</p> <p>Waiver services must comply with HCBS Settings Rule. Requirements to be addressed primarily in 455 IAC 2.1 revisions.</p> <p>Reference Module to be updated to reflect any changes made to HCBS waiver services or programs when they occur.</p>	<p>Reference Module reviewed for inclusion of HCBS settings language – November 2016 and May 2017</p> <p>Reference Module updated to</p>

		Reference Module will be reviewed for inclusion of language supporting HCBS settings requirements during semi-annual updates.	reflect any changes to waiver services or programs - ongoing
Housing with Services IC 12-10-15 IC 12-10-15-9	Silent Statute does not reference lockable doors in provider owned or controlled residential settings.	Additions to the new rule 455 IAC 2.1 will draw authority from IC 12-10-15 when referencing services, like assisted living, provided in housing with services establishments.	455 IAC 2.1 public comment period – February 2017 455 IAC 2.1 goes into effect – November 2017

Federal Requirement: In provider-owned or controlled residential settings individuals sharing units have a choice of roommates.

Applicable Indiana Regulation	Compliance with HCBS Settings Final Rule:	Remediation Activity	Timeline
Current DA Provider Rule 455 IAC 2	Silent Current rule does not reference choice of roommate’s provider owned or controlled residential settings.	455 IAC 2 is already open for review; language to be added includes: 455 IAC 2.1-3-27 "Home and community-based services" or "HCBS" means supportive services provided in the home or a community setting that meets the requirements of 42 CFR 441.301.” In 455 IAC 2.1, DA will add additional language to specify required characteristics of HCBS settings to include that, in provider-owned or controlled residential settings individuals sharing units have a choice of roommates. 455 IAC 2.1-6-6(b)(3) The assisted living facility must assure that the individual has the ability to choose whether to have a roommate and a choice of roommates, if desired.	455 IAC 2.1 public comment period – February 2017 455 IAC 2.1 goes into effect – November 2017
Current DA AL Rule 455 IAC 3 455 IAC 3-1-5 (e) “Residential units provided to recipients must be single units unless the recipient chooses to live in dual-occupied unit and the recipient and other occupant consent to the arrangement.”	Partially complies Reference to “consent” is not equivalent to choice in roommates.	455 IAC 3 will be rolled into the updated 455 IAC 2 which will be entitled 455 IAC 2.1	455 IAC 2.1 public comment period – February 2017 455 IAC 2.1 goes into effect – November 2017 455 IAC 3 repealed –

<p>Current ISDH Health Facilities Rule 410 IAC 16.2-5-1.2 410 IAC 16.2-5-1.2(m) “The facility must promptly notify the resident and, if known, the resident’s legal representative when there is a change in roommate assignment.” 410 IAC 16.2-5-1.2(q) Residents have the right to appropriate housing assignments as follows: (1) when both husband and wife are residents in the facility, they have the right to live as a family in a suitable room or quarters and may occupy a double bed unless contradicted for medical reasons by the attending physician. (2) Written facility policy and procedures shall address the circumstances in which persons of the opposite sex, other than husband and wife, will be allow to occupy a bedroom, if such an arrangement is agreeable to the residents or the residents’ legal representatives.</p>	<p>Does not comply</p> <p>Reference to “roommate assignment” is in direct conflict with choice of roommates.</p>	<p>410 IAC 16 contains licensing requirements for residential care facility (RCF); currently Medicaid waiver assisted living providers are required to be licensed as an RCF.</p> <p>DA will establish an MOU with ISDH to waive certain provisions of the RCF license for Medicaid waiver providers and/or participants as permitted by IC 16-28-1-10.</p> <p>DA will design, submit to CMS, and upon approval, implement a new Medicaid HCBS program. This program will include a congregate, residential option for consumers. It may or may not be called assisted living. DA will work with stakeholders and obtain technical assistance to evaluate the appropriate vehicle for this new program, possibly a Community First Choice or 1915(i) state plan service. DA will also engage with stakeholders to redefine the service definitions and requirements for the new program. A residential care facility license will not be required to participate in the new program. Standards will be developed to support a new certification system for these providers that will be administered through DA and not ISDH.</p>	<p>November 2017</p> <p>MOU between ISDH and FSSA/DA – February 2017</p> <p>New HCBS program submitted to CMS – January 2018</p> <p>Start of new HCBS program – July 2018</p>
<p>DA Medicaid Waiver Provider Reference Module</p>	<p>Silent</p> <p>Current rule does not reference choice of roommate’s provider owned or controlled residential settings.</p>	<p>DA will add additional language to specify required characteristics of HCBS settings to include that, in provider-owned or controlled residential settings individuals sharing units have a choice of roommates.</p> <p>Waiver services must comply with HCBS Settings Rule. Requirements to be addressed primarily in 455 IAC 2.1 revisions.</p> <p>Reference Module to be updated to reflect any changes made to HCBS waiver services or programs when they occur.</p> <p>Reference Module will be reviewed for inclusion of language supporting HCBS settings requirements during semi-annual updates.</p>	<p>Reference Module reviewed for inclusion of HCBS settings language – November 2016 and May 2017</p> <p>Reference Module updated to reflect any changes to waiver services or programs - ongoing</p>
<p>Housing with Services IC 12-10-15</p>	<p>Silent</p> <p>Current rule does not reference choice of roommate’s provider owned or controlled residential settings.</p>	<p>Additions to the new rule 455 IAC 2.1 will draw authority from IC 12-10-15 when referencing services, like assisted living, provided in housing with services establishments.</p>	<p>455 IAC 2.1 public comment period – February 2017</p> <p>455 IAC 2.1 goes into effect –</p>

			November 2017
Federal Requirement: In provider-owned or controlled residential settings, individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.			
Applicable Indiana Regulation	Compliance with HCBS Settings Final Rule:	Remediation Activity	Timeline
Current DA Provider Rule 455 IAC 2	<p>Silent</p> <p>Current rule does not reference the freedom to furnish and decorate their sleeping or living units in provider owned or controlled residential settings.</p>	<p>455 IAC 2 is already open for review; language to be added includes: 455 IAC 2.1-3-27 "Home and community-based services" or "HCBS" means supportive services provided in the home or a community setting that meets the requirements of 42 CFR 441.301."</p> <p>In 455 IAC 2.1, DA will add additional language to specify required characteristics of HCBS settings to include that, in provider-owned or controlled residential settings, individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.</p> <p>455 IAC 2.1-6-5 (d) (6) The adult family care provider must assure that participants have the ability to decorate or furnish their rooms as they choose. 455 IAC 2.1-6-6 (b) (7) The assisted living facility must assure that participants have the ability to decorate or furnish their rooms as they choose.</p>	<p>455 IAC 2.1 public comment period – February 2017</p> <p>455 IAC 2.1 goes into effect – November 2017</p>
<p>Current DA AL Rule 455 IAC 3</p> <p>(18) "Homelike" means 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, which promotes the dignity, security, and comfort of recipients through the provision of personalized care and services to encourage independence, choice, and decision making by the recipients. A homelike environment also provides recipients with an opportunity for self-expression and encourages interaction with the community, family, and friends.</p> <p>455 IAC 3-1-8 (b)(4) "A provider shall: (4) Provide a safe, clean, and comfortable homelike environment allowing recipients to use their personal belongings to the extent possible."</p>	<p>Fully complies</p>	<p>455 IAC 3 will be rolled into the updated 455 IAC 2 which will be entitled 455 IAC 2.1</p>	<p>455 IAC 2.1 public comment period – February 2017</p> <p>455 IAC 2.1 goes into effect – November 2017</p> <p>455 IAC 3 repealed – November 2017</p>
Current ISDH Health Facilities Rule 410 IAC 16.2-5-1.2	<p>Partially complies</p>	<p>410 IAC 16 contains licensing requirements for residential care facility (RCF); currently</p>	<p>MOU between ISDH and</p>

<p>410 IAC 16.2-5-1.2(gg) “Residents have the right to individual expression through retention of personal clothing and belongs as space permits unless to do so would infringe upon the rights of others or would create a health or safety hazard.”</p>	<p>The reference to the use of personal belongings does not go far enough to meet this requirement regarding the ability to decorate and furnish units.</p>	<p>Medicaid waiver assisted living providers are required to be licensed as an RCF.</p> <p>DA will establish an MOU with ISDH to waive certain provisions of the RCF license for Medicaid waiver providers and/or participants as permitted by IC 16-28-1-10.</p> <p>DA will design, submit to CMS, and upon approval, implement a new Medicaid HCBS program. This program will include a congregate, residential option for consumers. It may or may not be called assisted living. DA will work with stakeholders and obtain technical assistance to evaluate the appropriate vehicle for this new program, possibly a Community First Choice or 1915(i) state plan service. DA will also engage with stakeholders to redefine the service definitions and requirements for the new program. A residential care facility license will not be required to participate in the new program. Standards will be developed to support a new certification system for these providers that will be administered through DA and not ISDH.</p>	<p>FSSA/DA – February 2017</p> <p>New HCBS program submitted to CMS – January 2018</p> <p>Start of new HCBS program – July 2018</p>
<p>DA Medicaid Waiver Provider Reference Module</p>	<p>Silent</p> <p>Current rule does not reference choice of roommate’s provider owned or controlled residential settings.</p>	<p>DA will add additional language to specify required characteristics of HCBS settings to include that, in provider-owned or controlled residential settings, individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.</p> <p>Waiver services must comply with HCBS Settings Rule. Requirements to be addressed primarily in 455 IAC 2.1 revisions.</p> <p>Reference Module to be updated to reflect any changes made to HCBS waiver services or programs when they occur.</p> <p>Reference Module will be reviewed for inclusion of language supporting HCBS settings requirements during semi-annual updates.</p>	<p>Reference Module reviewed for inclusion of HCBS settings language – November 2016 and May 2017</p> <p>Reference Module updated to reflect any changes to waiver services or programs - ongoing</p>
<p>Housing with Services IC 12-10-15</p>	<p>Silent</p> <p>Statue does not reference choice of roommate’s provider owned or controlled residential settings.</p>	<p>Additions to the new rule 455 IAC 2.1 will draw authority from IC 12-10-15 when referencing services, like assisted living, provided in housing with services establishments.</p>	<p>455 IAC 2.1 public comment period – February 2017</p> <p>455 IAC 2.1 goes into effect – November 2017</p>

Federal Requirement: In provider-owned or controlled residential and non-residential settings, individuals have the freedom and support to control their schedules and activities, and have access to food any time.			
Applicable Indiana Regulation	Compliance with HCBS Settings Final Rule:	Remediation Activity	Timeline
Current DA Provider Rule 455 IAC 2	Silent The current rule does not reference control of schedule or access to food in provider owned or controlled residential settings.	455 IAC 2 is already open for review; language to be added includes: 455 IAC 2.1-3-27 "Home and community-based services" or "HCBS" means supportive services provided in the home or a community setting that meets the requirements of 42 CFR 441.301." In 455 IAC 2.1, DA will add additional language to specify required characteristics of HCBS settings to include that, in provider-owned or controlled residential settings, individuals have the freedom and support to control their schedules and activities, and have access to food any time. 455 IAC 2.1-6-5 (d) (7) The adult family care provider must assure that participants have the ability to control their own schedule and to choose whether to participate in activities. 455 IAC 2.1-6-6 (b) (8) The assisted living facility must assure that participants have the ability to control their own schedule and to choose whether to participate in activities. 455 IAC 2.1-6-5 (d) (5) The adult family care provider must assure that participants have the ability has access to food at all times. 455 IAC 2.1-6-6 (b) (6) The assisted living facility must assure that participants have the ability to have access to food at all times.	455 IAC 2.1 public comment period – February 2017 455 IAC 2.1 goes into effect – November 2017
Current DA AL Rule 455 IAC 3 455 IAC 3-1-8 (b)(1)-(3) “A provider shall: (1) promote the ability of recipients to have control over their time, space, and lifestyle to the extent that the health, safety, and well-being of other recipients is not disturbed; (2) promote the recipient's right to exercise decision making and self-determination to the fullest extent possible; 455 IAC 3-1-5 (4) A kitchenette that contains: (A) a refrigerator; (B) a food preparation area; and (C) a microwave. and (5) Access to a stovetop/oven for hot food preparation in the common area.	Partially complies There is a reference to control in terms of schedule but there is no reference to access to food specifically through the rule does require the presence of food storage and food preparation capability in the units.	455 IAC 3 will be rolled into the updated 455 IAC 2 which will be entitled 455 IAC 2.1	455 IAC 2.1 public comment period – February 2017 455 IAC 2.1 goes into effect – November 2017 455 IAC 3 repealed – November 2017
Current ISDH Health Facilities Rule 410 IAC 16.2-5-1.2	Partially complies	410 IAC 16 contains licensing requirements for residential care facility (RCF); currently	MOU between

<p>410 IAC 16.2-5-1.2 (u) The resident has the right to the following: (1) Choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care. (2) Interact with members of the community both inside and outside the facility.</p> <p>(ff) “Residents have right to participate in social, religious, community services, and other living activities of their choice that do not interfere with the rights of other residents at the facility.”</p> <p>410 IAC 16.2-5-5.1 (a) The facility shall provide, arrange, or make available three (3) well-planned meals a day, seven (7) days a week that provide a balanced distribution of the daily nutritional requirements. (b) The menu or substitutions, or both, for all meals shall be approved by a registered dietician. (c) The facility must meet: (1) daily dietary requirements and requests, with consideration of food allergies; (2) reasonable religious, ethnic, and personal preferences; and (3) the temporary need for meals delivered to the resident's room.</p> <p>410 IAC 16.2-5-1.6 (l) The facility shall have a nourishment station for supplemental food service separate from the resident's unit.</p>	<p>Language supports control of schedule and activities. Language also provides for provision of food but access is not control by the individual.</p>	<p>Medicaid waiver assisted living providers are required to be licensed as an RCF.</p> <p>DA will establish an MOU with ISDH to waive certain provisions of the RCF license for Medicaid waiver providers and/or participants as permitted by IC 16-28-1-10.</p> <p>DA will design, submit to CMS, and upon approval, implement a new Medicaid HCBS program. This program will include a congregate, residential option for consumers. It may or may not be called assisted living. DA will work with stakeholders and obtain technical assistance to evaluate the appropriate vehicle for this new program, possibly a Community First Choice or 1915(i) state plan service. DA will also engage with stakeholders to redefine the service definitions and requirements for the new program. A residential care facility license will not be required to participate in the new program. Standards will be developed to support a new certification system for these providers that will be administered through DA and not ISDH.</p>	<p>ISDH and FSSA/DA – February 2017</p> <p>New HCBS program submitted to CMS – January 2018</p> <p>Start of new HCBS program – July 2018</p>
<p>DA Medicaid Waiver Provider Reference Module</p>	<p>Silent</p> <p>The manual, i.e. reference module, does not reference control of schedule or access to food in provider owned or controlled residential settings.</p>	<p>DA will add additional language to specify required characteristics of HCBS settings to include that, in provider-owned or controlled residential settings, individuals have the freedom and support to control their schedules and activities, and have access to food any time.</p> <p>Waiver services must comply with HCBS Settings Rule. Requirements to be addressed primarily in 455 IAC 2.1 revisions.</p> <p>Reference Module to be updated to reflect any changes made to HCBS waiver services or programs when they occur.</p> <p>Reference Module will be reviewed for inclusion of language supporting HCBS settings requirements during semi-annual updates.</p>	<p>Reference Module reviewed for inclusion of HCBS settings language – November 2016 and May 2017</p> <p>Reference Module updated to reflect any changes to waiver services or programs - ongoing</p>
<p>Housing with Services IC 12-10-15</p>	<p>Silent</p>	<p>Additions to the new rule 455 IAC 2.1 will draw authority from IC 12-10-15 when</p>	<p>455 IAC 2.1 public</p>

	Statute language does not reference control of schedule or access to food in provider owned or controlled residential settings.	referencing services, like assisted living, provided in housing with services establishments.	comment period – February 2017 455 IAC 2.1 goes into effect – November 2017
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Federal Requirement: In provider-owned or controlled residential and non-residential settings, individuals are able to have visitors of their choosing at any time.

Applicable Indiana Regulation	Compliance with HCBS Settings Final Rule:	Remediation Activity	Timeline
Current DA Provider Rule 455 IAC 2	Silent Current rule language does not reference ability to have visitors in provider owned or controlled residential settings.	455 IAC 2 is already open for review; language to be added includes: 455 IAC 2.1-3-27 "Home and community-based services" or "HCBS" means supportive services provided in the home or a community setting that meets the requirements of 42 CFR 441.301." In 455 IAC 2.1, DA will add additional language to specify required characteristics of HCBS settings to include that, in provider-owned or controlled residential settings, individuals are able to have visitors of their choosing at any time. 455 IAC 2.1-6-5 (d) (4) The adult family care provider must assure that participants have the ability to have guest when they choose. 455 IAC 2.1-6-6 (b) (5) The assisted living facility must assure that participants have the ability to have guests when they choose.	455 IAC 2.1 public comment period – February 2017 455 IAC 2.1 goes into effect – November 2017
Current DA AL Rule 455 IAC 3	Silent Current rule language does not reference ability to have visitors in provider owned or controlled residential settings.	455 IAC 3 will be rolled into the updated 455 IAC 2 which will be entitled 455 IAC 2.1	455 IAC 2.1 public comment period – February 2017 455 IAC 2.1 goes into effect – November 2017 455 IAC 3 repealed –

<p>Current ISDH Health Facilities Rule 410 IAC 16.2-5-1.2 410 IAC 16.2-5-1.2(f) “Residents have the right to be informed of any facility policy regarding overnight guests. The policy shall be clearly stated in the admission agreement.”</p> <p>410 IAC 16.2-5-1.2(bb) Residents have the right and the facility must provide immediate access to any resident by: (1) individuals representing state or federal agencies; (2) any authorized representative of the state; (3) the resident's individual physician; (4) the state and area long term care ombudsman; (5) the agency responsible for the protection and advocacy system for developmentally disabled individuals; (6) the agency responsible for the protection and advocacy system for mentally ill individuals; (7) immediate family or other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time; (8) the resident's legal representative or spiritual advisor subject to the resident's right to deny or withdraw consent at any time; and (9) others who are visiting with the consent of the resident subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time.</p> <p>410 IAC 16.2-5-1.2(cc) “Residents have the right to choose with whom they associate. The facility shall provide reasonable visiting hours, which should include at least twelve (12) hours a day, and the hours shall be made available to each resident. Policies shall also provide for emergency visitation at other hours. The facility shall not restrict visits from the resident's legal representative or spiritual advisor, except at the request of the resident.”</p>	<p>Does not comply</p> <p>Rule only requires a 12 hour a day visiting hours’ schedule.</p>	<p>410 IAC 16 contains licensing requirements for residential care facility (RCF); currently Medicaid waiver assisted living providers are required to be licensed as an RCF.</p> <p>DA will establish an MOU with ISDH to waive certain provisions of the RCF license for Medicaid waiver providers and/or participants as permitted by IC 16-28-1-10.</p> <p>DA will design, submit to CMS, and upon approval, implement a new Medicaid HCBS program. This program will include a congregate, residential option for consumers. It may or may not be called assisted living. DA will work with stakeholders and obtain technical assistance to evaluate the appropriate vehicle for this new program, possibly a Community First Choice or 1915(i) state plan service. DA will also engage with stakeholders to redefine the service definitions and requirements for the new program. A residential care facility license will not be required to participate in the new program. Standards will be developed to support a new certification system for these providers that will be administered through DA and not ISDH.</p>	<p>November 2017</p> <p>MOU between ISDH and FSSA/DA – February 2017</p> <p>New HCBS program submitted to CMS – January 2018</p> <p>Start of new HCBS program – July 2018</p>
<p>DA Medicaid Waiver Provider Reference Module</p>	<p>Silent</p> <p>Current rule language does not reference ability to have visitors in provider owned or controlled residential settings.</p>	<p>DA will add additional language to specify required characteristics of HCBS settings to include that, in provider-owned or controlled residential settings, individuals are able to have visitors of their choosing at any time.</p> <p>Waiver services must comply with HCBS Settings Rule. Requirements to be addressed primarily in 455 IAC 2.1 revisions.</p>	<p>Reference Module reviewed for inclusion of HCBS settings language – November</p>

		<p>Reference Module to be updated to reflect any changes made to HCBS waiver services or programs when they occur.</p> <p>Reference Module will be reviewed for inclusion of language supporting HCBS settings requirements during semi-annual updates.</p>	<p>2016 and May 2017</p> <p>Reference Module updated to reflect any changes to waiver services or programs - ongoing</p>
<p>Housing with Services IC 12-10-15 IC 12-10-15-9(c)(3) except to protect the rights and activities of other residents, the housing with services establishment may not restrict the ability of the resident to have visitors and to receive family members and guests;</p>	Fully complies	<p>Additions to the new rule 455 IAC 2.1 will draw authority from IC 12-10-15 when referencing services, like assisted living, provided in housing with services establishments.</p>	<p>455 IAC 2.1 public comment period – February 2017</p> <p>455 IAC 2.1 goes into effect – November 2017</p>

Federal Requirement: In provider-owned or controlled residential and non-residential settings, the setting is physically accessible to the individual.

Applicable Indiana Regulation	Compliance with HCBS Settings Final Rule:	Remediation Activity	Timeline
<p>Current DA Provider Rule 455 IAC 2</p>	<p>Silent</p> <p>No mention of accessibility requirements for provider owned settings.</p>	<p>455 IAC 2 is already open for review; language to be added includes: 455 IAC 2.1-3-27 "Home and community-based services" or "HCBS" means supportive services provided in the home or a community setting that meets the requirements of 42 CFR 441.301."</p> <p>In 455 IAC 2.1, DA will add additional language to specify required characteristics of HCBS settings to include that, in provider-owned or controlled residential settings, the setting is physically accessible to the individual.</p> <p>455 IAC 2.1-6-5 (d) (2) The adult family care provider must assure that participants have a room that is physically accessible to them.</p> <p>455 IAC 2.1-6-6 (b) (2) The assisted living facility must assure that participants have the ability to have a room that is physically accessible to them.</p>	<p>455 IAC 2.1 public comment period – February 2017</p> <p>455 IAC 2.1 goes into effect – November 2017</p>
<p>Current DA AL Rule 455 IAC 3</p>	<p>Silent</p> <p>No mention of accessibility requirements for provider owned settings.</p>	<p>455 IAC 3 will be rolled into the updated 455 IAC 2 which will be entitled 455 IAC 2.1</p>	<p>455 IAC 2.1 public comment period – February 2017</p>

			<p>455 IAC 2.1 goes into effect – November 2017</p> <p>455 IAC 3 repealed – November 2017</p>
<p>Current ISDH Health Facilities Rule 410 IAC 16.2-5-1.2 410 IAC 16.2-5-1.6(n) (1) Dining, lounge, and activity areas shall be: (A) readily accessible to wheelchair and ambulatory residents (4)...a restroom large enough to accommodate a wheelchair and equipped with grab bars located near the activity room shall be provided.</p>	<p>Partially complies</p> <p>Reference is made to accessibility in dining and activity areas but is not sufficient in meeting this requirement.</p>	<p>410 IAC 16 contains licensing requirements for residential care facility (RCF); currently Medicaid waiver assisted living providers are required to be licensed as an RCF.</p> <p>DA will establish an MOU with ISDH to waive certain provisions of the RCF license for Medicaid waiver providers and/or participants as permitted by IC 16-28-1-10.</p> <p>DA will design, submit to CMS, and upon approval, implement a new Medicaid HCBS program. This program will include a congregate, residential option for consumers. It may or may not be called assisted living. DA will work with stakeholders and obtain technical assistance to evaluate the appropriate vehicle for this new program, possibly a Community First Choice or 1915(i) state plan service. DA will also engage with stakeholders to redefine the service definitions and requirements for the new program. A residential care facility license will not be required to participate in the new program. Standards will be developed to support a new certification system for these providers that will be administered through DA and not ISDH.</p>	<p>MOU between ISDH and FSSA/DA – February 2017</p> <p>New HCBS program submitted to CMS – January 2018</p> <p>Start of new HCBS program – July 2018</p>
<p>DA Medicaid Waiver Provider Reference Module</p>	<p>Silent</p> <p>No mention of accessibility requirements for provider owned settings.</p>	<p>DA will add additional language to specify required characteristics of HCBS settings to include that, in provider-owned or controlled residential settings, the setting is physically accessible to the individual.</p> <p>Waiver services must comply with HCBS Settings Rule. Requirements to be addressed primarily in 455 IAC 2.1 revisions.</p> <p>Reference Module to be updated to reflect any changes made to HCBS waiver services or programs when they occur.</p> <p>Reference Module will be reviewed for inclusion of language supporting HCBS settings requirements during semi-annual updates.</p>	<p>Reference Module reviewed for inclusion of HCBS settings language – November 2016 and May 2017</p> <p>Reference Module updated to reflect any changes to waiver services or programs – ongoing</p>

<p>Housing with Services IC 12-10-15 IC 12-10-15-9</p>	<p>Silent</p> <p>No mention of accessibility requirements for provider owned settings.</p>	<p>Additions to the new rule 455 IAC 2.1 will draw authority from IC 12-10-15 when referencing services, like assisted living, provided in housing with services establishments.</p>	<p>455 IAC 2.1 public comment period – February 2017</p> <p>455 IAC 2.1 goes into effect – November 2017</p>
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Federal Requirement: Any modifications of the additional conditions for provider-owned and controlled residential settings must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:

1. Identify a specific and individualized need.
2. Document the positive interventions and supports used prior to any modifications to the person-centered plan.
3. Document less intrusive methods of meeting the need that have been tried but did not work.
4. Include a clear description of the condition that is directly proportionate to the specific need addressed.
5. Include regular collection and review of data to measure the ongoing effectiveness of the modification.
6. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
7. Include the informed consent of the individual.
8. Include an assurance that interventions and supports will cause no harm to the individual.

Applicable Indiana Regulation	Compliance with HCBS Settings Final Rule:	Remediation Activity	Timeline
<p>Current DA Provider Rule 455 IAC 2 455 IAC 2-17-1 A provider of case management services shall have the following information about an individual receiving case management services: (1) The needs and wants of an individual, including the following: (A) Health. (B) Welfare. (C) Wishes for self-directed care. (2) The array of services available to an individual whether the services are available under this article or are otherwise available.</p>	<p>Silent</p> <p>Does not address modifications to HCBS settings requirements that may be as part of the person centered planning process.</p>	<p>455 IAC 2 is already open for review; language to be added includes: 455 IAC 2.1-3-27 "Home and community-based services" or "HCBS" means supportive services provided in the home or a community setting that meets the requirements of 42 CFR 441.301."</p> <p>455 IAC 2.1-3-16(2) - Case Management defined – "Case management means a comprehensive service including, but not limited to, the following, assisting participants in the establishment of a person centered service plan."</p> <p>455 IAC 2.1-3-39 - Person centered service planning process defined: "Person centered service planning process has the meaning set forth in 42 CFR 441.301 (c) (1).</p> <p>455 IAC 2.1-3-40 - Person centered service plan defined as "Person centered service plan has the meaning set forth in 42 CFR 441.301(c) (2)."</p> <p>455 IAC 2.1-6-5(e) and 455 IAC 2.1-6-6(c)- Any modifications to the requirements must be supported by specific need and justified in the participant's person-centered service plan.</p>	<p>455 IAC 2.1 public comment period – February 2017</p> <p>455 IAC 2.1 goes into effect – November 2017</p>

		<p>455 IAC 2.1-7-2 (f) - For individuals with dementia related issues who require modifications to HCBS settings characteristic due to safety risks, the person centered service plan must document:</p> <ol style="list-style-type: none"> (1) The personal history of the individual with dementia; (2) The person’s current health condition and remaining abilities; (3) The conditions that trigger wandering or exit-seeking, their history and background; (4) Previously tried responses to wandering and exit-seeking that respond to the person’s unique circumstances; (5) The specific modification being agreed to by the individual and/or their legal guardian; (6) The time period agreed to for the modification to be in place before the next review of the individual’s circumstances; this cannot exceed 180 days. <p>DA will add additional language to specify that any modifications of the additional conditions for provider-owned and controlled residential settings must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:</p> <ol style="list-style-type: none"> 1. Identify a specific and individualized need. 2. Document the positive interventions and supports used prior to any modifications to the person-centered plan. 3. Document less intrusive methods of meeting the need that have been tried but did not work. 4. Include a clear description of the condition that is directly proportionate to the specific need addressed. 5. Include regular collection and review of data to measure the ongoing effectiveness of the modification. 6. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated. 7. Include the informed consent of the individual. 8. Include an assurance that interventions and supports will cause no harm to the individual. 	
<p>Current DA AL Rule 455 IAC 3 455 IAC 3-1-8(d) “The provider shall ensure the service plan: (1) includes recognition of the recipient's capabilities and choices and defines the division of responsibility in the implementation of services; (2) addresses, at a minimum, the following elements: (A) assessed health care needs; (B) social needs and preferences;</p>	<p>Silent</p> <p>Does not address modifications to HCBS settings requirements that may be as part of the person centered planning process.</p>	<p>455 IAC 3 will be rolled into the updated 455 IAC 2 which will be entitled 455 IAC 2.1</p>	<p>455 IAC 2.1 public comment period – February 2017</p> <p>455 IAC 2.1 goes into effect –</p>

<p>(C) personal care tasks; and (D) limited nursing and medication services, if applicable, including frequency of service and level of assistance; (3) is signed and approved by: (A) the recipient; (B) the provider; (C) the licensed nurse; (D) the case manager; and (4) Includes the date the plan was approved.”</p>			<p>November 2017 455 IAC 3 repealed – November 2017</p>
<p>Current ISDH Health Facilities Rule 410 IAC 16.2-5-1.2</p>	<p>Silent Does not address modifications to HCBS settings requirements that may be as part of the person centered planning process.</p>	<p>Not applicable – covered in 455 IAC 2.1</p>	<p>MOU between ISDH and FSSA/DA – February 2017 New HCBS program submitted to CMS – January 2018 Start of new HCBS program – July 2018</p>
<p>DA Medicaid Waiver Provider Reference Module Page 23 - Medicaid waiver case managers coordinate and integrate all services required in a participant’s person centered service plan, link participants to needed services, and ensure that participants continue to receive and benefit from services. Waiver case managers enable participants to receive a full range of services needed due to a medical condition in a planned, coordinated, efficient, effective manner. Page 26, 16. Case managers will ensure that person centered planning is occurring on an ongoing basis.... 18. Case managers will base the service plan upon the individual’s needs, strengths, and preferences.</p>	<p>Silent Does not address modifications to HCBS settings requirements that may be as part of the person centered planning process.</p>	<p>DA will add additional language to specify that any modifications of the additional conditions for provider-owned and controlled residential settings must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan: 1. Identify a specific and individualized need. 2. Document the positive interventions and supports used prior to any modifications to the person-centered plan. 3. Document less intrusive methods of meeting the need that have been tried but did not work. 4. Include a clear description of the condition that is directly proportionate to the specific need addressed. 5. Include regular collection and review of data to measure the ongoing effectiveness of the modification. 6. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated. 7. Include the informed consent of the individual. 8. Include an assurance that interventions and supports will cause no harm to the individual. Waiver services must comply with HCBS Settings Rule. Requirements to be addressed primarily in 455 IAC 2.1 revisions.</p>	<p>Reference Module reviewed for inclusion of HCBS settings language – November 2016 and May 2017 Reference Module updated to reflect any changes to waiver services or programs – ongoing</p>

		Reference Module to be updated to reflect any changes made to HCBS waiver services or programs when they occur. Reference Module will be reviewed for inclusion of language supporting HCBS settings requirements during semi-annual updates.	
Housing with Services IC 12-10-15	Silent Does not address modifications to HCBS settings requirements that may be as part of the person centered planning process.	Not applicable – covered in 455 IAC 2.1	455 IAC 2.1 public comment period – February 2017 455 IAC 2.1 goes into effect – November 2017

SECTION 3: SITE SPECIFIC ASSESSMENT

The DA’s site specific assessment process generally consists of a provider self-survey, desk review of policy and procedure, and site assessments of all provider sites with current waiver participants to validate survey results.

- The DA’s plan for site specific assessments started with provider self-surveys. DA distributed these to providers beginning in 2014 through spring of 2015. Participation was voluntary and return rates varied by service. More detail is provided in the service specific descriptions below. The intent of the self-survey process was to obtain a broad sense of where compliance issues existed in each type of setting. Between late 2015 and early 2016, DA utilized a contractor to request documentation from some service providers to conduct a broad policy and procedure review. Again, participation by providers was voluntary and the response rates varied. Once again the intention was to obtain a broad sense of the compliance issues and begin to validate the results of the self-survey process. Beginning in the spring of 2016, DA utilized a contractor to conduct site visits at 100% of its AFC, ADS, and AL sites with active waiver participants. In the spring of 2017, DA will check again for providers with active participants and complete site visits at that time if they did not have a 2016 site visit. For those that still do not have any waiver participants, they will be notified of the need to be re-certified given new requirements since their initial certification. Again, more details on this process are provided in each service specific section below.
- **Adult Family Care (A&D, TBI):** Residential services provided in a family-like setting; the AFC homes are approved to serve not more than four participants in a home-like setting in a residential community with a live-in caregiver. While the HCBS waiver service definition reflects the requirements set forth in the final rule, it lacks the specificity of the rule. A self-survey of AFC providers was conducted as an initial assessment to identify areas in need of remediation. There are currently 39 enrolled AFC homes. There are 49 current waiver consumers in 24 AFC sites. The remaining 15 homes have no current waiver consumers residing in them. The response rate for the self-survey was 38%. The self-survey indicates that at least 73% of AFC homes will need to implement changes to address the standards:
 - The individual can have visitors at any time;
 - The individual controls his/her own schedule including access to food at any time;
 - The setting is integrated in and supports full access to the greater community;
 - The individual has choice of roommates; and
 - Results also indicate that approximately 64% of providers use a lease or residency agreement, but it has not been determined if these are legally enforceable.

Surveys of 23 sites with active waiver participants were completed between February 2016 and June 2016. One additional site now has an active participant and will have a site survey completed in the spring of 2017. The site surveys confirmed the issues identified in the self-survey process. The most common areas of non-compliance include:

- Freedom and support to control own schedule and activities.
 - Participants are able to participate in activities of their choice in the community alone.
- Ability to have visitors of choosing at any time
- Optimizes individual initiative, autonomy, and independence in making life choices.
 - Medications maintained and distributed in a way that promotes individual control and privacy.
- Units have locking doors; with only appropriate staff having keys/privacy in sleeping or living unit
- Setting is physically accessible to the individual - entrances, common areas, and dining rooms in the setting handicap accessible.

There may also be issues with lease agreements but additional document review will be necessary at each site.

The site surveys did not include any formal participant interviews. The surveyor may have spoken to several participants at each site informally but no specific questions were asked or answers recorded. Since all sites were found to need some measure of remediation, participant interviews will be conducted as part of the validation process once remediation is completed. For AFC settings, all participants at the site will receive a short interview. The questions asked will be focused on the areas that required remediation. Interviews will be conducted by phone or in person by DA staff or contractor staff.

By January 2017, DA will develop a remediation plan template for providers. In December of 2016, DA held a provider training and reviewed compliance criteria for HCBS settings and possible remediation strategies. Providers will receive a copy of their site survey as well as a letter outlining areas of non-compliance. These notifications will be sent out in January 2017. Provider remediation plans will be due back to DA in March 2017. DA will then review these plans, request changes as needed, and then compile a master calendar for remediation activities. DA will monitor, follow up with providers on their progress, and then complete a site visit to validate the completion of the plan. Providers who choose not to submit a remediation plan will not be permitted to accept any new participants. Current participants served in these locations will be assisted with the transition process according to their preferences. These providers and any others unable or unwilling to remediate areas of non-compliance will be decertified by March 2019. Participants in those sites will be transitioned to a fully compliant site or transition off the waiver if this is their choice by December of 2018.

Providers that do not have current waiver participants and who therefore did not have a site survey completed in the spring of 2016, will receive notice in April 2017 that requirements have changed for participation in the waiver program. They will be able to reapply for re-certification at that time if they chose to do so. Site visits will be used to validate compliance before these sites are re-certified. As these notices are prepared, DA will complete a check for any sites that may have active participants then that did not in the spring of 2016. If such sites are identified, a site visit will be completed so that any necessary remediation activities can be identified.

There are no regulatory barriers to remediation. Language in regulations is largely silent or partially compliant in reference to AFC. Language will be enhanced or added to assure that all settings are required to be fully compliant with the HCBS settings requirements. Providers will be notified of the issues identified at each site. The DA will provide technical assistance to those providers who wish to remediate. For those providers that do not wish to remediate, the DA will work with case managers to provide person centered service planning and support to each individual to transition them into compliant HCBS settings as they may choose. At this time, the DA believes all providers will participate in remediation and no individual transitions will be needed. No AFC sites are co-located with nursing facilities.

- **Assisted Living (A&D, TBI):** Residential services offering an increased level of support in a home or apartment-like setting.

Assisted Living (AL) facilities are, by nature, somewhat isolating as they provide a full range of services within a facility. DA fully supports the concept of “aging in place” for elderly individuals who choose to receive services conveniently or in a residence which allows them to remain close to a loved one in a nearby nursing facility. The

majority of Indiana's assisted living sites are co-located with nursing facilities. The physical arrangement varies from being completely under the same roof to sharing common areas, sharing a parking lot, sharing a breezeway, etc.

There are currently 90 enrolled Assisted Living (AL) providers. There are 2,286 current waiver participants in those 90 assisted living sites. 40% of the enrolled AL providers have 10 or fewer waiver participants. The self-surveys completed by AL providers in the fall of 2014 indicated a high percentage of compliance with isolated incidents of remediation needed to achieve the following standards:

- The individual controls his/her own schedule including access to food at any time
- The individual has privacy in their unit including lockable doors
- The individual has choice of roommates
- The individual has a lease or other legally enforceable agreement providing similar protections
- The setting is integrated in and supports full access to the greater community
- The setting ensures individual rights of privacy, dignity and respect, and freedom from coercion and restraint
- The individual can have visitors at any time

Documentation review of AL providers was completed in February 2016 with 56% of providers responding to the request for documentation, including policies, procedures, handbooks, staff training schedules, lease agreement templates, participant rights documents, etc. Documentation review and site surveys completed between February 2016 and June 2016 indicated more widespread lack of compliance in several key areas. These areas included:

- Freedom and support to control own schedule and activities.
 - Participants are able to freely move about inside and outside the site.
 - Participants are able to participate in activities of their choice in the community alone.
- Privacy in sleeping or living unit
 - Staff and/or other participants knock on each other's doors or ask for permission before entering participants' rooms.
 - Lockable bathrooms
- Ability to have visitors of choosing at any time – with appropriate privacy considerations.
- Access to food at any time – flexibility in meal times.
- Is the site free from gates, locked doors, or other barriers preventing individuals' entrance to and exit from all areas of the setting?
- Optimizes individual initiative, autonomy, and independent in making life choices.
 - Medications are maintained and distributed in a way that promotes individual control and privacy.
 - Participants are able to dine alone or in a private area.
 - Participants have easy access to have private communications with people outside the site by telephone, e-mail, and/or mail.
- Units have locking doors; with only appropriate staff having keys.

In total, 84 Assisted Living locations were surveyed as part of the site assessments. Following the visits, it was determined that:

1. 30 Assisted Living sites are co-located with a nursing facility but they did not house a secure memory care.
2. 15 Assisted Living sites are both co-located and have a secure memory care.
3. 12 Assisted Living sites were not co-located but do have a secure memory care.
4. 24 sites were not co-located and did not have a secure memory care.
5. All 84 sites (plus 6 that only one or two consumers plan to stop participating and so were not surveyed) are licensed as residential care facilities. The six sites that were not surveyed will formally indicate their intention to withdraw in early 2017. Meanwhile they are not taking on any new participants.

The site surveys did not include any formal participant interviews. The surveyor may have spoken to several participants at each site informally but no specific questions were asked or answers recorded. Since all sites were found to need some measure of remediation, participant interviews will be conducted as part of the validation process once remediation is completed. For AL settings, 10% of the site's participants, or 10 individuals whichever is greater, will receive a short interview. The questions asked will be focused on the areas that required remediation.

Interviews will be conducted by phone or in person by DA staff or contractor staff. More extensive interviews will be completed as part of any heightened scrutiny reviews.

Providers that do not have current waiver participants and who therefore did not have a site survey completed in the spring of 2016, will receive notice in April 2017 that requirements have changed for participation in the waiver program. They will be able to reapply for re-certification at that time if they chose to do so. Site visits will be used to validate compliance before these sites are re-certified. As these notices are prepared, DA will complete a check for any sites that may have active participants then that did not in the spring of 2016. If such sites are identified, a site visit will be completed so that any necessary remediation activities can be identified.

In February 2016, a comprehensive crosswalk was completed comparing the CMS Final Rule HCBS setting requirements to both current and proposed DA and Indiana State Department of Health (ISDH) regulations. This crosswalk focused on the services that had been identified as having possible compliance issues: assisted living, adult day service, adult family care, and structured day programs. The results of this comparison mapped out areas where regulations could include more specific provisions to ensure that sites are compliant with the HCBS requirements. Changes will be made in conjunction with stakeholder groups before the rule is put out for formal public comment.

The ISDH regulations are significant in regards to the Medicaid HCBS service of assisted living. It should be noted though that ISDH does not have licensure or regulations specific to the service of assisted living. ISDH regulations do not actually define or regulate “assisted living”. Currently both the A&D and TBI waivers require providers of the service of assisted living to be licensed by ISDH. These providers are therefore licensed as what ISDH rules refer to as residential care facilities. The residential care facility regulations clearly force providers towards institutional characteristics. Even the language used, residents, discharge, admission, etc. all speak to an institutional model. Removing the licensure requirement will not in and of itself make these settings home and community-based. However, it can remove substantial barriers that the regulations create for HCBS providers. A drawback to this option is the need to create a new oversight and monitoring structure in the absence of licensure. Most of the “assisted living” market in Indiana is private pay. According to our best data, Medicaid waiver accounts for about 10% of the licensed residential care capacity in the state. To impact this private pay market with large scale changes to the residential care licensure does not seem appropriate. A provider workgroup has been considering changes to the licensure but DA does not find that those proposed changes go far enough. Furthermore, DA has had extensive discussion with ISDH and they agree that it would not be appropriate to make changes to the residential care licensure driven by the Medicaid requirements for HCBS settings.

DA will be taking a two tiered approach to resolving this conflict. First, there will be an approximately six-month hiatus on new AL provider enrollment beginning in September 2016. During this time DA will enter into a memorandum of understanding (MOU) with ISDH to waive certain provisions of the residential licensure requirements for those providers participating in the Medicaid waiver program. This waiver is allowed under IC 16-28-1-10. DA will work with ISDH and providers to draft this MOU to address all areas identified as non-compliant in the systemic assessment. Additionally, DA staff will undergo training to be prepared to appropriately review and certify new AL providers after the hiatus is over. During this time, DA will conduct webinars for providers exploring each HCBS characteristic and what indicators need to be present as evidence of compliance. This process will address areas of partial compliance in IC 16-28-1-10. The certification process will be developed to include the following language:

- Settings must be integrated in and support full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
- Setting must be selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.
- Setting must ensure an individual's rights of privacy, dignity, respect, and freedom from coercion and restraint.
- Setting must optimize, but not regiment, individual initiative, autonomy, and independence in making life choices including but not limited to, daily activities, physical environment, and with whom to interact.

- Setting must facilitate individual choice regarding services and supports, and who provides them.
- Setting must be a specific physical place that is owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has the same responsibilities and protections from eviction as all tenants under landlord/tenant law of the State, county, city or other designated entity. In settings where tenant laws do not apply, a lease, residency agreement or other written agreement is in place providing protections to address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.
- Each individual must have privacy in their sleeping or living unit.
- Units must have entrance doors lockable by the individual, with only appropriate staff having keys to doors.
- Individuals sharing units must have a choice of roommates.
- Individuals must have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
- Individuals must have the freedom and support to control their schedules and activities, and have access to food any time.
- Individuals must be able to have visitors of their choosing at any time.
- The setting must be physically accessible to the individual.
- Any modifications of the requirements (other than physical accessibility which cannot be modified) must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:
 - Identify a specific and individualized need.
 - Document the positive interventions and supports used prior to any modifications to the person-centered plan.
 - Document less intrusive methods of meeting the need that have been tried but did not work.
 - Include a clear description of the condition that is directly proportionate to the specific need addressed.
 - Include regular collection and review of data to measure the ongoing effectiveness of the modification.
 - Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
 - Include the informed consent of the individual.
 - Include an assurance that interventions and supports will cause no harm to the individual.

This will allow existing licensed residential care facilities certified as waiver AL providers to continue participating in the current waiver programs, assuming they do meet all of the HCBS characteristics and pass heightened scrutiny review if they are presumed institutional. This will represent a minimally compliant tier 1 standard.

In the fall of 2016, a workgroup was established consisting of varied representatives of the provider community as well as other advocates and stakeholders. This workgroup will continue to collaborate with the DA to work on compliance evaluation criteria as well as the ISDH MOU. DA will develop a remediation plan template for providers. In December of 2016, DA held a provider training and reviewed compliance criteria for HCBS settings and possible remediation strategies. Providers, not presumed institutional, will then receive a copy of their site survey as well as a letter outlining areas of non-compliance. These notifications will be sent out in January 2017. Provider remediation plans will be due back to DA in March 2017. DA will then review these plans, request changes as needed, and then compile a master calendar for remediation activities. DA will monitor, follow up with providers on their progress, and then complete a site visit to validate the completion of the plan. Providers who choose not to submit a remediation plan will not be permitted to accept any new participants. Current participants served in these locations will be assisted with the transition process according to their preferences. These providers and any others unable or unwilling to remediate areas of non-compliance will be decertified by March 2019.

For tier 2, DA will design, submit to CMS, and upon approval, implement a new Medicaid HCBS program. This program will include a congregate, residential option for consumers. It may or may not be called assisted living. DA will work with stakeholders and obtain technical assistance to evaluate the appropriate vehicle for this new program, possibly a Community First Choice or 1915(i) state plan service. DA will also engage with stakeholders through the workgroup referenced above to redefine the service definitions and requirements for the new program. A residential

care facility license will not be required to participate in the new program. Standards will be developed to support a new certification system for these providers that will be administered through DA and not ISDH. These standards will be based on HCBS characteristics, Money Follows the Person qualified community setting guidelines, and state statute regarding housing with services establishments. Administrative rules will be amended to reflect these standards. Specific waiver, manual, and administrative code language for this new services will include the following requirements:

- Settings must be integrated in and support full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
- Setting must be selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.
- Setting must ensure an individual's rights of privacy, dignity, respect, and freedom from coercion and restraint.
- Setting must optimize, but not regiment, individual initiative, autonomy, and independence in making life choices including but not limited to, daily activities, physical environment, and with whom to interact.
- Setting must facilitate individual choice regarding services and supports, and who provides them.
- Setting must be a specific physical place that is owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has the same responsibilities and protections from eviction as all tenants under landlord/tenant law of the State, county, city or other designated entity. In settings where tenant laws do not apply, a lease, residency agreement or other written agreement is in place providing protections to address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.
- Each individual must have privacy in their sleeping or living unit.
- Units must have entrance doors lockable by the individual, with only appropriate staff having keys to doors.
- Individuals sharing units must have a choice of roommates.
- Individuals must have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
- Individuals must have the freedom and support to control their schedules and activities, and have access to food any time.
- Individuals must be able to have visitors of their choosing at any time.
- The setting must be physically accessible to the individual.
- Any modifications of the requirements (other than physical accessibility which cannot be modified) must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:
 - Identify a specific and individualized need.
 - Document the positive interventions and supports used prior to any modifications to the person-centered plan.
 - Document less intrusive methods of meeting the need that have been tried but did not work.
 - Include a clear description of the condition that is directly proportionate to the specific need addressed.
 - Include regular collection and review of data to measure the ongoing effectiveness of the modification.
 - Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
 - Include the informed consent of the individual.
 - Include an assurance that interventions and supports will cause no harm to the individual.

Additionally, rate methodology will be reassessed to align with the new service definition and assure that rates are sufficient to build provider capacity. DA hopes to implement this program no later than July 2018. Upon successful implementation, qualified providers and consumers in the current (c) waivers will be migrated to the new program.

- **Adult Day Services (A&D, TBI):** Activities provided in a group setting, outside the home; in February of 2015, a self-survey was requested of ADS providers to determine the level of compliance with the HCBS rule. There was a 75% response rate to the self-survey. The results of that self-survey of ADS providers indicates a high percentage of compliance with isolated incidents of remediation needed to achieve the following standards:
 - The individual can have visitors at any time
 - The individual can have privacy when desired, for instance to take a phone call
 - The individual receives activities of daily living (ADL) assistance and other care in areas of the center than allow them appropriate privacy
 - The individual's service plan is not posted in a public area
 - The individual has a secure place in which to store personal items
 - There are no physical barriers which prevent mobility-impaired individuals from accessing restrooms, appliances or other program areas which other participants can access
 - Settings are not restricted to individuals of one specific diagnosis or to a specific age group
 - Service plans are developed individually, taking into account personal preferences for activities and individualized schedules and routines
 - The individual is able to access food at times of their choosing
 - The individual is provided opportunities for activities outside the service site to allow interaction with the general community

Current service standards require the service be "...community-based group programs designed to meet the needs of adults with impairments through individual service plans."

Current waiver requirements forbid any use of individual restraint but do not extend this definition to include the restriction of facilities which may have secured perimeters or delayed egress systems. A significant percentage of ADS sites do have secured perimeters that in many cases prevent the ability of participants to leave the building. This will require remediation strategies as described below as well as person centered planning practices to identify individuals who have require such a safety measure as part of their service plan.

There are currently 43 enrolled ADS providers. There are 601 current waiver consumers receiving services in these 39 of these settings. The assessment and remediation strategies delineated below will be implemented to identify and correct deficiencies.

Documentation review of ADS providers was completed in February 2016 with 62% of providers responding to the request for documentation, including policies, procedures, handbooks, staff training schedules, lease agreement templates, client rights documents, etc. Some documents were reviewed as part of the site surveys. Any missing elements will be reviewed as part of the review to validate the site's eventual remediation.

Site visits were conducted at 37 of these sites serving current participants. Two sites that did not have active participants at the time of the site visits. These site visits will be completed in the spring of 2017. The site surveys confirmed the issues identified in the self-survey process. There are 3 sites that are co-located with nursing facilities. The DA will conduct a heightened scrutiny review of these sites including public comment and only submit to CMS for consideration as an HCBS site if they are found to have no institutional qualities and they fully comply with the HCBS requirements. The most common areas of non-compliance are:

- Freedom and support to control own schedule and activities.
 - Are participants able to freely move about inside and outside the site?
 - Are participants able to participate in activities of their choice in the community alone?
- Setting is physically accessible to the individual - entrances, common areas, and dining rooms in the setting handicap accessible.
- Optimizes individual initiative, autonomy, and independent in making life choices.
 - Medications maintained and distributed in a way that promotes individual control and privacy.
 - Presence of gates, locked doors, or other barriers preventing individuals' from freely coming and going.
- Access to food at any time - flexibility in meal times.

For the remaining sites, there are no regulatory barriers to remediation. Language in regulations is largely silent or partially compliant in reference to ADS. Language will be enhanced or added to assure that all settings are required to be fully compliant with the HCBS settings requirements. Providers will be notified of the issues identified at each site. The DA will provide technical assistance to those providers who wish to remediate. For those providers that do not wish to remediate, the DA will work with case managers to provide person centered service planning and support to each individual to transition them into compliant HCBS settings as they may choose. With ADS, the site is not the residence of the individual. So, the transition process would be less complicated. Part of the transition planning must include efforts to recruit more providers in order to fully cover the state and offer choice to consumers. At this time though, the DA believes all providers will participate in remediation, excluding the three sites that are co-located, and no individual transitions will be needed.

Some ADS sites do have secure perimeters, but the DA believes these can be modified to allow participants to come and go freely and only restrict those for whom a person centered planning process has identified an appropriate modification be made (such as to address safety issues caused by a documented issue with wandering due to dementia).

The site surveys did not include any formal participant interviews. The surveyor may have spoken to several participants at each site informally but no specific questions were asked or answers recorded. Since all sites were found to need some measure of remediation, participant interviews will be conducted as part of the validation process once remediation is completed. For ADS settings, 10% of the site's participants, or 10 individuals whichever is greater, will receive a short interview. The questions asked will be focused on the areas that required remediation. Interviews will be conducted by phone or in person by DA staff or contractor staff. More extensive interviews will be completed as part of any heightened scrutiny reviews.

Providers that do not have current waiver participants and who therefore did not have a site survey completed in the spring of 2016, will receive notice in April 2017 that requirements have changed for participation in the waiver program. They will be able to reapply for re-certification at that time if they chose to do so. Site visits will be used to validate compliance before these sites are re-certified. As these notices are prepared, DA will complete a check for any sites that may have active participants then that did not in the spring of 2016. If such sites are identified, a site visit will be completed so that any necessary remediation activities can be identified.

In the fall of 2016, a workgroup of providers in coordination with DA began developing a remediation plan template for providers. In December of 2016, DA held a provider training and reviewed compliance criteria for HCBS settings and discussed possible remediation strategies. Providers, not presumed institutional, will then receive a copy of their site survey as well as a letter outlining areas of non-compliance. These notifications will be sent out in January 2017. Provider remediation plans will be due back to DA in March 2017. DA will then review these plans, request changes as needed, and then compile a master calendar for remediation activities. DA will monitor, follow up with providers on their progress, and then complete a site visit to validate the completion of the plan. Providers who choose not to submit a remediation plan will not be permitted to accept any new participants. Current participants served in these locations will be assisted with the transition process according to their preferences. These providers and any others unable or unwilling to remediate areas of non-compliance will be decertified by March 2019.

- **Structured Family Care (A&D):** A living arrangement in which a participant lives in his or her private home or the private home of a principal caregiver who may be a nonfamily member or a family member who is not the participant's spouse, the parent of the participant who is a minor, or the legal guardian of the participant; support services are provided by the principal caregiver (family caregiver) as part of structured family caregiving; only agencies may be structured family caregiving providers, with the structured family caregiving settings being approved, supervised, trained, and paid by the approved agency provider.

This is not a provider owned or controlled setting as long as the caregiver is a related family member. DA will evaluate each situation individually to determine if the caregiver is not a related family member and if the participant resides in that caregiver's home. There are 4 current SFC providers. 3 of them are serving waiver participants. DA has worked with providers to determine the number of situations in which the caregiver is a non-related individual, and in which that unrelated caregiver owns or leases the residence in which they and the

consumer reside. These are estimated to be less than 50 individuals out of the 912 individuals receiving SFC services. These settings are therefore considered by CMS to be provider owned or controlled. They will be assessed and remediated individually for compliance with the HCBS settings requirements. Software changes will be made to record and track this information. These changes will be in place by July 2017. A new checklist will be created for case managers to complete and submit for review with DA review to validate the HCBS nature of the setting prior to initiation of SFC services. SFC is covered by language in 455 IAC 2 and will be covered by the amended version, 455 IAC 2.1. Requirements for provider owned or controlled residential settings will cover any SFC situations that do involve services in the home of an unrelated paid caregiver.

- **Structured Day Program (TBI):** Activities and rehabilitative services provided in a group setting outside the home. Current service standards do require the service to be tailored to the needs of the individual participant. Current waiver requirements forbid any use of individual restraint but do not extend this definition to include the restriction of facilities which may have secured perimeters or delayed egress systems.

Structured day programs provide assistance with acquisition; retention; or improvement in self-help, socialization, and adaptive skills. Services take place in a nonresidential setting, separate from the home in which the individual resides. There are currently 66 enrolled structured day providers certified under the TBI waiver. 13 of these providers have active waiver consumers through the TBI waiver program. There are 21 TBI waiver consumers receiving this service (12 in one on one, 9 in groups).

The structured day programs under the TBI waiver provides assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills and takes place in a non-residential setting, separate from the home in which the individual resides. The approved TBI waiver providers also serve individuals with intellectual and developmental disabilities in congregate community-based settings. The DA will work in conjunction with DDRS to evaluate these sites shared by the TBI waiver population and the individuals with intellectual disabilities/developmental disabilities (IID/DD) population. Since the TBI waiver has so very few active structured day providers and program participants compared to the DDRS operated waivers in Indiana, the DA will not utilize a separate assessment process for these providers. DA will abide by the conclusions reached in the DDRS site assessment process. Language in regulations is largely silent in reference to structured day programs. Language will be added to assure that all settings are required to be fully compliant with the HCBS settings requirements.

In the spring of 2017, DA will work with DDRS to align evaluation and remediation processes with these shared providers. All 66 SDP providers will be assessed. In addition to DDRS efforts, in March 2017 through June 2017, the participant's waiver case manager will conduct reviews with the individual SDP participants to identify any specific concerns indicating provider non-compliance with HCBS characteristics. Notifications of identified issues will be sent out to providers in July 2017 through September 2017. DA will then review these plans, request changes as needed, and then compile a master calendar for remediation activities. DA will monitor, follow up with providers on their progress, and then complete a site visit to validate the completion of the plan. Providers who choose not to submit a remediation plan will not be permitted to accept any new participants. Current participants served in these locations will be assisted with the transition process according to their preferences. These providers and any others unable or unwilling to remediate areas of non-compliance will be decertified by March 2019.

- **Supported Employment (TBI):** Supported employment (SE) includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training. Supported employment is conducted in a variety of settings, particularly worksites where persons without disabilities are employed. There are 61 certified providers for the TBI waiver. There are currently only three waiver participants receiving this service under the DA's TBI waiver, served by three providers. DA has reviewed the settings in which these three participants receive this service. One participant is being transferred to the Community Integration and Habilitation waiver operated by DDRS. These three providers are settings that serve a number of other individuals served on the DDRS waivers. Since the TBI waiver has so very few active supported employment providers and program participants compared to the DDRS operated waivers in Indiana, the DA will not utilize a separate assessment process for these providers. DA will abide by the conclusions reached in the DDRS provider assessment process. Language in regulations is largely silent in reference to structured day programs. Language will be added to assure that all settings are required to be fully compliant with the HCBS settings requirements.

In the spring of 2017, DA will work with DDRS to align evaluation and remediation processes with these shared providers. In addition to DDRS efforts, in March 2017 through June 2017, the participant’s waiver case manager will conduct reviews with the individual SE participants to identify any specific concerns indicating provider non-compliance with HCBS characteristics. Notifications of identified issues will be sent out to providers in July 2017 through September 2017. DA will then review submitted remediation plans, request changes as needed, and then compile a master calendar for remediation activities. DA will monitor, follow up with providers on their progress, and then complete a site visit to validate the completion of the plan. Providers who choose not to submit a remediation plan will not be permitted to accept any new participants. Current participants served in these locations will be assisted with the transition process according to their preferences. These providers and any others unable or unwilling to remediate areas of non-compliance will be decertified by March 2019.

Results and Remediation

None of DA’s provider owned or controlled sites were found to be fully compliant based on self-surveys, document reviews, and site surveys to date. All sites have issues that will require remediation. Sites subject to heightened scrutiny will be reviewed again following any remediation and only at that point will DA make the decision whether or not to submit the site for CMS heightened scrutiny review.

Initial Grouping of Settings	Description	Approximate Number of Sites	Approximate Number of Participants
Settings that are not HCB	NF, IMDs, ICF/ID, hospitals	0	0
Settings that are presumed not to be HCB	Co-located AL and ADS sites; AL sites with secure memory care	3 ADS sites 57 AL sites	17 ADS participants 1,120 AL participants
Settings that could be fully compliant with the HCB Rule with modifications	AL and ADS sites that are not co-located and do not have a secure memory care; all AFC sites	36 ADS sites 23 AFC sites 33 AL sites	584 ADS participants 49 AFC participants 1,166 AL participants
Settings presumed to be HCB and meet the rule without any changes required	All private residences that are not provider owned or controlled.	Maximum 11,500	Approximately 11,500

This table summarizes the four more specific groups into which provider owned and controlled sites are classified as a result of the participant experience surveys, site surveys and documentation reviews.

	Sites Not Subject to Heightened Scrutiny	Sites Subject to Heightened Scrutiny due to Co-Location	Sites That May be Subject to Heightened Scrutiny due to the presence of a Secure Memory Care Unit
Found to be institutional in nature – provider not able or willing to make modifications	Group 1	Group 1	Group 1
Found to be fully compliant with HCBS settings requirements	Group 3	Group 2	
Found to be partial compliant with HCBS settings requirements but can become fully compliant with modifications	Group 4	Group 4	
Modifications can remove characteristics that have the effect of isolating individuals as well as become fully compliant HCBS setting requirements			Group 4
Modifications can remove characteristics that have the effect of isolating individuals but the site is still found to be institutional in nature			Group 1

Modifications cannot remove the characteristics that have the effect of isolating but the site, with other modifications is found to be compliant by DA

Group 2

- Group 1 settings are not HCBS compliant. Provider will be decertified and afforded an appropriate appeal and review process. Participants in these settings will be transitioned to compliant settings.
- Group 2 settings will be submitted to CMS through the heightened scrutiny process for approval as a compliant HCBS setting.
- Group 3 settings are HCBS compliant and not subject to heightened scrutiny. Participants may remain in this setting with ongoing monitoring measures in place.
- Group 4 settings will make modifications in the remediation process and if successfully completed, will be fully compliant. Participants may remain in this setting with ongoing monitoring measures in place. Settings that do not successfully complete remediation will be moved to Group 1.

Based on current information from the completed site surveys,

- All AFC sites are in Group 4 and remediation activities will begin in early 2017.
- All ADS sites, except the three that are co-located, are also in Group 4 and will begin remediation activities in early 2017.
- The three co-located ADS sites will undergo further consideration and review by the Division if they will remain in Group 1 or move to Group 2.
- With respect to AL sites:
 - At most 24 sites could be in Group 4
 - All other AL sites would have to be in Group 1 or Group 2 depending on the degree of co-location and the ability and willingness of the provider to remediate
 - No AL sites are found to be in Group 3

For Group 4 providers, a corrective action plan will be developed and monitored to ensure the setting comes into compliance within a specified time period. The timeline will be dependent upon the modifications required but as specified in the table in Section 2, all remediation must be completed no later than July of 2018. Most will be much earlier than that. Specific corrective action(s) will be based on the noncompliance findings. For example, if there is a restriction in place for health or safety reasons that are not documented in the person centered plan, the corrective action would be for the person centered plan to be updated to include the required information consistent with DA policy.

Indiana Code and Indiana Administrative Code already provide for issuance of citation for violations of provider requirements, remedies, and considerations in determining remedy. Specifically, [455 IAC 2-6-4](#) provides for a monitoring, corrective action process. This process will be utilized in the setting modification process. Code and rule also provide guidance regarding appeal rights and remedies for violations. This will also provide an appeal process for those sites that are found to be institutional and thus will be decertified as waiver providers.

Service/Setting	Areas in Need of Remediation to Comply with HCBS Characteristics	Validation/Remediation Strategies	Timeline for Start/Completion	Assuring Ongoing Compliance
Adult Family Care (AFC) 39 enrolled providers 49 participants served by 23 providers	<ul style="list-style-type: none"> • Appropriate lease agreements • The individual can have visitors at any time • The individual controls his/her own schedule including access to food at any time • The setting is integrated in and supports full access to the greater community 	Provider self-surveys Site surveys completed on all sites Analysis of site survey results Develop remediation plan template Held provider education on remediation plan process and expectations for compliance	October 2014 February - June 2016 July 2016 - October 2016 October 2016 - January 2017 December 2016	Provider Compliance Reviews are conducted every three years. Person Centered Compliance Reviews (PCCR) are conducting annual

Service/ Setting	Areas in Need of Remediation to Comply with HCBS Characteristics	Validation/Remediation Strategies	Timeline for Start/Completion	Assuring Ongoing Compliance
	<ul style="list-style-type: none"> •The individual has choice of roommates •The individual is able to participate in activities of their choice in the community alone •Optimizes individual initiative, autonomy, and independence in making life choices. •Medications maintained and distributed in a way that promotes individual control and privacy. •Units have locking doors; with only appropriate staff having keys/privacy in sleeping or living unit •Setting is physically accessible to the individual - entrances, common areas, and dining rooms in the setting handicap accessible. 	<p>Provide each provider with a copy of their site survey results and a remediation plan template</p> <p>Hold provider technical assistance webinars on remediation activities</p> <p>Providers who wish to continue as a waiver provider return remediation plans to DA</p> <p>Providers who do not wish to be remediated will be blocked from accepting any new participants</p> <p>DA maintains remediation calendar and monitors for completion of the plan</p> <p>DA provides one on one technical assistance to providers as needed</p> <p>DA conducts semi-annual provider trainings including sessions on remediation plan activities</p> <p>DA offers quarterly webinars to updated on transition plan progress and highlight remediation best practices</p> <p>DA conducts site visits to validate completion of remediation plan</p> <p>Participants served by providers who either cannot or will not remediate will be notified of providers pending termination</p> <p>Providers who have failed to remediate will be decertified</p>	<p>January 2017</p> <p>January – April 2017</p> <p>January - April 2017</p> <p>As identified as early as January 2017, no later than June 2017</p> <p>January 2017 – July 2018</p> <p>January 2017 – July 2018</p> <p>January 2017 – July 2018</p> <p>July 2017 – March 2019</p> <p>As such providers are identified, no later than July 2018</p> <p>As such providers are identified, no later than July 2018</p> <p>January 2019 – March 2019 (once participants are transitioned according to their preferences)</p>	<p>on a random sample of participants.</p> <p>Case managers complete and document Person Centered Monitor Tool (PCMT) every 90 days for active participants. Items on this tool map to requirements of HCBS settings. Results can be monitored by provider.</p> <p>NCI-AD will be an annual random sampling survey. Items on the survey map to requirements of HCBS settings.</p>
<p>Adult Day Service (ADS)</p> <p>43 enrolled providers</p> <p>601 participants served by 39 providers</p>	<ul style="list-style-type: none"> •Freedom and support to control own schedule and activities. •Individuals are able to freely move about inside and outside the site. •Individuals are able to participate in activities of their choice in the community alone. 	<p>Provider self-surveys</p> <p>Site surveys completed on all sites</p> <p>Analysis of site survey results</p> <p>Develop remediation plan template and compliance expectation guidelines working with a stakeholder workgroup that includes providers and advocates</p>	<p>February 2015</p> <p>February - June 2016</p> <p>July 2016 - October 2016</p> <p>October 2016 – January 2017</p>	<p>Provider Compliance Reviews are conducted every three years.</p> <p>Person Centered Compliance Reviews (PCCR) are conducting annual</p>

Service/ Setting	Areas in Need of Remediation to Comply with HCBS Characteristics	Validation/Remediation Strategies	Timeline for Start/Completion	Assuring Ongoing Compliance
	<ul style="list-style-type: none"> •Setting is physically accessible to the individual - entrances, common areas, and dining rooms in the setting handicap accessible. •Optimizes individual initiative, autonomy, and independent in making life choices. •Medications maintained and distributed in a way that promotes individual control and privacy. •Presence of gates, locked doors, or other barriers preventing individuals' from freely coming and going. •Access to food at any time - flexibility in meal times. 	<p>Held provider education on remediation plan process and expectations for compliance</p> <p>Provide each provider with a copy of their site survey results and a remediation plan template</p> <p>Hold provider technical assistance webinars on remediation activities</p> <p>Providers who wish to continue as a waiver provider return remediation plans to DA</p> <p>Providers who do not wish to remediate will be blocked from accepting any new participants</p> <p>DA maintains remediation calendar and monitors for completion of the plan</p> <p>DA provides one on one technical assistance to providers as needed</p> <p>DA conducts semi-annual provider trainings including sessions on remediation plan activities</p> <p>DA offers quarterly webinars to updated on transition plan progress and highlight remediation best practices</p> <p>DA conducts site visits to validate completion of remediation plan</p> <p>Participants served by providers who either cannot or will not remediate will be notified of providers pending termination</p> <p>Providers who have failed to remediate will be decertified</p>	<p>December 2016</p> <p>January 2017</p> <p>January – April 2017</p> <p>January - April 2017</p> <p>As identified as early as January 2017, no later than June 2017</p> <p>January 2017 – July 2018</p> <p>January 2017 – July 2018</p> <p>January 2017 – July 2018</p> <p>July 2017 – March 2019</p> <p>As such providers are identified, no later than July 2018</p> <p>As such providers are identified, no later than July 2018</p> <p>January 2019 – March 2019 (once participants are transitioned according to their preferences)</p>	<p>on a random sample of participants.</p> <p>Case managers complete and document Person Centered Monitor Tool (PCMT) every 90 days for active participants. Items on this tool map to requirements of HCBS settings. Results can be monitored by provider.</p> <p>NCI-AD will be an annual random sampling survey. Items on the survey map to requirements of HCBS settings.</p>
<p>Assisted Living (AL)</p> <p>90 enrolled providers</p> <p>2,286 participants served by those 90 providers</p>	<ul style="list-style-type: none"> •The individual has a lease or other legally enforceable agreement providing similar protections. •Freedom and support to control own schedule and activities, including the ability to move about freely inside and outside of the site and the ability to participate in 	<p>Provider self-surveys</p> <p>Documentation and policy desk review</p> <p>Site surveys completed on all sites</p> <p>Analysis of site survey results</p> <p>Develop remediation plan template and compliance expectation guidelines working with a stakeholder workgroup that includes providers and advocates</p>	<p>October 2014</p> <p>January – February 2016</p> <p>February - June 2016</p> <p>July 2016 - October 2016</p> <p>October 2016 - January 2017</p>	<p>Provider Compliance Reviews will be conducted every three years.</p> <p>Person Centered Compliance Reviews (PCCR) are conducting annual</p>

Service/ Setting	Areas in Need of Remediation to Comply with HCBS Characteristics	Validation/Remediation Strategies	Timeline for Start/Completion	Assuring Ongoing Compliance
	<p>activities of their choice in the community alone.</p> <ul style="list-style-type: none"> • Privacy in sleeping or living unit, including having staff and/or other participants knock on each other's doors or ask for permission before entering participants' rooms. • Individuals are able to have visitors of choosing at any time. • Individuals are able to have access to food at any time as reflected in flexibility in meal times. • Site is from gates, locked doors, or other barriers preventing individuals' entrance to and exit from all areas of the setting. • Optimizes individual initiative, autonomy, and independent in making life choices. • Medications are maintained and distributed in a way that promotes individual control and privacy. • Individuals are able to dine alone or in their apartments. • Individuals have easy access to have private communications with people outside the site by telephone, e-mail, and/or mail. • Units have locking doors; with only appropriate staff having keys. 	<p>Held provider education on remediation plan process and expectations for compliance</p> <p>Provide each provider with a copy of their site survey results and a remediation plan template</p> <p>Hold provider technical assistance webinars on remediation activities</p> <p>Providers who wish to continue as a waiver provider return remediation plans to DA</p> <p>Providers who do not wish to be remediated will be blocked from accepting any new participants</p> <p>DA maintains remediation calendar and monitors for completion of the plan</p> <p>DA provides one on one technical assistance to providers as needed</p> <p>DA conducts semi-annual provider trainings including sessions on remediation plan activities</p> <p>DA offers quarterly webinars to updated on transition plan progress and highlight remediation best practices</p> <p>DA conducts site visits to validate completion of remediation plan</p> <p>Participants served by providers who either cannot or will not remediate will be notified of providers pending termination</p> <p>Providers who have failed to be remediated will be decertified</p>	<p>December 2016</p> <p>January 2017</p> <p>January – April 2017</p> <p>January - April 2017</p> <p>As identified as early as January 2017, no later than June 2017</p> <p>January 2017 – July 2018</p> <p>January 2017 – July 2018</p> <p>January 2017 – July 2018</p> <p>July 2017 – March 2019</p> <p>As such providers are identified, no later than July 2018</p> <p>As such providers are identified, no later than July 2018</p> <p>January 2019 – March 2019 (once participants are transitioned according to their preferences)</p>	<p>on a random sample of participants.</p> <p>Case managers complete and document Person Centered Monitor Tool (PCMT) every 90 days for active participants. Items on this tool map to requirements of HCBS settings. Results can be monitored by provider.</p> <p>NCI-AD will be an annual random sampling survey. Items on the survey map to requirements of HCBS settings.</p>
<p>Structured Family Care (SFC)</p> <p>4 enrolled provider agencies</p> <p>805 participants served by 3 agency providers employing and</p>	<ul style="list-style-type: none"> • No identified needs yet • Data not yet available on instances where this service is provided in a provider owned or controlled setting due to the caregiver both owning the residence and being unrelated to the participant. 	<p>DA will ask providers to self-assess for situations that may be provider owned or controlled</p> <p>DA will modify its case management software to collect needed information about the caregiver and the residence.</p> <p>The participant's waiver case manager will collect and enter required information during monitoring visits.</p>	<p>November 2016</p> <p>April 2017</p> <p>July 2017 – September 2017</p>	<p>Provider Compliance Reviews will be conducted every three years.</p> <p>Person Centered Compliance Reviews (PCCR) are conducting annual</p>

Service/ Setting	Areas in Need of Remediation to Comply with HCBS Characteristics	Validation/Remediation Strategies	Timeline for Start/Completion	Assuring Ongoing Compliance
<p>overseeing the individual caregiver</p> <p>782 of the 805 participants are with one provider agency</p> <p>DA does not believe this service is provided in any provider owned or controlled settings but will investigate that to verify and address as necessary</p>		<p>DA will review data to identify instances of where the caregiver owns the residence and is unrelated to the participant.</p> <p>DA will contact SFC providers and case managers of any participant that is found to be receiving SFC in a provider owned or controlled setting.</p> <p>Case managers will provide evaluations of impacted settings through the PCMT</p> <p>DA will review evaluations and work with case managers and SFC provider agencies to remediate any non-compliance areas</p> <p>Situations that cannot be remediated will be transitioned into other service options or settings as determined by the participant in the person centered planning process.</p>	<p>September 2017</p> <p>September 2017– December 2017</p> <p>January 2018 – March 2018</p> <p>March 2018 – July 2018</p> <p>Beginning as situations are identified and completed no later than March 2019</p>	<p>on a random sample of participants.</p> <p>Case managers complete and document Person Centered Monitor Tool (PCMT) every 90 days for active participants. Items on this tool map to requirements of HCBS settings. Results can be monitored by provider.</p> <p>NCI-AD will be an annual random sampling survey. Items on the survey map to requirements of HCBS settings</p>

Service/ Setting	Areas in Need of Remediation to Comply with HCBS Characteristics	Validation/Remediation Strategies	Timeline for Start/Completion	Assuring Ongoing Compliance
<p>Structured Day Program (SDP)</p> <p>66 enrolled providers</p> <p>21 participants served by 13 providers</p>	<ul style="list-style-type: none"> •The setting is integrated in and supports full access to the greater community. •Ensures individual rights of privacy, dignity and respect, and freedom from coercion and restraint. •Optimizes autonomy and independence in making life choices. 	<p>DA will collaborate with DDRS in their assessment process and follow their recommendations with regard to these shared providers.</p> <p>The participant’s waiver case manager will conduct reviews with the individual SDP and SE participant to identify any concerns indicating provider non-compliance with HCBS characteristics.</p> <p>DA will communicate expectations to specific providers identified to be out of compliance through the assessment processes and request remediation plans.</p> <p>Review of provider remediation plans</p> <p>DA maintains remediation calendar and monitors for completion of the plan</p> <p>DA conducts site visits to validate completion of remediation plan</p> <p>Providers who do not wish to be remediated will be blocked from accepting any new participants</p> <p>DA provides one on one technical assistance to providers as needed</p> <p>Participants served by providers who either cannot or will not remediate will be notified of providers pending termination</p> <p>Providers who have failed to be remediated will be decertified</p>	<p>February 2017</p> <p>July 2017</p> <p>October 2017</p> <p>January 2018 – March 2018</p> <p>March 2018 – July 2018</p> <p>As such providers are identified, no later than July 2018</p> <p>October 2017</p> <p>October 2017 – July 2018</p> <p>As such providers are identified, no later than July 2018</p> <p>January 2019 – March 2019 (once participants are transitioned according to their preferences)</p>	<p>Provider Compliance Reviews will be conducted every three years.</p> <p>Person Centered Compliance Reviews (PCCR) are conducting annual on a random sample of participants.</p> <p>Case managers complete and document Person Centered Monitor Tool (PCMT) every 90 days for active participants. Items on this tool map to requirements of HCBS settings. Results can be monitored by provider.</p> <p>NCI-AD will be an annual random sampling survey. Items on the survey map to requirements of HCBS settings.</p>

Service/ Setting	Areas in Need of Remediation to Comply with HCBS Characteristics	Validation/Remediation Strategies	Timeline for Start/Completion	Assuring Ongoing Compliance
<p>Supported Employment (SE)</p> <p>61 enrolled providers</p> <p>3 participants served by 3 providers</p>	<ul style="list-style-type: none"> •The setting is integrated in and supports full access to the greater community. •Ensures individual rights of privacy, dignity and respect, and freedom from coercion and restraint. •Optimizes autonomy and independence in making life choices. 	<p>DA will collaborate with DDRS in their assessment process and follow their recommendations with regard to these shared providers.</p> <p>The participant’s waiver case manager will conduct reviews with the individual SDP and SE participant to identify any concerns indicating provider non-compliance with HCBS characteristics.</p> <p>DA will communicate expectations to specific providers identified to be out of compliance through the assessment processes and request remediation plans.</p> <p>Review of provider remediation plans</p> <p>DA maintains remediation calendar and monitors for completion of the plan</p> <p>DA conducts site visits to validate completion of remediation plan</p> <p>Providers who do not wish to be remediated will be blocked from accepting any new participants</p> <p>DA provides one on one technical assistance to providers as needed</p> <p>Participants served by providers who either cannot or will not remediate will be notified of providers pending termination</p> <p>Providers who have failed to be remediated will be decertified</p>	<p>October 2016</p> <p>January 2017</p> <p>March 2017</p> <p>April – June 2017</p> <p>June 2017 – July 2018</p> <p>As such providers are identified, no later than July 2018</p> <p>March 2017</p> <p>April 2017 – July 2018</p> <p>As such providers are identified, no later than July 2018</p> <p>January 2019 – March 2019 (once participants are transitioned according to their preferences)</p>	<p>Provider Compliance Reviews will be conducted every three years.</p> <p>Person Centered Compliance Reviews (PCCR) are conducting annual on a random sample of participants.</p> <p>Case managers complete and document Person Centered Monitor Tool (PCMT) every 90 days for active participants. Items on this tool map to requirements of HCBS settings. Results can be monitored by provider.</p> <p>NCI-AD will be an annual random sampling survey. Items on the survey map to requirements of HCBS settings.</p>

DA will develop a remediation plan template that will be distributed to providers of AL, AFC, and ADS in January of 2017. The template will be provided to them along with the results of their site specific assessments. The plan will require each provider to identify strategies for becoming fully compliant with each HCB requirement. They will need to include milestones and dates as part of the plan. Plans will be due back to the DA by March of 2017. The DA will review all plans and work with the provider on any required changes prior to approval by June 2017. The DA will then enter these on to a master remediation calendar that will be used by DA staff to follow up with providers on their progress. DA staff will regularly check the calendar for milestones expected to be reached and contact the provider through email to request confirmation of the successful completion of the milestone. If there are barriers to completion this will afford the provider an opportunity to seek technical assistance from DA staff on those challenges.

When a provider believes they have completed remediation, they will be required to notify the DA. DA will then complete any validation activities required. These will vary based on the nature of the non-compliant issue. Some validation efforts will have to take place overtime to assure that remediation strategies have been fully implemented. Validation may take the form of document review, interviews with staff, participants, case managers, families or others, as well as site visits. All or some of these methods may be used again depending on the nature of what is being validated. For instance, if the primary non-compliance issue is the use of an appropriate lease. That remediation can largely be validated through document review and may not require a site visit. Other issues, like the ability to have visitors, might include a document review of a new or revised policy as well as site visits, perhaps multiple to observe visitor activity, as well as participant interviews by phone or in person.

Providers who fail to meet milestones or fail to communicate regularly with the DA during the remediation process or who fail to cooperate during the remediation validation process will be placed in a “suspend certification” status. During this time, they can continue to serve current participants but cannot accept any new participant until the remediation issues are resolved. If they cannot be resolved, the provider will be notified of non-compliance and beneficiaries will be notified of the need to select another provider and setting. These changes will be completed by March of 2019. (More detail provided under the Relocation of Beneficiaries sections)

Heightened Scrutiny

Using site assessment information, the DA will determine which settings are presumed institutional and subject to heightened scrutiny. This will include settings with the following characteristics:

- A waiver setting that is co-located in the same building as a provider of inpatient care or treatment; and/or
- A waiver setting that is operating under the same institutional license as a provider of inpatient care or treatment; and/or
- A waiver setting that is secured for the purpose of providing care to persons with dementia.

In January 2017, these providers will all receive a letter from the DA, notifying them that they have been identified as presumed institutional. They will be informed that, should they wish to continue providing services after March 2019, they will need to remediate any institutional characteristics and provide evidence of having done so to the DA. Such evidence shall include, but will not be limited to: policy documentation, copies of lease/residency agreements; organizational charts, specialized training in dementia care and/or person-centered care and planning; redacted service plans and the surrender of any institutional license. This evidence will be validated through participant survey input, site visits by DA or DA contractor staff, and public comment on each site requesting heightened scrutiny review.

If a setting has institutional qualities that cannot be addressed by modifications by the provider, the setting will be considered institutional (Group 1). If a setting does not have institutional qualities, it will be reviewed for HCBS settings characteristics. Heightened scrutiny requests for any sites the DA believes have overcome the presumption of institutionalization will be submitted by December of 2017 or sooner if the provider has completed remediation to overcome the presumption of institutionalization.

Relocation of Beneficiaries

The DA has not yet determined the number of individuals who may be affected by relocation. Estimates are included on the chart above, but the final number will be determined as provider remediation plans are submitted and reviewed and validated. For Group 1 sites, a transition plan will be established both for the site and each individual participant. The site transition plan shall include a list of participants requiring transition, a plan for communicating with these individuals and their person centered support circle throughout the transition period, a timeline for decertification of the provider, and regular progress

reports to be submitted to DA. Currently available appeal and administrative review processes will be provided to participants impacted, as well as to the providers that must be decertified.

The participant specific transition plan will be developed and monitored by the waiver case manager. It will provide for appropriate notice to the individual and their person centered support circle regarding the site's noncompliance, the action steps that will occur, and procedural safeguards available to them. The case manager will work with the participant and their representatives to examine all available options. Timelines will be established to support transitioning individuals to a compliant setting no later than December 2018, provided they wish to remain in the waiver program. Beginning summer of 2017, training will be provided to case managers and providers to ensure a smooth transition for the participant(s) requiring transition.

Beneficiary Communication Timeline

DA will seek to notify beneficiaries in a timely way. Notices should not be so early as to spark unnecessary panic for individuals and their families; yet the notice should give them as much time as possible to plan for a potential move. Additionally, DA does not want to alarm beneficiaries that may be confused by letters they receive without explanation.

Beginning in October of 2017 through July of 2018, case managers will hand deliver notices to beneficiaries residing in sites that will not or cannot become compliant. Most notices would be delivered by January of 2018 but later notices may be made if a provider is failing to make satisfactory progress towards remediation. In some cases, that may not become apparent until closer to the July 2018 target date for completion of remediation.

The new HCBS option that is part of DA's tier 2 strategy is intended to be available by July 2018 and may offer expanded provider choice and options for some beneficiaries. Beneficiaries will be provided with options counseling on all setting options available to them. Beneficiaries will also be notified of potential sources of advocacy (including Indiana Disability Rights, ombudsman, the Arc, other advocacy organizations) along with their right to appeal. The transition plan developed by the case manager will be completed as part of the person centered planning process involving the individual's circle of support. The transition plan document will be an addendum to the person centered service plan. Transition plans will be reviewed by DA as part of service plan review.

All transition plans should be submitted to the DA within 60 days of beneficiary notification. DA will complete their review within 30 days. The case manager will be able to document and track milestones in the case management system. The system will allow DA staff to monitor beneficiaries still in non-compliant settings as we approach March of 2014. DA staff will provide technical support and assistance to case managers as they aid the beneficiary in the transition process.

Ongoing Compliance and Monitoring of Settings

The Person Centered Monitoring Tool (PCMT), formerly the 90 Day Review tool, is administered by the case manager for every waiver participant, face-to-face, every 90 days. This will be the DA's primary compliance monitoring tool. To complete the PCMT, the case manager conducts an interview with the participant as well as anyone else the participant has identified. This tool has already been updated to include an assessment of the service and setting as experienced by the individual and reports have been developed to identify specific settings for which a service participant has indicated any state of non-compliance within the setting. These reports will be reviewed on a monthly basis and corrective actions required at that time.

Additionally, in 2016 DA began participating in the National Core Indicators survey for the aged and disabled population (NCI-AD). NCI-AD is being administered to a statistically valid sampling of participants in all of the DA's HCBS programs, Medicaid and non-Medicaid. This survey tool replaces the Participant Experience Survey (PES) that had been used with waiver participants for many years. The NCI-AD focuses on how participants experience the services they receive and how they impact the quality of life they experience. A number of the NCI-AD questions crosswalk to the characteristics of a HCBS setting. A crosswalk is provided below of PCMT items and NCI-AD questions to HCB characteristics. The DA also monitors providers and service delivery through Provider Compliance Reviews (PCR) and Participant-Centered Compliance Reviews (PCCRs). These assessments will continue throughout the transition process and will be updated to include the new standards as the State moves through the transition period.

The Participant Centered-Compliance Review is conducted for a statistically significant random sample of waiver participants each year. This review focuses on how the individual experiences the services they receive and how each individual's chosen providers comply with waiver standards in the delivery of services. The PCCR sample size is based on a

95% confidence level, 5% margin of error, and 50% response distribution using the Raosoft tool. Distribution is proportionate to waiver participants by geographic areas of the state and all service types were included. TBI waiver sample size is approximately 132 using the above formula and an estimated total population of 200. A&D Waiver is approximately 375 using the above formula and an estimated total population of 15,000. Because the PCCR uses a random sampling method, it is not guaranteed that each participant will receive a review within any particular time period.

The PCR is conducted every three years for all waiver providers not licensed by the ISDH. The PCR focuses on the provider’s policies and procedures and looks for evidence that those are being followed.

With both types of reviews, all negative findings must be addressed through a “corrective action plan” (CAP) which allows the provider to describe how it intends to address the problem. The DA then either approves the CAP, or works with the provider to develop an acceptable plan. DA intends to use these same tools and processes to assess and correct many of the areas which are identified as non-compliant with the HCBS rule, and will also continue to use updated versions of these tools to assure compliance with the HCBS rule over the long-term.

Offering Non-Disability Specific Setting Options

Case managers are required, as part of options counseling, to explain to individuals the various settings under which they may receive HCBS. This requirement will be documented in revisions to 455 IAC 2. Case managers will receive training as part of their orientation and ongoing training on this requirement and best practices for meeting it. Individuals will be supported in the decision making process so that their person centered service plan will include their selection of the setting in which they receive services. This may well be their current residence, private home or apartment, or a relative’s home, or a congregate, provider owned or controlled setting that has the characteristics of an HCB setting.

Crosswalk of NCI-AD and PCMT to HCBS Setting Characteristics

HCBS Settings Characteristics	NCI-AD Survey Questions	Person Centered Monitoring Tool (PCMT) Questions
The setting is integrated in and supports full access to the greater community	7. Can you see or talk to your friends and family (who do not live with you) when you want to? 48. Are you able to do things you enjoy outside of your home when and with whom you want to? (For example, visit with friends or neighbors, go shopping, go to a movie or a show or out to eat, to religious functions, to volunteer in the community)? 50. Do you have transportation when you want to do things outside of your home, like visit a friend, go for entertainment, or do something for fun? 53. Do you have a paying job in the community, either full-time or part-time?	F-2 Has the individual participated in community activities in the past 90 days? F-3 Does the individual have family or friends nearby who provide socialization on a regular basis? F-7 Does the individual participate in vocational activities as desired? (paid, training, or volunteer) NRS-1) Does the participant have the freedom to come and go from the setting as they please?
The setting is selected by the individual from among setting options	2. In general, do you like where you are living right now? 4. Would you prefer to live somewhere else? We are not talking about geography, but rather the kind of place you’d like to live in.	D-1 Has the individual or their legal guardian been provided information on their right to choose and change service providers and case managers?
Each individual has a right to privacy, is treated with dignity and respect, and is free from coercion and restraint	27. Do you feel that the people who are paid to help you treat you with respect? 44. Can you use the phone privately whenever you want to? 46. Do people read your mail or email without asking you first?	D-5 Is the individual free to receive and open mail in private? D-6 Is the individual free to use the telephone and internet at desired times? E-1 Does the individual make statements that indicate they may be feeling exploited? E-2 In the last 90 days has the individual experienced harm and/or abuse that resulted in a report of any kind? E-3 In the last 90 days has the individual experienced any unexplained injuries or bruises, or exhibited unusual fearful behaviors?

		G-3 Does the individual feel that they are being treated with respect by staff?
Provides individuals independence in making life choices	59. Do you get up and go to bed at the time when you want to? (No one else decides for you when you get up or go to bed, and you get the help you need to get up and go to bed when you want to?) 60. Can you eat your meals when you want to? (no one else decides for you when you eat)	A-6) Is the participant happy with their daily routine and how they spend their days? D-7 Does the individual have choices in what foods are available and when they eat?
The individual is given choice regarding services and who provides them	16. Can you choose or change what kind of services you get and determine how often and when you get them? 17. Can you choose or change who provides your services if you want to? 86. Do you feel in control of your life?	D-1 Has the individual or their legal guardian been provided information on their right to choose and change service providers and case managers?
Responsibilities and rights of tenant, legally enforceable agreement		RS-7) Does the individual have a lease or other legally enforceable agreement subject to applicable tenant protection laws?
Privacy in sleeping or living unit	38. Do people ask your permission before coming into your home/apartment? 40. Do you have enough privacy in your home? (<i>Can you have time to yourself?</i>)	D-8 Is the individual afforded a level of privacy that is acceptable and comfortable to the individual?
Lockable doors, staff have keys only as needed	39. Are you able to lock the doors to your room if you want to?	RS -1) Does the individual have privacy in their unit including a lockable door?
Freedom to furnish and decorate	41. Are you able to decide how you furnish and decorate your room?	RS-2) Does the participant have the freedom to furnish and decorate their residential unit?
Choice of roommates for shared rooms	47. Are you able to choose who your roommate is here?	F-4 Does the individual have the choice to have a roommate? RS-6) Does the individual have the freedom to live without a roommate, or with a roommate of their own choosing?
Control own schedule and activities and access to food at any time	45. Do you have access to food at all times of the day? Can you get something to eat or grab a snack when you get hungry?	D-7 Does the individual have choices in what foods are available and when they eat? F-5 Does the individual have a choice of activities and control over their schedule? RS-5) Does the participant have access to food at the times of their choosing?
Able to have visitors at any time	42. Are your visitors able to come at any time, or are there only certain times of day that visitors are allowed? 43. Do you have privacy with visitors at home if you want it?	D-4 Is the individual able to have visitors at times of their choosing? RS-4) Does the participant have the freedom to entertain visitors at the times of their choosing?
Physically accessible	32. Are you able to get to safety quickly in case of an emergency like a fire or a natural disaster? 30. Many people make changes to their homes, for example, adding grab bars, ramps, or bathroom modifications to make it easier for you to live at home. Do you have or need any of the following changes made to your home (or an upgrade to the one you have)? To clarify, we are not talking about general repairs to the house, but rather specialized modifications.	B-2 Can you walk safely in your own home? B-3 Is the individual able to exit the home UNASSISTED in an emergency? C-25 Are all identified environmental modifications/assistive devices needed by the individual in place? NRS-6) Are all program and personal service areas physically accessible to the participant?

Training and Technical Assistance

DA has identified four groups that require trainings on HCB characteristics: DA staff, case managers, providers of AL, ADS, and AFC services, and contractors completing provider and participant surveys. DA staff include individuals involved with the review of new provider sites, individuals that will complete remediation validation, individuals who conduct compliance reviews, individuals who review service plans, and individuals who monitor incident reports. All have been trained on the required HCB characteristics with the level appropriate to their role in the process. The DA Director and Deputy Director have taken a hands on approach in this training as the subject matter experts. A more formal online training will be created for use by DA staff as new staff come onboard. This training will be available by March 2017.

DA is also developing online training tools for case managers. Trainings will focus on general overview of the HCB settings requirements, the use of the PCMT for ongoing compliance monitoring, tips for monitoring compliance during onsite visits to provider owned and controlled settings, the completion of person centered modifications to HCB setting requirements, and the case manager's role in any heightened scrutiny submissions. Online trainings will be supplemented with webinars for Q&A and in person trainings largely in a train the trainer model.

For providers, the DA will offer semiannual in-person training opportunities, at least quarterly webinars, and template documents for remediation plans. DA will also make staff available to the extent necessary for one-on-one technical assistance to providers. DA will work with providers to identify and share best practices in their remediation efforts.

The DA uses contractors currently to complete PCCR and NCI-AD interviews. Other contractors may be used as part of the remediation validation reviews as well. Any contract staff will have to complete the same training as DA staff prior to completing any assessments of sites or interviews with participants.

SECTION 4: KEY STAKEHOLDERS AND OUTREACH

It is the DA's intention to assist each provider in reaching full compliance and assist each participant with realizing the full benefits of the HCBS rule. To achieve these outcomes, it is imperative that the providers and participants, as well as their advocates and representatives, are included in each step of the process. Steps taken to date include:

- Several meetings occurred with trade associations representing AL and ADS providers.
- During the month of October 2015, Division staff met with case managers in regional training sessions to introduce them to the HCBS requirements and to open dialog as to how they will be involved and asked them to encourage their consumers and advocates to participate in transition planning and processes.
- Five regional forums were scheduled in November 2014. These were conducted on-site at provider-owned AL facilities to meet with participants and their family members regarding the rule, the transition process, and opportunities to participate in that process.
- All DA HCBS waiver providers were invited to a provider training day November 10, 2014. This day included an "all-provider" session on the HCBS rule, as well as an extended session to gather provider input into the process.
- The DA has engaged with individual providers throughout the assessment process, explaining the need for self-surveys and emphasizing the need for public participation, both in scheduled forums and ongoing. The DA will continue this individual approach as opportunities arise.
- In February 2016, the DA met again with AL and ADS providers and the Alzheimer's Association specifically on the topic of secure memory care units.
- Meetings and discussions have been ongoing with provider associations, in particular assisted living provider associations.
- Training webinars will be developed by DA staff directed to audiences of case managers as well as providers of AL, ADS, AFC, and structured day programming.
- As a result of the comments received on this update, DA has reached out to include Indiana Disability Rights (IDR) more directly in this process.
- October 2016 through January 2016 two workgroups will collaborate on remediation plan template design and technical assistance materials that outline future requirements for ADS and AL.
- DA held an open provider forum in December 2016 to continue provider education on the settings rule, the state's transition plan, and the upcoming remediation process. Special breakout sessions were held for ADS, AFC, and AL providers to focus on a review of the survey results and the most common areas in need of remediation as well as best practices for coming into compliance.

The DA has identified some specific areas for key stakeholder participation in the transition plan. We will consider the process to be dynamic and will be looking for opportunities to include stakeholders, particularly DA HCBS waiver participants, in the development and implementation as it evolves.

We have identified "Key Stakeholders" to be the DA HCBS waiver participants, their family members and advocates; HCBS waiver providers, along with their various trade associations; case managers and their managing entities, the 16 Area Agencies on Aging, the Long-Term Care Ombudsman and local representatives; and established advocacy groups representing senior citizens and individuals with disabilities.

DIVISION OF DISABILITY AND REHABILITATIVE SERVICES (DDRS)
HCBS Programs
Community Integration and Habilitation (CIH) Waiver – 1915(c)
Family Supports Waiver (FSW) – 1915(c)

SECTION 1: SETTINGS INCLUDED IN THE STP

DDRS is evaluating all residential and non-residential settings for HCBS compliance. This includes provider owned or controlled residential settings, day service settings, congregate settings, and any setting where Home and Community Based Services are delivered. A full listing of settings evaluated for compliance can be located in the [SETTING ASSESSMENT](#) in Section 3.

SECTION 2: SYSTEMIC ASSESSMENT

From May through September 2014 the Division of Disability and Rehabilitative Services (DDRS), completed a systemic assessment of HCBS requirements. The systemic assessment examined the HCBS requirements and determined DDRS' level of compliance. The systemic assessment was completed by reviewing Indiana Administrative Code ([IAC 460](#)), policies, procedures, provider agreements, and ongoing monitoring forms by DDRS/BDDS internal staff, OMPP, and the FSSA Office of General Counsel (OGC) with the goal of identifying specific policies requiring updates, documents and processes requiring modifications in order to more appropriately represent HCBS compliance. DDRS' intent throughout this process was to determine where systemic improvements or changes would need to be made to meet CMS' Home and Community-Based Services Standards and identify areas which will require remediation.

This assessment determined changes may be needed to 460 IAC as well as policy and procedure to incorporate and reinforce the requirements of the HCBS Final Rule for both residential and nonresidential settings. These changes will need to specify the settings in which HCBS may not be provided and include the requirements that individuals be offered the opportunity to choose among services or a combination of services and settings that address the individual's assessed needs in the least restrictive manner, promote the individual's autonomy and full access to the broader community, and ensure an individual is provided with opportunities to seek employment and work in integrated settings. Changes will also outline the elements required for individuals choosing to receive services in provider-owned or controlled settings.

Through the systemic assessment it has also been determined that some service definitions in the waivers may need to be revised to strengthen requirements of the final rule. Both the CIH and FSW service definitions will be reviewed for compliance and any service definition found to be in conflict with the final rule will be updated through waiver changes (amendments or proposed waivers) and posted for public comment.

Any proposed modifications to Indiana Code will follow the [Administrative Rules drafting procedure](#) and will be published for a public comment period to ensure meaningful feedback from all stakeholders. It is anticipated Indiana Code will be updated prior to May 2018 as outlined in the remediation strategy to ensure compliance with the HCBS Final Rule. Additionally, the policies and procedures listed in the crosswalk that were reviewed and showed partial compliance, silence, or does not comply with the HCBS Final Rule will be updated as outlined in the proposed remediation strategies by December 2017 to reinforce the requirements of the HCBS Final Rule.

The table below outlines DDRS' systemic setting crosswalk. The systemic setting crosswalk shows the results of DDRS' level of compliance with the HCBS rules, identifies remediation activities, and constructs a timeline for completion of the remediation.

Systemic Assessment Crosswalk

Federal Requirement: Settings are integrated in and support full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

Applicable Indiana Regulation	Compliance with HCBS Settings Final Rule:	Remediation Activity	Timeline
460 IAC 6-20-2 “community-based employment services shall be provided in an integrated setting.”	Fully Complies due to requirement of being in the community and in an integrated setting	No remediation needed	n/a
460 IAC 6-24-3 Management of Individual’s financial resources (b) The provider shall assist an individual to: (1) obtain, possess, and maintain financial assets, property, and economic resources	Partially Complies due to requirement of assisting the individuals with maintaining financial assets and economic resources	Additional rule language will be added to policies/procedures that address both residential and non-residential settings to clarify CMS setting regulations to ensure protections are in place to address control of personal resources to the same degree of access as individuals not receiving Medicaid HCBS.	12/2017
460 IAC 6-3-58 “Transportation supports” means supports, such as tickets and passes to ride on public transportation systems, that enable an individual to have transportation for access to the community	Partially Complies due to supporting accessing the community	Additional rule language will be added to policies/procedures that address both residential and non-residential settings to clarify CMS setting regulations that address individuals accessing the community to the same degree of access as individuals not receiving HBCS.	12/2017
460 IAC 6-3-32 -"ISP" means a plan that establishes supports and strategies, based upon the person centered planning process	Partially Complies due to accommodating the resources of the individual to achieve outcomes	Additional rule language will be added to policies/procedures that address both residential and non-residential settings to clarify CMS setting regulations that address individuals accessing the community to the same degree of access as individuals not receiving HBCS.	12/2017
460 IAC 7-3-12 AND 6-3-38.5 (PCP) (4) empowers an individual and the individual's family to create a life plan and corresponding ISP for the individual that: (A) is based on the individual's preferences, dreams, and needs; (B) encourages and supports the individual's long term hopes and dreams; (C) is supported by a short term plan that is based on reasonable costs, given the individual's support needs; (D) includes individual responsibility; and (E) includes a range of supports, including funded, community, and natural supports.	Partially Complies due to full range of supports including community and natural supports based on the individual’s preference and needs through the person centered planning process	Additional rule language will be added to policies/procedures that address both residential and non-residential settings to clarify CMS setting regulations that address individuals receiving services to the same degree of access as individuals not receiving HBCS.	12/2017
460 IAC 6-9-4 System for protecting Individuals (h) A provider shall establish a system for providing an individual with the opportunity to participate in social, religious, and community activities.	Fully Complies due to requirement of providers to ensure opportunity for individuals to engage in community life	No remediation needed	n/a

Individual Rights and Responsibilities (NEW) (4600221014)	Fully Complies	Language has been drafted to include all aspects of HCBS rule surrounding individual rights containing the right to make choices in life. This includes, but is not limited to where and with whom to live, relationships with people in the community, how to spend time and participating in program planning and implementation.	12/2017
90-Day Checklist/ Monitoring Checklist Does the individuals' routine outlined in ISP include participation in community activities and events?	Partially Complies due to including participation in community activities and events	Additional rule language will be added to policies/procedures that address both residential and non-residential settings to clarify CMS setting regulations that address individuals receiving services to the same degree of access as individuals not receiving HBCS.	08/2016
90-Day Checklist/ Monitoring Checklist Does CCB/POC, ISP address the needs of the individual, implemented appropriately?	Fully Complies due to addressing the needs of the individual as outlined in the person centered planning process	No remediation needed	n/a
90-Day Checklist/ Monitoring Checklist Is the employment section of the ISP still current and is it being routinely discussed? -Confirm the individual is free from work without pay that benefits others?	Fully Complies due to ensuring individuals are supported in the opportunity to seek competitive employment	No remediation needed	n/a
ISP Is adequate Transportation being provided?	Partially Complies due to ensuring transportation is being provided	Additional rule language will be added to policies/procedures that address both residential and non-residential settings to clarify CMS setting regulations that address individuals receiving services to the same degree of access as individuals not receiving HBCS.	12/2017
Pre-Post Monitoring Checklist Transportation available to meet all community access needs	Fully Complies due to ensuring transportation is available to meet all community access needs prior to approving a transition	No remediation needed	n/a

Federal Requirement: Settings are selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.

Applicable Indiana Regulation	Compliance with HCBS Settings Final Rule:	Remediation Activity	Timeline
460 IAC 6-4 Rule 4. Types of Supported Living Services and Supports	Silent due to not specifying non-disability specific settings as an option	Additional rule language will be added to policies/procedures that address both residential and non-residential settings to clarify CMS setting regulations that ensure settings are selected by the individual from options including non-disability specific settings.	12/2017
460 IAC 6-29-3 Sec. 3. The provider designated in an individual's ISP as responsible for providing environmental and living arrangement support shall ensure that	Fully Complies due to setting option is identified and documented in the person centered planning process	No remediation necessary	n/a

appropriate devices or home modifications, or both (1) are provided to the individual in accordance with the individual's ISP			
(Part 4.5 and 4.6 of Manual-FSW/CIH) Participants may choose to live in their own home, family home, or community setting appropriate to their needs.	Fully Complies due to individual choice in where to live.	No remediation needed	n/a
460 IAC 7-3-12 (PCP)- (a) A provider shall train the provider's employees or agents in the protection of an individual's rights, including how to: (3) implement person centered planning and an individual's ISP;	Fully Complies due to setting option is identified and documented in the person centered planning process and employees are trained on protecting individual's rights	No remediation needed	n/a
460 IAC 7-4-2 Collection of information Sec. 2. The support team shall collect all the information required to complete the ISP. In collecting the information needed to complete the ISP, the team shall be cognizant of the past, present, and future influences of a variety of factors that define the individual's quality of life.	Fully Complies due to requirement of collecting all relevant information from the person centered planning process to complete the ISP	No remediation needed	n/a
460 IAC 6-3-32 "Individualized support plan" or "ISP" defined Sec. 32. "Individualized support plan" or "ISP" means a plan that establishes supports and strategies, based upon the person centered planning process, intended to accomplish the individual's long term and short term outcomes by accommodating the financial and human resources offered to the individual through paid provider services or volunteer services, or both, as designed and agreed upon by the individual's support team.	Fully Complies due to person centered planning process outlining the supports and strategies to accomplish goals and documenting a person's resources available.	No remediation needed	n/a
460 IAC 6-3-38.5 "Person centered planning" defined (1) allows an individual, the individual's legal representative, if applicable, and any other person chosen by the individual to direct the planning and allocation of resources to meet the individual's life goals; (2) achieves understanding of how an individual: (A) learns; (B) makes decisions; and C) is and can be productive; (3) discovers what the individual likes and dislikes; and (4) empowers an individual and the individual's family to create a life plan	Partially Complies. Language does not specify documenting residential options in the person centered planning process including non-disability specific and the option for a private unit in a residential setting.	Additional rule language will be added to policies/procedures to clarify CMS setting regulations that require documentation in the person centered planning process that settings are selected by the individual from options including non-disability specific settings and the requirement to document resources available for room and board.	12/2017

and corresponding ISP for the individual that: (A) is based on the individual's preferences, dreams, and needs; (B) encourages and supports the individual's long term hopes and dreams; (C) is supported by a short term plan that is based on reasonable costs, given the individual's support needs; (D) includes individual responsibility; and (E) includes a range of supports, including funded, community, and natural supports.			
460 IAC 6-24-3 Management of Individuals Financial Resources (b) The provider shall assist an individual to: (1) obtain, possess, and maintain financial assets, property, and economic resources; and (2) obtain insurance at the individual's expense to protect the individual's assets and property.	Partially Complies due to documenting resources available for room and board	Additional rule language will be added to policies/procedures to clarify CMS setting regulations that require documentation in the person centered planning process resources available for room and board.	12/2017
DSP Training (4600228027) Initial DSP training requires an approved core competency such as Person Centered Planning, Respect/Rights, Choice, Competence, and Community presence and participation	Fully Complies due to training requirements in choices, rights and the person centered planning process.	no remediation required	n/a
Professional Qualifications and Requirements (4600228021) Provider shall ensure that services provided to individual meet the needs of the individual	Partially Complies due to training requirements in choices, rights and the person centered planning process.	Additional rule language will be added to policies/procedures to clarify CMS setting regulations that require documentation in the person centered planning process that settings are selected by the individual from options including non-disability specific settings and the requirement to document resources available for room and board.	12/2017
(Part 4.5 and 4.6 of Manual-FSW/CIH) Participants develop an Individualized Support Plan (ISP) using a person centered planning process guided by an Individual Support Team (IST).	Partially Complies due to the person centered planning process based on an individual's needs and preferences	Additional rule language will be added to policies/procedures to clarify CMS setting regulations that require documentation in the person centered planning process that settings are selected by the individual from among setting options including non-disability specific settings and the requirement to document resources available for room and board.	12/2017

Federal Requirement: Settings ensure an individual's rights of privacy, dignity, respect, and freedom from coercion and restraint.

Applicable Indiana Regulation	Compliance with HCBS Settings Final Rule:	Remediation Activity	Timeline
460 IAC 7-3-12 "Person centered planning" or "PCP" defined- Sec. 12. "Person centered planning" or "PCP" means a process that:	Partially Complies due to the Person centered planning process is based on the individual's needs	Additional rule language will be added to policies/procedures to clarify CMS setting regulations that any use of restraint must be supported by a specific assessed need and	12/2017

<p>(1) allows an individual, the individual's legal representative, if applicable, and any other person chosen by the individual to direct the planning and allocation of resources to meet the individual's life goals; (2) achieves understanding of how an individual: (A) learns; (B) makes decisions; and (C) is and can be productive; (3) discovers what the individual likes and dislikes; and (4) empowers an individual and the individual's family to create a life plan and corresponding ISP for the individual that: (A) is based on the individual's preferences, dreams, and needs; (B) encourages and supports the individual's long term hopes and dreams; (C) is supported by a short term plan that is based on reasonable costs, given the individual's support needs; (D) includes individual responsibility; and (E) includes a range of supports, including funded, community, and natural supports.</p>		<p>justified in the person-centered planning process</p>	
<p>460 IAC 6-8-2 - Constitutional and statutory rights Sec. 2. (a) A provider shall ensure that an individual's rights as guaranteed by the Constitution of the United States and the Constitution of Indiana are not infringed upon.</p>	<p>Fully Complies due to requirement of ensuring individual's rights</p>	<p>No remediation needed</p>	<p>n/a</p>
<p>IC 12-27-4 – Seclusion and Restraint laws IC 12-27-4-1 Cases in which seclusion or restraint may be used Sec. 1. A service provider may use seclusion or restraint of a patient only in the following cases: (1) When necessary to prevent danger of abuse or injury to the patient or others.</p>	<p>Fully Complies due to limits on restraints</p>	<p>No remediation needed</p>	<p>n/a</p>
<p>460 IAC 6-8-3 Promoting the exercise of rights Sec. 3. To protect an individual's rights and enable an individual to exercise the individual's rights, a provider shall do the following: (3) Obtain written consent from an individual, or the individual's legal representative, if applicable, before releasing information from the individual's records unless the person requesting</p>	<p>Fully Complies due to ensuring an individual's rights and privacy are protected and individuals are informed of their rights</p>	<p>No remediation needed</p>	<p>n/a</p>

<p>release of the records is authorized by law to receive the records without consent. (5) Inform an individual, in writing and in the individual's usual mode of communication, of: (A) the individual's constitutional and statutory rights using a form approved by the BDDS; and (B) the complaint procedure established by the provider for processing complaints.</p>			
<p>460 IAC 6-10-8 - Resolution of disputes (b) The resolution of a dispute shall be designed to address an individual's needs.</p>	<p>Fully Complies due to any resolution of a dispute will address the individual's needs</p>	<p>No remediation needed</p>	<p>n/a</p>
<p>460 IAC 6-9-4 – Systems for protecting individuals (b) A provider shall require that at regular intervals, as specified by the individual's ISP, the individual be informed of the Following (1) The individual's medical condition. (2) The individual's developmental and behavioral status. (3) The risks of treatment. (4) The individual's right to refuse treatment. A provider shall establish a protocol for ensuring that an individual is free from unnecessary medications and physical restraints. A provider shall establish a system to reduce an individual's dependence on medications and physical restraints. (e) A provider shall establish a system to ensure that an individual has the opportunity for personal privacy.</p>	<p>Partially Complies due to requirement of providers to ensure unnecessary medications and restraints are not used. The word <i>unnecessary</i> to be removed.</p>	<p>Necessary modifications will be made to 460 IAC 6 to reach HCBS compliance</p>	<p>12/2017</p>
<p>460 IAC 6-9-3 Prohibiting violations of individual rights Sec. 3. (a) A provider shall not: (1) abuse, neglect, exploit, or mistreat an individual; or (2) violate an individual's rights.</p>	<p>Fully Complies due to language prohibiting the violations of rights</p>	<p>No remediation needed</p>	<p>n/a</p>
<p>Aversive Techniques (BDDS 4601207003) It is the policy of the Bureau of Developmental Disabilities Services (BDDS) that aversive techniques shall not be used to support individuals receiving waiver funded services.</p>	<p>Fully Complies due to restrictions on any aversive techniques</p>	<p>No remediation needed</p>	<p>n/a</p>
<p>Use of Restrictive Interventions, Including Restraint (BDDS 460 0228 025) It is the policy of the Bureau of Developmental Disabilities Services (BDDS) and Bureau of Quality Improvement Services (BQIS) that behavioral support plans containing</p>	<p>Fully Complies due to need to document any nonrestrictive plans that have been attempted and limitations on interventions</p>	<p>No remediation needed</p>	<p>n/a</p>

restrictive interventions are the least desirable approach to supporting individuals receiving waiver funded services, and that restrictive interventions will be used only with those individuals presenting challenging/dangerous behaviors for which nonrestrictive behavioral support plans have been attempted and documented as ineffective.			
Human Rights Committee (BDDS 460 0221 012) c. have a written policy defining the committee’s functions, including review of: i. the use of restrictive interventions with an individual; and ii. other human rights issues for individuals.	Fully Complies due to requirement of a HRC to review any restrictive interventions and other human rights issues	No remediation needed	n/a
Protection of Individual Rights (4600228022) It is the policy of the Bureau of Developmental Disabilities Services (BDDS) that an individual’s rights shall not be violated and shall be protected under penalty of the law.	Fully Complies due to ensuring an individual’s rights shall not be violated and are protected under penalty of the law	No remediation needed. This policy to be revised into the Individual Rights and Responsibilities	n/a
Requirements & Training of Direct Support Professional Staff (4600228027) – Annual Training on the protection of individual rights and respecting dignity of individual	Fully Complies due to requirement for all direct support professionals to be trained annually on dignity and rights	No remediation needed	n/a
Professional Qualifications and Requirements (4600228021) 3. A Provider’s owners, directors, officers, employees, contractors, subcontractors or agents performing any management, administrative or direct service to an Individual on behalf of a Provider company shall receive initial and at minimum annual training in the protection of an Individual’s rights, including: a. respecting the dignity of an Individual; b. protecting an Individual from Abuse, Neglect, and Exploitation	Fully Complies due to requirements for all employees to be trained annually on rights, respects, and protection from exploitations	No remediation needed	n/a
Individual Rights and Responsibilities (NEW) (4600221014) <i>In process of being updated to enhance support of CMS regulations</i>	Fully Complies	Language has been drafted to include all aspects of HCBS rule surrounding individual rights including rights of privacy, dignity, respect, and freedom from coercion and restraint and individual rights within provider owned or controlled settings	12/2017

<p>DDRS Policy: Personnel Policies and Manuals The written personnel policy required by 460 IAC 6-16-2 shall include:</p> <p>A process for suspension of the owner, director, officer, employee, contractor, subcontractor or agent from services to Individuals following a report of, and during an investigation of, alleged Abuse, Neglect, or Exploitation of an Individual by the owner, director, officer, employee, contractor subcontractor or agent.</p> <p>Safeguards that ensure compliance with HIPAA and all other Federal and State privacy laws.</p>	<p>Fully Complies due to requirements of ensuing all privacy laws are followed</p>	<p>No remediation needed</p>	<p>n/a</p>
<p>Provider Agreement Checklist 12. Prohibiting Violations of Individual Rights The provider must have a written policy and procedures that prohibit its employees/agents from violating individuals' rights</p>	<p>Fully Complies due to ensuring an individual's rights shall not be violated and are protected under penalty of the law</p>	<p>No remediation needed</p>	<p>n/a</p>
<p>Provider Agreement Checklist 14 Individual Freedoms The provider must have a written protocol for ensuring individuals' rights as outlined in 460 IAC and DDRS Policies</p>	<p>Fully Complies due to requirement of written protocol for ensuing individual rights</p>	<p>No remediation needed</p>	<p>n/a</p>
<p>Provider Agreement Checklist 15 Personnel Policy- Safeguards that ensure compliance with HIPAA and all other Federal and State Privacy Laws.</p>	<p>Fully Complies due to requirement of written procedure for compliance of all privacy laws</p>	<p>No remediation needed</p>	<p>n/a</p>
<p>90-Day Checklist/ Monitoring Checklist Free from ANE? Informed and able to understand/ exercise their rights as individual receiving services? Is the individual being treated with respect by the support staff?</p>	<p>Fully Complies due to ensuring each individual is informed annually or more often of their rights and ensuring the individual is being treated with respect</p>	<p>No remediation needed</p>	<p>n/a</p>

Federal Requirement: Settings optimize, but do not regiment, individual initiative, autonomy, and independence in making life choices including but not limited to, daily activities, physical environment, and with whom to interact.

Applicable Indiana Regulation	Compliance with HCBS Settings Final Rule:	Remediation Activity	Timeline
<p>460 IAC 6-24-1 Coordination of training services and training plan (be</p>	<p>Fully Complies due to optimizing the environment</p>	<p>No remediation needed</p>	<p>n/a</p>

designed to enhance skill acquisition and increase independence).	to enhance skill acquisition and increase independence.		
460 IAC 6-8-2 Constitutional and statutory rights	Fully Complies due to requirement of ensuring individual's rights including promoting rights	No remediation needed	n/a
460 IAC 6-8-3 promoting the exercise of rights Sec. 3. To protect an individual's rights and enable an individual to exercise the individual's rights, a provider shall do the following: (2) Provide services that: (A) are meaningful and appropriate;	Fully Complies due to requirement of ensuring individual's rights including promoting rights	No remediation needed	n/a
460 IAC 6-36-2 Code of ethics Sec. 2. A provider, in the provision of services under this article, shall abide by the following code of ethics: (1) A provider shall provide professional services with objectivity and with respect for the unique needs and values of the individual being provided services. (3) A provider shall provide sufficient objective information to enable an individual, or the individual's guardian, to make informed decisions.	Fully Complies due to enabling individuals to make informed decisions.	No remediation needed	n/a
460 IAC 6-3-54 "Support team" defined are designated by the individual;	Fully Complies due to individual designating members of the team.	No remediation needed	n/a
Individual Rights and Responsibilities (NEW) (4600221014)	Fully Complies	Language has been drafted to include all aspects of HCBS rule on individual rights that ensures individuals have independence in making life choices including but not limited to, daily activities, physical environment, and with whom to interact.	12/2017
90-Day Checklist/ Monitoring Checklist Does the individual's routine outlined in the ISP include participation in community activities and events?	Fully Complies due to ensuring individual is participating in activities of their choice	No remediation needed	n/a

Federal Requirement: Settings facilitate individual choice regarding services and supports, and who provides them.

Applicable Indiana Regulation	Compliance with HCBS Settings Final Rule:	Remediation Activity	Timeline
460 IAC 7-4-3 Composition of the support team	Fully Complies due to individual choosing members of team	No remediation necessary	n/a
460 IAC 7-3-12 AND 6-3-38.5 (PCP) (4) empowers an individual and the individual's family to create a life plan	Fully Complies due to individual creating life plan based on preferences, needs and dreams	No remediation necessary	n/a

<p>and corresponding ISP for the individual that:</p> <p>(A) is based on the individual's preferences, dreams, and needs;</p> <p>(B) encourages and supports the individual's long term hopes and dreams;</p> <p>(C) is supported by a short term plan that is based on reasonable costs, given the individual's support needs;</p> <p>(D) includes individual responsibility; and</p> <p>(E) includes a range of supports, including funded, community, and natural supports.</p>			
<p>460 IAC 7-5-5 (Outcome section)</p> <p>(4) Proposed strategies and activities for meeting and attaining the outcome, including the following:</p> <p>(5) The party or parties, paid or unpaid, responsible for assisting the individual in meeting the outcome. A responsible party cannot be changed unless the support team is reconvened and the ISP is amended to reflect a change in responsible party.</p>	Fully Complies due to requirements for amending ISP	No remediation necessary	n/a
<p>Individual Rights and Responsibilities (NEW) (4600221014)</p>	Fully Complies	Language has been drafted to include all aspects of HCBS rule surrounding individual rights including individual rights that ensure individual choice regarding services and supports, and who provides them.	12/2017
<p>IST (4600228016)</p> <p>Coordinate the provision and monitoring of needed supports for the individual</p>	Fully Complies due to the IST supporting the Individual in coordinating supports. Identifies other persons identified by the individual AND requires the individual to be present at all meetings	No remediation needed	n/a
<p>(Part 4.5 and 4.6 of Manual-FSW/CIH)</p> <p>The participant with the IST selects services, identifies service providers of their choice and develops a Plan of Care/Cost Comparison Budget (CCB). Freedom of Choice Form Provider Pick List</p>	Fully Complies due to ensuring the participant selects providers of their choice	No remediation needed	n/a
<p>90-Day Checklist/Monitoring Checklist</p>	Fully Complies due to ensuring a participant is informed of their choice to	No remediation needed	n/a

Provided information on their right to choose and change providers and case managers?	choose and change providers at any time		
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Federal Requirement: In provider-owned or controlled residential settings, the setting is a specific physical place that is owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has the same responsibilities and protections from eviction as all tenants under landlord/tenant law of the State, county, city or other designated entity. In settings where tenant laws do not apply, a lease, residency agreement or other written agreement is in place providing protections to address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.

Applicable Indiana Regulation	Compliance with HCBS Settings Final Rule:	Remediation Activity	Timeline
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IC 22-9-6-3 Full and equal access to housing- Sec. 3. All persons with disabilities are entitled to full and equal access, as other members of the public, to all housing accommodations offered for rent, lease, or compensation in Indiana.	Fully Complies due to state land lord/tenant law	No remediation needed	n/a
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460 IAC 6-24-3 Management of Individual's financial resources (b) The provider shall assist an individual to: (1) obtain, possess, and maintain financial assets, property, and economic resources	Partially Complies due to requirement of assisting the individuals with maintaining property	Additional rule language will be added to policies/procedures to clarify CMS setting regulations to ensure protections are in place to address the eviction process.	12/2017
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Individual Rights and Responsibilities (NEW) (4600221014)	Fully Complies	Language has been drafted to include all aspects of HCBS rule surrounding individual rights including individual rights within provider owned or controlled settings	12/2017
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90-Day Checklist Has the provider obtained a rental agreement in the individuals' name? Monitoring Checklist Does the individual have the same responsibilities/protections from eviction as all tenants under landlord tenant law of state, county, city or other designated entity?	Complies due to checking of rental agreement and assuring protections are in place.	Additional rule language has been added to clarify CMS setting regulations to ensure protections are in place to address the eviction process.	08/2016
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ISP Are the Individuals' Property/Financial resources being properly managed?	Partially Complies due to assuring individuals property is being properly managed	Additional rule language will be added to policies/procedures to clarify CMS setting regulations to ensure protections are in place to address the eviction process.	12/2017
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Federal Requirement: In provider-owned or controlled residential settings, each individual has privacy in their sleeping or living unit.

Applicable Indiana Regulation	Compliance with HCBS Settings Final Rule:	Remediation Activity	Timeline
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460 IAC 6-9-4 Systems for protecting individuals (e) A provider shall establish a system to ensure that an individual has the opportunity for personal privacy.	Fully Complies due to requirement for individuals to have the opportunity for personal privacy	No remediation needed	n/a
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<p>(1) the opportunity to communicate, associate, and meet privately with persons of the individual's choosing;</p> <p>(2) the means to send and receive unopened mail; and</p> <p>(3) access to a telephone with privacy for incoming and outgoing local and long distance calls at the individual's expense</p>			
<p>Individual Rights and Responsibilities (NEW) (4600221014)</p>	<p>Fully Complies</p>	<p>Language has been drafted to include all aspects of HCBS rule surrounding individual rights including having privacy in their sleeping or living unit.</p>	<p>12/2017</p>

Federal Requirement: In provider-owned or controlled residential settings, units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.

Applicable Indiana Regulation	Compliance with HCBS Settings Final Rule:	Remediation Activity	Timeline
<p>No applicable regulation</p>	<p>Silent due to rules not currently addressing lockable doors in residences</p>	<p>Additional rule language will be added to policies/procedures to clarify CMS setting regulations to address in provider-owned or controlled residential settings units having entrance doors lockable by the individual, with only appropriate staff having keys to doors.</p>	<p>12/2017</p>

Federal Requirement: In provider-owned or controlled residential settings individuals sharing units have a choice of roommates.

Applicable Indiana Regulation	Compliance with HCBS Settings Final Rule:	Remediation Activity	Timeline
<p>No applicable regulation</p>	<p>Silent due to rules not currently addressing individuals having a choice of roommates.</p>	<p>Additional rule language will be added to policies/procedures to clarify CMS setting regulations to address in provider-owned or controlled residential settings that individuals sharing units have a choice of roommates.</p>	<p>12/2017</p>

Federal Requirement: In provider-owned or controlled residential settings, individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

Applicable Indiana Regulation	Compliance with HCBS Settings Final Rule:	Remediation Activity	Timeline
<p>460 IAC 6-9-4 Systems for protecting individuals (g) A provider shall establish a system that ensures that an individual has: (i) A provider shall establish a system that ensures that an individual has the right to retain and use appropriate personal possessions and clothing.</p>	<p>Does Not Comply. Need to remove language <i>appropriate</i>.</p>	<p>Additional rule language will be added to policies/procedures to clarify CMS setting regulations that in provider-owned or controlled residential settings, individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.</p>	<p>12/2017</p>

Individual Rights and Responsibilities (NEW) (4600221014)	Fully Complies	Language has been drafted to include all aspects of HCBS rule surrounding individual rights including the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.	12/2017
90-Day Checklist Unrestricted access to their personal possessions? Monitoring Checklist Does the individual have the freedom to furnish and decorate their sleeping or living quarters within the lease or other agreement?	Complies due to unrestricted access to personal possessions and freedom to furnish and decorate.	Additional rule language has been added to clarify CMS setting regulations that in provider-owned or controlled residential settings, individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.	08/2016

Federal Requirement: In provider-owned or controlled residential and non-residential settings, individuals have the freedom and support to control their schedules and activities, and have access to food any time.

Applicable Indiana Regulation	Compliance with HCBS Settings Final Rule:	Remediation Activity	Timeline
460 IAC 6-3-38.5 "Person centered planning" defined Sec. 38.5. "Person centered planning" means a process that: (1) allows an individual, the individual's legal representative, if applicable, and any other person chosen by the individual to direct the planning and allocation of resources to meet the individual's life goals; (4) empowers an individual and the individual's family to create a life plan and corresponding ISP for the individual that:	Partially Complies due to the individual directing the planning of services. Language does not address <i>freedom and support to control of activities and schedules.</i>	Additional rule language will be added to policies/procedures to clarify CMS setting regulations that individuals have the freedom and support to control their activities and schedules.	12/2017
460 IAC 6-14-2 Requirement for qualified personnel Sec. 2. A provider shall ensure that services provided to an individual: (1) meet the needs of the individual;	Partially Complies. Language does not address <i>freedom and support to control of activities and schedules.</i>	Additional rule language will be added to policies/procedures to clarify CMS setting regulations that individuals have the freedom and support to control their activities and schedules.	12/2017
460 IAC 6-19-1 Information concerning an individual Sec. 1. A provider of case management services shall have the following information about an individual receiving case management services from the provider: (1) The wants and needs of an individual, including the health, safety and behavioral needs of an individual.	Partially Complies. Language does not address <i>freedom and support to control of activities and schedules.</i>	Additional rule language will be added to policies/procedures to clarify CMS setting regulations that individuals have the freedom and support to control their activities and schedules.	12/2017
460 IAC 6-36-2 Code of ethics (1) A provider shall provide professional services with objectivity and with respect for the unique needs	Partially Complies. Does not address specific language.	Additional rule language will be added to policies/procedures to clarify CMS setting regulations.	12/2017

and values of the individual being provided services.			
90-Day Checklist Does the individual's routine outlined in the ISP include participation in community activities and events? Monitoring Checklist Does the individual have the freedom and support to control their schedules and activities?	Complies. Language addresses <i>freedom and support to control of activities and schedules</i> .	Additional rule language has been added to clarify CMS setting regulations that individuals have the freedom and support to control their activities and schedules	08/2016
460 IAC 6-9-3 Prohibiting violations of individual rights (4) A practice that denies an individual any of the following without a physician's order (C) Food	Partially complies due to language does not address <i>access to food at any time</i>	Additional rule language will be added to policies/procedures to clarify CMS setting regulations that individuals have access to food at anytime	12/2017
90-Day Checklist Individualized dining plan, does it include food restrictions? Monitoring Checklist Does the individual have the freedom and support to control their schedules and activities and have access to food at any time?	Complies due to language addresses <i>access to food at any time</i>	Additional rule language has been added to clarify CMS setting regulations that individuals have access to food at any time and any modification must be addressed in the person centered planning process.	08/2016
Individual Rights and Responsibilities (NEW) (4600221014)	Fully Complies	Language has been drafted to include all aspects of HCBS rule surrounding individual rights including ensuring individuals have the freedom and support to control their schedules and activities, and have access to food any time.	12/2017
Protection of Individual Rights (4600228022) Practices prohibited under this section include but are not limited to the following c. A practice that denies an Individual any of the following without a physician's order: iii. Food. iv. Drink.	Partially complies due to language does not address <i>access to food at any time</i>	This policy to be revised into the Individual Rights and Responsibilities	12/2017
Federal Requirement: In provider-owned or controlled residential and non-residential settings, individuals are able to have visitors of their choosing at any time.			
Applicable Indiana Regulation	Compliance with HCBS Settings Final Rule:	Remediation Activity	Timeline
460 IAC 6-9-4 (1) the opportunity to communicate, associate, and meet privately with persons of the individual's choosing;	Partially Complies. Language does not address <i>at any time</i>	Additional rule language will be added to policies/procedures to clarify CMS setting regulations that individuals are able to have visitors of their choosing at any time.	12/2017

<p>460 IAC 6-9-3 Prohibiting violations of individual rights Sec. 3. (a) A provider shall not: (1) abuse, neglect, exploit, or mistreat an individual; or (2) violate an individual's rights.</p>	<p>Fully Complies due to requirement of not violating an individual's rights</p>	<p>No remediation needed</p>	<p>n/a</p>
<p>90-Day Checklist/ Monitoring Checklist Free to receive visitors with no restrictions?</p>	<p>Fully Complies due to verifying visitors can be received without any restrictions</p>	<p>No remediation needed</p>	<p>n/a</p>

Federal Requirement: In provider-owned or controlled residential or non-residential settings, the setting is physically accessible to the individual.

Applicable Indiana Regulation	Compliance with HCBS Settings Final Rule:	Remediation Activity	Timeline
<p>460 IAC 6-29-2 Safety of individual's environment (c) If an environmental assessment determines that an environment is unsafe for an individual, the provider shall take the appropriate steps to ensure that the individual is safe</p>	<p>Fully Complies due to requirement for provider to ensure an individual's environment is safe</p>	<p>No remediation needed</p>	<p>n/a</p>
<p>460 IAC 6-29-3 Monitoring an individual's environment Sec. 3. The provider designated in an individual's ISP as responsible for providing environmental and living arrangement support shall ensure that appropriate devices or home modifications, or both: (1) are provided to the individual in accordance with the individual's ISP; and (2) satisfy the federal Americans with Disabilities Act requirements and guidelines</p>	<p>Fully Complies with due to requirements for providing environmental and living supports based on individual need</p>	<p>No remediation needed</p>	<p>n/a</p>
<p>Environmental Requirements (BDDS 460 1216039) A Provider designated in the Individual's Individual Support Plan (ISP) as responsible for providing environmental and living arrangement support for the individual shall ensure that an Individual's physical environment included modification and adaptations in compliance with the requirements of a. The individual's ISP</p>	<p>Fully Complies due to requirement of provider to ensure accessibility to the individual.</p>	<p>No remediation needed</p>	<p>n/a</p>
<p>Transition Activities (4600316031)</p>	<p>Fully Complies due to requirement of BDDS to only approve transitions after</p>	<p>No remediation needed</p>	<p>n/a</p>

	home visits that verify individuals in residential settings receive services and supports appropriate to meet their needs including the completion of a pre-post monitoring checklist.		
Pre-Post Monitoring Checklist Home Adaptations in place?	Fully Complies due to requirement of having home adaptations in place prior to and after residential moves	No remediation needed	n/a

Federal Requirement: Any modifications of the additional conditions for provider-owned and controlled residential settings must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:

1. Identify a specific and individualized need.
2. Document the positive interventions and supports used prior to any modifications to the person-centered plan.
3. Document less intrusive methods of meeting the need that have been tried but did not work.
4. Include a clear description of the condition that is directly proportionate to the specific need addressed.
5. Include regular collection and review of data to measure the ongoing effectiveness of the modification.
6. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
7. Include the informed consent of the individual.
8. Include an assurance that interventions and supports will cause no harm to the individual.

Applicable Indiana Regulation	Compliance with HCBS Settings Final Rule:	Remediation Activity	Timeline
<p>460 IAC 7-3-12 "Person centered planning" or "PCP" defined- Sec. 12. "Person centered planning" or "PCP" means a process that:</p> <p>(1) allows an individual, the individual's legal representative, if applicable, and any other person chosen by the individual to direct the planning and allocation of resources to meet the individual's life goals;</p> <p>(2) achieves understanding of how an individual:</p> <p>(A) learns;</p> <p>(B) makes decisions; and</p> <p>(C) is and can be productive;</p> <p>(3) discovers what the individual likes and dislikes; and</p> <p>(4) empowers an individual and the individual's family to create a life plan and corresponding ISP for the individual that:</p> <p>(A) is based on the individual's preferences, dreams, and needs;</p> <p>(B) encourages and supports the individual's long term hopes and dreams;</p> <p>(C) is supported by a short term plan that is based on reasonable costs, given the individual's support needs;</p> <p>(D) includes individual responsibility; and</p>	Does Not Comply. Language does not address documentation requirements	Additional rule language will be added to policies/procedures to clarify CMS setting regulations that any modifications of the additional conditions for provider-owned and controlled residential and non-residential settings must be supported by a specific assessed need and justified with the requirements outlined above documented in the person-centered service plan	12/2017

(E) includes a range of supports, including funded, community, and natural supports.			
460 IAC 7-4-1 Development of an ISP- Sec. 1. (a) An ISP shall be developed by an individual's support team using a "person centered planning" process. The support team shall be led by a facilitator chosen by the individual.	Does Not Comply. Language does not address documentation requirements	Additional rule language will be added to policies/procedures to clarify CMS setting regulations that any modifications of the additional conditions for provider-owned and controlled residential and non-residential settings must be supported by a specific assessed need and justified with the requirements outlined above documented in the person-centered service plan	12/2017
POLICY: BEHAVIORAL SUPPORT PLAN- 5. All efforts at positive behavioral and environmental supports shall be assessed by the behavioral support services provider on a regular basis, with at minimum quarterly reports to the IST of progress that include graphs of both targeted behavior and replacement behavior. 6. A BSP is a component of the individual's ISP.	Complies due to requirement of documentation of efforts at positive and environmental supports	No remediation necessary	12/2017

SECTION 3: SITE SPECIFIC ASSESSMENT

The site-specific assessment activities were general in nature and did not imply that any specific provider or location is non-compliant solely by classification or service type. Final determination will depend upon information gathered through additional assessment activities, outlined in this comprehensive transition plan. This will include but many not be limited to, onsite reviews, provider self-assessments, internal and external programmatic data, and provider/participant surveys. These activities will place a direct focus on the member's experience within the DDRS system.

The National Core Indicators (NCI) data and existing 90-Day Checklist data were initially reviewed to determine settings compliance. DDRS utilized the NCI data as a starting point/initial indicator to identify the status of the program. When DDRS measured this information against data collected from the 90-Day Checklist, the need for further review was determined due to inconsistencies in the data outcomes. A more in-depth analysis was then conducted via the Individual Experience Survey (IES) that targets the specific requirements. Upon review of all data, DDRS was able to gauge compliance with the specific HCBS Settings requirements. In addition to the NCI, 90-Day Checklist, and the IES data, Indiana's waiver data system, INsite, was also used to determine service settings based upon the information noted in the system for individuals.

National Core Indicators (NCI) Data Review

In order to ascertain the level of compliance with the HCBS requirements, DDRS had chosen to utilize the NCI data to begin the process by which to evaluate compliance. The [core indicators](#) are standard measures used across states to assess the outcomes of services provided to individuals and families. Indicators address key areas of concern including employment, rights, service planning, community inclusion, choice, and health and safety. The data obtained from the NCI was derived from a random sample of waiver participants across Indiana. A statistically valid sample was obtained and in person interviews were conducted with individuals and family members (as available) to gather information by asking the same questions of all participants. NCI findings, including those specific to Indiana, are available at <http://www.nationalcoreindicators.org/states/>.

The initial review of the NCI data found that it did not include measurement of all necessary areas of HCBS compliance. In addition, due to the use of a sample size, DDRS has determined it will not use the NCI data to measure initial HCBS compliance. DDRS will continue to review the data as a way to confirm or validate other information and data collected outside of the NCI analysis.

90-Day Checklist Data Review

The 90-Day Checklist is used as a monitoring tool for case managers to ensure supports are provided consistent with BDDS policies and procedures. The 90-Day Checklist has been modified and is now called the Monitoring Checklist. While the state was unable to validate a settings compliance based solely on past data of the 90-Day Checklist, the updated Monitoring Checklist will allow for ongoing compliance measurement. Since August 2016, for provider controlled or owned residential settings; the below questions are currently addressed in the Monitoring Checklist with a corrective action being generated for any 'No' answer that has not been supported by a specific need and justified in the person-centered service plan:

- Has the identified provider obtained a rental agreement in the individual's name?
- Does the individual have the same responsibilities/protections from eviction as all tenants under landlord tenant law of state, county, city or other designated entity?
- If the individual shares living quarters, did the individual have a choice of roommates?
- Are the individual's safety and environmental requirements included in the ISP and all needed modifications and assistive devices identified in place and available to the individual?
- Does the individual have the freedom to furnish and decorate their sleeping or living quarters within the lease or other agreement?
- Does the individual have the freedom and support to control their schedules and activities and have access to food at any time?
- Does the individual's living quarters have lockable entrance doors, with the individual and appropriate staff having keys to doors as needed?
- Does the individual have privacy in their sleeping or living quarters?
- Does record review and discussion with staff, the individual and legal guardian if indicated confirm the individual is free to receive visitors with no restrictions?
- Does record review and discussion with staff, the individual and legal guardian if indicated confirm the individual is free to receive/open their own mail and receive/make phone calls without restriction?
- Is there documentation confirming that the individual and/or their legal guardian have been informed of their rights as an individual receiving services?
- Is the setting physically accessible to the individual?

If the response to any question on the Monitoring Checklist related to HCBS requirements is evaluated to be out of compliance, the case managers notify the responsible party that a corrective action is required to be completed and submitted. The case manager then verifies that the corrective action has been completed which results in the responsible party being back in compliance with the requirement(s). If compliance cannot be achieved within the specified timelines, Bureau of Quality Improvement Services (BQIS) would be notified and the current process outlined in [IC 12-11-1.1-11](#) Issuance of citation for violations; requirements; remedies; considerations of determining remedy would be used. The Monitoring Checklist is one monitoring tool that will be used to ensure ongoing compliance after the March 2019 deadline.

DDRS is also making enhancements to the Person Centered Planning process through the LifeCourse Framework. As part of these enhancements, non-disability specific options will be discussed and documented throughout the Person Centered Planning process. In addition, the current process and forms will be reevaluated to ensure compliance to the new rules and any modifications of those rules.

The specific categories below will also be addressed through the LifeCourse Framework with a systemic verification process that will ensure ongoing monitoring of HCBS compliance of the following sections:

1. The individual's setting is integrated in and supports access to the greater community
2. The individual's setting provides opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources
3. The individual's setting ensures the individual receives services in the community to the same degree of access as individuals not receiving Medicaid home and community based services
4. The individual's setting was selected by the individual from among setting options, including non-disability specific settings and an option for a private unit in a residential setting
5. The individual's setting ensures their rights of privacy, dignity, respect, and freedom from coercion and restraint
6. The individual's setting optimizes the individual's initiative, autonomy, and independence in making life choices

Individual's HCBS requirements will be reviewed for compliance on a yearly basis through the Monitoring Checklist as well as the LifeCourse Framework's person centered planning process. For non-residential settings, revisions to the provider enrollment process and the Compliance Evaluation and Review Tool (CERT) will be made to cover all aspects of the HCBS rule to measure ongoing compliance. Trainings will be scheduled for state staff, members, providers and case managers on any changes in policies, procedures, and the monitoring process of the HCBS rules. These training will ensure a clear understating of the steps DDRS will be undertaking and the ongoing compliance tools that will be used.

Individual Experience Survey

The DDRS developed a high quality, comprehensive survey that targets the specific HCBS requirements and provides additional data to determine DDRS' compliance status. DDRS contracted with The Indiana Institute on Disability and Community (IIDC) to design and develop the survey to be completed by participants when able or the person who knows them best.

Prior to the implementation of a statewide survey, DDRS, in conjunction with the IIDC, administered the survey using a pilot group which allowed DDRS to be confident in the validity and reliability of the survey questions. The IIDC, in consultation with DDRS, then finalized the survey questions for dissemination to all waiver participants. In November 2014, individuals and their families were invited to participate in an educational webinar on the HCBS rule which outlined the setting requirements as well as rights of beneficiaries.

Various trainings had taken place prior to the implementation of the IES for staff administering the survey. Case managers participated in mandatory webinar trainings conducted by DDRS and IIDC explaining in detail the IES process and how to implement the survey. Guidance materials and an FAQ were also provided to case managers prior to implementing the survey.

Case managers were instructed to educate and introduce members and family to the survey by explaining why DDRS was conducting the survey prior to actually completing it. The individual's case manager was responsible for ensuring completion of the survey with the individual during their quarterly meeting. If an individual was unable to answer the questions, the case manager was trained to work with the individual's guardian or other close advocate to complete the survey.

All case managers were instructed to complete the survey in person at a face to face meeting with the individual or their chosen family member. Since it was a face to face meeting, all individuals' responses were protected and not shared with the providers of services. 95% of waiver participants completed the survey. Data was not collected on those who assisted beneficiaries with completion of the survey.

DDRS released the IES Report on June 28th, 2016 to all stakeholders throughout the system outlining the results of the survey, the methodology behind the survey, as well as the intent of the survey to bring services into HCBS compliance by March 2019. Through the [Individual Experience Survey](#), DDRS identified and analyzed the experiences and choices individuals with intellectual and developmental disabilities have in their daily lives.

The IES was a starting point to a better understanding of individual experiences in the system which leads to a more in-depth analysis and validation of the data through record reviews, provider surveys and site visits. A review of the IES base line data provided guidance to DDRS to establish a process for engaging in site-specific validations that will ensure all HCBS service sites are within compliance.

Provider Assessments

DDRS determined the need for providers of identified residential and all non-residential settings to complete a self-assessment of their current policies and procedures to report compliance of HCBS Final Rule to the State. DDRS also concluded responses garnered from the IES will be used to validate the responses from the provider self-assessment to gain a global prospective of compliance.

All Non-Residential Day Service sites have completed an online self-assessment. The self-assessment was designed to identify areas where non-residential service sites are HCBS compliant as well as identify any gaps that would require modifications to become complaint. In preparation for the assessment, DDRS hosted a mandatory webinar, two technical webinar sessions, as well as provided a tutorial and FAQ for providers.

Based on the results of the [Individual Experience Survey](#) and other data, DDRS has identified specific residential sites that require a review prior to the determination of compliance.

Validation of the compliance of the specific sites is determined by CMS guidance as to what is and is not a community setting. CMS has issued clear guidance that any setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS is presumed to have the qualities of an institution. DDRS utilized this guidance in developing and establishing the criteria for engaging in site-specific assessments.

Settings that are presumed to be HCB and meet the rule without any changes required include individually owned homes, individualized supported employment and individualized community day activities.

DDRS is presuming individual private homes that are integrated in community neighborhoods meet home and community based requirements. In order to verify that the individuals continue to reside in such settings, the case manager will note in the person centered planning service plan the individuals' living arrangements and update any changes to monitor compliance over time. If at any time a setting in question is shown to be potentially isolating to individuals, the state will review the setting to ensure compliance and submit necessary information to CMS to conduct a Heightened Scrutiny review.

DDRS has also determined individualized supported employment and individualized community day activities (referred to as Extended Services and Community-Based Habilitation- Individual in our waivers) meet the HCBS requirements due to only providing Community-Based Habilitation Individual in the greater community and Extended Services providing supports to individuals who are in integrated competitive employment. There are approximately 24,645 service delivery sites that meet the rule without any changes.

A tiered evaluation process is being used to determine each settings' compliance with the HCBS Final Rule. All settings are being evaluated for full compliance with the rule. For tier 1, non-residential providers were first asked to complete a self-assessment, responding to a series of questions regarding their setting and the options individuals have within that setting. Once the providers completed the self-assessment, responses were reviewed for potential compliance with the rule and initial determinations of compliance were made (Compliant, Additional Information Needed, Site Visit Needed).

For tier 2 of the validation process, providers are being asked to provide documentation that validate their answers to the self-assessment and support their level of compliance with the rule. Documentation may include: policies and procedures, manuals, staff training materials, or any other documentation necessary to assess compliance with each requirement within the rule. This documentation will be reviewed, and a secondary determination of compliance will be sent to the provider (Compliant-no site visit needed; Non-compliant or partially compliant-Site visit needed). Materials will be submitted to DDRS and the contracted entity through a secure e-mail that was developed for this process.

If a setting is found to be non-compliant or partially compliant, a site visit will be scheduled. Site assessors will review each of the settings to make a determination of compliance based on the site assessment findings. If a provider is found not to be in compliance with the rule after the site visit, DDRS will work with the provider to develop a remediation plan to achieve full compliance. If providers are unable or unwilling to complete remediation, DDRS will work with the individual to assess their needs and preferences, and develop a transition plan for the individual.

Exact compliance levels will be determined after the evaluation process has been completed in 2017. DDRS is in the process of beginning Tier 2. The table below specifically identifies the setting results based on Tier 1 assessment activities. This

assessment is an estimate of total settings in each category and does not imply that any specific provider or location is non-compliant solely by classification. Final determination will depend upon information gathered through all assessment activities outlined in the comprehensive Statewide Transition Plan, including but not limited to onsite reviews, provider self-assessments, internal programmatic data, and provider/participant surveys.

SETTING ASSESSMENT							
CMS Criteria	NCI Data Analysis	90-Day Checklist Data Analysis	IES Data	Comprehensive Settings Results	Remediation		
Is integrated in and supports access to the greater community	Analysis of the NCI data revealed less than 100% compliance	Analysis of the 90-Day Checklist data revealed less than 100% compliance	Analysis of the IES data revealed less than 100% compliance	<p><i>Settings that are presumed to be HCB and meet the rule without any changes required:</i></p> <ul style="list-style-type: none"> • Individually owned homes <ul style="list-style-type: none"> ○ Approximately 1,760 sites** • Family homes <ul style="list-style-type: none"> ○ Approximately 14,385 sites** • Individualized community employment <ul style="list-style-type: none"> ○ Approximately 1,500 sites** • Individualized community day activities <ul style="list-style-type: none"> ○ Approximately 7,000 sites** <p><i>**Source: INsite – Indiana’s Waiver Data System</i></p>	<p><i>Settings that are presumed to be HCB and meet the rule without any changes required:</i></p> <p>No remediation required</p>		
Provide opportunities to seek employment and work in competitive integrated settings	Analysis of the NCI data revealed less than 100% compliance	Analysis of the 90-Day Checklist data revealed less than 100% compliance	Analysis of the IES data revealed less than 100% compliance				
Control Personal Resources	Analysis of the NCI data revealed less than 100% compliance	Analysis of the 90-Day Checklist data revealed less than 100% compliance	Analysis of the IES data revealed less than 100% compliance				
Ensures the individual receives services in the community with the same degree of access as individuals not receiving Medicaid HCBS	No NCI data	Analysis of the 90-Day Checklist data revealed less than 100% compliance	Analysis of the IES data revealed less than 100% compliance				
Allow full access to the greater community/Engaged in community life	Analysis of the NCI data revealed less than 100% compliance	Analysis of the 90-Day Checklist data revealed less than 100% compliance	Analysis of the IES data revealed less than 100% compliance				
Setting is chosen among setting options including non-disability specific settings and options for a private unit in residential settings	Analysis of the NCI data revealed less than 100% compliance	This information was not obtainable through the 90-Day Checklist	Analysis of the IES data revealed less than 100% compliance				
Ensures right to privacy, dignity, and respect and	Analysis of the NCI data revealed less than	Analysis of the 90-Day Checklist data revealed less than 100% compliance	Analysis of the IES data revealed less than 100% compliance				
						<p><i>Settings identified that could meet the HCBS rule with modifications:</i></p> <ul style="list-style-type: none"> • Provider owned or controlled residential settings <ul style="list-style-type: none"> ○ Approximately 1,044 sites* • Homes with more than 4 individuals residing together <ul style="list-style-type: none"> ○ Approximately 10 sites** <p><i>*Source – Indiana’s Individual Experience Survey – 2015</i> <i>**Source: INsite – Indiana’s Waiver Data System</i></p>	<p><i>Settings identified that could meet the HCBS rule with modifications:</i></p> <p>Provider self-survey to be validated. Site visits as warranted. Corrective action plans to be developed to bring setting into compliance</p>

SETTING ASSESSMENT					
CMS Criteria	NCI Data Analysis	90-Day Checklist Data Analysis	IES Data	Comprehensive Settings Results	Remediation
freedom from coercion and restraint	100% compliance				
The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board (taken from Federal Register)	No NCI data available	This information was not obtainable through the 90-Day Checklist	Analysis of the IES data revealed less than 100% compliance		
Optimizes, but does not restrain, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.	Analysis of the NCI data revealed less than 100% compliance	This information was not obtainable through the 90-Day Checklist	Analysis of the IES data revealed less than 100% compliance		
Facilitates choice of services and who provides them	Analysis of the NCI data revealed less than 100% compliance	Analysis of the 90-Day Checklist data revealed less than 100% compliance	Analysis of the IES data revealed less than 100% compliance	Settings that may be presumed as not HCBS complaint to be reviewed to determine if Heightened Scrutiny is warranted:	Settings that may be presumed as not HCBS complaint to be reviewed to determine if Heightened Scrutiny is warranted:
A lease or other legally enforceable agreement to protect from eviction (Provider owned or controlled residential setting)	No NCI Data Available	Due to the majority of responses to this question on the 90-Day Checklist being "n/a" validity of the data is unable to be determined	Analysis of the IES data revealed less than 100% compliance	<ul style="list-style-type: none"> Settings located in a public or privately owned building that provides inpatient institutional treatment <ul style="list-style-type: none"> o Approximately 0 sites** Settings located on the grounds of or immediately adjacent to a public institution <ul style="list-style-type: none"> o Approximately 7 sites. Settings that DDRS and its contractors are using a tiered evaluation process for determining each settings' compliance with 	Provider self-survey to be validated. Site visits as warranted. Corrective action plans to be developed to bring setting into compliance. Settings that are determined to require Heightened Scrutiny

SETTING ASSESSMENT					Remediation
CMS Criteria	NCI Data Analysis	90-Day Checklist Data Analysis	IES Data	Comprehensive Settings Results	
Privacy in their unit including entrances lockable by the individual	Analysis of the NCI data revealed less than 100% compliance	This information was not obtainable through the 90-Day Checklist	Analysis of the IES data revealed less than 100% compliance	<p>the HCBS Final Rule. All settings are being evaluated for full compliance with the rule. Providers were first have the effect of isolating individuals</p> <ul style="list-style-type: none"> ○ Residential settings where respondents to the IES indicated few social interactions outside of their home <ul style="list-style-type: none"> • Approximately 500 sites* ○ Day Service Settings <ul style="list-style-type: none"> • Approximately 182 sites** ○ Congregate Settings of 4 or more homes located close together <ul style="list-style-type: none"> • Approximately 50 sites** <p><i>*Source: Indiana's Individual Experience Survey – 2015</i> <i>**Source: INsite – Indiana's Waiver Data System</i></p>	will be submitted to CMS for approval
Freedom to furnish and decorate their unit	No NCI Data Available	This information was not obtainable through the 90-Day Checklist	Analysis of the IES data revealed less than 100% compliance		
Control of schedule and activities	Analysis of the NCI data revealed less than 100% compliance	Analysis of the 90-Day Checklist data revealed less than 100% compliance	Analysis of the IES data revealed less than 100% compliance	<p><i>Settings that are not HCBS complaint:</i></p> <ul style="list-style-type: none"> • Nursing Facilities <ul style="list-style-type: none"> ○ 0 sites • Institution for Mental Diseases (IMD) <ul style="list-style-type: none"> ○ 0 sites • Intermediate Care Facility for Individuals with I/DD (ICF/IID) <ul style="list-style-type: none"> ○ 0 sites • Hospitals <ul style="list-style-type: none"> ○ 0 sites 	<p><i>Settings that are found not HCBS complaint:</i></p> <p>No remediation required for settings not HCBS compliant</p>
Access to food at any time	No NCI Data Available	Analysis of the 90-Day Checklist data revealed less than 100% compliance	Analysis of the IES data revealed less than 100% compliance		
Visitors at any time	Analysis of the NCI data revealed less than 100% compliance	Analysis of the 90-Day Checklist data revealed less than 100% compliance	Analysis of the IES data revealed less than 100% compliance		
Setting is physically accessible to the individual	No NCI Data available	This information was not obtainable through the 90-Day Checklist	Analysis of the IES data revealed less than 100% compliance		

SETTING ASSESSMENT					
CMS Criteria	NCI Data Analysis	90-Day Checklist Data Analysis	IES Data	Comprehensive Settings Results	Remediation
Individuals sharing units have a choice of roommates in that setting	Analysis of the NCI data revealed less than 100% compliance	This information was not obtainable through the 90-Day Checklist	Analysis of the IES data revealed less than 100% compliance		

Validation Process for Residential and Non-residential Settings

DDRS has not yet determined the number of individuals in settings who may be affected by relocation. This will be determined as a result of the provider surveys and site visit verifications. At this time, since no settings were determined institutional, DDRS estimates through the validation process and remediation efforts, no members will require a transition plan.

The Tier 1 analysis of both residential and non-residential settings have determined the below compliance levels:

Residential

- 89% of residential sites were found to be in compliance with the final rule. A breakdown of the findings and next steps is below:
 - o 16,145 residential settings were found to be in compliance with the final rule.
 - o 1,044 sites will require additional information before a determination can be made. DDRS or its contracted entity will be requesting additional information. There may be provider owned or controlled homes that require no modifications to meet the settings rule.
 - o 500 sites were identified as provider owned or controlled requiring additional validation to determine if a site visit is warranted. This number reflects the provider owned or controlled residential settings where respondents (1,011) to the IES indicated few social interactions outside of their home (potentially isolating).

Non-Residential

- 18% of non-residential sites were found to be in compliance with the final rule. A breakdown of the findings and next steps is below:
 - o 64 sites were determined compliant based on the self-survey. DDRS contracted entity will be validating the responses by requesting any supporting documentation.
 - o 172 sites were determined to require a site visit based on responses from the survey.
 - o 109 sites will require additional information before a determination can be made. DDRS contracted entity is in the process of requesting additional information.
 - o 19 sites did not complete the survey and will be required to do so before a determination can be made.

Continuing with the validation process, if a setting is found to be non-compliant or partially compliant, a site visit will be scheduled. DDRS has determined from initial findings that 172 non-residential service delivery settings will require a site visit. Validation on residential settings will determine the total number of additional residential site visits.

DDRS is working with a contracted entity as an impartial third party to conduct and validate the non-residential provider self-assessment responses. DDRS will be using the same tiered system for identified residential settings to ensure consistency across all HCBS delivery sites.

Once site visits have been completed and sites have been either verified as meeting the HCBS requirements, not meeting the requirements, or requiring Heightened Scrutiny, the number of individuals potentially affected by relocation will be determined. Currently, no sites have been identified as non-HCBS-compliant as outlined in the setting assessment.

The data derived from the IES will be used to validate compliance of provider's responses to the self-survey of settings. Validation will be comprised of reviewing provider policies and procedures as well as person specific information such as:

1. The individual's PCP/ISP (*is there a reason they are not engaging in the community and is that addressed in the Person Centered Planning process?)
2. Are there medical issues preventing community involvement? Are these addressed in the Person Centered Planning process?
3. Are there behavioral issues preventing community involvement? Are these addressed in PCP/ISP?
4. Are there lease agreements in place to protect the individuals from eviction?
5. Do the individuals have keys to home and are able to come and go as they please, or are any restrictions addressed in the Person Centered Planning process?

As part of the validation process, the self-survey will require providers of HCBS services to submit policies, procedures and other documentation proving it meets the HCBS requirements. If a provider finds itself out of compliance in any area of the HCBS Final Rule, DDRS will work with the provider to create a provider specific transition plan to address each identified issue and DDRS will monitor the time frames for completion. A template will be provided to ensure consistency. This will be a desk review/validation process. The IES data will be used to validate the responses of the provider surveys. If there is a discrepancy, a site visit will be required.

Once the desk review/validation process is completed, any residential or non-residential setting that is assessed as potentially not having the qualities of a home and community-based setting will require a site visit to validate the findings.

During the site-specific visits, DDRS or its contracted agents will review the results of the assessments to validate the findings. Prior to the site-specific visits, DDRS will conduct a comprehensive training for all designated reviewers in order to ensure consistency of all reviews. Results of the site-specific assessments will be used to identify specific settings that either do not meet the HCBS requirements or require Heightened Scrutiny.

Remediation Strategies

As part of CMS regulations, DDRS must develop a plan to correct, through various means, any areas of non-compliance with HCBS rules. In order to do this, DDRS has developed a remediation plan with specific strategies and timelines. It is important to note that the desire of the transition plan and remediation strategies is not to close or terminate providers but instead, to work with members, providers and other stakeholders to come into compliance with the HCBS Final Rule and the vision of ensuring members are fully integrated into the community, afforded choice, and have their health and safety needs met.

DDRS used the results of the provider self-assessment and the Individual Experience Survey (IES) to identify settings that may not be in compliance. After the validation process, if a setting has been identified as either non-complaint or partially complaint, a site visit will be conducted. The process for corrective action will begin as soon as any areas of non-compliance are identified.

Site-specific remedial plans will be created by the provider based on findings identified by DDRS or its contracted entity. A template will be provided with issues identified and the provider will be responsible for developing the corrective action and providing a time frame. The plan will then be reviewed by DDRS and either approved or modified to ensure each identified area is addressed and the time frame is appropriate for remediation activities that allow for confirmation and ample time for relocation if the plan is not achieved. As outlined in the remediation strategies that DDRS has developed, all provider corrective action timelines and plans will be reviewed and approved by 12/2017.

Examples of what will be in plans will be determined by the findings. For instance, if it is found that a provider does not have a policy to address an individual's rights to access to food at any time, the remediation action will include development of a policy that addresses documentation of any modifications in the person centered service planning process while ensuring individual's rights are protected. Another example would be if it is identified that the setting was designed specifically for people with disabilities and therefore potentially isolating, the provider would be required to have policies to address ensuring individuals are integrated into the community to the same degree of access of those not receiving HCBS services.

Monitoring completion of remedial plans will be done through various means. For identified providers of residential and non-residential settings, a tracking database will be used to ensure timelines are met. Quarterly communication will be sent to providers to request progress updates on milestone achievements. If timelines change or providers are having difficulty achieving the remedial plans, DDRS will offer technical guidance to ensure completion. Verification of completion will include documentation reviews as well as follow up site visits.

For individual-specific remediation, the monitoring checklist is housed in a web based system which creates corrective action for any areas of non-compliance. Case managers will be responsible for verifying completion of any outstanding compliance. DDRS at any time can pull and review data from this system for additional monitoring of HCBS compliance.

DDRS will apply a combination of existing guidelines to address the necessary remedial strategies. Mirroring Indiana Code, [IC 12-11-1.1-11 Issuance of citation for violations; requirements; remedies; considerations in determining remedy](#), once DDRS identifies an issue that requires corrective action, DDRS will document the findings within the citation and identify the necessary corrective action for the provider. Mirroring an existing process outlined within Indiana Administrative Code, [460 IAC 6-7-2 Monitoring, corrective action](#), DDRS will then identify the time period in which corrective action shall be submitted to the Division or its designee and the time period in which the corrective action is to be completely implemented by the provider. Further, [IC 12-11-1.1-11](#) provides applicable guidance regarding appeal rights and remedies for violations. Timelines will be determined based on the final results of the summarized data.

DDRS understands that remedial issues must also be addressed within the allotted time for completion of the waiver transition plan. The specified time for settings to dispute the compliance findings will mirror those of current Indiana Code, [IC 12-11-1.1 for BDDS; Community-Based Services](#), which allows a time period of fifteen days from the date of any citation for a dispute to be filed. **Item (b) of IC 12-11-1.1-11 Issuance of citation for violations; requirements; remedies; considerations in determining remedy states**, “A person aggrieved by a citation issued under this section may request a review under [IC 4-21.5-3-7](#). If a request for a hearing is not filed within the fifteen (15) day period, the determination contained in the citation is final.”

In general, DDRS will utilize pre-existing guidance found in Indiana Code and Indiana Administrative Code to address remedial strategies related to this transition.

The table below outlines the remediation strategies that DDRS has developed to both assess compliance and to then address areas of non-compliance.

Action Item	Description	Remediation Strategies	Timeline for Completion	Source Document	Key Stakeholders
Provider and Member Surveys	DDRS has developed a comprehensive survey targeting specific HCBS requirements that will provide data to further determine DDRS compliance status with the HCBS rules.	Survey results will serve as a tool to identify settings that may not be in compliance with HCBS rules and allow DDRS to develop strategies for working with these providers to come in to compliance in the required timelines.	Pilot IES Survey: 01/2015	IES Survey Document Aggregate and site -specific survey results Online provider self-survey	DDRS/BDDS internal staff, OMPP, DDRS Advisory Council, IIDC, Pilot group, Providers, Individuals Served
	DDRS has contracted with The Indiana Institute on Disability and Community (IIDC) to design, develop, and administer a survey to individuals receiving Home and Community-Based Services.		Comprehensive Survey: 01/2016		
	Prior to the implementation of a statewide survey, DDRS, in conjunction with the IIDC, will administer the survey using a pilot group in order to assess the validity and reliability of the survey.		IES Survey Results: 04/2016		
			Provider Self Survey: 08/2016-09/2016		
			Provider Self Survey Responses		

Action Item	Description	Remediation Strategies	Timeline for Completion	Source Document	Key Stakeholders
	<p>Once the survey has been validated IIDC will disseminate it electronically to providers throughout Indiana to complete with the individuals they serve.</p> <p>At the time of survey completion, the contractor, in consultation with DDRS, will analyze the data and provide a comprehensive report on the survey results.</p> <p>The aggregate results will be disseminated to stakeholders throughout the system.</p>		<p>Validated: 12/2016</p> <p>Ongoing monitoring of approved Provider Specific Transition Plans: 08/2016-04/2018</p>		
Site-Specific Assessment	<p>Based on the results of the preliminary settings inventory and statewide survey, DDRS has identified specific sites that will need further review. In addition, specific sites have been identified for data validation.</p>	<p>Validation of the compliance of the specific sites will be determined by CMS guidance as to what is and is not a community setting.</p> <p>Specifically, DDRS will identify any setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS.</p> <p>DDRS will utilize this guidance in developing and establishing criteria for engaging in site- specific assessments.</p>	7/31/2016	STP	DDRS or its contracted entity.
Evaluation of Collected Data	<p>After completion of the site- specific surveys, DDRS will evaluate all collected data</p>	<p>The information gathered will be utilized to develop a Comprehensive Settings Result Document</p>	<p>7/31/2016 for site- specific assessment</p> <p>12/2016 for Provider Self Survey</p>	Aggregate and site-specific survey results	DDRS/BDDS/ IIDC
Comprehensive Setting Results	<p>DDRS will develop a comprehensive setting results document, which identifies DDRS level of compliance with HCBS standards and identifies settings that will be required to go through the Heightened Scrutiny Process. This document will be disseminated to stakeholders throughout the system.</p>	<p>The data gathered from the comprehensive setting results document will be utilized to begin the process of correction and implementation of the necessary remedial strategies.</p>	12/2017 for comprehensive setting results to include sites identified for Heightened Scrutiny	STP	DDRS/BDDS internal staff, OMPP, DDRS Advisory Council, IIDC, Advocacy groups, Providers, Participants, Self-Advocates and Families
Heightened Scrutiny	<p>DDRS will identify settings that require Heightened Scrutiny and submit for public comment.</p>	<p>Settings identified that overcome the institutional presumption will be submitted to CMS for approval.</p>	04/2018	STP	DDRS/BDDS internal staff, OMPP, DDRS Advisory Council, IIDC, Advocacy groups, Providers, Participants, Self-

Action Item	Description	Remediation Strategies	Timeline for Completion	Source Document	Key Stakeholders
					Advocates and Families
Revisions to Indiana Administrative Code	DDRS will initiate the rule making process in order to revise Indiana Administrative Code. Indiana will revise rules related to community integration, individual rights, and individual choice.	Revisions to Indiana Administrative Code	05/2018	http://www.in.gov/legislative/iac/IACDrftMan.pdf	DDRS/BDDS internal staff, OMPP
Revisions to Forms	Revise all applicable internal and external forms to meet HCBS final rule, administrative rules and policy and procedures.	Revisions to Forms	12/2017	To Be Determined	DDRS/BDDS internal staff, OMPP, Case Management Companies
Revisions to DDRS Waiver Manual	In order to ensure current and ongoing compliance with the HCBS requirements, DDRS will review the DDRS Waiver Provider Policy and Procedure Manual. Changes to this Manual may constitute changes to the FSW and CIH application. Amendments to the FSW and CIH application will be completed to maintain program consistency.	Revisions to DDRS Provider Policy and Procedure Manual	12/2017	DDRS Waiver Manual and DDRS HCBS Provider Waivers Reference Module	DDRS/BDDS internal staff, OMPP
Participant Rights and Responsibilities Policy/ Procedure Modifications	DDRS will revise policies and procedures related to participant rights, due process, and procedural safeguards.	Participant Rights and Responsibilities Policy/Procedure Modifications	12/2017	Review of current Rights and Responsibilities policy Review of Protection of Individual Rights	DDRS/BDDS internal staff, OMPP, Self-Advocates, individuals served
Review and Revisions to Provider Enrollment and Provider Training	Review and potentially revise the provider enrollment and recertification process. Provide training to new and existing providers to educate them on the HCBS requirements.	Review and Revisions to Provider Enrollment/Provider Training	12/2017	Review of current enrollment/recertification process	DDRS/BDDS internal staff, OMPP, Providers
Corrective Action Process	The provider corrective action process/plan is to ensure providers are in compliance with HCBS requirements. Once a provider has been identified as non-compliant, DDRS will work to develop a provider remediation process and framework of plans.	Provider training on the HCBS requirements Deadlines for completion & periodic status update requirements for significant remediation activities	12/2017	IC 12-11-1.1-11 460 IAC 6-7-2	DDRS/BDDS internal staff, OMPP

Action Item	Description	Remediation Strategies	Timeline for Completion	Source Document	Key Stakeholders
Develop process for Provider Sanctions and Disenrollment	In the event the provider has gone through remediation activities and continues to demonstrate noncompliance with HCBS requirements, DDRS will develop a specific process for issuing provider sanctions and dis-enrollments.	DDRS will dis-enroll or sanction providers that fail to meet remediation standards and fail to comport with the HCBS setting requirements.	06/2018	DDRS will formally disseminate the provider sanctions and disenrollment criterion during a public comment period.	DDRS/BDDS internal staff, OMPP, Providers
Convene a Transition Taskforce	DDRS will develop a Transition Taskforce to provide technical assistance and support for individuals identified as requiring significant changes, such as, relocation, adjustments to allocation, mediations to resolve internal conflicts and compliance issues.	The identified areas of noncompliance will be used to guide the Transition Taskforce to gather further qualitative feedback from providers, participants, and their families.	03/2017	To be determined	DDRS/BDDS staff, Self-Advocates, individuals served, Providers, Advocacy groups
Relocation	Identification of settings that have not achieved compliance after all remedial strategies have been employed.	DDRS will begin notification to providers and individual identified in 2018. The Transition Taskforce will provide technical assistance as well.	03/2019	460 IAC 6-29-9 BDDS Transition Activities Policy	DDRS/BDDS staff Transition Taskforce
Ongoing Monitoring	DDRS will continue to monitor ongoing compliance through utilizing the Monitoring Checklist, utilizing self-reporting from stakeholders as well as incorporating ongoing monitoring through the provider re-certification processes	DDRS will apply a combination of existing guidelines to address the necessary remedial strategies	05/2018 and beyond	IC 12-11-1.1-11 460 IAC 6-7-2 Monitoring Checklist	DDRS/BDDS staff, Self-Advocates, individuals served, Providers, Advocacy groups

Heightened Scrutiny

Any residential or non-residential setting that is suspected to not have the qualities of a home and community-based setting will require a site visit to validate the findings. These settings may be found to meet the HCBS requirements, may be found to not meet the requirements, or be determined to require Heightened Scrutiny.

DDRS has identified preliminary settings that may require a Heightened Scrutiny Review by CMS. These settings include any setting that is found to be located on or adjacent to a public institution. DDRS will be reaching out to field staff, providers and case managers to verify that no residential settings are located on the grounds of or immediately adjacent to a public institution. The non-residential assessment conducted indicated 7 potential sites were identified to be in this category. Site visits will verify the locations meet this criterion and determine if Heightened Scrutiny is warranted.

Other settings to be reviewed for Heightened Scrutiny include settings that may have the effect of isolating individuals from the greater community including residential settings where respondents indicated few social interactions outside of the home, day settings and congregate settings of four or more homes located close together.

The below steps will determine if Heightened Scrutiny will be submitted to CMS:

1. Settings identified will be validated.
2. Validation process will determine if a site visit is required.
3. If remediation is warranted, a remediation plan will be submitted.

4. The site visit will determine if site meets the criteria for Heightened Scrutiny. Criteria for Heightened Scrutiny submission to CMS will include:
 - a. Settings located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment (DDRS has zero settings that meet this criteria)
 - b. The location of the setting is on the grounds of or adjacent to a public institution
 - c. Settings that have the effect of isolating individuals
5. Settings identified for Heightened Scrutiny will be posted for public comment
6. If site is found to require a Heightened Scrutiny review and is in compliance with HCBS rules during site visit, public comment and/or after remediation, evidence including public comment will be submitted to CMS for Heightened Scrutiny review.

Prior to any site visits, a comprehensive tool will be developed to ensure consistency upon all determinations. Trainings will be conducted with the state or contracted staff completing the site visit. In addition, trainings will be conducted with providers and families to explain the Heightened Scrutiny Process.

Prior to the site visit, providers and individuals will be notified in writing of the date of the upcoming site visit. The notification will include a summary of the findings of the review, an explanation of what the site visit will entail, and education on the process. Once DDRS or its contracted agents completes the site visit, a summary of the findings will be distributed to the parties involved. If after the site visit it is determined that the setting is home and community-based, DDRS will continue ongoing monitoring to ensure continuing compliance.

DDRS is evaluating if the setting isolates the individual from the broader community or otherwise has the characteristics of an institution or fails to meet the characteristics of a home and community-based setting. If the setting fails to meet the characteristics of a home and community-based setting it would not be considered to be compliant with the regulation.

If it is found that the setting would meet the criteria of being presumed non-compliant but DDRS believes it can present an indication that the setting meets the requirements; Heightened Scrutiny will be applied. Heightened Scrutiny will include a period of public comment to be submitted with other evidence to CMS for approval. If DDRS determines the setting cannot meet the requirements with modifications, the relocation process/timelines outlined below will commence.

Relocation of Beneficiaries

Reasonable notice will be given to the participant and the Individual Support Team (IST) regarding any setting found to be non-compliant. Action steps will be provided as well as procedural safeguards explained. Members will be provided a choice of remaining in the HCBS funded program or choosing to remain in their current location. It is anticipated per the remediation strategies DDRS has developed that teams will be provided with 6 months' notice prior to transitioning individuals from identified non-compliant settings. The below steps outline this process:

- Site has been determined as non-compliant for the following reasons
 - Provider declines to become compliant
 - Site has still been determined to be non-compliant after all remedial action
- Notification of non-compliance will be sent to Provider and IST outlining findings and cause
- Per [460 IAC 6-7-6](#) Administrative Review, the provider has 15 days to request Administrative Review, preserving the right to appeal
- The IST notification will outline individuals' choices to remain in setting and locate an alternative funding source or transition to HCBS Complaint setting
- This will allow for the IST's to meet and conduct the following transition steps as outlined in [BDDS Transition Activities Policy](#)
 - Coordination of transition planning meetings
 - Person Centered Planning process
 - Updating of the Individualized Support Plan
 - Referrals to HCBS approved providers
 - Meeting and selection of roommates for residential moves
 - Home visits

- Safety inspections
- Pre- and post-monitoring by the individual's Case Manager
- BDDS shall ensure individuals are provided with a choice of providers and facilitate the transition process to ensure all supports are in place prior to any movement.

BDDS will use its process for transitioning people from the non-compliant setting to a setting that meets HCBS requirements. Individuals will be informed in writing of the agency's decision outlining the procedure established for transitioning to an approved HCBS setting. This will ensure reasonable notice and procedural safeguards are provided to anyone needing to transition.

A transition plan will be developed to allow for sufficient time to safely transition individuals to compliant settings of their choice. BDDS or its contracted entity will ensure individuals are informed of the opportunity to select settings and roommates of their choice and will facilitate all transitions as outlined in the [BDDS Transition Activities Policy](#). Both the existing provider and the newly selected provider will participate in the transition activities. The change in the individual's residence may not take place until written approval is received from the individual's service coordinator. The participant and the Individual Support Team will actively participate in the transition process.

The 460 IAC 6 citations are found at <http://www.in.gov/legislative/iac/T04600/A00060.PDF>

SECTION 4: KEY STAKEHOLDERS AND OUTREACH

As DDRS moves forward in assessing the system's compliance with HCBS rules, DDRS intends to continue to work closely with providers, self-advocates, individuals served and families. DDRS' intent is to engage in a collaborative process which will involve a high level of inclusion of all stakeholders. Throughout the five-year transition process DDRS will continually seek out and incorporate stakeholder and other public input.

DDRS posts all ongoing activities around the transition plan online through DDRS Announcements. In addition, announcements of the public comment periods and other related activities are posted on the BDDS Provider Portal and the BDDS Case Management system encouraging all to become familiar with the new HCBS criteria outlined in the rule and to assist in informing members and their families about the transition plan and asking that they submit their comments, questions, or concerns. DDRS continues to work with stakeholders such as the ARC of Indiana, INARF, and providers to promote public input through various public meetings including quarterly provider meetings.

Outreach activities have included webinars, resources, FAQ's, Power Point Presentations and the development of a HCBS workgroup group that has been actively assisting in crafting provider and family messaging related to the STP, providing feedback on assessment activities, and providing ongoing feedback and input around the STP activities. In addition, family listening sessions have been taking place throughout the state to allow families an open forum to share their desired service needs for both the CIH and FS waivers for input into any new HCBS services.

DDRS is committed to a high level transparency and will continue to publish the planned steps to ensure that all providers, families, participants, and potential participants are given meaningful opportunity for public input.

DIVISION OF MENTAL HEALTH AND ADDICTION - YOUTH (DMHA-Y) HCBS Programs Psychiatric Residential Treatment Facility (PRTF) Transition Waiver – 1915(c) Child Mental Health Wraparound (CMHW) – 1915(i)

Update October 2016: The DMHA Youth programs portion of the STP has been modified from the version published for public comment and submitted to CMS to incorporate requested technical corrections. Narrative texts and action items have been updated as well.

Background

The Division of Mental Health and Addiction youth division administers two Home and Community-Based Service (HCBS) Programs, one that serves eligible youth with serious emotional disturbance (SED), and one that serves youth with SED or serious mental illness (MI) diagnosis. The two programs are the Child Mental Health Wraparound (CMHW) 1915(i) HCBS program and the 1915(c) HCBS Psychiatric Residential Treatment Facility (PRTF) transition waiver, respectively. These HCBS programs are available to eligible youth and include Wraparound Facilitation, and may include Habilitation, Respite, and Family Support & Training. The 1915(c) HCBS Psychiatric Residential Treatment Facility (PRTF) transition waiver current has only one recipient in services who is expected to transition out of services before the end of 2016. There are no open slots on this program; therefore, this program will not be addressed in remediation occurring after 2016.

SECTION 1: SETTINGS INCLUDED IN THE STP

The Family and Social Services Administration Division of Mental Health and Addiction, youth services completed an internal review and analysis of all settings where HCBS services are provided. The Child Mental Health Wraparound program does not provide residential supports, though services may be provided in the home as well as the community. Youths in services reside in the family home, natural or foster, in the community. Services available on the Child Mental Health Wraparound program include the following:

- **Wraparound Facilitation (Care Coordination):** Comprehensive service that follows a series of steps and is provided in the community through a Child and Family Wraparound Team.
- **Habilitation:** Enhances a participant's level of functioning through one-on-one support.
- **Training and Support for Unpaid Caregivers:** Provide education and support to the unpaid caregiver of a participant.
- **Respite¹:** Short-term relief for person who normally provides care for the participant.

All services offered by PRTF and CMHW are individualized services, chosen by the Child and Family Team, and provided in one of the following settings:

- 1) Public, community-based, non-disability specific settings such as retail locations, public parks, community spaces, etc. used by the general public;
- 2) Youth's private family home; and
- 3) Home of a licensed foster family if the child is under the jurisdiction of the Department of Child Services (DCS).

Services and the settings in which they are provided are individualized according to the participant's needs as outlined in the plan of care, and must include options for non-disability specific settings. The plan is developed with the child and family team in which the participant and family choose on what they will be working, when, with whom, and where. Services are expected to occur in the family home and community-based environment so as to allow for a smooth transition to natural supports when it is time for a youth to transition out of the program.

¹ Respite in a Psychiatric Residential Treatment Facility is an approved service, as allowable under 42 CFR § 441.310(a)(2)(i). CMS indicates in the HCBS Final Rule that "Institutional Respite" is an allowable setting.

The number of settings may only be calculated by multiplication of the number of participants in the programs by the number of services settings outlined in their plans of care. Currently, there is only one participant receiving services through the PRTF Waiver and approximately 700 through the CMHW.

SECTION 2: SYSTEMIC ASSESSMENT

The Family and Social Services Administration’s Division of Mental Health and Addiction Services conducted a systemic assessment, including a crosswalk of the final rule and sections of Indiana Administrative Code related to the Child Mental Health Wraparound services program ([405 IAC 5-21.7](#)) and the Child Welfare Services ([465 IAC 2](#)).

Systemic Assessment Crosswalk

Federal Requirement: Settings are integrated in and support full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.			
Applicable Indiana Regulation	Compliance with HCBS Settings Final Rule:	Remediation Activity	Timeline
In the 405 IAC 5-21.7-2 Definitions	Silent, there is no definition of “Home and Community Based.”	While the term “home and community based” is used frequently in IAC, as well as in policies, manuals, and training materials, the term is not defined. DMHA will add the definition of Home and Community-Based to 405 IAC 5-21.7 to mean a setting which is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS. This applies to all setting in which HCBS are provided.	9/2018
In the general provisions section of IAC (405 IAC 5-21.7-1) General provisions Sec. 1. (a) This rule provides . . . (CMHW) services, which are intensive, home and community-based intervention services provided according to a systems of care philosophy within a wraparound model of service delivery.	Partially complies, states Home and Community based, but this term is not defined.	Once the definition of Home and Community Based is added to 405 IAC 5-21.7, this portion will be in full compliance.	9/2018
In the general provisions section of IAC (405 IAC 5-21.7-1) General provisions Sec. 1 (g) The state’s purposes for providing CMHW services are to: (2) enable them to benefit from receiving . . . services within their home and community with natural family supports.	Partially complies, states Home and Community based, but this term is not defined.	Once the definition of Home and Community Based is added to 405 IAC 5-21.7, this portion will be in full compliance.	9/2018
In the 405 IAC 5-21.7-2 Definitions (g) "Child mental health wraparound" or "CMHW" services mean intensive, home and	Partially complies, states Home and Community based, but this term is not defined.	Once the definition of Home and Community Based is added to 405 IAC 5-21.7, this portion will be in full compliance.	9/2018

community-based , behavioral health wraparound services and interventions . . .			
405 IAC 5-21.7-17 Habilitation services Sec. 17. (b) Habilitation services are provided face-to-face in either the participant's home or other Community-based setting , based upon the preferences of the participant and the participant's family.	Partially complies, states Home and Community based, but this term is not defined.	Once the definition of Home and Community Based is added to 405 IAC 5-21.7, this portion will be in full compliance.	9/2018
405 IAC 5-21.7-19 Training and support for unpaid caregiver services (g) The hourly training and support service is provided in the following manner: (2) The service is provided face-to-face in the home or a community-based setting .	Partially complies, states Home and Community based, but this term is not defined.	Once the definition of Home and Community Based is added to 405 IAC 5-21.7, this portion will be in full compliance.	9/2018
465 IAC 2-1.5-13 Care of Children: general. The foster family shall include the child in the normal routine of the foster family unless the department determines that specific aspects of the routine are inappropriate.	Partially complaint: Lacks detail.	DMHA and DCS will work together to update the regulation. The regulation shall be amended to include a provision for children receiving CMHW HCBS, be in compliance with the requirements of 405 IAC 5-21.7. Failure to adhere to the regulation will be transitioned from the program, and will instead receive services through the DCS-funded Child Mental Health Initiative, or similar program.	9/2018

Federal Requirement: Settings are selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.

Applicable Indiana Regulation	Compliance with HCBS Settings Final Rule:	Remediation Activity	Timeline
405 IAC 5-21.7-6 Individualized plan of care (c) The CMHW services plan of care developed within the team, with participant and family input and inclusion, must meet the following criteria: (2) Reflect the participant's and the family's preferences and choices for services and providers.	Partially Complies: Service settings are determined by the child and family team and documented in the plan of care. Residential setting for the youth are determined by the guardian. The state has no jurisdiction tell the guardian that they must offer a private unit. Not offering a private unit is the same degree of privacy that would be offered to their non-disabled counterparts. The state may not tell a family that they must include non-disabled children in the home to meet the standard of inclusion.	405 IAC 5-21.7-6(c)(2) will be updated to include the words "and among setting options including settings that offer the same degree of access as individuals not receiving Medicaid home and community based services." Regarding residential placement, DMHA has consulted with DCS. Children placed in family foster homes will live in compliant settings, be moved to a compliant setting within 90-days, or will be transitioned from the program and instead receive services through the DCS-funded Child Mental Health Initiative, or similar program.	9/2018

Federal Requirement: Settings ensure an individual's rights of privacy, dignity, respect, and freedom from coercion and restraint.

Applicable Indiana Regulation	Compliance with HCBS Settings Final Rule:	Remediation Activity	Timeline
<p>405 IAC 5-21.7-7 Participant freedom of choice Sec. 7. The participant and the participant's family have freedom of choice regarding the following aspects of CMHW service delivery:</p> <p>(1) Determining who will participate in the team. (2) Identifying the plan of care goals and the method for achieving those goals. (3) Selecting the CMHW services, as supported by the participant's assessment and level of need that will be included in the plan of care. (4) Choosing the DMHA-certified CMHW service provider or providers who will provide, oversee, and monitor implementation of the plan of care. (5) Changing the CMHW service provider or providers at any time during the participant's enrollment in the CMHW services program.</p>	<p>Partially Complies: A systems of care philosophy within a wraparound model of service deliver requires the respect for an individual's rights of privacy, dignity, respect, and freedom from coercion and restraint, and is stated as required in IAC; however, this component of the High Fidelity Wraparound model is not detailed in IAC.</p>	<p>Under 405 IAC 5-21.7-1 General Provisions Sec. 1 (b) will add (4) Respect an individual's rights of privacy, dignity, respect, and freedom from coercion and restraint.</p> <p>In cases where the safety of the individual necessitates the use of a restraint, e. g. child running into traffic, the use of restraints must be documented through the person-centered planning process.</p>	<p>9/2018</p>
<p>405 IAC 5-21.7-6 Individualized plan of care (d) In addition to the plan of care, the team shall develop a crisis plan . . . and The Division of Mental Health and Addiction Child Mental Health Wraparound (CMHW) Services Provider Module in Section 8: Crisis Plan Development states, "Seclusion and restraint are not allowed interventions in the crisis plan." 405 IAC 5-21.7-14 Provider sanctions (b) The loss of DMHA authorization for a provider to deliver CMHW services may occur due to, but not limited to, the following: (1) The provider's failure to adhere to and follow CMHW services policies and procedures for behavior, documentation, billing, or service delivery.</p>	<p>Partially Complies: 405 IAC 5-21.7-6 states that a crisis plan is a required component of a plan of care; in the provider module under crisis plan development that seclusion and restraint are not allowed; and 405 IAC 5-21.7-14 state that a provider may lose authorization to provider services for failure to comply with policies and procedures.</p>	<p>405 IAC 5-21.7-6 Individualized plan of care (d) will be updated to state, "Seclusion and restraint are not allowed interventions in the crisis plan."</p>	<p>9/2018</p>
<p>465 IAC 2-1.5-17 Foster parents shall not use mechanical or chemical restraints on the child. Foster parents may not use physical restraint on a child unless: (1) it is specifically authorized by the department in</p>	<p>Partially compliant. The use of coercion and restraints are prohibited by DCS, unless ". . . authorized in advance." This authorization comes via an individualized, written plan.</p>	<p>DMHA and DCS will work collaboratively to address through policy the expectation that children in foster family homes receiving CMHW services will be free from the use of seclusion and restraint. Modifications made for individualized assessed need will be incorporated into the person-centered plan.</p>	<p>9/2018</p>

advance in writing, (2) the foster parent has been appropriately trained and certified by a department approved body in the prevention and use of physical restraint, (3) it is an emergency situation and the child is a clear and present danger to himself or herself or others, (4) less restrictive interventions have been determined to be ineffective.			
465 IAC 2-1.5-13 Care of Children: general. The foster family shall include the child in the normal routine of the foster family unless the department determines that specific aspects of the routine are inappropriate.	Silent: the child's rights of privacy, dignity, respect, and freedom from coercion and restraint are not detailed.	DMHA and DCS will work together to update the regulation. The regulation shall be amended to include a provision for children receiving CMHW HCBS, be in compliance with the requirements of updated 405 IAC 5-21.7. Failure to adhere to the regulation will be transitioned from the program, and will instead receive services through the DCS-funded Child Mental Health Initiative, or similar program.	9/2018

Federal Requirement: Settings optimize, but do not regiment, individual initiative, autonomy, and independence in making life choices including but not limited to, daily activities, physical environment, and with whom to interact.

Applicable Indiana Regulation	Compliance with HCBS Settings Final Rule:	Remediation Activity	Timeline
405 IAC 5-21.7-6 Individualized plan of care (c) The CMHW services plan of care developed within the team, with participant and family input and inclusion, must meet the following criteria: (1) Be developed for each participant based upon the participant's unique strengths and needs, as ascertained in the evaluation or assessment. (2) Reflect the participant's and the family's preferences and choices for services and providers.	Fully complies: All participants must have a plan of care, and the plan of care must reflect the participant's and the family's preferences and choices including services and the settings in which they are provided.	N/A	N/A
405 IAC 5-21.7-15 Services: general provisions (a) All CMHW services provided to a participant must meet the following requirements: (1) Be supported by the participant's level of need. (2) Be documented in the participant's plan of care.	Fully complies: Applies to all services, and references the requirement that services are documented in the plan of care, which is required to reflect the participant's and the family's preferences and choices for services and providers.	N/A	N/A
465 IAC 2-1.5-14(b) Children shall be encouraged to participate in extracurricular school and educational activities where appropriate.	Fully complies	N/A	N/A

Federal Requirement: Settings facilitate individual choice regarding services and supports, and who provides them.

Applicable Indiana Regulation	Compliance with HCBS Settings Final Rule:	Remediation Activity	Timeline
<p>405 IAC 5-21.7-7 Participant freedom of choice Sec. 7. The participant and the participant's family have freedom of choice regarding the following aspects of CMHW service delivery: (1) Determining who will participate in the team. (2) Identifying the plan of care goals and the method for achieving those goals. (3) Selecting the CMHW services, as supported by the participant's assessment and level of need that will be included in the plan of care. (4) Choosing the DMHA-certified CMHW service provider or providers who will provide, oversee, and monitor implementation of the plan of care. (5) Changing the CMHW service provider or providers at any time during the participant's enrollment in the CMHW services program.</p>	<p>Fully Complies: All participants must have a plan of care, and the plan of care must reflect the participant's and the family's preferences and choices including services, who provides them, and the settings in which they are provided.</p>	<p>N/A</p>	<p>N/A</p>
<p>405 IAC 5-21.7-15 Services: general provisions (a) All CMHW services provided to a participant must meet the following requirements: (1) Be supported by the participant's level of need. (2) Be documented in the participant's plan of care.</p>	<p>Fully complies: Applies to all services, and reference the requirement that services are documented in the plan of care, which is required to reflect the participant's and the family's preferences and choices for services and providers.</p>	<p>N/A</p>	<p>N/A</p>
<p>465 IAC 2-1.5-19 Care of Children: Health. The foster parents shall do the following: (1) Cooperate with the department and CPA in providing proper: (A) physical; (B) mental; (C) dental; (D) visual; (E) auditory; and (F) developmental; care for the child. (2) Assist the department in using Medicaid eligible providers for Medicaid eligible services on Medicaid eligible children. (3) Keep the department informed of any health needs of the child.</p>	<p>Silent: choice is not stated.</p>	<p>DMHA and DCS will work together to update the regulation. The regulation shall be amended to include a provision for children receiving CMHW HCBS, be in compliance with the requirements of updated 405 IAC 5-21.7. Failure to adhere to the regulation will be transitioned from the program, and will instead receive services through the DCS-funded Child Mental Health Initiative, or similar program.</p>	<p>9/2018</p>
<p>Federal Requirement: In provider-owned or controlled residential settings, the setting is a specific physical place that is owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has the same responsibilities and protections from eviction as all tenants under landlord/tenant law of the State, county, city or other designated entity. In settings where tenant laws do not apply, a lease, residency agreement or other written agreement is in place providing protections to address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.</p>			
Applicable Indiana Regulation	Compliance with HCBS Settings Final Rule:	Remediation Activity	Timeline

<p>405 IAC 5-21.7-2 Definitions</p>	<p>Silent: IAC does not have a definition for provider-owned or controlled residential setting.</p>	<p>Update 405 IAC 5-21.7 to include “For the purposes of Medicaid funded home and community based services programs, foster family homes are considered provider owned or controlled settings.</p> <p>For individuals under the age of 18 receiving HCBS in a provider-controlled or owned residential setting, the expectation is that the individual will have access to the all of the rights and protections outlined in the federal HCBS rule to the same degree as other individuals under the age of 18 that are not HCBS beneficiaries and are experiencing such rights and protections within the setting. Modifications to any of the HCBS requirements for individuals in these settings should be clearly articulated in the person-centered plan. This includes the following:</p> <ol style="list-style-type: none"> 1. The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the legal guardian of the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction’s landlord tenant law. 2. Each individual has privacy in their sleeping or living unit: (1) Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors. (2) Individuals sharing units have a choice of roommates in that setting. (3) Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement. 3. Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time. 4. Individuals are able to have visitors of their choosing at any time. 5. The setting is physically accessible to the individual. 	<p>9/2018</p>
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		<p>6. Any modification of the additional conditions for provider-owned and controlled residential settings must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:</p> <ul style="list-style-type: none"> (a) Identify a specific and individualized assessed need. (b) Document the positive interventions and supports used prior to any modifications to the person-centered service plan. (c) Document less intrusive methods of meeting the need that have been tried but did not work. (d) Include a clear description of the condition that is directly proportionate to the specific assessed need. (e) Include regular collection and review of data to measure the ongoing effectiveness of the modification. (f) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated. (g) Include the informed consent of the individual. (h) Include an assurance that interventions and supports will cause no harm to the individual. 	
<p>405 IAC 5-21.7-2 Definitions (g) (3) The services include clinical and supportive behavioral health services provided for eligible participants who are: (A) living with their family in the community</p>	<p>Fully complies: There are no residential services available on the DMHA Youth HCBS Wraparound programs. Participants are children who live at home with their families. These children have the same degree of access and opportunity as children not receiving Medicaid HCBS.</p>	<p>N/A</p>	<p>N/A</p>
<p>405 IAC 5-21.7-6 Individualized plan of care (b) The plan of care must include all indicated medical and behavioral support services needed by a participant in order to assist the participant in the following: (1) Remaining in the home or community.</p>	<p>Fully complies: There are no residential services available on the DMHA Youth HCBS Wraparound programs. Participants are children who live at home with their families. These children have the same degree of access and opportunity as children not receiving Medicaid HCBS.</p>	<p>N/A</p>	<p>N/A</p>

Federal Requirement: In provider-owned or controlled residential settings, each individual has privacy in their sleeping or living unit.

Applicable Indiana Regulation	Compliance with HCBS Settings Final Rule:	Remediation Activity	Timeline
405 IAC 5-21.7	Silent: This regulation does not govern residential setting requirements. Youths in Family Foster homes are the only participants in provider owned or controlled settings.	DMHA shall amend IAC to provide that these children have the same degree of privacy in their sleeping or living unit as children not receiving Medicaid HCBS.	9/2018
465 IAC 2-1.5-9 Bedrooms shall have adequate ventilation for the health, safety, and welfare for the child. Bedrooms shall be clearly identified as bedrooms. Living, dining, and other areas not commonly used for a bedroom	Not compliant: Privacy is stated.	DMHA and DCS will work together to update the regulation. The regulation shall be amended to include a provision for children receiving CMHW HCBS, be in compliance with the requirements of updated 405 IAC 5-21.7. Failure to adhere to the regulation will be transitioned from the program, and will instead receive services through the DCS-funded Child Mental Health Initiative, or similar program.	9/2018

Federal Requirement: In provider-owned or controlled residential settings, units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.

Applicable Indiana Regulation	Compliance with HCBS Settings Final Rule:	Remediation Activity	Timeline
405 IAC 5-21.7	Silent: This regulation does not govern residential setting requirements. Youths in Family Foster homes are the only participants in provider owned or controlled settings.	DMHA shall amend IAC to provide that these children have the same degree of access to lockable entrance doors with only appropriate individuals having keys as children not receiving Medicaid HCBS.	9/2018
465 IAC 2-1.5-9 Bedrooms shall have adequate ventilation for the health, safety, and welfare for the child. Bedrooms shall be clearly identified as bedrooms. Living, dining, and other areas not commonly used for sleeping shall not be used for a bedroom.	Not compliant, no mention of lockable doors or staff having keys.	DMHA and DCS will work together to update the regulation. The regulation shall be amended to include a provision for children receiving CMHW HCBS, be in compliance with the requirements of updated 405 IAC 5-21.7. Failure to adhere to the regulation will be transitioned from the program, and will instead receive services through the DCS-funded Child Mental Health Initiative, or similar program.	9/2018

Federal Requirement: In provider-owned or controlled residential settings individuals sharing units have a choice of roommates.

Applicable Indiana Regulation	Compliance with HCBS Settings Final Rule:	Remediation Activity	Timeline
405 IAC 5-21.7	Silent: This regulation does not govern residential setting requirements. Youths in Family Foster homes are the	DMHA shall amend IAC to provide that these children have the same degree of choice of roommates as children not receiving Medicaid HCBS.	9/2018

	only participants in provider owned or controlled settings.		
465 IAC 2-1.5-9 Children (6) years of age and older, who share a room, shall be of the same sex. Children over twelve (12) months of age shall not share a bedroom with adults, except in the case of illness of developmental disabilities requiring close supervision and only with approval of department.	Not compliant, the choice of roommates is not included when a room is shared.	DMHA and DCS will work together to update the regulation. The regulation shall be amended to include a provision for children receiving CMHW HCBS, be in compliance with the requirements of updated 405 IAC 5-21.7. Failure to adhere to the regulation will be transitioned from the program, and will instead receive services through the DCS-funded Child Mental Health Initiative, or similar program.	9/2018

Federal Requirement: In provider-owned or controlled residential settings, individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

Applicable Indiana Regulation	Compliance with HCBS Settings Final Rule:	Remediation Activity	Timeline
405 IAC 5-21.7	Silent: This regulation does not govern residential setting requirements. Youths in Family Foster homes are the only participants in provider owned or controlled settings.	DMHA shall amend IAC to provide that these children have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement to the same degree as children not receiving Medicaid HCBS.	9/2018
465 IAC 2-1.5-9 Bedrooms shall have adequate ventilation for the health, safety, and welfare for the child. Bedrooms shall be clearly identified as bedrooms. Living, dining, and other areas not commonly used for a bedroom	Silent: this regulation does not address the issue of room decorations.	DMHA and DCS will work together to update the regulation. The regulation shall be amended to include a provision for children receiving CMHW HCBS, be in compliance with the requirements of updated 405 IAC 5-21.7. Failure to adhere to the regulation will be transitioned from the program, and will instead receive services through the DCS-funded Child Mental Health Initiative, or similar program.	9/2018

Federal Requirement: In provider-owned or controlled residential and non-residential settings, individuals have the freedom and support to control their schedules and activities, and have access to food any time.

Applicable Indiana Regulation	Compliance with HCBS Settings Final Rule:	Remediation Activity	Timeline
405 IAC 5-21.7	Silent: This regulation does not govern residential setting requirements. Youths in Family Foster homes are the only participants in provider owned or controlled settings.	DMHA shall amend IAC to provide that these children have the freedom and support to control their schedules and activities, and to have access to food at any time to the same degree as children not receiving Medicaid HCBS.	9/2018
465 IAC 2-1.5-13 Care of Children: general. The foster family shall include the child in the normal routine of the foster family unless the department determines that specific aspects of the routine are inappropriate.	Silent, does not state the requirement	DMHA and DCS will work together to update the regulation. The regulation shall be amended to include a provision for children receiving CMHW HCBS, be in compliance with the requirements of updated 405 IAC 5-21.7. Failure to adhere to the regulation will be transitioned from the program, and will instead receive services through the DCS-funded Child Mental Health Initiative, or similar program.	9/2018

<p>465 IAC 2-1.5-20 The foster family shall provide food of sufficient quality and quantity to meet the nutritional, medical, and psychological requirements of the child. The child's diet shall be well balanced.</p>	<p>Partially compliant, addresses the provision of food by not access to food.</p>	<p>DMHA and DCS will work together to update the regulation. The regulation shall be amended to include a provision for children receiving CMHW HCBS, be in compliance with the requirements of updated 405 IAC 5-21.7. Failure to adhere to the regulation will be transitioned from the program, and will instead receive services through the DCS-funded Child Mental Health Initiative, or similar program.</p>	<p>9/2018</p>
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Federal Requirement: In provider-owned or controlled residential and non-residential settings, individuals are able to have visitors of their choosing at any time.

Applicable Indiana Regulation	Compliance with HCBS Settings Final Rule:	Remediation Activity	Timeline
<p>405 IAC 5-21.7</p>	<p>Silent: This regulation does not govern residential setting requirements. Youths in Family Foster homes are the only participants in provider owned or controlled settings.</p>	<p>DMHA shall amend IAC to provide that these children have visitors of their choosing at any time to the same degree as children not receiving Medicaid HCBS.</p>	<p>9/2018</p>
<p>465 IAC 2-1.5-13 Care of Children: general. The foster family shall include the child in the normal routine of the foster family unless the department determines that specific aspects of the routine are inappropriate.</p>	<p>Silent, does not address the subject of visitors.</p>	<p>DMHA and DCS will work together to update the regulation. The regulation shall be amended to include a provision for children receiving CMHW HCBS, be in compliance with the requirements of updated 405 IAC 5-21.7. Failure to adhere to the regulation will be transitioned from the program, and will instead receive services through the DCS-funded Child Mental Health Initiative, or similar program.</p>	<p>9/2018</p>

Federal Requirement: In provider-owned or controlled residential and non-residential settings, the setting is physically accessible to the individual.

Applicable Indiana Regulation	Compliance with HCBS Settings Final Rule:	Remediation Activity	Timeline
<p>405 IAC 5-21.7</p>	<p>Silent: This regulation does not govern physical accessibility.</p>	<p>DMHA shall amend IAC to provide that children have settings which are physically accessible to the individual to the same degree as children not receiving Medicaid HCBS.</p>	<p>9/2018</p>
<p>465 IAC 2-1.5-8 Physical facilities of the foster family home: General. The Foster family home shall be located, constructed, arranged, and maintained to provide adequately for the health, safety, and moral welfare of all occupants:</p>	<p>Partially compliant, does not specifically state physical accessibility.</p>	<p>DMHA and DCS will work together to update the regulation. The regulation shall be amended to include a provision for children receiving CMHW HCBS, be in compliance with the requirements of updated 405 IAC 5-21.7. Failure to adhere to the regulation will be transitioned from the program, and will instead receive services through the DCS-funded Child Mental Health Initiative, or similar program.</p>	<p>9/2018</p>

Federal Requirement: Any modifications of the additional conditions for provider-owned and controlled residential settings must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:

1. Identify a specific and individualized need.

2. Document the positive interventions and supports used prior to any modifications to the person-centered plan.
3. Document less intrusive methods of meeting the need that have been tried but did not work.
4. Include a clear description of the condition that is directly proportionate to the specific need addressed.
5. Include regular collection and review of data to measure the ongoing effectiveness of the modification.
6. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
7. Include the informed consent of the individual.
8. Include an assurance that interventions and supports will cause no harm to the individual.

Applicable Indiana Regulation	Compliance with HCBS Settings Final Rule:	Remediation Activity	Timeline
<p>405 IAC 5-21.7-16 Wraparound facilitation services Authority: IC 12-8-6.5-5; IC 12-15 Affected: IC 12-13-7-3; IC 12-29; IC 25-23.6-10.5; IC 25-27.5-5 Sec. 16. (a) Wraparound facilitation services are as follows: (1) Comprehensive services comprised of a variety of specific tasks and activities designed to carry out the wraparound process. (2) A required component of the CMHW services program. (b) Wraparound facilitation is: (1) a planning process that follows a series of steps; and (2) provided through a child and family wraparound team. (c) The team is responsible for assuring that a participant's needs, and the entities responsible for addressing those needs, are identified in a written plan of care. (d) The wraparound facilitator manages and supervises the wraparound process through the following activities: (1) Completing a comprehensive evaluation of the participant, including administration of the DMHA-approved behavioral assessment tool. (2) Guiding the family engagement process by exploring and assessing strengths and needs. (3) Facilitating, coordinating, and attending team meetings. (4) Working in full partnership with the participant, family, and team members to ensure that the plan of care is developed, written, and approved by the DMHA. (5) Assisting the participant and the participant's family in gaining access to the full array of services,</p>	<p>Partially compliant: Not addressed were the documentation of less restrictive previous interventions, as well as the requirement of informed consent.</p>	<p>DMHA shall amend IAC to include the documentation of less restrictive previous interventions, as well as the requirement of informed consent.</p>	<p>9/2018</p>

<p>that is, medical, social, educational, or other needed services.</p> <p>(6) Guiding the planning process for the plan of care by: (A) informing the team of the family's vision; and (B) ensuring that the family's vision is central to the planning and delivery of services.</p> <p>(7) Ensuring the development, implementation, and monitoring of a crisis plan.</p> <p>(8) Assuring that all work to be done to assist the participant and the participant's family in achieving goals on the plan of care is identified and assigned to a team member.</p> <p>(9) Overseeing and monitoring all services authorized for a participant's plan of care.</p> <p>(10) Reevaluating and updating the plan of care as dictated by the participant's needs and securing DMHA approval of the plan of care.</p> <p>(11) Assuring that care is delivered in a manner consistent with strength-based, family-driven, and culturally competent values.</p> <p>(12) Offering consultation and education to all CMHW service providers regarding the values and principles of the wraparound services model.</p> <p>(13) Monitoring a participant's progress toward meeting treatment goals.</p> <p>(14) Ensuring that necessary data for evaluation is gathered, recorded, and preserved.</p> <p>(15) Ensuring that the CMHW services assessment and service-related documentation are gathered and reported to the DMHA as required by the DMHA.</p> <p>(16) Completing an annual CMHW services level of need reevaluation, with active involvement of the participant, the participant's family, and the team.</p> <p>(17) Guiding the transition of the participant and the participant's family from CMHW services to state plan services or other community-based services when indicated.</p>			
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<p>465 IAC 2-1.5-20 The foster family shall provide food of sufficient quality and quantity to meet the nutritional, medical, and psychological requirements of the child. The child's diet shall be well balanced.</p>	<p>Partially complies, does not detail components of the regulation.</p>	<p>DMHA and DCS will work together to update the regulation. The regulation shall be amended to include a provision for children receiving CMHW HCBS, be in compliance with the requirements of updated 405 IAC 5-21.7. Failure to adhere to the regulation will be transitioned from the program, and will instead receive services through the DCS-funded Child Mental Health Initiative, or similar program.</p>
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SECTION 3: SITE SPECIFIC ASSESSMENT

To validate the State's assumption that no youth was living in or receiving services in an institutional or otherwise non-compliant setting, a [survey](#) was conducted of all interested participants that includes: living environment, number of individuals with or without disabilities living in residence, whether or not there is paid staff, number of hours with which the person spends time, activities in the community and choice in daily routine. Completion of the survey was required for each active participant by the Wraparound Facilitator at a Child and Family Team Meeting. The survey was developed to make it appropriate for youth. Many, if not most of the items considered to indicate choices appropriate for an adult to make were not indicative of institutional care for children. For example, while adults may determine when and what to eat, control of one's own schedule, and have visitors at any time, such measures are inappropriate, even irresponsible areas of control to grant to children. Children not living in the natural family home should only be residing in family foster homes if enrolled in the program. In the case of child in a family foster home setting, the choices of where to live and with who are as likely to be out of the parents' control as the child's. Many questions were therefore adapted to suit age appropriate decision-making for youth, and to assess if the children have the same degree of access and opportunity as children not receiving Medicaid HCBS. Questions were included to be answered by the conflict-free Wraparound Facilitator, such as descriptor of the living, service, and school environments. Wraparound Facilitators and WF Supervisors received distributions of the IN FSSA Home and Community Based Settings Statewide Transition Plan Newsletter, a link to the Final Rule, as well as detailed instructions on the completion of the survey. DMHA Site Coaches were available for follow-up, both for questions from the Wraparound Facilitators and their supervisors, as well as to encourage completion of the surveys in a timely manner. The completed surveys were submitted to DMHA by March 11, 2016. The survey completion rate was 81%, with 379 responding of 469 participants. These surveys were linked to specific sites and used to validate the results of DMHA's systemic assessments. DMHA has completed a detailed review of each member survey.

Results and Remediation

DMHA reviewed and analyzed surveys of 379 participants with the following results:

Category of Compliance	Number of settings in category	Total number of settings surveyed	Percentage of Total
Fully align with the Federal requirements.	379	379	100%
Does not comply and will require modifications.	0	379	0%
Cannot meet the requirements and will require removal from the program and/or relocation of individuals.	0	379	0%
Heightened Scrutiny	0	379	0%
Totals	379	379	100%

All settings surveyed, 379 of them, were found to fully align with the Federal Requirements. Most participants (358 of 379, or 94%) were found to live in single family homes in the community with less than 6% (21 of 379) of youth in foster care family homes in the community. DMHA followed up with 36 youth and families with additional questions to ensure settings were complaint. Follow-up inquiries included 100% of the 21 participants living in foster care, which is 58% (21 of 36) of follow-up inquiries. DMHA follow-up consisted of emails and phone calls with the conflict-free Wraparound Facilitators

(care coordinators) to gain clarification of questions. All were found to be in compliance. Additionally, DMHA has analyzed and compared the findings of youth living in family homes with youth living in foster homes to determine if there are fundamental differences between the settings. DMHA found that overall, foster homes were no more restrictive on average than non-foster home settings; and often were less restrictive. Neither setting type, natural family nor foster family, was noted to present with indicators of institutional qualities or to have a lesser degree of access and opportunity as settings of children not receiving Medicaid HCBS; and therefore do not require remediation.

The survey completion rate was 81%, with 379 responding of 469 participants. To ensure that 100% of those living in foster home settings were surveyed, DMHA ran a query, finding that approximately ten youth were living in foster care settings receiving HCBS who did not have a survey completed by them or on their behalf. DMHA is currently following up with these youths to conduct the survey and determine the compliance of their settings. The target date to complete this activity is March 31, 2017.

If, in the future, a setting is found to be out of compliance, DMHA would require the provider and/or participant to come into compliance.

If a CMHW provider is providing a service in a non-compliant setting, such as a Habilitation provider working with a youth in the school setting, DMHA would place the provider on a corrective action.

If the setting involved a licensed DCS foster care setting, it would be out of compliance with DCS standards as well. DMHA would work in conjunction with DCS to review the setting. A review of the setting would include observation, interviews, a review of the DCS home study that was conducted on the foster parent where indicated, and other document review. The results of a foster family setting review would be analyzed and communicated to the interested parties. Settings which are out of compliance would result in DMHA placing the provider on a corrective action and requiring the participant to move to a compliant setting within 90 days of receipt of notification of non-compliance. The determination of this 90-day window was developed in cooperation with DCS as a reasonable timeframe for remediation and relocation if necessary of participants.

Heightened Scrutiny

After review of the results of the initial survey, no settings were found to be out of compliance.

If any residential setting is suspected to be out of compliance, a site visit will be conducted to determine if the setting 1) meets the HCBS requirements, 2) does not meet the requirements, or 3) requires heightened scrutiny.

Settings to be reviewed for heightened scrutiny include settings that are on the grounds of or adjacent to a nursing facility, ICF/ID facility, IMD, hospital, other public institution, and/or have the effect of isolating individuals from the greater community including residential settings where respondents indicate few social interactions outside of the home, school, and congregate settings of four or more homes located close together.

The below steps will determine if a setting requires heightened scrutiny, and therefore submitted to CMS:

7. An initial site visit will be conducted by the conflict free Wraparound Facilitator.
8. If indicated, a follow-up site visit will be conducted by a representative of DMHA.
9. If the setting requires heightened scrutiny, the setting identified will be posted for public comment.
10. If remediation is warranted, a remediation plan will be submitted.
11. If site is in compliance with HCBS rules during site visit, public comment and/or after remediation, evidence including public comment will be submitted to CMS for Heightened Scrutiny review.
12. If it is determined that the setting is compliant, DMHA will continue monitoring to ensure ongoing compliance.
13. If DMHA determines the setting cannot or will not come into compliance, the relocation process will commence.

Relocation of Beneficiaries Process

If it was determined that a participant in a foster care setting was living in a non-compliant setting, and despite working with DCS to remediate the setting, it is not brought into compliance, DMHA would require the participant to move to a compliant setting within 90 days of receipt of notification of non-compliance, or be transitioned from the program to other services. The determination of this 90-day window was developed in cooperation with DCS as a reasonable timeframe for remediation and relocation if necessary of participants.

Participants who reside with family members in homes or apartments in typical community neighborhoods where people who do not receive home and community-based services reside are presumed to be in compliance. If it is found that a participant living with family members who do not reside in typical community neighborhoods, but have relocated to an institution or institution-like setting will be considered as not fully complying with federal and state requirements. DMHA would require the participant and family to move to a compliant setting, but rather than the 90-day timeframe required of foster families found to be out of compliance, would work with the family on a month-by-month basis with demonstrated progress (such as the exploration of alternate residences) as is reasonable to accommodate any lease or other legal obligations, not to exceed one year from the date of formal notice. Progress toward this transition would have been monitored no less often than monthly as part of the required monthly Child and Family Team meetings, and would include assistance from the local System of Care and DMHA where appropriate.

Ongoing Compliance and Monitoring of Settings

In order to ensure ongoing compliance and monitoring of settings, DMHA will continue to train all providers on the setting requirements; Access personnel will include an assessment of the residential setting as part of the initial application for eligibility process; require an annual confirmation of the compliance of the residential setting (attestation form); require Wraparound Facilitators to assess any changes in the residential setting during the program year, and report the assessment to the State; and the Child and Family Team, guided by the Wraparound Facilitator and other providers, will determine the settings in which services will be delivered as part of plan development, to be reviewed and approved by the State.

All providers must attend orientation training and service specific training. This training includes HCBS Settings Final Rule requirements. A description of the setting in which services are delivered is required in all service notes, as discussed in training. Demonstrated competency measures are included in DMHA trainings, and questions on this requirement have been included. Potential providers are required to pass the competency measure in order to be approvable as a provider. Ongoing support is available to providers who may have questions regarding allowable settings. All providers are given state contacts for technical assistance in any areas of need.

As part of the initial application for eligibility and again at the time of annual eligibility renewal, questions related to settings compliance will be addressed and included in the DMHA Youth and Family Rights Attestation form, which includes all of the rights offered to all participants. A field will be added to the Youth and Family Rights Attestation form that the family signs to validate the compliance of the participant's residential setting. Access personnel (who complete initial assessments for application for eligibility on behalf of the State) receive training on the setting requirements, understanding that it is a fundamental part of the initial assessment. A description of the participants living situation has always been a requirement of the initial and annual application which is then reviewed by the State as part of the eligibility process. The Wraparound Facilitators are in the participants' home at least once per month. As part of the State's plan to ensure ongoing compliance, DMHA will draft a policy requiring that Wraparound Facilitators review any relocation of the participant to a new setting to ensure that the setting is compliant with the federal requirements, and communicate that to DMHA when updating the participant's demographic information.

If, during the eligibility period the participant is found to be in an institutional, institution-like, or otherwise non-compliant setting, the Wraparound Facilitator will immediately notify DMHA to begin the remediation process.

Wraparound Facilitators guide the Child and Family Team meeting for plan of care development including determining services, strategies, responsible parties, and the setting in which services will take place. The plan of care is then reviewed and approved by DMHA quality assurance staff for compliance. DMHA quality assurance staff review 100% of service plans submitted before approval.

There is currently an established process for the Wraparound Facilitator to notify DMHA if the participant will be out the identified setting for more than 24 hours. This includes but is not limited to camp, overnight with relatives or placement in an acute setting. This allows for DMHA to monitor changes in the living arrangement.

Upon enrollment in the program, youth and families are also given information regarding contacting DMHA for assistance with any concerns they may have.

Anyone, provider, family member, or other, may submit a complaint to DMHA about any concern they may have including services provided in non-compliant or questionable settings. Access to the web-based complaint portal is provided on several DMHA webpages.

DMHA-YOUTH REMEDIATION CHART:

Action Item	Description	Strategies	Timeline for Completion	Source Documentation	Key Stakeholders
Participant Surveys Conducted	DMHA and PCG have developed a survey specifically tailored for youth targeting specific HCBS requirements that will provide data to further determine Indiana’s compliance status with the HCBS rules.	Survey results will serve as a tool to identify settings that may not be in compliance with HCBS rules and allow DMHA to develop strategies for working with these providers to come in to compliance in the required timelines.	Surveys completed by March 11, 2016. These surveys have been completed.	Survey document	Participants and families; Conflict free Wraparound Facilitators, DMHA Youth team.
Participant Survey Analysis	DMHA will complete a detailed review of each member survey and the final results will be available by March 31, 2016.	Settings indicating non-compliance or potential non-compliance will be scheduled for an on-site review by DMHA staff, and by DCS where that setting is indicated to be under the licensure jurisdiction of Indiana’s Department of Child Services.	State analysis completed by May 31, 2016. This analysis has been completed.	Member surveys and aggregate analysis.	DMHA and DCS staff.
Site Specific Review and Analysis	State conducts site specific surveys and reviews. A review of the home study to help determine compliance with HCBS settings final rule will be conducted.	DMHA staff would conduct an on-site review of the setting to determine if the setting required remediation to bring it into compliance. DMHA would work in conjunction with DCS to review the setting.	June 30, 2016 This process has been completed. All settings were found to fully comply with Federal requirements.	Review of the settings would include observation, interviews, a review of the DCS home study that was conducted on the foster parent where indicated, and other document review.	Participants and families; Foster parents; Child Placement Agencies; Providers; Conflict free Wraparound Facilitators, DMHA and DCS staff.
Comprehensive Setting Results and Formal Notices Requiring Corrective Actions (where indicated)	The results of the review would be analyzed and communicated to the interested parties.	The settings which are found to be out of compliance will result in DMHA placing the provider on a corrective action and/or requiring the participant to move to a compliant setting within 90-day of receipt	Communications distributed by July 29, 2016. No remediation was required.	Aggregate and site specific survey results	Participants and families; Foster parents; Child Placement Agencies; Providers; Conflict free Wraparound Facilitators, DMHA and DCS staff.

		of notification of non-compliance.			
<p>Site Specific Remediation and/or Beneficiary Relocation as a result of the initial survey.</p>	<p>Implementation of Corrective Action Plan submitted by providers where the provider is found to be non-compliant. Where the youth resides with the family, but the family is living in a setting that does not fully comply with federal and state requirements, DMHA will require the participant modify their setting or relocate to a compliant setting, or be transitioned to appropriate services.</p>	<p>To be determined by the Corrective Action Plan with no less often than monthly monitoring by DMHA.</p>	<p>Corrective Action Plans submitted by a CMHW service provider, or involving a foster care setting must come into compliance no later than 90-days from the date of the plan's acceptance by DMHA. Where the non-compliance involves the family living in a setting that does not fully comply, and/or a setting determined to require Heightened Scrutiny, DMHA may extend the transition period on a month-by-month basis with demonstrated progress as is reasonable to accommodate any lease or other legal obligations not to exceed one year from the date of formal notice. Progress toward this transition would be monitored no less often than monthly as part of the required monthly Child and Family Team meetings, and may include assistance from the local System of Care and DMHA where appropriate. With this in mind, all settings found to potentially be out of compliance would be remedied or the participants</p>	<p>Corrective Action Plans; Monthly Child and Family Team meeting notes.</p>	<p>Participants and families; Foster parents; Child Placement Agencies; Providers; Conflict free Wraparound Facilitators, DMHA and DCS staff.</p>

			discharged no later than December 2018, or one year after the identification of the non-compliant setting. No remediation from the initial survey was required.		
Sites requiring Heightened Scrutiny	Settings to be reviewed for heightened scrutiny include settings that are on the grounds of or adjacent to a nursing facility, ICF/ID facility, IMD, hospital, other public institution, and/or have the effect of isolating individuals from the greater community including residential settings where respondents indicate few social interactions outside of the home, school, and congregate settings of four or more homes located close together.	The below steps will determine if a setting requires heightened scrutiny, and therefore submitted to CMS: 1. An initial site visit will be conducted by the conflict free Wraparound Facilitator. 2. If indicated, a follow-up site visit will be conducted by a representative of DMHA. 3. If the setting requires heightened scrutiny, the setting identified will be posted for public comment. 4. If remediation is warranted, a remediation plan will be submitted. 5. If site is in compliance with HCBS rules during site visit, public comment and/or after remediation, evidence including public comment will be submitted to CMS for Heightened Scrutiny review. 6. If it is determined that the setting is compliant, DMHA will continue monitoring to ensure ongoing compliance. 7. If DMHA determines the setting cannot or will not come into compliance, the relocation process will commence.	Any setting identified as requiring Heightened Scrutiny will be submitted to CMS for review by March 2018. Any recipients requiring relocation will be remediated by Dec 2018.	Documentation of site visit/s; Corrective Action Plans; Monthly Child and Family Team meeting notes.	Participants and families; Foster parents; Child Placement Agencies; Providers; Conflict free Wraparound Facilitators, DMHA, OMPP, Indiana System of Care Governance Board; Youth and Family Subcommittee
Follow-up survey of youths in foster care setting not included in initial survey to determine	DMHA ran a query to determine if all youth in foster care settings receiving HCBS were included in the surveys, finding that approximately ten	DMHA will contact the conflict-free wraparound facilitator of the participant to conduct a survey. The survey will be reviewed by DMHA to determine if a follow-	March 31, 2017 to complete surveys on all youth listed as living in foster care settings. Remediation of any non-	Completed survey; communications between DMHA and stakeholders; formal notices and	Participants and families; Foster parents; Child Placement Agencies; Providers; Conflict free Wraparound Facilitators, DMHA

compliance of their settings.	youth were living in foster care settings receiving HCBS who did not have a survey completed by them or on their behalf. DMHA is currently following up with these youths to conduct the survey and determine the compliance of their settings.	up inquiry is indicated to determine compliance, non-compliance, or if a setting meets the heightened scrutiny criteria. Remediation will be implemented as indicated.	compliant findings would be conducted based on timeframes detailed in the relocation of beneficiaries table.	corresponding documentation as indicated.	
Update Indiana Administrative Code 405 IAC 5-21.7	Specify living with family in a compliant community setting as a requirement for eligibility for the program.	Work with state agencies and lawmakers with public input to draft updated language.	September 30, 2018	Updated, promulgated IAC.	Participants and families; Foster parents; Child Placement Agencies; Providers; Conflict free Wraparound Facilitators, DMHA, OMPP, Indiana System of Care Governance Board; Youth and Family Subcommittee
Update Indiana Administrative Code 405 IAC 5-21.7, cont.	Update reasons for denial of eligibility to include non-compliant residential setting.	Work with state agencies and lawmakers with public input to draft updated language.	September 30, 2018	Updated, promulgated IAC.	Participants and families; Foster parents; Child Placement Agencies; Providers; Conflict free Wraparound Facilitators, DMHA, OMPP, Indiana System of Care Governance Board; Youth and Family Subcommittee
Update Indiana Administrative Code 405 IAC 5-21.7, cont.	Documentation of a complaint setting required as a part of the initial assessment.	Work with state agencies and lawmakers with public input to draft updated language.	September 30, 2018	Updated, promulgated IAC.	Participants and families; Foster parents; Child Placement Agencies; Providers; Conflict free Wraparound Facilitators, DMHA, OMPP, Indiana System of Care Governance Board; Youth and Family Subcommittee
Update Indiana Administrative Code 465 IAC 2	DMHA and DCS will work together to update the regulation. The regulation shall be amended to include a provision for children receiving CMHW HCBS, be in compliance with the requirements of updated 405 IAC 5-21.7. Failure to adhere to the regulation will be transitioned from the	Work with state agencies and lawmakers with public input to draft updated language.	September 30, 2018	Updated, promulgated IAC.	Participants and families; Foster parents; Child Placement Agencies; Providers; Conflict free Wraparound Facilitators, DMHA, OMPP, Indiana System of Care Governance Board; Youth and Family Subcommittee

	program, and will instead receive services through the DCS-funded Child Mental Health Initiative, or similar program.				
The Application for Eligibility and Approval Process	As part of the initial individualized planning process and again at the time of annual renewal of the plan, questions related to settings compliance will be addressed and included in the DMHA Youth and Family Rights Attestation form, which includes all of the rights offered to all participants. DMHA plans to add a field on the Youth and Family Rights Attestation form to validate the compliance of the participants' setting.	Modify Attestation form.	September 30, 2018	Updated Attestation form	DMHA
Ongoing Compliance: Quality Assurance Review	Field audits that include a review of the service settings for all services to ensure compliance.	DMHA will continue its current compliance reviews and monitoring activities to ensure continued compliance with the HCBS settings requirements. The audits include at least one of the following: a review of the case file, including a review of service notes, interviews with providers, and interviews with participants and family. These reviews included a review of settings where services are provided as well as settings where participants reside.	On-going indefinitely. DMHA will continue its current compliance reviews and monitoring activities beyond March 2019 to ensure continued compliance with the HCBS settings requirements. Policies will be completed and in place by September 30, 2018	Site review reports. Policies will be included in the CMHW Provider Modules (manuals) and posted on the DMHA website.	Participants and families; Foster parents; Child Placement Agencies; Providers; Conflict free Wraparound Facilitators, DMHA and DCS staff.
Ongoing Compliance: Review of Residential Changes	When residential setting changes during the approval period, the Wraparound Facilitator (care coordinator) and DMHA will validate that the new setting is compliant.	The DMHA case management data base will be updated to include a notification when the address of a participant changes. This will require that the Wraparound Facilitator (care coordinator) validate that the new setting is compliant. DMHA staff will	DMHA will update the case management database to include a notification when the address of a participant changes and to alert DMHA staff to review for compliance.	Case management database; DMHA Policies will be included in the CMHW Provider Modules (manuals) and posted on the DMHA website.	Participants and families; Foster parents; Child Placement Agencies; Providers; Conflict free Wraparound Facilitators, State Medicaid DMHA and DCS staff.

		likewise be alerted and review for compliance. Policies will be drafted requiring this to be completed.	Policies will be completed and in place by September 30, 2018		
Ongoing Compliance: Review of Service Changes	When services are updated, the Wraparound Facilitator (care coordinator) and DMHA will validate that the new setting is compliant.	Wraparound Facilitators work with the child and family team to establish goals and strategies for the plan of care to ensure individualization of services, respect and dignity of the participant, individual rights including choice, and compliance with standards. DMHA QA staff review each care plan prior to approval for compliance.	Policies will be completed and in place by September 30, 2018	Policies will be included in the CMHW Provider Modules (manuals) and posted on the DMHA website.	Participants and families; Foster parents; Providers; Conflict free Wraparound Facilitators, and DMHA QA staff.
Provider Reference Materials	Policies and procedures related to the final rule will be added to the Provider Reference Materials.	DMHA regularly updates Provider Reference Materials to communicate Policies and Procedures for its Home and Community Based Services. All policies are reviewed and approved of by the Youth and Family Subcommittee and the Indiana SOC Board.	September 30, 2017.	Provider Reference Materials	DMHA, OMPP, Indiana System of Care Governance Board; Youth and Family Subcommittee
Provider Training and Support	New providers/provider applicants will be given an understanding of compliant settings, both residential settings and service delivery settings, and will be able to demonstrate competency with these concepts before approval as providers.	All providers must attend orientation training and service specific training; and an important piece of this training will include HCBS Settings Final Rule requirements. Demonstrated competency measures are included in DMHA trainings, and questions on this requirement will be included. Potential providers are required to pass the competency measure in order to be approvable as a provider.	Training materials and competency measures were updated March 2016. DMHA will incorporate settings requirements into required training materials beyond March 2019 to ensure continued compliance with the HCBS settings requirements.	DMHA training materials and competency measures.	DMHA, DMHA HCBS Providers.
Provider Training and Support	Existing providers will be given an understanding of the final rule and compliant residential and service delivery settings.	DMHA will conduct a required webinar for existing providers where they will be able to review the requirements and ask questions of DMHA, both during the webinar, and as needed	Implemented by September 30, 2017.	Webinar recording.	DMHA, DMHA HCBS Providers.

		afterward to ensure understanding.			

SECTION 4: KEY STAKEHOLDERS AND OUTREACH

DMHA posted a copy of the Statewide Transition Plan to its website and sent emails to notify stakeholders when it was available for review and public comment. Stakeholders include family advocacy agencies, community mental health centers, persons with lived experience, youth and family participants, state agencies, community services agencies and individual providers. DMHA also receives input from families by way of the Indiana Systems of Care Youth and Family Subcommittee, a body which approves and provides input to all new DMHA Youth policies related to programming, including policies generated as a result of the STP.

Services are offered through a local System of Care (SOC) that includes the ten Wraparound Principles: Family Voice and Choice, Team-based, Natural Supports, Collaboration, Community-based, Culturally Competent, Individualized, Strengths-based, Persistent and Outcome-based.

DIVISION OF MENTAL HEALTH AND ADDICTION – ADULT (DMHA-A)
HCBS Programs
Behavioral and Primary Healthcare Coordination (BPHC) – 1915(i)
Adult Mental Health Habilitation (AMHH) – 1915(i)

Update December 2016: The DMHA HCBS Adult Programs portion of the STP has been modified from the version published for public comment and submitted to CMS in July 2016 as follows:

- 1) Updated number of settings assessed and number of settings that fall into each compliance category, based on newly identified settings and ongoing assessment of identified settings
- 2) Technical corrections requested by CMS, which were submitted in November 2016, are included in this version of the STP
- 3) Previous versions of the STP reported numbers of settings and compliance status based on estimates and known data at the time of submission to CMS. This version contains data as of December 13, 2016, reflecting DMHA's ongoing site-specific identification, assessment, and compliance determination program
- 4) Language in several sections was updated to indicate that site-specific assessments and compliance determinations are currently in progress

Update July 2016: The DMHA HCBS Adult Programs portion of the STP has been modified from the version published for public comment and submitted to CMS in April 2016 as follows:

- 1) Publication date of February 25, 2016 for both the Adult Mental Health Habilitation Provider Module and Behavioral and Primary Healthcare Coordination Services Provider Module was added to the DMHA-A Systemic Assessment Crosswalk table
- 2) Updated number of settings assessed and number of settings that fall into each compliance category, based on data collected through June 30, 2016
- 3) Modified and extended timeframes for data collection and analysis
- 4) Provided links to assessment tools used for data collection
- 5) Reorganized and expanded Section 3: Remedial Strategies to include:
 - a. New Subsection 3-A: Remediation Action Plans
 - b. New Subsection 3-B: Site-Specific Remediation Methodology and Milestones
 - c. Defined timeframes for required member transitions
 - d. Added description for how settings will be designated “Unable to Fully Comply” and established timeframes and remediation steps for those settings
- 6) Added information regarding content of evidence packets submitted for heightened scrutiny, and extended timeframe for submission of evidence packets from March 31 to June 30, 2017, to permit ample time for required public comment

Update January 2016: The DMHA HCBS Adult Programs portion of the STP has been modified from the original version published for public comment and submitted to CMS in 2014 as follows.

- 1) The sections have been expanded and reorganized to align with the order of topic areas included in the CMS letter sent to Indiana on October 8, 2015. Table of contents has been updated and sections added in the updated STP
- 2) A new definition for provider owned, controlled, or operated residential settings has been incorporated
- 3) The Section 2 Heading was changed; deleted Proposed Remedial Strategies and replaced it with Systemic Assessments
- 4) In Section 2 of the initial STP document submitted in December 2014, the Proposed Remediation DMHA Adult table was deleted and replaced with a narrative description of the identified setting types, systemic assessment, the site-specific assessment plan, and remedial strategies, and on-going monitoring of compliance
- 5) Estimates have been updated, using more recent information, with regard to: program enrollment numbers, number of identified setting types, number of HCBS members expected to be impacted by the federal regulations
- 6) An updated systemic assessment was completed
- 7) Revised site-specific assessment plans and timelines are included

Background

The Division of Mental Health and Addiction (DMHA) sets care standards for the provision of mental health and addiction services to Hoosiers throughout Indiana. DMHA is committed to ensuring that clients have access to quality services that promote individual, family and community resiliency and recovery. The division also certifies all community mental health centers (CMHCs) and addiction treatment services provider agencies.

Indiana has two CMS approved 1915(i) HCBS programs for adults with serious mental illness: Adult Mental Health Habilitation (AMHH; SPA 3.1-I [TN 12-003]) and Behavioral and Primary Healthcare Coordination (BPHC; SPA 3.1-I [TN 13-013]). AMHH and BPHC are community-based programs, designed with the expectation and focus on ensuring members have access to necessary supports and services for them to be engaged in and be an active part of their community, alongside and with the same opportunities as their fellow community members who do not have a disability. These programs' services, per the CMS-approved SPAs, are required to be delivered in community settings, not institutional settings. Participation in each of these programs is voluntary, and enrolled individuals choose if, when and where they receive AMHH/BPHC services. Statewide there are 25 DMHA-certified community mental health centers (CMHCs) who are the exclusive providers of AMHH and BPHC services in Indiana.

Adult Mental Health Habilitation (AMHH) is a comprehensive service program which provides community-based opportunities for adults with serious mental illness or co-occurring mental illness and addiction disorders who may most benefit from keeping or learning skills to maintain a healthy and safe lifestyle in the community. AMHH was implemented November 1, 2014, and consists of nine services which are individually selected, approved, and delivered to meet an enrolled member's individualized service needs and preferences.

Behavioral and Primary Healthcare Coordination (BPHC) consists of one service, which focuses on coordination of healthcare services to manage the healthcare needs of the individual. BPHC includes logistical support, advocacy and education to assist individuals in navigating the healthcare system. BPHC consists of activities that help participants gain access to needed health (physical and behavioral health) services, manage their health conditions such as adhering to health regimens, scheduling and keeping medical appointments, obtaining and maintaining a primary medical provider and facilitating communication across providers. Direct assistance in gaining access to services, coordination of care within and across systems, oversight of the entire case and linkage to appropriate services are also included. BPHC was implemented June 1, 2014.

Per CMS, DMHA is required to conduct at least annual on-site quality assurance/quality improvement (QA/QI) visits with each approved provider of AMHH and BPHC services, in order to ensure that program standards are being met. DMHA plans to incorporate monitoring of HCBS compliance during these scheduled QA/QI visits, to ensure ongoing compliance of these programs with the federal HCBS final rule.

SECTION 1: SETTINGS INCLUDED IN THE STP

Residential settings: Members who receive AMHH and/or BPHC services are categorized as living in one of two kinds of residential settings: Provider Owned, Controlled, or Operated (POCO) settings, and non-POCO settings.

POCO residential settings, as defined by CMS, are those settings in which an individual resides that are specific physical places that are owned, co-owned, and/or operated by a provider of HCBS. DMHA recognizes that any residence an individual lives in that is owned by a paid caregiver that is not a family member must be treated as a provider owned and controlled setting. For purposes of the STP, DMHA's Adult 1915(i) programs compliance focus is on the 25 DMHA-certified community mental health centers, who are the exclusive providers of AMHH and BPHC services in Indiana [per 1915(b)(4) waiver]. DMHA regularly coordinates with sister divisions that have authority over non-CMHC providers of HCBS (including DMHA Youth Services, Division of Aging, and Division of Disability and Rehabilitative Services) to ensure that the residential setting of each individual receiving HCBS is or becomes compliant with the federal HCBS final rule.

In the December 2014 version of this STP, four types of DMHA-certified residential facilities for adults were identified: alternative family homes for adults (AFA), transitional residential living facility (TRS), semi-independent living facilities

(SILP), and supervised group living (SGL). Each of these DMHA-certified residential facilities meets the definition of a POCO residential setting. However, the designation as a POCO residential setting is not limited to only DMHA-certified residential facilities. AMHH/BPHC providers in Indiana can own, control, or operate other types of residential settings.

Non-POCO residential settings are those for which there is no financial relationship between the provider agency and the property owner. These include private homes owned/leased by the member or the member’s family or friends, as well as apartments, condominiums, multi-family/multi-resident homes (duplexes and boarding homes, for example), manufactured homes, and other types of congregated residences leased by the member or the member’s family or friends from a property owner who has no financial relationship with an HCBS provider agency. For purposes of this STP, DMHA defines “non-POCO” as a setting not owned or operated by a CMHC. DMHA recognizes that some settings in which an individual lives, while not owned or operated by a CMHC, may be owned or operated by another paid caregiver that is not a family member, and must be treated as a provider owned and controlled setting. As with POCO residential settings, DMHA regularly coordinates with state agencies that have authority over non-CMHC providers of HCBS (including DMHA Youth Services, Division of Aging, and Division of Disability and Rehabilitative Services) to ensure that the residential setting of each individual receiving HCBS is or becomes compliant with the federal HCBS final rule.

Non-residential settings: While some AMHH and BPHC services may be delivered in the member’s home/place of residence, some can be (or are required to be) provided at various locations throughout the community. These community locations may include non-institutional, non-residential public settings (restaurants, libraries, service centers, stores, etc.) which are available to everyone in the community, and are therefore compliant with the federal HCBS Final Rule. Some of the activities permitted under AMHH and BPHC may be delivered in a provider-operated non-residential community setting, typically an outpatient community-based clinic operated by the provider agency.

The AMHH Adult Day Service may not be delivered in a member’s home or residential setting, or an institutional setting. The intent of the AMHH Adult Day Service is to maximize community access and integration for the member, by providing opportunities to participate in community activities to develop, enhance, and maintain previously learned social and daily living skills. Adult Day Service is typically delivered in a provider-operated non-residential setting which may or may not be co-located with an outpatient community-based clinic operated by the provider agency.

SECTION 2: SYSTEMIC ASSESSMENT

From March through September 2014 the Family and Social Services Administration Division of Mental Health and Addiction (DMHA), with the Office of General Counsel (OGC) and the Office of Medicaid Policy and Planning (OMPP), completed a preliminary review and analysis of all settings where HCBS services are provided to BPHC members. The analysis included a review of Indiana Administrative Code, program policy, provider manuals, and the CMS approved 1915(i) State Plan Amendments. Through this process, DMHA determined that all services offered by the **Adult Mental Health Habilitation (AMHH) Services program and the Behavioral and Primary Healthcare Coordination (BPHC) program** fully complied with the regulatory requirements because they are individualized services provided in a community-based setting or in the member’s private home.

Since the original systemic assessment occurred in 2014, prior to full implementation of the AMHH and BPHC programs, DMHA undertook a second systemic review of State standards for residential and non-residential settings, and cross-walked those standards with the federal requirements for HCBS. The second systemic review took place in January 2016, and the results are presented in the DMHA-A Systemic Assessment Crosswalk table. DMHA has determined that all State standards for both residential and non-residential settings remain in full compliance with the federal HCBS Final Rule.

DMHA-A Systemic Assessment Crosswalk

Federal Requirement: Settings are integrated in and support full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

Applicable Indiana Regulation	Compliance with HCBS Settings Final Rule:	Remediation Activity	Timeline
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<p>AMHH: IC 12-8-6.5-5;</p> <p>The Secretary may adopt rules under IC 4-22-2 to implement this chapter and the State Medicaid program.</p> <p>405 IAC 5-21.6 Section 4(a)(6)</p> <p>“The applicant either: (A) resides in a community-based setting that is not an institutional setting; or (B) will be discharged from an institutional setting back to a community-based setting.”</p> <p>Adult Mental Health Habilitation Provider Module: Section 2 and Section 6 (published February 25, 2016)</p> <p>In January 2014, the Centers for Medicare & Medicaid Services (CMS) published regulations to better define the settings in which states can provide Medicaid Home and Community-Based Services. The HCBS Final Rule became effective March 17, 2014. The HCBS Final Rule, along with additional guidance and fact sheets, is available on the CMS Home and Community Based Services site. Per the CMS final rule on HCBS, service settings must exhibit the following qualities to be eligible sites for delivery of HCBS:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Are integrated in and support full access to the greater community <input type="checkbox"/> Are selected by the individual from among setting options <input type="checkbox"/> Ensure the individual’s rights of privacy, dignity, and respect, and freedom from coercion and restraint <input type="checkbox"/> Optimize autonomy and independence in making life choices <input type="checkbox"/> Facilitate choice regarding services and who provides them 	<p>Fully Complies –All settings in which AMHH or BPHC services are provided are required to be “home and community based” settings. In the program modules, providers are specifically required to implement the requirements in the federal rule. If the regulatory language is considered ambiguous, the provider module may be used as evidence of the agency’s intended interpretation. This pertains to both residential and non-residential settings.</p>	<p>The Adult DMHA 1915(i) team will update the AMHH policy module to reflect that all individuals receiving HCBS services in non-residential settings must have experiences consistent with those individuals not receiving HCBS services, for example, the same access to food and visitors.</p>	<p>This will be completed during the next module update scheduled to begin in January 2017.</p>
<p>BPHC: IC 12-8-6.5-5;</p> <p>The Secretary may adopt rules under IC 4-22-2 to implement this chapter and the State Medicaid program.</p> <p>405 IAC 5-21.8 Section 4(4)(A)</p> <p>The applicant either: (A) resides in a community-based setting that is not an institutional setting; or (B) will be</p>	<p>Fully Complies –All settings in which AMHH or BPHC services are provided are required to be “home and community based” settings. In the program modules, providers are specifically required to implement the requirements in the federal rule. If the regulatory language is considered ambiguous, the provider</p>	<p>The Adult DMHA 1915(i) team will update the BPHC policy module to reflect that all individuals receiving HCBS services in non-residential settings must have experiences consistent with those individuals not receiving HCBS services, for example, the same access to food and visitors.</p>	<p>This will be completed during the next module update scheduled to begin in January 2017.</p>

<p>discharged from an institutional setting back to a community-based setting.</p> <p>Behavioral and Primary Healthcare Coordination Services Provider Module: Section 4 and Section 12 (published February 25, 2016)</p> <p>BPHC is a home and community-based service (HCBS) program. In accordance with federal regulations for 1915(i) State Plan HCBS programs, service activities are to be provided within the individual’s home (place of residence) or at other locations based in the community. Service activities cannot not be provided in an institutional setting.</p>	<p>module may be used as evidence of the agency’s intended interpretation.</p>		
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Federal Requirement: Settings are selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual’s needs, preferences, and, for residential settings, resources available for room and board.

Applicable Indiana Regulation	Compliance with HCBS Settings Final Rule:	Remediation Activity	Timeline
<p>AMHH: IC 12-8-6.5-5;</p> <p>The Secretary may adopt rules under IC 4-22-2 to implement this chapter and the State Medicaid program.</p> <p>405 IAC 5-21.6 Section 4(a)(6)</p> <p>“The applicant either: (A) resides in a community-based setting that is not an institutional setting; or (B) will be discharged from an institutional setting back to a community-based setting.”</p> <p>Adult Mental Health Habilitation Provider Module: Section 2 and Section 6 (published February 25, 2016)</p> <p>In January 2014, the Centers for Medicare & Medicaid Services (CMS) published regulations to better define the settings in which states can provide Medicaid Home and Community-Based Services. The HCBS Final Rule became effective March 17, 2014. The HCBS Final Rule, along with additional guidance and fact sheets, is available on the CMS Home and Community Based Services site. Per the CMS final rule on HCBS, service settings must exhibit the following qualities to be eligible sites for delivery of HCBS:</p>	<p>Fully Complies - All settings in which AMHH or BPHC services are provided are required to be “home and community based” settings. In the program modules, providers are specifically required to implement the requirements in the federal rule. The provider module language should be considered evidence of the agency’s interpretation of its regulation, and given deference over any other possible interpretations.</p>	<p>In an effort to bring our rule into compliance with the requirement for members to be offered a choice of non-disability setting choices, the Adult 1915(i) program team will review and draft language specifically addressing this issue during the next AMHH module review.</p>	<p>During the 2017 module review.</p>

<ul style="list-style-type: none"> <input type="checkbox"/> Are integrated in and support full access to the greater community <input type="checkbox"/> Are selected by the individual from among setting options <input type="checkbox"/> Ensure the individual’s rights of privacy, dignity, and respect, and freedom from coercion and restraint <input type="checkbox"/> Optimize autonomy and independence in making life choices <input type="checkbox"/> Facilitate choice regarding services and who provides them 			
<p>BPHC: IC 12-8-6.5-5;</p> <p>The Secretary may adopt rules under IC 4-22-2 to implement this chapter and the State Medicaid program.</p> <p>405 IAC 5-21.8, Section 3(d)</p> <p>“(d) An application must, at a minimum, include documentation demonstrating the following: [...] (3) The applicant has chosen, from a randomized list of eligible BPHC service providers in the applicant’s community, a provider to deliver the office authorized BPHC services under this rule.”</p> <p>Behavioral and Primary Healthcare Coordination Services Provider Module: Section 4 and Section 12 (published February 25, 2016)</p> <p>Before a member’s selection of a residential placement, alternatives are discussed with the member, family, and guardian, as applicable. The decision for the choice of residence is based on the member’s identified needs, goals, and resources. After the resident chooses a residence, an Individualized Integrated Care Plan (IICP) is developed or updated with the resident. The IICP reflects his or her aspirations and goals toward an independent lifestyle and how the residential setting contributes to empowering the member to continue to live successfully in the community.</p>	<p>Fully Complies –All settings in which AMHH or BPHC services are provided are required to be “home and community based” settings. In the program modules, providers are specifically required to implement the requirements in the federal rule. If the regulatory language is considered ambiguous, the provider module may be used as evidence of the agency’s intended interpretation.</p>	<p>In an effort to bring our rule into compliance with the requirement for members to be offered a choice of non-disability setting choices, the Adult 1915(i) program team will review and draft language specifically addressing this issue during the next BPHC module review.</p>	<p>During the 2017 module review.</p>
<p>Federal Requirement: Settings ensure an individual’s rights of privacy, dignity, respect, and freedom from coercion and restraint.</p>			
<p>Applicable Indiana Regulation</p>	<p>Compliance with HCBS Settings Final Rule:</p>	<p>Remediation Activity</p>	<p>Timeline</p>

<p>AMHH: IC 12-8-6.5-5;</p> <p>The Secretary may adopt rules under IC 4-22-2 to implement this chapter and the State Medicaid program.</p> <p>405 IAC 5-21.6 Section 4(6)(A)</p> <p>“The applicant either: (A) resides in a community-based setting that is not an institutional setting; or (B) will be discharged from an institutional setting back to a community-based setting.”</p> <p>Adult Mental Health Habilitation Provider Module: Section 2 and Section 6 (published February 25, 2016)</p> <p>In January 2014, the Centers for Medicare & Medicaid Services (CMS) published regulations to better define the settings in which states can provide Medicaid Home and Community-Based Services. The HCBS Final Rule became effective March 17, 2014. The HCBS Final Rule, along with additional guidance and fact sheets, is available on the CMS Home and Community Based Services site. Per the CMS final rule on HCBS, service settings must exhibit the following qualities to be eligible sites for delivery of HCBS:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Are integrated in and support full access to the greater community <input type="checkbox"/> Are selected by the individual from among setting options <input type="checkbox"/> Ensure the individual’s rights of privacy, dignity, and respect, and freedom from coercion and restraint <input type="checkbox"/> Optimize autonomy and independence in making life choices <input type="checkbox"/> Facilitate choice regarding services and who provides them 	<p>Fully Complies - All settings in which AMHH or BPHC services are provided are required to be “home and community based” settings. In the program modules, providers are specifically required to implement the requirements in the federal rule. The provider module language should be considered evidence of the agency’s interpretation of its regulation, and given deference over any other possible interpretations.</p>	<p>No remediation is required.</p>	
<p>BPHC: IC 12-8-6.5-5;</p> <p>The Secretary may adopt rules under IC 4-22-2 to implement this chapter and the State Medicaid program.</p> <p>405 IAC 5-21.8 Section 4(4)(A)</p> <p>“The applicant either: (A) resides in a community-based setting that is not an institutional setting; or (B) will be</p>	<p>Fully Complies –All settings in which AMHH or BPHC services are provided are required to be “home and community based” settings. In the program modules, providers are specifically required to implement the requirements in the federal rule. If the regulatory language is considered ambiguous, the provider</p>	<p>No remediation is required.</p>	

<p>discharged from an institutional setting back to a community-based setting.”</p> <p>Behavioral and Primary Healthcare Coordination Services Provider Module: Section 4 and Section 12 (published February 25, 2016)</p> <p>Each member’s essential personal rights of privacy, dignity, and respect, and freedom from coercion and restraint, are protected.</p>	<p>module may be used as evidence of the agency’s intended interpretation.</p>		
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Federal Requirement: Settings optimize, but do not regiment, individual initiative, autonomy, and independence in making life choices including but not limited to, daily activities, physical environment, and with whom to interact.

Applicable Indiana Regulation	Compliance with HCBS Settings Final Rule:	Remediation Activity	Timeline
<p>AMHH: IC 12-8-6.5-5;</p> <p>The Secretary may adopt rules under IC 4-22-2 to implement this chapter and the State Medicaid program.</p> <p>405 IAC 5-21.6 Section 4(6)(A)</p> <p>“The applicant either: (A) resides in a community-based setting that is not an institutional setting; or (B) will be discharged from an institutional setting back to a community-based setting.”</p> <p>Adult Mental Health Habilitation Provider Module: Section 2 and Section 6 (published February 25, 2016)</p> <p>In January 2014, the Centers for Medicare & Medicaid Services (CMS) published regulations to better define the settings in which states can provide Medicaid Home and Community-Based Services. The HCBS Final Rule became effective March 17, 2014. The HCBS Final Rule, along with additional guidance and fact sheets, is available on the CMS Home and Community Based Services site. Per the CMS final rule on HCBS, service settings must exhibit the following qualities to be eligible sites for delivery of HCBS:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Are integrated in and support full access to the greater community <input type="checkbox"/> Are selected by the individual from among setting options 	<p>Fully Complies - All settings in which AMHH or BPHC services are provided are required to be “home and community based” settings. In the program modules, providers are specifically required to implement the requirements in the federal rule. The provider module language should be considered evidence of the agency’s interpretation of its regulation, and given deference over any other possible interpretations.</p>	<p>No remediation is required.</p>	

<ul style="list-style-type: none"> ☐ Ensure the individual’s rights of privacy, dignity, and respect, and freedom from coercion and restraint ☐ Optimize autonomy and independence in making life choices ☐ Facilitate choice regarding services and who provides them 			
<p>BPHC: IC 12-8-6.5-5;</p> <p>The Secretary may adopt rules under IC 4-22-2 to implement this chapter and the State Medicaid program.</p> <p>405 IAC 5-21.8 Section 4(4)(A)</p> <p>“The applicant either: (A) resides in a community-based setting that is not an institutional setting; or (B) will be discharged from an institutional setting back to a community-based setting.”</p> <p>Behavioral and Primary Healthcare Coordination Services Provider Module: Section 4 and Section 12 (published February 25, 2016)</p> <p>“The overall atmosphere of the setting is conducive to the achievement of optimal independence, safety, and development by the resident with his or her input.”</p>	<p>Fully Complies –All settings in which AMHH or BPHC services are provided are required to be “home and community based” settings. In the program modules, providers are specifically required to implement the requirements in the federal rule. If the regulatory language is considered ambiguous, the provider module may be used as evidence of the agency’s intended interpretation.</p>	<p>No remediation is required.</p>	

Federal Requirement: Settings facilitate individual choice regarding services and supports, and who provides them.

Applicable Indiana Regulation	Compliance with HCBS Settings Final Rule:	Remediation Activity	Timeline
<p>AMHH: IC 12-8-6.5-5;</p> <p>The Secretary may adopt rules under IC 4-22-2 to implement this chapter and the State Medicaid program.</p> <p>405 IAC 5-21.6 Section 3(d)</p> <p>“The applicant must, at a minimum, include documentation indicating the following: (1) the applicant is requesting the service or services listed on the proposed IICP submitted with the application, or (2) the applicant chose, from a randomized list of eligible AMHH service providers in the applicant’s community, a provider to</p>	<p>Fully Complies - All settings in which AMHH or BPHC services are provided are required to be “home and community based” settings. In the program modules, providers are specifically required to implement the requirements in the federal rule. The provider module language should be considered evidence of the agency’s interpretation of its regulation, and given deference over any other possible interpretations. Additionally, the state</p>	<p>No remediation is required.</p>	

<p>deliver the office authorized AMHH services under this rule.”</p> <p>Adult Mental Health Habilitation Provider Module: Section 7 (published February 25, 2016)</p> <p>The FSSA/DMHA-approved AMHH provider agency is responsible for informing the applicant of his or her right to select an AMHH provider.</p>	<p>regulation requires providers to provide a choice of services to the member.</p>		
<p>BPHC: IC 12-8-6.5-5;</p> <p>The Secretary may adopt rules under IC 4-22-2 to implement this chapter and the State Medicaid program.</p> <p>405 IAC 5-21.8 3(d)(2)</p> <p>“An application must, at a minimum, include documentation demonstrating the following: [...] (2) The applicant is requesting the services listed on the proposed IICP submitted with the application.”</p> <p>Behavioral and Primary Healthcare Coordination Services Provider Module: Section 6 (published February 25, 2016)</p> <p>“Each resident shall have the freedom and support to control his or her own schedules and activities and have access to food at any time.”</p>	<p>Fully Complies –All settings in which AMHH or BPHC services are provided are required to be “home and community based” settings. In the program modules, providers are specifically required to implement the requirements in the federal rule. If the regulatory language is considered ambiguous, the provider module may be used as evidence of the agency’s intended interpretation.</p>	<p>No remediation is required.</p>	

Federal Requirement: In provider-owned or controlled residential settings, the setting is a specific physical place that is owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has the same responsibilities and protections from eviction as all tenants under landlord/tenant law of the State, county, city or other designated entity. In settings where tenant laws do not apply, a lease, residency agreement or other written agreement is in place providing protections to address eviction processes and appeals comparable to those provided under the jurisdiction’s landlord tenant law.

Applicable Indiana Regulation	Compliance with HCBS Settings Final Rule:	Remediation Activity	Timeline
<p>AMHH: IC 12-8-6.5-5;</p> <p>The Secretary may adopt rules under IC 4-22-2 to implement this chapter and the State Medicaid program.</p> <p>405 IAC 5-21.6 Section 4(6)(A)</p> <p>“The applicant either: (A) resides in a community-based setting that is not an institutional setting; or (B) will be discharged from an institutional setting back to a community-based setting.”</p>	<p>Fully Complies - All settings in which AMHH or BPHC services are provided are required to be “home and community based” settings. In the program modules, providers are specifically required to implement the requirements in the federal rule. Additionally, the state program modules specifically require that providers use leases that are compliant with state eviction laws. The provider</p>	<p>No remediation is required.</p>	

<p>Adult Mental Health Habilitation Provider Module: Section 2 and Section 6 (published February 25, 2016)</p> <p>There are additional requirements for provider-owned or -controlled home and community-based residential settings. These requirements include:</p> <ul style="list-style-type: none"> <input type="checkbox"/> The individual has a lease or other legally enforceable agreement providing similar protections. <input type="checkbox"/> The individual has privacy in his or her unit, including lockable doors, choice of roommates, and freedom to furnish or decorate the unit. <input type="checkbox"/> The individual controls his or her own schedule, including access to food at any time. <input type="checkbox"/> The individual can have visitors at any time. <input type="checkbox"/> The setting is physically accessible. 	<p>module language should be considered evidence of the agency’s interpretation of its regulation, and given deference over any other possible interpretations.</p>		
<p>BPHC: IC 12-8-6.5-5;</p> <p>The Secretary may adopt rules under IC 4-22-2 to implement this chapter and the State Medicaid program.</p> <p>405 IAC 5-21.8 Section 4(4)(A)</p> <p>“The applicant either: (A) resides in a community-based setting that is not an institutional setting; or (B) will be discharged from an institutional setting back to a community-based setting.”</p> <p>Behavioral and Primary Healthcare Coordination Services Provider Module: Section 4 and Section 12 (published February 25, 2016)</p> <p>“The tenant’s housing is not contingent on the person participating in any mental health or addiction services. The member has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord tenant law of the state...”</p>	<p>Fully Complies –All settings in which AMHH or BPHC services are provided are required to be “home and community based” settings. In the program modules, providers are specifically required to implement the requirements in the federal rule. If the regulatory language is considered ambiguous, the provider module may be used as evidence of the agency’s intended interpretation.</p>	<p>No remediation is required.</p>	
<p>Federal Requirement: In provider-owned or controlled residential settings, each individual has privacy in their sleeping or living unit.</p>			
<p>Applicable Indiana Regulation</p>	<p>Compliance with HCBS Settings Final Rule:</p>	<p>Remediation Activity</p>	<p>Timeline</p>

<p>AMHH: IC 12-8-6.5-5;</p> <p>The Secretary may adopt rules under IC 4-22-2 to implement this chapter and the State Medicaid program.</p> <p>405 IAC 5-21.6 Section 4(6)(A)</p> <p>“The applicant either: (A) resides in a community-based setting that is not an institutional setting; or (B) will be discharged from an institutional setting back to a community-based setting.”</p> <p>Adult Mental Health Habilitation Provider Module: Section 2 and Section 6 (published February 25, 2016)</p> <p>There are additional requirements for provider-owned or -controlled home and community-based residential settings. These requirements include:</p> <ul style="list-style-type: none"> <input type="checkbox"/> The individual has a lease or other legally enforceable agreement providing similar protections. <input type="checkbox"/> The individual has privacy in his or her unit, including lockable doors, choice of roommates, and freedom to furnish or decorate the unit. <input type="checkbox"/> The individual controls his or her own schedule, including access to food at any time. <input type="checkbox"/> The individual can have visitors at any time. <input type="checkbox"/> The setting is physically accessible. 	<p>Fully Complies - All settings in which AMHH or BPHC services are provided are required to be “home and community based” settings. In the program modules, providers are specifically required to implement the requirements in the federal rule. The provider module language should be considered evidence of the agency’s interpretation of its regulation, and given deference over any other possible interpretations.</p>	<p>No remediation is required.</p>	
<p>BPHC: IC 12-8-6.5-5;</p> <p>The Secretary may adopt rules under IC 4-22-2 to implement this chapter and the State Medicaid program.</p> <p>405 IAC 5-21.8 Section 4(4)(A)</p> <p>“The applicant either: (A) resides in a community-based setting that is not an institutional setting; or (B) will be discharged from an institutional setting back to a community-based setting.”</p>	<p>Fully Complies –All settings in which AMHH or BPHC services are provided are required to be “home and community based” settings. In the program modules, providers are specifically required to implement the requirements in the federal rule. If the regulatory language is considered ambiguous, the provider module may be used as evidence of the agency’s intended interpretation.</p>	<p>No remediation is required.</p>	

<p>Behavioral and Primary Healthcare Coordination Services Provider Module: Section 4 and Section 12 (published February 25, 2016)</p> <p>“Each resident has the right to privacy in his or her sleeping or living unit.”</p>			
<p>Federal Requirement: In provider-owned or controlled residential settings, units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.</p>			
Applicable Indiana Regulation	Compliance with HCBS Settings Final Rule:	Remediation Activity	Timeline
<p>IC 12-8-6.5-5;</p> <p>The Secretary may adopt rules under IC 4-22-2 to implement this chapter and the State Medicaid program.</p> <p>405 IAC 5-21.6 Section 4(a)(6)</p> <p>“The applicant either: (A) resides in a community-based setting that is not an institutional setting; or (B) will be discharged from an institutional setting back to a community-based setting.”</p> <p>Adult Mental Health Habilitation Provider Module: Section 2 and Section 6 (published February 25, 2016)</p> <p>There are additional requirements for provider-owned or -controlled home and community-based residential settings. These requirements include:</p> <ul style="list-style-type: none"> <input type="checkbox"/> The individual has a lease or other legally enforceable agreement providing similar protections. <input type="checkbox"/> The individual has privacy in his or her unit, including lockable doors, choice of roommates, and freedom to furnish or decorate the unit. <input type="checkbox"/> The individual controls his or her own schedule, including access to food at any time. <input type="checkbox"/> The individual can have visitors at any time. <input type="checkbox"/> The setting is physically accessible. 	<p>Fully Complies – All settings in which AMHH or BPHC services are provided are required to be “home and community based” settings. In the program modules, providers are specifically required to implement the requirements in the federal rule. The provider module language should be considered evidence of the agency’s interpretation of its regulation, and given deference over any other possible interpretations.</p>	<p>No remediation is required.</p>	
<p>BPHC: IC 12-8-6.5-5;</p> <p>The Secretary may adopt rules under IC 4-22-2 to implement this chapter and the State Medicaid program.</p>	<p>Fully Complies –All settings in which AMHH or BPHC services are provided are required to be “home and community based” settings. In the</p>	<p>No remediation is required.</p>	

<p>405 IAC 5-21.8 Section 4(4)(A)</p> <p>“The applicant either: (A) resides in a community-based setting that is not an institutional setting; or (B) will be discharged from an institutional setting back to a community-based setting.”</p> <p>Behavioral and Primary Healthcare Coordination Services Provider Module: Section 4 and Section 12 (published February 25, 2016)</p> <p>“Each resident has the right to units having lockable entrance doors, with only appropriate staff having keys to doors.”</p>	<p>program modules, providers are specifically required to implement the requirements in the federal rule. If the regulatory language is considered ambiguous, the provider module may be used as evidence of the agency’s intended interpretation.</p>		
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Federal Requirement: In provider-owned or controlled residential settings individuals sharing units have a choice of roommates.

Applicable Indiana Regulation	Compliance with HCBS Settings Final Rule:	Remediation Activity	Timeline
<p>IC 12-8-6.5-5;</p> <p>The Secretary may adopt rules under IC 4-22-2 to implement this chapter and the State Medicaid program.</p> <p>405 IAC 5-21.6 Section 4(a)(6)</p> <p>“The applicant either: (A) resides in a community-based setting that is not an institutional setting; or (B) will be discharged from an institutional setting back to a community-based setting.”</p> <p>Adult Mental Health Habilitation Provider Module: Section 2 and Section 6 (published February 25, 2016)</p> <p>There are additional requirements for provider-owned or -controlled home and community-based residential settings. These requirements include:</p> <ul style="list-style-type: none"> <input type="checkbox"/> The individual has a lease or other legally enforceable agreement providing similar protections. <input type="checkbox"/> The individual has privacy in his or her unit, including lockable doors, choice of roommates, and freedom to furnish or decorate the unit. 	<p>Fully Complies - All settings in which AMHH or BPHC services are provided are required to be “home and community based” settings. In the program modules, providers are specifically required to implement the requirements in the federal rule. The provider module language should be considered evidence of the agency’s interpretation of its regulation, and given deference over any other possible interpretations.</p>	<p>No remediation is required.</p>	

<ul style="list-style-type: none"> <input type="checkbox"/> The individual controls his or her own schedule, including access to food at any time. <input type="checkbox"/> The individual can have visitors at any time. <input type="checkbox"/> The setting is physically accessible. 			
<p>IC 12-8-6.5-5;</p> <p>The Secretary may adopt rules under IC 4-22-2 to implement this chapter and the State Medicaid program.</p> <p>405 IAC 5-21.8 Section 4(4)(A)</p> <p>“The applicant either: (A) resides in a community-based setting that is not an institutional setting; or (B) will be discharged from an institutional setting back to a community-based setting.”</p> <p>Behavioral and Primary Healthcare Coordination Services Provider Module: Section 4 and Section 12 (published February 25, 2016)</p> <p>“When sharing living units, each resident has a choice of roommates.”</p>	<p>Fully Complies –All settings in which AMHH or BPHC services are provided are required to be “home and community based” settings. In the program modules, providers are specifically required to implement the requirements in the federal rule. If the regulatory language is considered ambiguous, the provider module may be used as evidence of the agency’s intended interpretation.</p>	<p>No remediation is required.</p>	

Federal Requirement: In provider-owned or controlled residential settings, individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

Applicable Indiana Regulation	Compliance with HCBS Settings Final Rule:	Remediation Activity	Timeline
<p>IC 12-8-6.5-5;</p> <p>The Secretary may adopt rules under IC 4-22-2 to implement this chapter and the State Medicaid program.</p> <p>405 IAC 5-21.6 Section 4(a)(6)</p> <p>“The applicant either: (A) resides in a community-based setting that is not an institutional setting; or (B) will be discharged from an institutional setting back to a community-based setting.”</p> <p>Adult Mental Health Habilitation Provider Module: Section 2 and Section 6 (published February 25, 2016)</p>	<p>Fully Complies - All settings in which AMHH or BPHC services are provided are required to be “home and community based” settings. In the program modules, providers are specifically required to implement the requirements in the federal rule. The provider module language should be considered evidence of the agency’s interpretation of its regulation, and given deference over any other possible interpretations.</p>	<p>No remediation is required.</p>	

<p>There are additional requirements for provider-owned or -controlled home and community-based residential settings. These requirements include:</p> <ul style="list-style-type: none"> <input type="checkbox"/> The individual has a lease or other legally enforceable agreement providing similar protections. <input type="checkbox"/> The individual has privacy in his or her unit, including lockable doors, choice of roommates, and freedom to furnish or decorate the unit. <input type="checkbox"/> The individual controls his or her own schedule, including access to food at any time. <input type="checkbox"/> The individual can have visitors at any time. <input type="checkbox"/> The setting is physically accessible. 			
<p>IC 12-8-6.5-5;</p> <p>The Secretary may adopt rules under IC 4-22-2 to implement this chapter and the State Medicaid program.</p> <p>405 IAC 5-21.8 Section 4(4)(A)</p> <p>“The applicant either: (A) resides in a community-based setting that is not an institutional setting; or (B) will be discharged from an institutional setting back to a community-based setting.”</p> <p>Behavioral and Primary Healthcare Coordination Services Provider Module: Section 4 and Section 12 (published February 25, 2016)</p> <p>“Each resident has the freedom to furnish and decorate his or her sleeping or living units.”</p>	<p>Fully Complies –All settings in which AMHH or BPHC services are provided are required to be “home and community based” settings. In the program modules, providers are specifically required to implement the requirements in the federal rule. If the regulatory language is considered ambiguous, the provider module may be used as evidence of the agency’s intended interpretation.</p>	<p>No remediation is required.</p>	

Federal Requirement: In provider-owned or controlled residential and non-residential settings, individuals have the freedom and support to control their schedules and activities, and have access to food any time.

Applicable Indiana Regulation	Compliance with HCBS Settings Final Rule:	Remediation Activity	Timeline
<p>AMHH: IC 12-8-6.5-5;</p> <p>The Secretary may adopt rules under IC 4-22-2 to implement this chapter and the State Medicaid program.</p>	<p>Fully Complies – All settings in which AMHH or BPHC services are provided are required to be “home and community based” settings. In the</p>	<p>No remediation is required.</p>	

<p>405 IAC 5-21.6 Section 4(6)(A)</p> <p>“The applicant either: (A) resides in a community-based setting that is not an institutional setting; or (B) will be discharged from an institutional setting back to a community-based setting.”</p> <p>Adult Mental Health Habilitation Provider Module: Section 2 and Section 6 (published February 25, 2016)</p> <p>There are additional requirements for provider-owned or -controlled home and community-based residential settings. These requirements include:</p> <ul style="list-style-type: none"> <input type="checkbox"/> The individual has a lease or other legally enforceable agreement providing similar protections. <input type="checkbox"/> The individual has privacy in his or her unit, including lockable doors, choice of roommates, and freedom to furnish or decorate the unit. <input type="checkbox"/> The individual controls his or her own schedule, including access to food at any time. <input type="checkbox"/> The individual can have visitors at any time. <input type="checkbox"/> The setting is physically accessible. 	<p>program modules, providers are specifically required to implement the requirements in the federal rule. The provider module language should be considered evidence of the agency’s interpretation of its regulation, and given deference over any other possible interpretations.</p>		
<p>BPHC: IC 12-8-6.5-5;</p> <p>The Secretary may adopt rules under IC 4-22-2 to implement this chapter and the State Medicaid program.</p> <p>405 IAC 5-21.8 Section 4(4)(A)</p> <p>“The applicant either: (A) resides in a community-based setting that is not an institutional setting; or (B) will be discharged from an institutional setting back to a community-based setting.”</p> <p>Behavioral and Primary Healthcare Coordination Services Provider Module: Section 4 and Section 12 (published February 25, 2016)</p> <p>“Each resident shall have the freedom and support to control his or her own schedules and activities and have access to food at any time.”</p>	<p>Fully Complies –All settings in which AMHH or BPHC services are provided are required to be “home and community based” settings. In the program modules, providers are specifically required to implement the requirements in the federal rule. If the regulatory language is considered ambiguous, the provider module may be used as evidence of the agency’s intended interpretation.</p>	<p>No remediation is required.</p>	

Federal Requirement: In provider-owned or controlled residential and non-residential settings, individuals are able to have visitors of their choosing at any time.			
Applicable Indiana Regulation	Compliance with HCBS Settings Final Rule:	Remediation Activity	Timeline
<p>AMHH: IC 12-8-6.5-5;</p> <p>The Secretary may adopt rules under IC 4-22-2 to implement this chapter and the State Medicaid program.</p> <p>405 IAC 5-21.6 Section 4(6)(A)</p> <p>“The applicant either: (A) resides in a community-based setting that is not an institutional setting; or (B) will be discharged from an institutional setting back to a community-based setting.”</p> <p>Adult Mental Health Habilitation Provider Module: Section 2 and Section 6 (published February 25, 2016)</p> <p>There are additional requirements for provider-owned or -controlled home and community-based residential settings. These requirements include:</p> <ul style="list-style-type: none"> <input type="checkbox"/> The individual has a lease or other legally enforceable agreement providing similar protections. <input type="checkbox"/> The individual has privacy in his or her unit, including lockable doors, choice of roommates, and freedom to furnish or decorate the unit. <input type="checkbox"/> The individual controls his or her own schedule, including access to food at any time. <input type="checkbox"/> The individual can have visitors at any time. <input type="checkbox"/> The setting is physically accessible. 	<p>Fully Complies – All settings in which AMHH or BPHC services are provided are required to be “home and community based” settings. In the program modules, providers are specifically required to implement the requirements in the federal rule. The provider module language should be considered evidence of the agency’s interpretation of its regulation, and given deference over any other possible interpretations.</p>	<p>No remediation is required.</p>	
<p>BPHC: IC 12-8-6.5-5;</p> <p>The Secretary may adopt rules under IC 4-22-2 to implement this chapter and the State Medicaid program.</p> <p>405 IAC 5-21.8 Section 4(4)(A)</p>	<p>Fully Complies –All settings in which AMHH or BPHC services are provided are required to be “home and community based” settings. In the program modules, providers are specifically required to implement the requirements in the federal</p>	<p>No remediation is required.</p>	

<p>“The applicant either: (A) resides in a community-based setting that is not an institutional setting; or (B) will be discharged from an institutional setting back to a community-based setting.”</p> <p>Behavioral and Primary Healthcare Coordination Services Provider Module: Section 4 and Section 12 (published February 25, 2016)</p> <p>Each resident is able to have visitors of his or her choosing at any time.</p>	<p>rule. If the regulatory language is considered ambiguous, the provider module may be used as evidence of the agency’s intended interpretation.</p>		
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Federal Requirement: In provider-owned or controlled residential and non-residential settings, the setting is physically accessible to the individual.

Applicable Indiana Regulation	Compliance with HCBS Settings Final Rule:	Remediation Activity	Timeline
<p>AMHH: IC 12-8-6.5-5;</p> <p>The Secretary may adopt rules under IC 4-22-2 to implement this chapter and the State Medicaid program.</p> <p>405 IAC 5-21.6 Section 4(6)(A)</p> <p>“The applicant either: (A) resides in a community-based setting that is not an institutional setting; or (B) will be discharged from an institutional setting back to a community-based setting.”</p> <p>Adult Mental Health Habilitation Provider Module: Section 2 and Section 6 (published February 25, 2016)</p> <p>There are additional requirements for provider-owned or -controlled home and community-based residential settings. These requirements include:</p> <ul style="list-style-type: none"> <input type="checkbox"/> The individual has a lease or other legally enforceable agreement providing similar protections. <input type="checkbox"/> The individual has privacy in his or her unit, including lockable doors, choice of roommates, and freedom to furnish or decorate the unit. <input type="checkbox"/> The individual controls his or her own schedule, including access to food at any time. 	<p>Fully Complies – All settings in which AMHH or BPHC services are provided are required to be “home and community based” settings. In the program modules, providers are specifically required to implement the requirements in the federal rule. The provider module language should be considered evidence of the agency’s interpretation of its regulation, and given deference over any other possible interpretations.</p>	<p>No remediation is required.</p>	

<p><input type="checkbox"/> The individual can have visitors at any time.</p> <p><input type="checkbox"/> The setting is physically accessible.</p>			
<p>BPHC: IC 12-8-6.5-5;</p> <p>The Secretary may adopt rules under IC 4-22-2 to implement this chapter and the State Medicaid program.</p> <p>405 IAC 5-21.8 Section 4(4)(A)</p> <p>“The applicant either: (A) resides in a community-based setting that is not an institutional setting; or (B) will be discharged from an institutional setting back to a community-based setting.”</p> <p>Behavioral and Primary Healthcare Coordination Services Provider Module: Section 4 and Section 12 (published February 25, 2016)</p> <p>“The setting is physically accessible to each resident.”</p>	<p>Fully Complies –All settings in which AMHH or BPHC services are provided are required to be “home and community based” settings. In the program modules, providers are specifically required to implement the requirements in the federal rule. If the regulatory language is considered ambiguous, the provider module may be used as evidence of the agency’s intended interpretation.</p>	<p>No remediation is required.</p>	

Federal Requirement: Any modifications of the additional conditions for provider-owned and controlled residential settings must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:

1. Identify a specific and individualized need.
2. Document the positive interventions and supports used prior to any modifications to the person-centered plan.
3. Document less intrusive methods of meeting the need that have been tried but did not work.
4. Include a clear description of the condition that is directly proportionate to the specific need addressed.
5. Include regular collection and review of data to measure the ongoing effectiveness of the modification.
6. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
7. Include the informed consent of the individual.
8. Include an assurance that interventions and supports will cause no harm to the individual.

Applicable Indiana Regulation	Compliance with HCBS Settings Final Rule:	Remediation Activity	Timeline
<p>AMHH: IC 12-8-6.5-5;</p> <p>The Secretary may adopt rules under IC 4-22-2 to implement this chapter and the State Medicaid program.</p> <p>405 IAC 5-21.6 Section 4(6)(A)</p> <p>“The applicant either: (A) resides in a community-based setting that is not an institutional setting; or (B) will be discharged from an institutional setting back to a community-based setting.”</p>	<p>Compliant – The state regulation requires all settings in which AMHH services are provided be HCBS compliant. The policy module explains that compliance includes documentation of modifications according to the person-centered IICP process in compliance with HCBS requirements.</p>	<p>No remediation required.</p>	

<p>Adult Mental Health Habilitation Provider Module: Section 6 (published February 25, 2016)</p> <p>Any modification of the resident’s rights must be supported by a specific assessed need and documented in the person-centered IICP.</p>			
<p>BPHC: IC 12-8-6.5-5:</p> <p>The Secretary may adopt rules under IC 4-22-2 to implement this chapter and the State Medicaid program.</p> <p>405 IAC 5-21.8 Section 4(4)(A)</p> <p>“The applicant either: (A) resides in a community-based setting that is not an institutional setting; or (B) will be discharged from an institutional setting back to a community-based setting.”</p> <p>Behavioral and Primary Healthcare Coordination Services Provider Module:</p> <p>Section 4 (published February 25, 2016)</p> <p>Any modification of the resident’s rights must be supported by a specific assessed need and documented in the person-centered treatment plan, IICP.</p>	<p>Compliant – The state regulation requires all settings in which BPHC services are provided be HCBS compliant. The policy module explains that compliance includes documentation of modifications according to the person-centered IICP process in compliance with HCBS requirements.</p>	<p>No remediation required.</p>	

SECTION 3: SITE SPECIFIC ASSESSMENT

Since the initial 2014 Statewide Transition Plan was published and submitted, DMHA’s experience has grown with regard to the implementation, operation, monitoring, and oversight of the AMHH and BPHC programs. DMHA’s understanding of the federal HCBS Final Rule and its impact on the adult 1915(i) State Plan benefit programs has evolved, as well. These changes, along with a CMS request for additional information, created the need for a revised DMHA-A plan to conduct site-specific assessments for settings affected by the HCBS final rule. DMHA implemented separate site-specific assessment plans for POCO residential settings, non-POCO residential settings, other non-residential settings, and POCO non-residential settings.

Previous versions of the STP reported numbers of settings and compliance status based on estimates and known data at the time of submission to CMS. This version contains data as of December 13, 2016, reflecting DMHA’s ongoing site-specific identification, assessment, and compliance determination program. Language in this section was also updated to indicate that site-specific assessments and compliance determinations are currently in progress.

Number of Residential Settings That Fall into Each HCBS Compliance Category

The number of identified residential settings in Indiana in which members enrolled in AMHH or BPHC live experiences some variability, often from day to day. Member enrollment in AMHH and BPHC changes daily, as does those members’ current living situation. CMHCs continue to identify or acquire new POCO residential settings, while “retiring” or otherwise discontinuing to operate others. Below is a summary table of identified residential settings for AMHH and BPHC enrolled members in Indiana, as of December 13, 2016.

Summary of Identified Residential Settings for AMHH/BPHC Enrollees in Indiana (as of December 13, 2016)					
	Total Number Identified	Fully Compliant	Needs Modifications	Unable to Comply	Assessment in Progress
POCO Residential Setting	209	11	191	0	7
POCO Non-Residential Setting	188	186	2	0	0
Non-POCO Residential Setting	35	0	0	0	35*
Private/Independent Home	2477	Private/Independent Homes are presumed to be fully compliant with the federal HCBS final rule.			

Note: * indicates DMHA is in the process of gathering additional information about these sites, to determine the proper course of action to assess their compliance with the federal HCBS final rule.

Methodology and Milestones for Site-Specific Assessments: Screening for Qualities of an Institution

All identified POCO settings (residential and non-residential) are screened for institutional qualities by DMHA desk audit during the initial phase of assessment. DMHA staff enter the physical address for each identified POCO setting into MapQuest, Google Maps, or another Internet open-source mapping and satellite imaging service. The locations are cross-referenced with the street addresses of known publicly or privately operated facilities that provide inpatient institutional treatment, and proximity to other residences, businesses, public transportation services, and other community features is assessed. If a setting is found to potentially have one or more qualities of an institution, then that setting is preliminarily designated “Potential Presumed Institutional”.

As of December 13, 2016, 56 POCO settings were preliminarily designated “Potential Presumed Institutional”. Whether a setting has qualities of an institution is an independent determination from the compliance status of a setting (either “Fully Compliant” or “Needs Modifications”). These 56 sites are a subset of the total number of identified POCO settings (41 of the 209 POCO residential settings, and 15 of the 188 POCO non-residential settings).

Between July 1, 2016 and December 7, 2016, DMHA conducted on-site assessments at each of the 56 settings. The purpose of the on-site assessment was two-fold: (1) to establish whether the setting does in fact have qualities of an institution, and (2) if so, to determine whether DMHA will submit evidence to CMS for heightened scrutiny, in an attempt to have the setting deemed home and community-based. The table below contains the results of the on-site assessments.

Summary of “Potential Presumed Institutional” Site Visit Determinations (as of December 13, 2016)		
	POCO Residential Setting	POCO Non-Residential Setting
Number Identified as “Potential Presumed Institutional”	41	15
Number Determined “Not Institutional”	26	5
Number Determined “Presumed Institutional”	12	10
Number of “Prong 1” Settings	1	10
Number of “Prong 2” Settings	1	0
Number of “Prong 3” Settings	10	0
Number of “Presumed Institutional” Settings to be Referred to CMS for Heightened Scrutiny	12	10
Number of Settings in “Assessment/Decision Pending” Status	3	0

For those settings preliminarily designated “Potential Presumed Institutional”, information about the compliance status is also communicated to providers, so that those settings could complete any required remediation to become fully compliant with the federal HCBS final rule. DMHA anticipates that all of the “Presumed Institutional” settings referred for heightened scrutiny will ultimately be deemed home and community-based.

Methodology and Milestones for Site-Specific Assessments: POCO Residential Settings

All identified POCO residential settings are assessed for preliminary compliance with the federal HCBS Final Rule by provider self-assessment, and the provider self-reports validated by a follow-up cross-walked resident survey. All POCO residential settings are screened for institutional qualities by DMHA desk audit. After screening for qualities of an institution and completion of the validation crosswalk, each identified POCO residential setting is preliminarily assigned to one of three HCBS compliance categories (Fully Compliant, Needs Modifications, and Potential Presumed Institutional). The majority of preliminary compliance designations were communicated to providers between May 27, 2016 and June 22, 2016. For settings identified and assessed since then, preliminary compliance designations are communicated to providers within 7 calendar days of DMHA receiving all required assessment data (provider self-assessments and resident surveys).

A comprehensive provider self-assessment tool was developed by DMHA, using the CMS “Exploratory Questions to Assist States in Assessment of Residential Settings” document from the Settings Requirements Compliance Toolkit on the medicaid.gov HCBS website. The self-assessment tool was made available to agency staff at each of the 25 CMHCs via an open-source online data collection service (link: <https://www.surveymonkey.com/r/GJ5BFVJ>). CMHC’s were instructed to complete one self-assessment for each of their POCO residential settings, regardless of whether there are any members enrolled in AMHH or BPHC currently residing there. Each of the 25 community mental health centers (CMHCs), who are the exclusive providers of AMHH and BMHC services, responded to the self-assessment survey (100% response rate). 164 settings were initially identified statewide (that number has grown to 209), and features of those settings as they pertain to HCBS requirements were reported. The majority of provider self-assessments were completed between September 2015 and June 2016, but providers must submit self-assessments on additional POCO residential settings as those settings are identified or acquired.

A resident survey was developed by DMHA which closely mirrors the items on the provider self-assessment tool, but worded in a way intended to capture the resident’s experience living in the POCO residential setting. On February 2, 2016, an electronic communication (e-mail) was sent to the 25 CMHC providers with detailed instructions regarding the administration of the resident survey. The instructions stated explicitly that residents were to complete the survey without input from provider staff. An on-line survey tool was accessible by agency staff at each of the 25 CMHCs in Indiana (link:

<https://www.surveymonkey.com/r/9MCPNWC>). Each CMHC was required to facilitate the opportunity for every resident living in each of the CMHC's POCO residential settings to complete and return the survey to DMHA during the availability period. Each CMHC was also required to ensure that residents have the means and opportunity to complete the resident survey in private, either electronically or by printed hard copy. Surveys were completed and submitted electronically, or printed and distributed to residents along with envelopes marked "HCBS Resident Survey - 1915(i) State Evaluation Team." A survey drop box was made available as a collection point at each POCO residential setting, and also at each CMHC clinic location. Providers batched and sent the anonymous survey envelopes to DMHA. Resident survey responses, whether submitted electronically or by hard copy, were reviewed and tabulated only by DMHA staff. The majority of resident surveys were distributed and returned between February and June 2016, but resident surveys must be completed and submitted, as new POCO residential settings are identified or acquired.

Validation of the provider self-assessment occurs by cross-walking the resident survey responses with the provider self-assessments. The responses from both provider self-assessment data and resident surveys are sorted into ten (10) compliance categories, which relate directly to each of the required qualities of home and community-based settings and the additional conditions for POCO residential settings. The majority of the validation crosswalks were completed by June 22, 2016, and DMHA continues to validate data from newly identified POCO residential settings as they are reported and assessed. Compliance categories for which the provider response and the resident response(s) are in agreement (whether or not the federal HCBS Final Rule requirement is met) are accepted as valid. Compliance categories for which the provider response and the resident response have discrepancies in reporting that the federal HCBS Final Rule requirement is met are preliminarily designated as not compliant. Validation and/or clarification regarding areas of discrepancy between the provider self-assessment and resident survey responses is completed through desk audit, follow-up contact with the provider, and/or DMHA site visits (to include resident interviews). Validation/clarification of discrepancies began July 1, 2016, and will be an ongoing process.

CMS expressed concern about CMHCs being involved in the distribution and collection of resident surveys at POCO residential settings. The resident surveys contain a specific instruction for provider agencies that CMHC staff are not to complete surveys for residents. Residents are given the option of completing surveys on paper and sealing them in envelopes, for forwarding to DMHA. 85% of the approximately 1230 resident survey responses received (as of December 13, 2016) were on paper, meaning that DMHA had the opportunity to physically view those surveys. Skipped questions, various writing implements used, handwritten comments, handwriting differences, and other features observed in the paper surveys served to confidently establish that the surveys were completed by residents, not providers. In addition, based on analysis of provider and resident survey responses, the SET determined that only one out of 164 initially identified POCO residential sites was deemed "Fully Compliant". The remaining 163 sites were deemed "Needs Modifications", based largely upon discrepancies between provider and resident responses (both hand written and electronically submitted) as to whether a requirement of the federal HCBS Final Rule was met at the setting. DMHA considers this variation in responses between the provider and resident surveys to validate that resident surveys were completed without the input or influence of providers.

After DMHA staff analyzed the responses and assigned compliance categories (see below), DMHA communicated these designations to the providers and requested written responses detailing the provider's plan for compliance activity. Additionally, DMHA conducted technical assistance calls with each provider in order to review the designation reports and compliance plan. Much of the corrective action only requires provider policy modification. Sites that only require policy modifications will receive desk audits of the provider's program leases, resident agreements, program modules and other relevant documents in order to ensure compliance. Sites that require physical changes, such as installing locks on doors, will receive a site visit to verify physical changes have been made, prior to the CMS-established compliance deadline of March 17, 2019.

Current Compliance Designations for POCO Residential Settings

As of December 13, 2016, the number of POCO residential settings in each compliance status is:

FULLY COMPLIANT – 11
NEEDS MODIFICATIONS – 191
ASSESSMENT IN PROGRESS – 7

A status of “Fully Compliant” is based on the following criteria:

1. There are no qualities of the setting that render it presumptively institutional, as defined in 42 CFR 441.710 (a)(2)(v), AND
2. The provider self-assessment and the resident survey(s) were in agreement that one or more of the ten required qualities of POCO residential settings specified in 42 CFR 441.705(a)(1)(i-vi) are present at the setting, AND
3. For those required qualities of POCO residential settings specified in 42 CFR 441.705(a)(1)(i-vi) that were initially assessed as not being present at the setting, the provider has submitted and completed an HCBS Setting Action Plan (described below under “Remediation Action Plans”) to bring the setting into compliance with those requirements

A status of “Needs Modifications” is based on the following criteria:

1. There are no qualities of the setting that render it presumptively institutional, as defined in 42 CFR 441.710 (a)(2)(v), AND
2. The provider self-assessment and the resident survey(s) were not in agreement that each of the ten required qualities of POCO residential settings specified in 42 CFR 441.705(a)(1)(i-vi) are present at the setting, AND
3. The provider has not yet submitted, or has submitted but not yet completed, an HCBS Setting Action Plan (described below under “Remediation Action Plans”) to bring the setting into compliance with those required qualities of POCO residential settings specified in 42 CFR 441.705(a)(1)(i-vi) that were initially assessed as not being present at the setting

A status of “Assessment in Progress” means that DMHA has not received all data (provider self-assessment, resident surveys, or both) from the setting, and is unable to make a compliance designation.

DMHA anticipates that most, if not all, of the 191 POCO residential settings currently designated “Needs Modifications” will successfully complete their HCBS Setting Action Plans and be re-designated as “Fully Compliant”. Settings designated “Fully Compliant” will begin to be validated on-site by the DMHA 1915(i) State Evaluation Team during scheduled SFY2017 QA/QI site visits.

Methodology and Milestones for Site-Specific Assessments: Non-POCO Residential Settings

Non-POCO residential settings began to be identified in April 2016 using a DMHA-developed HCBS Residential Setting Screening Tool (RSST), and by implementing modifications to the online application process for the adult 1915(i) programs. Through this process, 35 non-POCO residential settings have been identified as of December 13, 2016. DMHA is in the process of gathering additional information about these settings, to determine the type of setting and best course of action for assessing compliance with the federal HCBS Final Rule.

Beginning April 1, 2016, the DMHA-developed HCBS Residential Setting Screening Tool (RSST) is required to be completed collaboratively by the member and their provider during every initial and renewal application for AMHH and/or BPHC eligibility. The screening tool helps identify the type of setting in which an applying member lives, and whether that setting has been determined to meet or not meet federal HCBS requirements (including settings which may have qualities of an institution). The characteristics of a non-compliant setting preventing it from being fully compliant with federal HCBS setting requirements are identified, and the information used by DMHA and the provider agency to initiate the appropriate remedial activities to bring the setting into full HCBS compliance.

An attestation on the application must be checked, indicating: a) the RSST has been completed with the member, and b) the member was provided an HCBS information pamphlet, before the application may be submitted (all AMHH and BPHC applications are submitted electronically). The consumer-signed and dated screening tool must be maintained in the member’s medical record. To ensure the accuracy and completeness of the HCBS settings compliance attestations, review of the signed and dated RSST in randomly selected member clinical charts will be performed by the 1915(i) State Evaluation Team during on-site reviews (not less than annually) of provider agencies for QA/QI monitoring.

Along with the required HCBS Residential Setting Screening Tool, a modification to the AMHH and BPHC applications was introduced, to help identify specific areas which are not in compliance with the federal HCBS Final Rule. The provider agency and member completing the application are required to select from the following list of community-based residential setting descriptions:

- Homeless
- Private/Independent Home

- A non-POCO residential setting that is fully compliant with the HCBS final rule
- A non-POCO residential setting that is not fully compliant with the HCBS final rule
- A POCO residential setting that is fully compliant with the HCBS final rule
- A POCO residential setting that is not fully compliant with the HCBS final rule
- Potential Presumed Institutional

A narrative section below the residential choices requires a description of the residential setting selected. The instructions for this section have been amended for settings which are reported as not fully compliant with the HCBS Final Rule, to require documentation of which of the HCBS features specified in the Final Rule are not present at the selected setting, as indicated from the screening tool. This will furnish additional information for DMHA to identify non-compliant settings, and initiate the appropriate remediation process. If areas of non-compliance are indicated, DMHA will send a notice of non-compliance to the provider and member, to initiate the “Non-POCO Residential Settings Identified as Non-HCBS Compliant” remediation strategy described in Section 3.

Methodology and Milestones for Site-Specific Assessments: POCO Non-Residential Settings

Provider owned, controlled, or operated (POCO) non-residential settings in which some HCBS services are or are expected to be provided (for example, CMHC outpatient clinics, community rooms, etc.) are identified and assessed by provider self-report. The majority of these settings were identified and assessed between May 17, 2016 and June 27, 2016 (the timeframe for POCO non-residential assessment was changed from April 1-30, 2016, to May 17-June 27, 2016, based on public comment from providers expressing concern about the compressed assessment schedule), and providers must continue to identify and submit self-assessments on previously unidentified POCO non-residential settings.

A combined identification and provider self-assessment tool was developed by DMHA, using the CMS “Exploratory Questions to Assist States in Assessment of Non-Residential Home and Community-Based Services (HCBS) Settings” document from the Settings Requirements Compliance Toolkit on the www.medicaid.gov HCBS website. The self-assessment tool was made available to each of the 25 CMHCs via an open-source online data collection service (link: <https://www.surveymonkey.com/r/JGMM5Q3>) between May 17, 2016 and June 27, 2016. CMHCs were instructed to complete one self-assessment for each of the non-residential, non-institutional settings in which they deliver, or expect to deliver, AMHH and BPHC services. Based on the results of the provider self-assessment, each of the identified settings was preliminarily designated “Fully Compliant”, “Needs Modifications”, or “Potential Presumed Institutional”. The preliminary compliance designations were made by DMHA and the majority of findings were communicated to providers by July 15, 2016. For settings identified and assessed since then, preliminary compliance designations are communicated to providers within 7 calendar days of DMHA receiving the provider self-assessment.

As of December 13, 2016, 188 POCO non-residential settings have been identified and assessed statewide. For all POCO non-residential, non-institutional settings which are not fully compliant with the federal HCBS Final Rule, according to the provider self-report, DMHA will initiate the remediation process.

Current Compliance Designations for POCO Non-residential Settings

As of December 13, 2016, the number of POCO non-residential settings in each compliance status is:

FULLY COMPLIANT – 186
NEEDS MODIFICATIONS – 2

A status of “Fully Compliant” is based on the following criteria:

1. There are no qualities of the setting that render it presumptively institutional, as defined in 42 CFR 441.710 (a)(2)(v), AND
2. The provider self-assessment indicates that all five of the required qualities of an eligible home and community-based setting specified in 42 CFR 441.705(a)(1)(i-v) are present at the setting, OR
3. For those required qualities of an eligible home and community-based setting specified in 42 CFR 441.705(a)(1)(i-v) that were initially assessed as not being present at the setting, the provider has submitted and completed an HCBS Setting Action Plan (described below under “Remediation Action Plans”) to bring the setting into compliance with those requirements

A status of “Needs Modifications” is based on the following criteria:

1. There are no qualities of the setting that render it presumptively institutional, as defined in 42 CFR 441.710 (a)(2)(v), AND
2. The provider self-assessment indicates that one or more of the five required qualities of an eligible home and community-based setting specified in 42 CFR 441.705(a)(1)(i-v) are not present at the setting, AND
3. The provider has not yet submitted, or has submitted but not yet completed, an HCBS Setting Action Plan (described below under “Remediation Action Plans”) to bring the setting into compliance with those required qualities of an eligible home and community-based setting specified in 42 CFR 441.705(a)(1)(i-v) are were initially assessed as not being present at the setting

DMHA anticipates that the two settings currently designated “Needs Modifications” will successfully complete their HCBS Setting Action Plans and be re-designated as “Fully Compliant”. Settings designated “Fully Compliant” will begin to be validated on-site by the DMHA 1915(i) State Evaluation Team during scheduled SFY2017 QA/QI site visits.

Remedial Strategies

The original version of this STP contained tables describing proposed remediation activities and timelines for each of the previously identified DMHA-certified residential facilities and the AMHH Adult Day Service. As with the assessment plans, a need for developing a revised remediation strategy and timelines became evident since the initial version of this STP was submitted in December 2014.

As of December 13, 2016, preliminary compliance designations for POCO settings that were preliminarily assessed to belong to an HCBS compliance category associated with a need for remediation (“Needs Modifications” and “Potential Presumed Institutional”) have been communicated to providers for 202 of 209 identified POCO residential settings (7 settings are still pending assessment) and all 188 identified POCO non-residential settings. Non-POCO residential settings which may not be fully compliant with federal HCBS requirements began to be identified April 1, 2016, and is an ongoing process. DMHA is determining the best course of action to assess these settings for compliance.

Proposed remedial actions for all identified settings are both member-specific and site-specific, based on the type of setting and the preliminary compliance designations made by DMHA following collection of all data from providers and members. For all settings identified as requiring remediation, an action plan specifying required remediation activities and establishing a timetable for completion of required remediation actions will be developed by the responsible provider agency/CMHC, in partnership between DMHA and members enrolled in HCBS programs, their families/friends, guardians, and other persons chosen by the member. In response to a comment received during the public comment period, DMHA is assessing the most appropriate avenues to engage stakeholders and anticipates working with some or all of the following groups/organizations in the ongoing process of refining and implementing the STP: DMHA Consumer Council; Mental Health and Addiction Planning and Advisory Council (MHAPAC); NAMI Indiana; Indiana’s Key Consumer organization; Mental Health America of Indiana Mental Health Ombudsman program, Indiana Disability Rights, and the Indiana Council of Community Mental Health Centers.

Remediation Action Plans

Two types of action plans will be used by DMHA and provider agencies to identify, monitor, and document completion of required remediation for HCBS settings: an HCBS Setting Action Plan and a Member Transition Plan.

HCBS Setting Action Plan: Settings which are not fully HCBS compliant, but for which the operating authority has agreed to complete modifications in order to bring the setting into full compliance, must submit an HCBS Setting Action Plan. DMHA will provide an HCBS Setting Action Plan template to the CMHC providing AMHH/BPHC services at that setting, to be used by the provider agency to address areas of non-compliance at that setting. DMHA requires that all remediation must be completed within 180 days of the agency receiving their Preliminary Compliance Designation (PCD) report. A one-time extension for the HCBS Setting Action Plan may be requested if there is clear documentation of extenuating circumstances which prohibit the plan from being completed within the designated timeframe. The CMHC must collaborate with the affected residents and their families/guardians/caregivers to complete the HCBS Setting Action Plan (coordinating with non-CMHC operating authorities, as needed), with information that details the activities the CMHC/operating authority will complete to remediate the areas of non-compliance and bring the setting into full HCBS compliance, specifies the person

or party/parties responsible for implementing the modifications, and establishes a timeline for completion of all required modifications. Completed HCBS Setting Action Plans have been submitted by all 25 CMHCs. As described in the section titled Methodology and Milestones for Site-Specific Assessment: POCO Residential Settings (p. 142), DMHA is using desk reviews, technical assistance calls, and site visits to verify completion of the Setting Action Plans. Each CMHC has received a technical assistance call to review their Setting Action Plan. Sites that require only policy changes are reviewed by desk review to ensure policy changes are compliant with the federal rule. Settings requiring physical changes, such as locks on doors, are receiving a site visit.

Member Transition Plan: Some members may choose to make changes in their living setting or their person-centered treatment plan, if their current living setting is unable/unwilling to become fully compliant with the federal HCBS Final Rule. In these cases, a Member Transition Plan will be developed by the responsible provider agency, collaboratively with the member and their family/guardian/caretakers. Member Transition Plans will assist members and providers in identifying, exploring, and deciding what changes must be made as a result of HCBS compliance implementation, particularly with regard to continuation of HCBS and/or potential relocation from the member's current residence. The member's decision to discontinue receiving HCBS and continue to live at the HCBS non-compliant residential setting, or to relocate to an HCBS-compliant residential setting, must be documented on the Member Transition Plan. In response to a comment received during the public comment period, individuals for whom a Member Transition Plan is required will be provided contact information for advocacy groups, including the DMHA Consumer Service Line, Indiana Disability Rights, and the Mental Health America of Indiana Mental Health Ombudsman program. The Member Transition Plan must be submitted to DMHA for review no later than 30 calendar days following notification to the member that their current residential setting will not become HCBS compliant. As of December 28, 2016, it is anticipated that 12 members may require a member transition plan. As final determinations are made for all settings, this number will likely change.

Transition Option – Relocation: For members who opt to move to a fully compliant setting in order to continue to receive HCBS, the provider is required to assist the member in identifying other possible living setting options that are HCBS compliant and available to the member. DMHA requires such options must include “non-disability specific” settings. The provider agency, member, and their family/guardian/caretakers will collaborate to determine the soonest possible/practical move date for the member. Transition from the current living setting must occur no later than 180 calendar days from the onset of the Member Transition Plan, and in all cases no later than March 31, 2018. A one-time extension for the HCBS Member Transition Plan may be requested if there is clear documentation of extenuating circumstances which prohibit the plan from being completed within the designated timeframe.

Transition Option – Discontinue Participation in HCBS: For members who choose to continue to live in an HCBS non-compliant setting and opt to discontinue participation in HCBS, the provider is required to assist the member in identifying and exploring other treatment options that may meet their needs. Transition from HCBS participation must occur no later than 180 days from the onset of the Member Transition Plan, and in all cases no later than March 31, 2018. A one-time extension for the HCBS Member Transition Plan may be requested if there is clear documentation of extenuating circumstances which prohibit the plan from being completed within the designated timeframe. A member will remain eligible for HCBS only while their Member Transition Plan is in effect. If the member continues to live in an HCBS non-compliant setting beyond the end date of their Member Transition Plan, the SET will end the member's program eligibility status in AMHH and/or BPHC HCBS programs. The member may re-apply for AMHH and/or BPHC eligibility determination at any time, however if not living in an HCBS compliant setting, eligibility and service authorization will be denied.

Site-Specific Remediation Methodology and Milestones

Settings Designated “Unable to Fully Comply” With HCBS Settings Requirements

DMHA has not designated any setting affected by the federal HCBS Final Rule as “Unable to Fully Comply”. DMHA's expectation is that most settings, given the opportunity to make required modifications or to submit evidence for heightened scrutiny in order to become fully compliant with HCBS settings requirements, will do so. The designation of a setting as “Unable to Fully Comply” will only be made under one of the following four scenarios:

1. A setting designated as “Needs Modifications” opts not to complete remediation
2. A setting designated as “Needs Modifications” fails to complete required remediation by the timeframe specified in the HCBS Setting Action Plan
3. A setting is designated “Presumed Institutional” and DMHA opts not to submit evidence for heightened scrutiny

4. A setting designated “Presumed Institutional” for which CMS, after reviewing the evidence submitted for heightened scrutiny, determines that the setting is not home or community-based

For those settings designated “Unable to Fully Comply,” DMHA will notify the responsible CMHC within 7 calendar days of the date of designation. The responsible CMHC must notify all affected residents at the setting of the designation, and collaborate with those members and their family/guardians/caretakers, to develop and submit a Member Transition Plan within 30 calendar days of the date the CMHC was notified of the “Unable to Fully Comply” designation.

POCO Residential Settings Designated as “Needs Modifications”

DMHA issued Preliminary Compliance Designation (PCD) reports to the responsible CMHC of each identified POCO residential setting, informing the CMHC of the setting’s designation as “Needs Modifications” to become fully compliant with federal HCBS requirements. The majority of these notifications were made by June 22, 2016; for those settings identified and assessed after that date, DMHA issues PCD reports within 7 calendar days of receiving all required data on the setting (provider self-assessment and resident surveys). The notification identifies areas of non-compliance with federal HCBS requirements (as indicated by the validated site-specific assessment) and specifies required actions of the CMHC to be completed within 30 calendar days from date of notification. The actions required to be completed within 30 calendar days of notification include: notification of affected members, decision to remediate or accept non-compliant designation, and submit either an HCBS Setting Action Plan or a Member Transition Plan.

The CMHC must notify affected residents (those currently enrolled in and receiving AMHH/BPHC services) that the setting has been determined not to be fully compliant with the HCBS final rule within 7 calendar days from the date of DMHA notification. Following the notification, the CMHC will decide whether to implement modifications to bring the setting into full compliance, or to accept the designation of the setting as HCBS non-compliant, and notify the affected member(s) of the decision. Providers who choose to perform modifications to bring the setting into full compliance will complete and submit an HCBS Setting Action Plan. DMHA will review the submitted plan and provide technical assistance as needed. Verification will occur through desk audits for those sites requiring policy modifications and site visits for those sites requiring physical modifications.

If a provider agency elects not to complete remediation at a setting, the agency must notify in writing both DMHA and affected members at the setting within 7 calendar days of the decision. Upon receipt of notification by the provider agency that remediation will not be undertaken, DMHA will designate the setting “Unable to Fully Comply.” The provider agency, together with the member and their family/guardian/caretaker, must complete and submit to DMHA a Member Transition Plan for each affected member at the setting within 30 calendar days of the date the provider agency notified DMHA of their intention not to pursue remediation.

If a provider agency does not complete remediation by the end of the designated timeframe (including any granted extensions), the HCBS Setting Action Plan will end and DMHA will designate the setting “Unable to Fully Comply.” DMHA will notify the provider agency of the designation within 7 calendar days of the expiration of the HCBS Setting Action Plan. The provider agency, together with the member and their family/guardian/caretaker, must complete and submit to DMHA a Member Transition Plan for each affected member at the setting within 30 calendar days of the date the provider agency was notified by DMHA that the setting was designated “Unable to Fully Comply.”

POCO Residential Settings Designated as “Potential Presumed Institutional”

DMHA issued Preliminary Compliance Designation (PCD) reports to the responsible CMHC of each POCO residential setting, informing the CMHC of the setting’s designation as “Potential Presumed Institutional”. The majority of these notifications were made by June 22, 2016; for those settings identified and assessed after that date, DMHA issues PCD reports within 7 calendar days of receiving all required data on the setting (provider self-assessment and resident surveys). On-site visits were conducted at each setting between July 1, 2016 and December 7, 2016, and the results communicated to all providers by December 15, 2016.

If the identified setting does not have institutional qualities, based on the findings from the on-site assessment, the setting will be determined not institutional and reassigned to either the “Fully Compliant” or “Needs Modifications” categories (and, if required, referred for remediation). If the identified setting does have institutional qualities, based on the findings from the

on-site assessment, the setting will be designated “Presumed Institutional” and one of the following remediation plans will be implemented.

Targeted for heightened scrutiny: DMHA is developing guidelines for compilation of evidence packets for those settings designated “Presumed Institutional” which will be referred to CMS for heightened scrutiny. DMHA is targeting March 31, 2017 as the due date for compilation of evidence packets, with the required public comment period targeted for April-June 2017. DMHA is targeting June 30, 2017 as the submission date to CMS for all heightened scrutiny evidence packets. Evidence packets for heightened scrutiny will seek to establish that the setting does not have qualities of an institution, and does have qualities of a home or community-based setting.

Information included in the evidence packets for Prong 1 and Prong 2 settings can include, but is not limited to:

- Information clarifying that there is a meaningful distinction between the facility and the community-based setting, such that the latter is integrated in and supports full access of individuals receiving HCBS to the greater community
- Information establishing that the services provided to the individual at the setting, and activities in which each individual participates at the setting, are engaged with the broader community

Information included in the evidence packets for Prong 3 settings can include, but is not limited to:

- Evidence that the setting is integrated in the community to the extent that persons without disabilities in the same community would consider it a part of their community and not associate the setting with the provision of services to persons with disabilities
- Evidence that beneficiaries participate regularly in typical community life activities outside of the setting to the extent the individual desires, and those activities are engaged with the broader community

Examples of documentation to be included in evidence packets can include:

- Observations from on-site reviews
- Licensure requirements or other state regulations
- Residential housing or zoning requirements
- Proximity to/scope of interactions with community settings
- Provider qualifications for HCBS staff
- Service definitions that explicitly support setting requirements
- Evidence that setting complies with requirements of POCO settings
- Documentation in the person-centered treatment plan that individual’s preferences and interests are being met
- Evidence that the individual chose the setting from among setting options, including non-disability specific setting
- Details of proximity to public transport or other transportation strategies to facilitate integration
- Pictures of the site and other demonstrable evidence
- Other information designed to capture beneficiary experience at the setting
- Comments submitted by the public during the public comment period

Presumption allowed to stand: Settings designated “Presumed Institutional” for which DMHA and the CMHC do not intend to provide evidence for heightened scrutiny to rebut the presumption will be surveyed by the CMHC, to determine whether there are any members receiving AMHH or BPHC services who reside there at the time of the determination. If there are AMHH/BPHC-enrolled members living in one of these designated settings, the CMHC must notify affected residents that the setting has been determined not to be fully compliant with HCBS Final Rule within 7 calendar days from the date of notification. The CMHC, together with the affected member(s) and their family/guardian/caretaker, will initiate a Member Transition Plan and submit it to DMHA within 30 calendar days.

Non-POCO Residential Settings Identified as Non-HCBS Compliant

Non-POCO residential settings which are not fully compliant with federal HCBS guidelines began to be identified April 1, 2016 using the screening and assessment process embedded in the AMHH and BPHC application process. As of December

13, 2016, 35 settings statewide have been identified by the reporting provider agency as non-POCO residential settings. Of the 35, only one was reported as not fully compliant with HCBS settings requirements. DMHA is in the process of gathering more information about the 35 identified non-POCO residential settings, to determine the best course of action to assess the HCBS compliance of those settings. In some cases, other State agencies may have authority over the identified non-POCO residential setting, and will be responsible for assessing and ensuring compliance with the federal HCBS Final Rule. The agency with authority over the setting will also have responsibility for developing remediation plans, as required, for the setting. DMHA meets regularly with partner/sister state agencies to facilitate coordination, communication, and collaboration across agencies working together to ensure compliance with the federal HCBS Final Rule.

The remediation plan for non-POCO residential settings that do not fall under the authority of another Indiana state agency is similar to the remediation plan for POCO residential settings. DMHA will inform the provider of a member residing in a non-POCO residential setting of that setting's designation as not fully compliant with federal HCBS requirements within 15 calendar days of the DMHA determination. The notification will identify areas of non-compliance with federal HCBS requirements as reported on the AMHH or BPHC application and specify required actions of the CMHC to be completed within 45 calendar days from date of notification. The required actions will include:

- Notification of affected members,
- Notification of the owner, landlord, property management company, or other party responsible for the setting (the Setting Operating Authority, or SOA) of the determination that the setting is not fully compliant with federal HCBS guidelines,
- Conduct an on-site assessment and meeting with the SOA and member,
- Ascertain and report to DMHA the SOA's decision to remediate or accept the non-compliant designation, and submit either the SOA's HCBS Setting Action Plan or a Member Transition Plan.

Within 7 calendar days of the DMHA notification, the CMHC is required to notify the member and the SOA of the determination that the setting is not fully compliant with federal HCBS guidelines. Within 45 calendar days of the DMHA notification of a non-compliant non-POCO residential setting, the CMHC will facilitate an on-site meeting with the member(s) and the SOA. The purpose of this meeting is to:

- Conduct an on-site assessment of the setting and assess the status of all identified non-compliant areas and update the setting assessment if needed.
- Determine whether there are clinical needs that support no remediation necessary (must document it in the member's care plan), and update the setting assessment if needed.
- Educate (verbally and in writing) the SOA and member about HCBS requirements, importance of remediation, and consequences if not remediated. If the setting is remediated to full compliance, the member may continue to receive HCBS while living in the setting. If the setting is not remediated and brought into full compliance with HCBS standards, the member must decide whether they will relocate to a HCBS compliant living setting and continue receiving HCBS, or remain in the HCBS non-compliant setting and no longer receive HCBS.
- Ascertain and report to DMHA the SOA's decision to remediate or accept the non-compliant designation.
- If the SOA agrees to take remedial action to bring the setting into full HCBS compliance, the CMHC will collaborate with the member and SOA to develop the SOA's HCBS Setting Action Plan.

The completed SOA's HCBS Setting Action Plan must specify the identified areas of non-compliance, the activities the SOA will complete to remediate the areas of non-compliance, who is responsible for completing each remedial action, and a timeline for completion to bring the setting into full HCBS compliance. Required remediation actions are expected to be completed within 180 calendar days of the date the CMHC submits the Setting Action Plan to DMHA. A one-time extension for the SOA's HCBS Setting Action Plan may be requested if there is clear documentation of extenuating circumstances which prohibit the plan from being completed within the designated timeframe. The SOA's HCBS Setting Action Plan will be submitted to DMHA within 45 calendar days of DMHA notification of noncompliance. DMHA will review the submitted plan and provide technical assistance as needed. The CMHC is responsible for reporting monthly to DMHA on the SOA efforts and progress toward meeting the milestones and timelines established in the plan.

If an SOA elects not to complete remediation at a setting, the responsible provider agency must notify in writing both DMHA and affected members at the setting within 7 calendar days of the decision. Upon receipt of notification from the provider agency that remediation will not be undertaken, DMHA will designate the setting "Unable to Fully Comply". The provider agency, together with the member and their family/guardian/caretaker, must complete and submit to DMHA a Member

Transition Plan for each affected member at the setting within 30 calendar days of the date the provider agency notified DMHA of the SOA's intention not to pursue remediation.

If an SOA does not complete remediation by the end of the designated timeframe (including any granted extensions), the SOA's HCBS Setting Action Plan will end and DMHA will designate the setting "Unable to Fully Comply". DMHA will notify the responsible provider agency of the designation within 7 calendar days of the expiration of the SOA HCBS Setting Action plan. The provider agency, together with the member and their family/guardian/caretaker, must complete and submit to DMHA a Member Transition Plan for each affected member at the setting within 30 calendar days of the date the provider agency was notified by DMHA that the setting was designated "Unable to Fully Comply".

Oversight of Remediation Activities and Milestones

DMHA will assess and monitor remediation activities and milestones through monthly provider reports, desk reviews, and site visits by the DMHA 1915(i) State Evaluation Team during scheduled QA/QI visits beginning in SFY2017. Per the 1915(i) State Plan benefit, DMHA is required to conduct at least annual on-site quality assurance/quality improvement (QA/QI) visits with each approved provider of AMHH and BPHC services, in order to ensure that standards for those programs are being met. DMHA is incorporating assessment of HCBS compliance into these scheduled QA/QI visits, to ensure and monitor ongoing compliance of these programs with the federal HCBS Final Rule. DMHA and a provider agency may schedule technical assistance specifically to address HCBS compliance at applicable settings.

Ongoing Monitoring of Settings

Ongoing monitoring of and compliance with HCBS requirements beyond the March 2019 implementation deadline will be facilitated by continuing the on-going requirement for an HCBS Residential Setting Screening Tool (RSST) to be completed in conjunction with all AMHH/BPHC applications and by integrating HCBS compliance activities with required 1915(i) quality assurance/quality improvement (QA/QI) on-site assessments. Providers are tasked with assessing private homes and ensuring access to the greater community. They will report this to the SET via the RSST. In February 2016, DMHA provided a live training for completing the RSST. In April 2016, DMHA provided another follow up training via a provider conference call. Each community mental health center (CMHC), as the exclusive provider of 1915(i) adult services, is required to participate in an on-site review of their AMHH and BPHC programs at least annually or more frequently as determined by the DMHA 1915(i) State Evaluation Team (SET). Integrating HCBS compliance monitoring includes:

1. Physical assessment of POCO residential settings. Beginning in July 2016, during each scheduled CMHC QA/QI site visit, at least one randomly selected POCO residential setting will be visited by the SET. The on-site assessment will include verification of physical HCBS setting requirements and interview(s) with residents, to ensure their living and treatment experience incorporates the rights, freedoms, protections, and choices specified by HCBS requirements.
2. Physical assessment of POCO non-residential settings. Beginning in July 2016, during each scheduled CMHC QA/QI site visit, at least one POCO non-residential setting will be visited by the SET. The on-site assessment will include verification of physical HCBS setting requirements and interview(s) with members present at the setting, to ensure their service experience incorporates the rights, freedoms, protections, and choices specified by HCBS requirements. Priority will be placed on assessing provider-operated non-residential settings where the AMHH Adult Day Service is delivered.
3. Clinical documentation review. Beginning in July 2016, during each scheduled CMHC QA/QI site visit, verification of residential setting will be assessed, and the signed HCBS Residential Setting Screening Tool will be viewed.

SECTION 4: KEY STAKEHOLDERS AND OUTREACH

DMHA is working in partnership with members and advocates, providers and other stakeholders to create a sustainable, person-driven long-term support system in which people with mental illness have choice, control and access to a full array of quality services that assure optimal outcomes, such as independence, health and quality of life.

The programs and partnerships contained in this section are aimed at achieving a system that is:

- **Person-driven:** affords people with disabilities and/or chronic illness the opportunity to decide where and with whom they live, to have control over the services they receive and who provides the services, to work and earn money, and to include friends and supports to help them participate in community life.

- **Inclusive:** The system encourages and supports people to live where they want to live with access to a full array of quality services and supports in the community.
- **Effective and Accountable:** The system offers high quality services that improve quality of life. Accountability and responsibility is shared between public and private partners and includes personal accountability and planning for long-term care needs, including greater use and awareness of private sources of funding.
- **Sustainable and Efficient:** The system achieves economy and efficiency by coordinating and managing a package of services paid that are appropriate for the beneficiary and paid for by the appropriate party.
- **Coordinated and Transparent:** The system coordinates services from various funding streams to provide a coordinated, seamless package of supports, and makes effective use of health information technology to provide transparent information to members, providers and payers.
- **Culturally Competent:** The system provides accessible information and services that take into account people's cultural and linguistic needs.

In preparation for the transition plan, DMHA hosted three regional provider trainings in which state staff shared information pertaining to the comprehensive state plan. Since November of 2013, DMHA has shared the proposed HCBS requirements and their impact on providers of AMHH and BPHC services through webinars, technical assistance, and conference calls. Ongoing, DMHA will provide information about the HCBS State Transition Plan to and see feedback from providers, members, and stakeholder groups such as: DMHA's Mental Health and Addiction Planning and Advisory Council, NAMI, Key Consumers, Indiana Council of CMHCs, and Mental Health America of Indiana. DMHA will seek input from key stakeholders and work with them to assure members are aware of the transition plan and methods in which they can provide feedback and comments. DMHA will also continue these collaborations and partnerships with members and advocates, providers and other stakeholders beyond March, 2019 to ensure on-going communication and compliance with the HCBS settings rules.

PUBLIC INPUT

Indiana's Version 6 Statewide Transition Plan was open for public comment for **30 days, January 18, 2017 through February 17, 2017**. The comment period allowed all HCBS members, potential members, providers and other stakeholders an opportunity to provide input to the plan.

Version 6 of the Statewide Transition Plan and related materials are available at FSSA's [Home and Community-Based Services Final Rule website](#). Indiana provided public notice in print and electronic form through the Indiana Register, print articles in newsletters disseminated by advocacy groups and trade organizations, newsletters and list serves. Paper copies were available in all local Division of Family Resources (DFR) offices and upon request. Written comments were received by email via HCBSrulecomments@fssa.in.gov, or by mail to:

State of Indiana

FSSA/OMPP

Attn: HCBS Final Rule – Kelly Flynn, Manager, State Plan and Waivers
402 W. Washington St., Rm. W374 MS-07
Indianapolis, IN 46204-2739

All comments were tracked and summarized by FSSA. The summary of comments follows, by division, in addition to a summary of modifications made in response to the public comments. The division summary provides the page number where revisions or new content are located (in this document) and division responses appear in **bold**. In cases where the State's determination differs from public comment, the additional evidence and rationale the State used to confirm the determination is included.

All versions of Indiana's Statewide Transition Plan will be posted online and available for review for the duration of the transition period.

PUBLIC INPUT
OFFICE OF MEDICAID POLICY AND PLANNING (OMPP)
Administrative Authority for Indiana Medicaid HCBS

SUMMARY:

The Office of Medicaid Policy and Planning (OMPP) solicited comments on the Statewide Transition Plan as it applies to administration of the Statewide Transition Plan (STP).

PUBLIC COMMENTS:

Comment: Each time there are revisions to the State Transition Plan is there a location where I can see what revisions were made? Maybe highlighting the changes so it will be easy to locate?

Response: Thank you for your comment. If another version of the STP is required, the State will consider posting a version that reflects changes made for review during public comment.

Comment: One commenter noted whenever possible, the divisions within FSSA should coordinate rules, assessments, and procedural safeguards to ensure consistency and fairness across settings. The commenter understands that settings across divisions do not always line up, however, standards for things like procedural safeguards for participants can more easily be systematized across divisions.

Response: Thank you for your comment. The State currently coordinates efforts to the extent possible. CMS establishes some minimum requirements for procedural safeguards, but the divisions have freedom to incorporate enhanced or additional safeguards based on the needs of the populations they serve.

PUBLIC INPUT
DIVISION OF AGING (DA)
HCBS Programs
Aged and Disabled (A&D) Waiver – 1915(c)
Traumatic Brain Injury (TBI) Waiver – 1915(c)

SUMMARY:

The Division of Aging (DA) solicited comments on the Statewide Transition Plan as it applies to the two 1915(c) programs; the Aged and Disabled (A&D) Waiver and the Traumatic Brain Injury (TBI) Waiver. The comments resulted in changes to pages 7, 60, 64, and the Acronym table on page 173.

PUBLIC COMMENTS:

Comment: Commenter has concerns that the HCBS settings rule creates further limitations for residential options by denying true choice and potentially very beneficial opportunities.

Response: Thank you for your comments. DA agrees it is important to expand and not limit choices while working with the framework of the programs and services available.

Comment: Commenter requested to know the criteria Division of Aging will use to determine if the Structured Family Care giving is provider owned or controlled.

Response: Thank you for your comments. To your question on how DA will determine if SFC is provider owned and controlled, that will hinge primarily on whether the paid caregiver is a related or unrelated individual. But in either case, there are core provisions of the Settings Rule that apply in ALL settings and those will always be monitored for compliance...

Comment: Would like to encourage DA to include more people with disabilities or participants of those services and advocacy groups in the DA initiative to design a new program to replace or augment the service of assisted living.

Response: DA appreciates the need to involve consumers and their families in the stakeholder process. DA continues to work on ways to do that effectively and is always open to suggestions.

Comment: The continued use of a 90-day checklist may be limiting and not give the full picture of the individual's true needs and wants. Commenter recommends evaluating case management and the use of standardized tools like checklists to ensure they provide meaningful information about the participants wants and needs, especially if this tool is to be used to help determine a settings on-going compliance with HCBS rules.

Response: DA has appreciated your comments before on the limitations of the 90 day checklist and hope to engage with you and other stakeholders on a thorough review of this tool in the coming year.

Comment: Commenter cited the Federal Requirement: Right to privacy, dignity, respect, and freedom from coercion and restraint. Commenter would encourage DA to restrict a provider's ability to serve as a guardian over the participant. Commenter feels strongly that the direct conflict of interest organically creates a situation where coercion is more likely to happen. Apart from requiring a written record to be made when either measure is used, the statute does not contain reporting requirements or review measures. The application of the new HCBS requirements are an ideal time for the Division to take a stronger approach to protecting the dignity and well-being of consumers. DA should also include a prohibition against involuntary seclusion, or forced social isolation by any provider in code (not just in the ISDH health facilities rule).
Federal Requirement: Settings optimize, but do not regiment individual initiative . . .

455 IAC 2.1-6-4(2) - a provider should not "allow" the person to engage in decision-making and self-determination. Rather, that should be a given, automatic standard. Rather the facility should respect the person's right to make decisions and engage in self-determination. "Allow" implies that the facility can remove that allowance.

455 IAC 2.1-6-6(b)(1) - participants should be able to lock their unit, not just their room.

Physical accessibility - it's not just the room that would need to be accessible, but the entire unit, including common areas, the bathroom, kitchen, etc.

Response: DA agrees that it would be inappropriate for the provider to act as guardian and will consider language for DA's draft rule. A number of your suggestions are directly related to rule language and DA will consider them as comments in that process as well.

Comment: Commenter encourages the use of independent surveyors and those trained in communicating with individuals with disabilities to complete the participant surveys. Surveys should be conducted in a private setting of the participants' choice and participants should be allowed to opt-out if they choose.

Commenter also encourages frequent input from participants through survey and/or town hall forums. Participants should be a part of the process early on and frequently throughout.

Finally, commenter supports the coordination among the various FSSA agencies to ensure consistency for participants across settings.

Response: DA agrees that the use of trained surveyors and interviewers will be critical in obtaining reliable information.

Comment: Relocation of beneficiaries - participants should also be notified of potential sources of advocacy organizations along with their right to appeal. Whenever possible, procedural safeguards should be adequately explained and be consistent across FSSA agencies.

Response: Notifying individuals who may need to be relocated about advocacy organizations available to them is a great idea. DA has revised the STP on page 60 to add language pertaining to notifying beneficiaries about advocacy organizations.

Comment: Ongoing Compliance and Monitoring – Commenter recommends evaluating case management and the use of standardized tools like checklists to ensure they provide meaningful information about the participant's wants and needs and the setting's on-going compliance with HCBS. IDR continues to have reservations regarding the heavy reliance DA plans to place upon the 90-day Monitoring Checklist. As recommended in comments for a previous iteration of the STP, Commenter would like to assert that the DA should integrate regularly occurring face-to-face interviews with a statistically significant population of participants as an additional monitoring tool. This should be carried out by an independent third party, and can be utilized as a means to verify data gathered through the Checklist.

Commenter also encourages inclusion of participants and advocacy groups in developing trainings as well.

Response: Thank you for your comments. DA appreciates the need to involve consumers and their families in the stakeholder process. We continue to work on ways to do that effectively and are always open to suggestions.

Comment: Commenter noted Indiana Protection & Advocacy Services on page 64 should be corrected to Indiana Disability Rights.

Response: DA will make the change on page 64 to reflect Indiana Disability Rights.

Comment: One commenter noted: implicit in the statewide transition plan is the assumption that providers cannot comply with both the current Indiana Residential Care Facility (RCF) licensure rules and the Settings Rule. However, a review of several individual provider reviews (mailed to providers in February 2017) failed to identify any instance where a provider's remediation would conflict with RCF licensure rules.

Response: Thank you for your comments. DA would note that the Settings Rule requirement to provide for the responsibilities and rights of tenant, in a legally enforceable agreement (§441.301(c)(4)(vi)(A)) was not

addressed in the survey tool and will need to be addressed in every remediation plan. That is one significant area of conflict. DA has specifically identified the following areas of conflict:

- 1. Transfer and Discharge of Residents (410 IAC 16.2-5-0.5(f) and 410 IAC 16.2-5-1.2(r))**
- 2. Residency Agreements (410 IAC 16.2-5-1.2(g))**
- 3. Person Centered Planning (410 IAC 16.2-5-1.2(j)(2))**
- 4. Visitors (410 IAC 16.2-5-1.2(cc))**

Comment: One commenter noted: while it may be appropriate to include proposed Division of Aging rule language, the STP should include recognition that Indiana's rule promulgation process will be followed and in so doing, some of the proposed language may be revised.

Response: DA has included proposed rule language in the transition plan a timeline for rule promulgation. Some of that language has been refined already as a result of our assisted living workgroup. DA thanks you for being part of that group.

Comment: In the Statewide Transition Plan, Indiana has indicated that SFC is not a provider owned-or controlled setting as long as the participant lives in a home that is owned or rented by themselves or by a caregiver who is a family member. This interpretation of the Home and Community Based Services Final Rule (HCBS Final Rule) implies that when participants live in a private home that is owned or rented by an un-related caregiver, this home is considered a provider owned or controlled setting. When a setting is considered provider owned or controlled, additional components of the HCBS Final Rule apply. We strongly disagree with this interpretation of the HCBS Final Rule. SFC providers do not own or control the home where SFC is provided.

As you know, caregivers can be related or unrelated, and SFC pays for the care provided to participants and the clinical support provided to caregivers. SFC rules govern how care is provided to participants and how caregivers are supported by SFC agency providers, both components are based on individualized consumer and caregiver assessments and outlined in person centered care plans.

Response: Thank you for your comments on structured family care. DA has continued to seek clarification from CMS on its intent with regard to some of the relationships you have listed here as examples of "unrelated" caregivers.

Comment: One commenter noted as the DA designs a new Medicaid HCBS, bear in mind that the program needs to be some type of certification or license. The terms, certification or license, allow for the Residents to access their long term care benefits and VA benefits for "Assisted Living".

Response: Thank you for your comments. Most of your comments related to specific language for new administrative code/rule language. Some of your comments are directed at current language which is in the draft process now for our new rule. DA will consider all your comments in drafting that language as well as in the transition plan.

DIVISION OF DISABILITY AND REHABILITATIVE SERVICES (DDRS)
HCBS Programs
Community Integration and Habilitation (CIH) Waiver – 1915(c)
Family Supports Waiver (FSW) – 1915(c)

SUMMARY:

The Division of Disability and Rehabilitative Services (DDRS) solicited comments on the Statewide Transition Plan as it applies to the two 1915(c) programs; Community Integration and Habilitation (CIH) and Family Support Waiver (FSW). The comments resulted in changes to pages to pages 83, 85, 87, and 89 of the plan.

PUBLIC COMMENTS:

Comment: Commenter noted that the ADA was not written to create further limitations. It was to allow, to the greatest extent possible, participation for all within community life. This rule simply creates further limitations for residential options by denying true choice and potentially very beneficial opportunities!! Why can't we let the individuals and those that love and support them decide which setting might offer them the best opportunities for a healthy, happy and fulfilling life working within the framework of the funds and services available.

It has been our experience that when you attempt to 'force' situations it often does not go well....but when you create an environment of respect and allow for opportunity.....more good will flourish!

Response: Thank you for the comment, DDRS is committed to supporting families and improving available programs and supports. DDRS agrees with the importance of opportunity and individual choice.

Comment: Commenter noted there is language in the Systemic Assessment Crosswalk about using the individual's PCP/ISP to ascertain if there is compliance in the following areas: ensure choice of living arrangement, rights protection, and development of a life plan, and reason for someone not being engaged in the community. Currently, the training and documents associated with the PCP/ISP do not outline all the examples that the transition plan gives in this section as being reflective in these plans. In addition, the current PCP format is reflective of an individual's current and historical status, it does not fully encompass a life plan or hopes and dreams.

It is suggested to note that the PCP/ISP process and forms are being reevaluated so they can be comprehensive of the outline of the new rules and any modifications of those rules.

Response: Thank you for your comments. DDRS will update the STP to include language that it is currently reviewing the PCP/ISP process through the Life Course Alignment Project. As part of this project the current process and forms will be reevaluated to ensure compliance to the new rules and any modifications of those rules.

Comment: Commenter noted the new BDDS Individual Rights and Responsibilities document is referenced several times as evidence of compliance. Historically, BDDS documents have only been available in English. Will this form be available in multiple languages and accessible formats so that it can be presented in an individual's typical mode of communication?

Response: Thank you for the suggestion to have forms available in multiple languages. While the STP will not be updated with this specific language, the information provided will be helpful as the State incorporates the suggestions within development of policies and procedures.

Comment: For the following, it is indicated that Indiana is in full compliance due to the statement that includes "access to food at any time" on the Monitoring Checklist: Does the individual have the freedom and support to control their schedules and activities and have access to food at any time? At this time, the Monitoring Checklist does not have language that addresses if food needs to be modified. Can the checklist be modified to include this?

Response: In regards to the Monitoring Checklist lacking specific language that addresses food modification, it is expected the ISP/PCP process will address and document any limitations. The monitoring checklist is a monitoring tool to ensure the PCP process is being followed.

Comment: Commenter noted from Transition Plan: The data derived from the Individual Experience Survey will be used to validate compliance of provider's responses to the self-survey of settings. Validation will be comprised of reviewing provider policies and procedures as well as person specific information such as: The individual's PCP/ISP (*is there a reason they are not engaging in the community and is that addressed in the Person Centered Planning process?) Are there Medical issues preventing community involvement?

Are these addressed in the Person Centered Planning process? Are there Behavioral issues preventing community involvement? Are these addressed in PCP/ISP?

There is concern that the IES is reflective of a higher percentage of choice, integration, etc. than there is in actuality.

Participant experience really relies on informed choice. A lack of experiences and clear understanding of options could lead some to answer that they had more choice and integration than they actually did. For example, an individual could be asked, "did you get a choice in roommates?" The answer could be "yes" because they met them ahead of time once and were given the option to stay where they were or go with this new roommate. That is not choice in its truest form, but the choice as the individual may understand it.

It is suggested to keep this in mind when comparing the IES data to the site-specific setting assessment. In addition, the responses received from the IES completed in 2015 would no longer be current data when compared to provider self-assessments and documentation provided in 2017.

Response: For validation of Preliminary Settings Inventory and Proposed Remediation Strategies section of the STP, DDRS recognizes challenges in interpreting data. While the IES data will be used as a validation/comparison to measure the survey responses, it will not be the only factor utilized in determining HCBS compliance. DDRS recognizes settings and experiences may have changed from the original responses provided. The IES data also will be validated to ensure consistency of answers. Measuring the responses against provider responses are just one way of validating the information.

Comment: Commenter noted that for sites that are determined to be compliant based on the provider self-assessment and provider supplied documentation, they would recommend additional verification be completed with individuals supported. Provider reports and documentation may not accurately reflect the actual experience of an individual.

Response: DDRS thanks you for your recommendation. DDRS will utilize site visits with individuals and providers to assist in determining compliance of HCBS delivery sites.

Comment: Commenter stated that it is noted that the process for provider sanctions and dis-enrollment will be complete by June 2018, however, relocation for individuals will not begin until March 2019. What steps will be implemented if a provider is dis-enrolled prior to March 2019? In the review of the transition task force, can clarity be added to advise who will be part of that task force?

Response: If a provider is dis-enrolled prior to March 2019, DDRS will follow the same steps outlined in the STP for Relocation of Beneficiaries on page 95. It is anticipated in the STP by 2018 that sites found to be in non-compliance after all remedial activities will be notified upon determination in order to allow ample time for individuals to follow this process. DDRS is in the process of identifying members of the taskforce. It is anticipated that the taskforce will be convened in late March 2017.

Comment: Commenter noted from Transition Plan: Throughout the five-year transition process DDRS will continually seek out and incorporate stakeholder and other public input. It is suggested to incorporate additional focus groups of individuals and families to gain input on the state's transition plan. Requesting feedback in a 30-day comment period does not lend itself to being accessible to individuals and families. There are some inherent challenges in obtaining feedback from this group.

Individuals and families need to find that there is a comment period. They then need to read through the transition plan and understand what it means. They then have to figure out how to write up their feedback and submit. These barriers lend themselves to not obtaining quality feedback from individuals and families. Sponsoring focus groups that can give verbal feedback in discussion format would generate valuable input as this plan continues to be revised, updated and ultimately implemented.

Response: For the section Key Stakeholders and Outreach, the information provided will be helpful as the State incorporates the suggestions within a communication plan. The State will ensure stakeholders have an opportunity to review any policy/process changes and, to the greatest extent possible, the State will incorporate the suggestions within the specific processes.

Comment: Commenter noted the PCP appears to be inclusive of many remediation efforts however the form and practice right now does not incorporate all the components outlined in the transition plan. This should be noted in the Transition plan along with how this is being addressed.

Response: Under General Suggestions for the STP, DDRS will update the STP to include language that it is currently reviewing the PCP/ISP process through the Life Course Alignment Project. As part of this project the current process and forms will be reevaluated to ensure compliance to the new rules and any modifications of those rules.

Comment: Commenter noted there should be a systematic sharing of the CMS guidance that they are putting out on a regular basis. This should be shared with all stakeholders in an accessible way.

Response: Thank you for the suggestion, while the STP will not be updated with this specific language, the suggestions provided will be helpful as the State incorporates the information within education and training on the HCBS Final Rule of all stakeholders.

Comment: Commenter noted Training should be presented on an ongoing basis for individuals and families in order to clarify the intent of the rules and the state's plan to implement these rules. These trainings should be held in an accessible way for all individuals and families.

Response: Thank you for the suggestion, while the STP will not be updated with this specific language, the information provided will be helpful as the State incorporates the suggestions within education and training on the HCBS Final Rule of all stakeholders.

Comment: Commenter noted Self-Directed Services should be considered with the amendment to the waivers as that service lends itself to fully meeting the requirements of the HCBS rule.

Response: While Self Directed Services are not specifically addressed in the high level STP, service definitions, budgets, funding parameters, codes, etc. are all being looked at to ensure we are able to support compliance.

Comment: Commenter has concerns regarding the lack of specificity provided as to how DDRS intends to amend its regulations to comply with the new HCBS requirements. Commenter will pay close attention to the proposed rules as they are released, and urges CMS to withhold approval of the STP until these amendments are completed. In the meantime, they would like to comment on some of the regulations which the Division acknowledges are implicated by the new requirements, but asserts no remediation is necessary. Federal Requirement: Settings are integrated in and support full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS (p. 66) Page 66 suggests that because 460 IAC 6-20-2 states "community-based employment services will be provided in integrated setting," the rule is already in compliance with the

new HCBS regulations. While that may be true on paper, does DDRS still intend to provide pre-vocational services in non-integrated settings, as it currently does (i.e., sheltered workshops)? Because, based on my reading, that placement would not comply with the HCBS regulations.

DDRS states that 460 IAC 6-9-4 is fully compliant “due to requirement of providers to ensure opportunity for individuals to engage in community life.” However, we must note there is a substantive distinction in the phrases “opportunities to...engage in community life” and “opportunity to participate in...community activities.” The former suggests the provision of opportunities allowing consumers to become contributing members of their communities, while the latter suggests consumers are simply provided a chance to “do things” in the community. Commenter supports the addition of language that would encourage providers to seek out opportunities for community engagement which reflect the choices and values of individual consumers. Commenter looks forward to release of the proposed regulation regarding Individual Rights and Responsibilities. We would like to stress the importance of the language within this regulation being written so as to appropriate for individual consumers. It is crucial the language is not so vague as to encourage technical compliance with the rule.

Commenter continues to have reservations regarding the heavy reliance DDRS plans to place upon the 90-day Monitoring Checklist. As recommended in comments for a previous iteration of the STP, Commenter would like to assert that the Division should integrate regularly occurring face-to-face interviews with a statistically significant population of participants as an additional monitoring tool. This should be carried out by an independent third party, and can be utilized as a means to verify data gathered through the Checklist. Federal Requirement: Settings ensure an individual’s rights of privacy, dignity, respect, and freedom from coercion and restraint.

Commenter would encourage DDRS (and other FSSA agencies) to restrict a provider's ability to serve as a guardian over the participant. Commenter feels strongly that the direct conflict of interest organically creates a situation where coercion is more likely to happen. Regarding the utilization of seclusion or restraint by providers, commenter finds the Division’s assertion that IC 12-27-4-1 is fully compliant with HCBS requirements, without supplementary regulations limiting and prescribing the appropriate use of each, to be insufficient. DDRS neglects to mention that the statute’s second clause (2) permits seclusion and restraint “[a]s a measure of therapeutic treatment.” This is an especially vague standard, and in the opinion of commenter, gives providers far too much discretion in determining when the use of seclusion and restraint is permissible. Although the Division does note its internal written policies regarding prohibitions of abuse and neglect of consumers, these would carry greater solemnity and would be far more accessible to the public were they formalized in the Indiana Administrative Code. Additionally, apart from requiring a written record to be made when either measure is used, the statute does not contain reporting requirements or review measures. The application of the new HCBS requirements are an ideal time for the Division to take a stronger approach to protecting the dignity and well-being of consumers. Federal Requirement: In provider-owned or controlled residential settings, each individual has privacy in their sleeping or living unit. 460 IAC 6-9-4 talks about the "opportunity for personal privacy" but that is not the same as privacy in a sleeping or living unit. Additionally, access via electronic communications should also be protected similar to mail and telephone calls. Federal Requirement: In provider-owned or controlled residential or non-residential settings, the setting is physically accessible to the individual. The Division asserts that regulations within Rule 29 of Article 6 are sufficiently compliant with the HCBS requirement for provider-owned or controlled settings to be physically accessible. However, a reading of the apparent lone reference to physical accessibility within the Rule is found in 460 IAC 6-29-3, which refers to the responsibility of providers to “ensure that appropriate devices or home modifications” are provided in accordance with the consumer’s ISP and satisfy the requirements found in the Americans with Disabilities Act. This regulation, standing alone, is insufficient. First, it ignores the reality that for many consumers, most members of the support team responsible for formulating the ISP may rarely, if ever, visit the consumer’s home. Often, the consumer’s residential provider and case manager are the only team members who visit the home on a regular or even semi-regular basis. Second, consistent with Rule 29, the section of the form ISP that applies to a consumer’s home is almost exclusively concerned with safety. The lone question the support team is required to answer regarding accessibility is “If Special Devices and Home Modifications are required, are they present?”

Commenter recommends the Division take steps to flesh out this process. The support team is currently required to confirm the presence of smoke and carbon monoxide detectors, fire extinguishers, anti-scalding devices, etc. In order to fully comply with the HCBS requirement of physical accessibility, there should be documentation requirements similar to those already in place regarding consumer safety.

Response: Thank you for the above comments and insights into the systemic assessment process. The feedback provided will be taken into consideration as the State revises policies and procedures to ensure full HCBS compliance. DDRS recognizes current policies and procedures require revision in order to fully establish HCBS-compliant rules. In addition, DDRS is currently reviewing the PCP/ISP process through the Life Course Alignment Project. As part of this project the current process and forms utilized in Person Centered Planning will be revised to ensure continued compliance to the new rules and any modifications of those rules. As outlined in the STP, any proposed modifications to Indiana Code will follow the

Administrative Rules drafting procedure and will be published for a public comment period to ensure meaningful feedback from all stakeholders.

Comment: Commenter encourages the use of multiple mechanisms to determine a setting's initial and on-going compliance with HCBS rules. Commenter would also stress that settings should be 100% compliant before being found to be an HCBS setting.

Response: DDRS has determined a variety of mechanisms to determine a settings initial and ongoing compliance. Final determination will depend on results of surveys, site visits to validate findings, and completion of corrective action plans to bring settings into compliance. All settings are required to be 100% complaint by March 17, 2019.

Comment: Commenter encourages the use of independent surveyors and those trained in communicating with individuals with disabilities to complete the participant surveys. Surveys should be conducted in a private setting of the participant's choice and participants should be allowed to opt-out if they choose.

Response: Thank you for the suggestion. DDRS may work in conjunction with a contracted entity on various components of the STP. While participants may opt out of the survey process, all sites will still be required to be assessed for HCBS compliance.

Comment: Commenter encourages frequent input from participants through survey and/or town hall forums. Participants should be a part of the process early on and frequently throughout.

Response: Thank you for the suggestion, DDRS agrees and will continue to seek frequent input from participants through various means.

Comment: Commenter supports the coordination among the various FSSA agencies to ensure consistency for participants across settings.

Response: Thank you for the suggestion, DDRS agrees with the coordination of divisions to ensure consistency for all participants.

Comment: Commenter noted for relocation of beneficiaries - participants should also be notified of potential sources of advocacy (including IDR, ombudsman, the Arc, other advocacy organizations) along with their right to appeal. Whenever possible, procedural safeguards should be adequately explained and be consistent across FSSA agencies.

Response: Thank you for the suggestion. DDRS will ensure notification of sources of advocacy be provided as part of the process.

Comment: Commenter recommends evaluating case management and the use of standardized tools like checklists to ensure they provide meaningful information about the participant's wants and needs and the setting's on-going compliance with HCBS. Commenter continues to have reservations regarding the heavy reliance DDRS plans to place upon the 90-day Monitoring Checklist. As recommended in comments for a previous iteration of the STP, Commenter would like to assert that the Division should integrate regularly occurring face-to-face interviews with a statistically significant population of participants as an additional monitoring tool. This should be carried out by an independent third party, and can be utilized as a means to verify data gathered through the Checklist.

Response: DDRS will incorporate a variety of means of ensuring ongoing compliance. The monitoring checklist completed by case managers will be one tool to ensure ongoing compliance. Revisions to provider enrollment, re-certifications, policies and procedures as outlined in the STP will all be part of the ongoing monitoring process.

Comment: Commenter encourages inclusion of participants and advocacy groups in developing trainings as well.

Response: Thank you for the suggestion.

Comment: Process for Provider Sanctions and Disenrollment - Commenter looks forward to reviewing the specific processes for issuing sanctions and provider disenrollment.

Response: Thank you. DDRS appreciates your feedback.

Comment: Commenter would like to encourage its inclusion in the convening of a Transition Taskforce. Commenter often assists individuals transitioning out of institutions.

Response: DDRS would be appreciative of commenter's assistance on the Transition Taskforce and will be reaching out to various stakeholders to form the taskforce.

Comment: Commenter applauds the changes to code, policies, and procedures that have been modified or drafted in pursuit of compliance with the rule. We note that some code, policies, and procedures state that language will be added, particularly 460 IAC citations. Commenter appreciates the process and the length of time required to change Indiana Code (IC) and Indiana Administrative Code (IAC), and we noted that the Systemic Assessment section lists the timeline for completion of changes to IAC as December 2017 and changes to IC as May 2018. This timeline seems aggressive for the amount of changes needed to achieve compliance. Commenter requests clarification of the timeline for revisions to Administrative Code and recommends that the timeline may need to be adjusted. Commenter continues to advocate for the inclusion of stakeholders such as providers, the Arc of Indiana, Case Management organizations, and individuals receiving services in the revision process for IAC, policies, procedures, the Waivers, and the service definitions. These stakeholders will provide good insight and perspective concerning how modifications would impact individuals served by the industry and their advocates. The inclusion of stakeholders in these processes could also decrease the number of comments received during the public comment period and subsequent modifications needed before these policies and processes could be finalized.

Response: Thank you for the comment. DDRS will continue to seek out ways to engage stakeholders in the process in order to allow for meaningful feedback.

Comment: Will stakeholders have the opportunity to review and provide feedback concerning changes that have been made to code, policies, and procedures before these changes are fully implemented?

Response: As outlined in the STP, any proposed modifications to Indiana Administrative Code will follow the Administrative Rules drafting procedure and will be published for a public comment period to ensure meaningful feedback from all stakeholders.

Comment: Many items related to the 90-Day Checklist/Monitoring Checklist are marked as fully compliant or partially compliant. The link to this document in the STP currently does not work, so stakeholders cannot access this document to review it and provide their feedback concerning compliance. Could the link to this document be fixed or the document be shared with stakeholders prior to the comment period for the next version of the STP?

Response: Thank you for the comment. DDRS will ensure the document is available prior to the next public comment period.

Comment: The timeline for completion of many remediation activities for the 90 Day Checklist/Monitoring Checklist is listed as August 2016, yet one item is still stated to be partially compliant with language to be added (see STP page 67). Should the timeline for this item be revised to state the timeline when changes are expected to be completed?

Response: The 90 day checklist was modified in August 2016 and is now called the Monitoring Checklist. While that one area is not currently addressed in the Monitoring Checklist, DDRS will update the STP to include language that it is currently reviewing the PCP/ISP process through the Life Course Alignment Project. As part of this project the current process and forms, including the monitoring checklist will be reevaluated to ensure ongoing compliance to the new rules and any modifications of those rules.

Comment: Concerning the Individual Rights and Responsibilities (4600221014) policy, the chart states that Language has been drafted to include all aspects of HCBS rule surrounding individual rights containing the right to make choices in life. Will stakeholders have the opportunity to review this draft language and provide feedback?

Response: Any Policy that is substantially modified will be posted for review.

Comment: The chart lists one IC citation related to seclusion and restraint that already fully complies with the HCBS Rule. Has DDRS identified any other specific Indiana Code changes that will be needed to achieve full compliance, particularly related to client rights? If so, when those changes will occur?

Response: While DDRS does not draft Indiana Code, sub regulatory guidance changes such as Administrative Code, policies and procedures will address all HCBS requirements.

Comment: Commenter appreciates the additional information included in this version of the STP concerning the revisions to the 90-Day Checklist/Monitoring Checklist and its use for compliance measurement. We would appreciate additional clarification and detail concerning the requirements for “No” answers to be supported by a specific need and justified in the person-centered service plan. We would also request the addition of specific information concerning the enhancements to the Person Centered Planning process and the corresponding annual systemic verification process that DDRS will implement to ensure ongoing monitoring and compliance.

Response: Thank you for the suggestion, while the STP will not be updated with this specific language, information requested will be distributed through various provider trainings and guidance.

Comment: What would the minimum requirement be for a specific need that would support or justify a No answer?

Response: A “no” answer would be determined by following the Monitoring Checklist Interpretive Guidelines. Each HCBS related question has a criteria that should be met.

Comment: Who decides if the specific need provides sufficient justification for the No answer?

Response: The case manager completes the Monitoring checklist and will be the one making the determination.

Comment: For cases in which the provider and the case manager do not agree, who would make the final decision concerning the need to submit a corrective action plan?

Response: In cases where there is a disagreement between team members, BDDS will make the final determination as outlined in 460 IAC 6-10-8 Resolution of disputes.

Comment: Will the additional monitoring and compliance activities outlined in the STP significantly add to the workload of case managers? If so, what actions will be taken to address this?

Response: DDRS does not expect individual remediation will significantly increase the workload of case managers. If it is found to have a significant impact, DDRS can review and adjust the activities if warranted.

Comment: What kinds of revisions will be made to the provider enrollment process and the Compliance Evaluation and Review Tool (CERT) to measure ongoing compliance? Will stakeholders have the opportunity to provide feedback concerning these changes?

Response: DDRS has not yet finalized the proposed changes to the enrollment process or CERT to measure ongoing compliance of HCBS settings.

Comment: Commenter appreciates the additional information and clarification provided concerning the design, development, administration, and analysis of the Individual Experience Survey (IES), including the details concerning which entities were

responsible for the completion of specific activities. While we acknowledge that the information concerning activities related to the survey describes how the survey process was designed to be completed, we question if the description reflects the reality of how the survey was completed. For example, the narrative in the STP states that “[t]he individual’s case manager was responsible for ensuring completion of the survey with the individual during their quarterly meeting.” However, the IES report indicates that only 70% of surveys were completed with case managers and the consumer participated in the completion of only 60% of the surveys. In addition, the data gleaned from the IES is now dated as it was collected from late 2015 to early 2016. While information for some waiver participants will be the same, it may be different for many. Although the IES does provide data that serves as a starting point, the survey had some significant limitations and the data gleaned from it must be considered through the lens of these limitations. Because of the limitations of the data, we recommend that DDRS rely more on provider surveys and self-assessments, documentation received from providers, and site visits for determinations of compliance.

Response: While the IES data will be validated, it will not be the only factor utilized in determining HCBS compliance. DDRS recognizes settings and experiences may have changed from the original responses provided. Measuring the responses against other information will allow for determination of compliance.

Comment: Commenter applauds the inclusion of additional information concerning the tiered evaluation process for determining each setting’s compliance. Commenter appreciates the webinars, technical assistance sessions, tutorials, and FAQs issued by DDRS for the self-assessment and validation processes. We recommend including a brief explanation of the tiered evaluation process before the explanation of the provider self-assessments to provide greater clarity for stakeholders who are unfamiliar with the full process.

Response: The STP will be modified to include the explanation of the tiered process before the explanation of the provider self-assessments.

Comment: The plan lists 1,044 sites as Settings identified that could meet the HCBS rule with Modifications; Provider owned or controlled residential settings. Commenter recommends noting that there may be provider owned homes that require no modifications to meet the settings rule.

Response: STP language will be updated to include noting that there may be provider owned homes that require no modifications to meet the settings rule.

Comment: The plan lists approximately 10 sites as Settings identified that could meet the HCBS rule with Modifications; Homes with more than 4 individuals residing together. Could DDRS provide clarification concerning why homes with more than 4 individuals residing together are specifically identified as a potential issue?

Response: Even though CMS opted not to use the four person definition in their final version of the CMS settings final rule, from Indiana Code 12-11-1.1-1, unless the supported living services arrangement was once a supervised group living setting that converted to a waiver program setting, no more than four unrelated individuals may reside in any one setting as part of the waiver program. In order to ensure these sites do not have the qualities of an institution, DDRS has opted to categorize these settings as having the potential of those that could meet with modifications. Final determination will depend on results of surveys, site visits to validate findings, and completion of corrective action plans to bring settings into compliance. All settings are required to be 100% compliant by March 17, 2019.

Comment: Regarding Settings located on the ground of or immediately adjacent to a public institution, could DDRS provide additional information concerning what these settings are and to what kinds of institutions they are adjacent?

Response: The settings identified are self-reported. DDRS will conduct site visits to verify they meet CMS definition of being located on the ground of or immediately adjacent to a public institution. Medicaid regulations in Title 42 of the Code of Federal Regulations (42 CFR §435.1010) specify that the term public institution means an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control.

Comment: Regarding “Settings that have the effect of isolating individuals; Residential settings where respondents to the IES indicated few social interactions outside of their home”: Since site visits have not yet occurred to review these settings, we recommend changing the language to “Settings that may have the effect of isolating individuals.” The current language implies that they have already been found to be isolating. In addition, we have already noted the limitations of the IES and the data gleaned from this survey. We request additional information concerning these settings and how they may have the effect of isolating individuals.

Response: Thank you for the comment. The language will be revised to “Settings that may have the effect of isolating individuals.”

Comment: Regarding Day Service Settings, Approximately 182 sites and Congregate Settings of 4 or more homes located close together, Approximately 50 sites: Commenter requests additional information concerning these settings and how they have the effect of isolating individuals. In addition, apartments are typically built close together. Individuals can choose to live in apartments or homes that are located close to the residences of other individuals with disabilities. How will DDRS determine if these instances are congregate settings, and why is 4 or more homes located close together cited as the threshold?

Response: DDRS will revise the language to “Settings that may have the effect of isolating” as they have not yet been determined as such. CMS has defined examples of settings that may have the effect of isolating individuals as multiple settings co-located and operationally related that congregate people with disabilities together such that people’s ability to interact with the broader community is limited. Final determination will depend on results of surveys, site visits to validate findings, and completion of corrective action plans to bring settings into compliance.

Comment: Commenter appreciates the inclusion of additional information about the validation process for residential and non-residential settings, especially the data concerning the Tier 1 analysis and the associated preliminary determinations of compliance. Commenter asked: The language in the setting assessment chart and the narrative information regarding the 1,044 and 1,011 sites is inconsistent. The chart lists 1,044 sites that are provider owned or controlled while the narrative lists 1,011, with 1,044 sites requiring additional information before a determination can be made. We would appreciate clarification concerning the number of sites in each category.

Response: Thank you. The number 1,011 reflects the Residential settings where respondents to the IES indicated few social interactions outside of their home (potentially isolating). Approximately 500 sites with 1,011 individuals residing there. The 1,044 sites, represents the total number of provider owned or controlled sites. The STP will be amended to clarify.

Comment: The narrative states that 18% of non-residential sites were found to be in compliance. Is it realistic to expect that the other 82% will be able to achieve compliance by the current stated deadline?

Response: DDRS expects all sites to be in compliance by the March 17, 2019 deadline as mandated by CMS.

Comment: Is the DDRS contracted entity completing all of the validation of the non-residential provider self-assessment responses and site visits?

Response: DDRS may work in conjunction with a contracted entity on various components of the STP.

Comment: Could DDRS provide additional information concerning the comprehensive training and guidance staff of DDRS and the contracted entity did/will receive in order to complete the validation process and site visits?

Response: Additional information will be presented to providers via web trainings and posted guidance prior to the implementation stage of validation.

Comment: With 172 initially requiring a site visit, 109 sites requiring additional information, and an additional 19 that did not complete the survey likely requiring a site visit, does the contracted entity have the capacity to complete the validations and site visits? When are the site visits expected to be completed? Will there be sufficient time for the site visits to be

completed, the results to be compiled and disseminated, and the corrective action plans to be developed and approved by DDRS by December 2017?

Response: DDRS anticipates all steps to be accomplished by the stated time line. If it is found additional time is needed, DDRS may request a modification upon CMS approval.

Comment: When does DDRS anticipate that the secondary determinations of compliance and need for site visits will be completed and sent to providers?

Response: For non-residential providers, it is anticipated secondary determinations of compliance will be made and sites identified for visits will be identified by April 2017.

Comment: Could DDRS provide additional information concerning the site visits and what will occur during site visits? Has a comprehensive tool been developed for site assessors to complete at each site? How will accuracy and consistency be ensured?

Response: DDRS's contracted entity has a comprehensive tool that site assessors will utilize. It is anticipated the same tool or a modification of the tool will be used for residential sites in order to ensure consistency.

Comment: Again, due to the limitations of the IES, commenter recommends not relying too heavily on the data from the IES to validate compliance of providers' responses.

Response: DDRS recognizes challenges in interpreting data. While the IES data will be used as a validation/comparison to measure the Non-Residential Survey responses, it will not be the only factor utilized in determining HCBS compliance. DDRS is exploring having the identified residential settings providers complete the same assessment that the non-residential providers completed. This is a provider specific survey rather than individual specific. DDRS will then compare the results of the two surveys to determine if a site visit will be warranted to determine final compliance or the need for heightened scrutiny. In addition, a section of the case managers monitoring tool will address HCBS Residential requirements and allow for client specific remediation. DDRS is exploring when the IES survey should be re-administered and if it could be utilized as a means of ongoing compliance. It is expected the IES will be administered at least one more time, possibly more.

Comment: Commenter appreciates the additional information concerning remediation strategies included in this version of the STP. Commenter asked: Could DDRS provide additional information concerning the template that will be developed for provider specific transition plans?

Response: Additional information will be presented to providers via web trainings and posted guidance prior to the implementation stage of remediation.

Comment: How will findings of non-compliance be communicated to providers? How long will providers have after they receive their findings of areas of non-compliance to develop their provider specific transition plan/corrective action timeline and plan?

Response: Additional information will be presented to providers via web trainings and posted guidance prior to the implementation stage of remediation.

Comment: Will providers have access to the tracking database to review the status of their remedial plans and the associated timelines, or will they have to request status updates from DDRS if they want to check on the status of their plans more often than the quarterly communications?

Response: It is not anticipated providers would have access to a data base. DDRS will be responsible for monitoring the timeliness and completion of remediation. A provider may request a review of their status at any time.

Comment: Will DDRS or a contracted entity provide the technical guidance concerning completion of remedial plans?

Response: DDRS may work in conjunction with a contracted entity on various components of the STP.

Comment: Will DDRS or a contracted entity complete the verification of completion activities including site visits and documentation review?

Response: DDRS may work in conjunction with a contracted entity on various components of the STP.

Comment: Does DDRS anticipate that verifying completion of corrective actions for individual-specific remediation activities will significantly increase the workload of case managers?

Response: DDRS does not expect individual remediation will significantly increase the workload of case managers. If it is found to have a significant impact, DDRS can review and adjust the activities if warranted.

Comment: Commenter recommends reviewing the dates outlined in the action item chart and revising the timeline for completion chart as needed to reflect updated timelines and dates of completion.

Response: Thank you for the comment.

Comment: Commenter notes that there are several significant action items with a timeline for completion of December 2017. We recommend reviewing these action items and their timelines for completion to ensure that the identified timelines for completion are realistic. If not, COMMENTER recommends revising them as needed.

Response: In order to timely meet HCBS criteria, DDRS has set the timeline for completion of certain steps for 2017. This is to allow for a full year to remediate any issues.

Comment: The timeline for completion of the Transition Taskforce is March 2017. Have members of the Transition Taskforce been identified? When will the taskforce be convened, and will meetings be open to the public? Will information and proposals from these meetings be disseminated to stakeholders for feedback?

Response: DDRS is in the process of identifying members of the taskforce. It is anticipated that the taskforce will be convened in late March 2017. It has not yet been determined if meetings will be open to the public.

Comment: CMS has set the deadline for compliance with the HCBS Rule on March 17, 2019. DDRS has a significant amount of action steps to complete prior to this date. Commenter believes that a lengthened timeline for compliance with the HCBS Rule in Indiana would enable providers to more easily achieve compliance and allow the transition period to be smoother and more successful for individuals, families, providers, and the state.

Response: CMS has set the date for compliance at March 17, 2019.

Comment: Commenter appreciates the additional information provided concerning heightened scrutiny, particularly the steps to determine if Heightened Scrutiny will be submitted to CMS. Commenter requests that additional information concerning CMS' role in the Heightened Scrutiny process be added to the STP.

Response: As outlined in the STP, CMS will make the final determination when the State submits sites for Heightened Scrutiny.

DIVISION OF MENTAL HEALTH AND ADDICTION - YOUTH (DMHA-Y)
HCBS Programs
Psychiatric Residential Treatment Facility (PRTF) Transition Waiver – 1915(c)
Child Mental Health Wraparound (CMHW) – 1915(i)

SUMMARY:

The Division of Mental Health and Addiction (DMHA) solicited comments on the Statewide Transition Plan as it applies to youth 1915(c) program Psychiatric Residential Treatment Facility (PRTF) Transition Waiver and the 1915(i) Child Mental Health Wraparound (CMHW) program. The comments resulted in no changes to this portion of the STP.

PUBLIC COMMENTS:

Comment: One commenter noted: I am writing to urge those in governing positions to allow for options and choice!! The ADA was not written to CREATE further limitations. It was to allow, to the greatest extent possible, participation for all within community life. This rule simply creates further limitations for residential options by denying true choice and potentially very beneficial opportunities!! Why can't we let the individuals and those that love and support them decide which setting might offer them the best opportunities for a healthy, happy and fulfilling life working within the framework of the funds and services available.

It has been our experience that when you attempt to 'force' situations it often does not go well....but when you create an environment of respect and allow for opportunity.....more good will flourish!

Response: Thank you for your input. The DMHA Youth Services shares your commitment to respecting individual choice to the fullest extent allowed.

Comment: One commenter shared that their organization has concerns regarding the lack of specificity provided as to how DMHA intends to amend some of its regulations to comply with the new HCBS requirements. The commenter will pay close attention to the proposed rules as they are released, and urges CMS to withhold approval of the STP until these amendments are completed.

Federal Requirement: In provider-owned or controlled residential and non-residential settings, the setting is physically accessible to the individual.

The commenter is concerned by DMHA's note that it will amend IAC to provide that children have settings which are physically accessible to the individual to the same degree as children not receiving Medicaid HCBS. Physical accessibility is specifically defined by law and is not comparable to children not receiving Medicaid HCBS.

Response: DMHA Youth would like to thank the commenter for your input regarding the Statewide Transition Plan. DMHA Youth Team welcomes the input of the commenter, and invites representative to a seat at our table for review of and recommendations for changes to the proposed regulations. A DMHA representative will contact the commenter to arrange; or the commenter may contact us at DMHAYouthServices@fssa.in.gov.

Comment: One commenter shared that their organization encourages the inclusion of its organization as an advocacy stakeholder for children with mental illness.

Response: DMHA welcomes the commenter as an advocacy stakeholder for children with SED. A DMHA representative will contact the commenter to arrange; or the commenter may contact us at DMHAYouthServices@fssa.in.gov.

**DIVISION OF MENTAL HEALTH AND ADDICTION – ADULT (DMHA-A)
HCBS Programs
Behavioral and Primary Healthcare Coordination (BPHC) – 1915(i)
Adult Mental Health Habilitation (AMHH) – 1915(i)**

SUMMARY:

The Division of Mental Health and Addiction (DMHA) solicited comments on the Statewide Transition Plan as it applies to two adult 1915(i) programs; the Adult Mental Health Habilitation (AMHH) and Behavioral and Primary Healthcare Coordination (BPHC) programs. The comments resulted in no changes to this portion of the STP.

PUBLIC COMMENTS:

Comment: I am writing to urge those in governing positions to allow for options and choice!! The ADA was not written to CREATE further limitations. It was to allow, to the greatest extent possible, participation for all within community life. This rule simply creates further limitations for residential options by denying true choice and potentially very beneficial opportunities!! Why can't we let the individuals and those that love and support them decide which setting might offer them the best opportunities for a healthy, happy and fulfilling life working within the framework of the funds and services available. It has been our experience that when you attempt to 'force' situations it often does not go well....but when you create an environment of respect and allow for opportunity....more good will flourish!

Response: Thank you for your comment. The Adult DMHA supports treating members in integrated settings.

Comment: One commenter is concerned with the methodology for site-specific assessments. On-site assessments should be done for each POCO setting to ensure compliance with HCBS.

Response: The Adult 1915(i) DMHA State Evaluation Team (SET) appreciates the comments from the commenter regarding the STP. According to the STP, settings requiring physical modifications will receive an on-site visitation. Settings requiring policy modifications will receive a desk audit. On an on-going basis, a setting's compliance will be verified by an on-site visit in conjunction with regular, annual Quality Assurance visits. Currently, DMHA staff have visited approximately 60 of the 200 settings statewide. As such, the STP does allow for visits at each site.

Comment: One Commenter would like to see participant/resident surveys be conducted independently without the involvement of the provider.

Response: In 2015 and 2016, initial assessment was conducted through member and provider surveys. DMHA Adult 1915(i) SET used multiple mechanisms to determine initial compliance as mandated by CMS. These mechanisms included client surveys, provider surveys, preliminary designation reports and setting action plans in which the provider described their plan for remediation. Additionally, the client surveys were administered with instructions to providers that explicitly requested providers not aid the client with the survey or influence the results in any manner. The survey results indicated a significant disparity between member results and provider results. DMHA believes this disparity in results is a strong indication that providers did not influence the member's survey results.

Comment: One commenter encourages the use of multiple mechanisms to determine a setting's initial and on-going compliance with HCBS rules. The commenter would also stress that settings should be 100% compliant before being found to be an HCBS setting. Compliance should not be granted until any remediation has been completed and re-assessed by DMHA to ensure compliance.

Response: DMHA Adult 1915(i) SET used multiple mechanisms to determine initial compliance as mandated by CMS. These mechanisms included client surveys, provider surveys, preliminary designation reports and

setting action plans in which the provider described their plan for remediation. The SET team does not designate a setting compliant prior to the completion of remediation.

Comment: DMHA lists Indiana Disability Rights (IDR) as a member of the DMHA Consumer Council. However, IDR is not currently aware of a staff member tasked with attending these meetings or when the meetings are to occur. IDR would greatly appreciate the opportunity to participate and looks forward to the invitation from DMHA.

Response: Thank you for your interest. This request will be shared with the state staff responsible for the DMHA Consumer Council.

Comment: One commenter is concerned that the heightened scrutiny packets do not contain information from service participants themselves through surveys or on-site participant interviews.

Response: Concerning heightened scrutiny, the evidence packets are based largely on participant interviews conducted by DMHA staff. Each residential Provider Owned, Controlled, and/or Operated (POCO) setting was visited by DMHA staff, and consisted of site observations and member interviews. The evidence packets will contain the results of these member interviews.

Comment: One commenter shared: We work with our CMHC but are unable to utilize a lot of the great services that they offer because we aren't deemed a facility to use this type of Medicaid. I spoke with other county homes in Indiana that do use the BPCMH Medicaid in their facilities, and don't understand why we cannot here. How do we become an acceptable facility and our CMHC can get our residents who qualify for these Medicaid? Any help or guidance you can give would be greatly appreciate it!

Response: Thank you for your comment, and for your efforts to ensure that individuals in St. Joseph County with mental health issues have a place to live and recover. A bit of background information might be useful in understanding the current situation.

The Behavioral and Primary Healthcare Coordination (BPHC) program was implemented in 2014, as a way for vulnerable Hoosiers with high behavioral health needs who were not otherwise eligible for traditional Medicaid to gain access to the full array of Medicaid-funded health services. Eligible participants for BPHC have mental health and physical health issues. Their mental health condition impairs their ability to manage their physical health issues, and they frequently experience difficulty in accessing and coordinating their physical health care.

Individuals participating in BPHC must live in a setting which is compliant with requirements set forth by the Centers for Medicare and Medicaid Services (CMS) Home and Community Based Services (HCBS) Settings Final Rule ("the Final Rule"). The Final Rule became effective in 2014, and it specifies certain standards for the residential setting of individuals participating in HCBS programs, which includes BPHC. The requirements of the CMS HCBS Final Rule apply to all residential settings, including those not owned, controlled, or operated by a community mental health center like Oaklawn. While the Division of Mental Health and Addiction has been heavily involved in the assessment and compliance process for those settings which are owned, controlled, or operated by a CMHC, it is the responsibility of each CMHC to assess and ensure compliance for residential settings the CMHC does not own, control, or operate.

HCBS participants are not eligible to receive HCBS services if they live in a CMS defined institutional setting (nursing home, ICF/IID, IMD, etc.). One of the requirements of the CMS HCBS Final Rule is that settings must not have any qualities typically associated with an institution, namely:

- 1. The setting is located in a facility which also provides inpatient institutional care;**
- 2. The setting is located on the grounds of, or adjacent to, a public institution; or**
- 3. The setting has the effect of isolating individual receiving Medicaid HCBS from the greater community of individuals not receiving Medicaid HCBS**

Settings which have one or more of these qualities are defined by CMS as “Presumed Institutional”, and are therefore ineligible settings for individuals to live and receive home and community based services such as BPHC. There is a process by which a setting determined to be “Presumed Institutional” can submit evidence to CMS to demonstrate that the setting is in fact a home and community based setting and should be an eligible site for HCBS delivery. This process, known as heightened scrutiny, requires sufficient evidence to demonstrate that the setting (a) overcomes the institutional presumption, and (b) is otherwise fully compliant with the requirements of the Final Rule.

DMHA had been focusing primarily on assisting and supporting CMHCs to assess their own residential settings and bring them into CMS HCBS compliance. The next phase of CMS HCBS compliance work will be to support and assist CMHCs to assess residential settings which they do not own, control, or operate. DMHA will do this in conjunction with other FSSA agencies who administer HCBS programs.

Again, thank you for your email, for the work you and your staff do every day, and for your role in providing care to Hoosiers in St. Joseph County.

TABLE OF ACRONYMS

Activities of Daily Living	ADL
Adult Day Services	ADS
Adult Family Care	AFC
Adult Mental Health Habilitation	AMHH
Aged and Disabled	A&D
Alternative Family Homes for Adults	AFA
Assisted Living	AL
Behavioral and Primary Healthcare Coordination	BPHC
Bureau of Developmental Disabilities Services	BDDS
Bureau of Quality Improvement Services	BQIS
Centers for Medicare and Medicaid Services	CMS
Child Mental Health Wraparound	CMHW
Community Integration and Habilitation	CIH
Community Mental Health Center	CMHC
Direct Service Provider	DSP
Division of Aging	DA
Division of Disability and Rehabilitative Services	DDRS
Division of Mental Health and Addiction	DMHA
Family and Social Services Administration	FSSA
Family Supports Waiver	FSW
Home and Community-Based Services	HCBS
Indiana Administrative Code	IAC
Indiana Department of Child Services	DCS
Indiana Disability Rights	IDR
Indiana Institute on Disability and Community	IIDC
Indiana State Department of Health	ISDH
Individual Experience Survey	IES
Individual Support Team	IST
Individualized Support Plan	ISP

Individuals with Intellectual Disabilities/Developmental Disabilities	IID/DD
Institution for Mental Diseases	IMD
Intermediate Care Facility for Individuals with Intellectual Disabilities/Developmental Disabilities	ICF/IID
Memorandum of Understanding	MOU
Mental Health and Addiction Planning and Advisory Council	MHAPAC
Mental Illness	MI
National Core Indicators	NCI
National Alliance on Mental Illness	NAMI
Nursing Facility	NF
Office of General Counsel	OGC
Office of Medicaid Policy and Planning	OMPP
Participant-Centered Compliance Review	PCCR
Person Centered Monitoring Tool	PCMT
Person Centered Plan	PCP
Preliminary Compliance Designation	PCD
Provider Compliance Reviews	PCR
Provider Owned, Controlled or Operated	POCO
Psychiatric Residential Treatment Facility	PRTF
Public Consulting Group	PCG
Quality Assurance/Quality Improvement	QA/QI
Residential Care Facility	RCF
Residential Setting Screening Tool	RSST
Semi-Independent Living Facilities	SILP
Serious Emotional Disturbance	SED
Setting Operating Authority	SOA
State Evaluation Team	SET
Statewide Transition Plan	STP
Structured Day Program	SDP
Structured Family Caregiving	SFC
Supervised Group Living	SGL

Supported Employment	SE
System of Care	SOC
Transitional Residential Living Facility	TRS
Traumatic Brain Injury	TBI