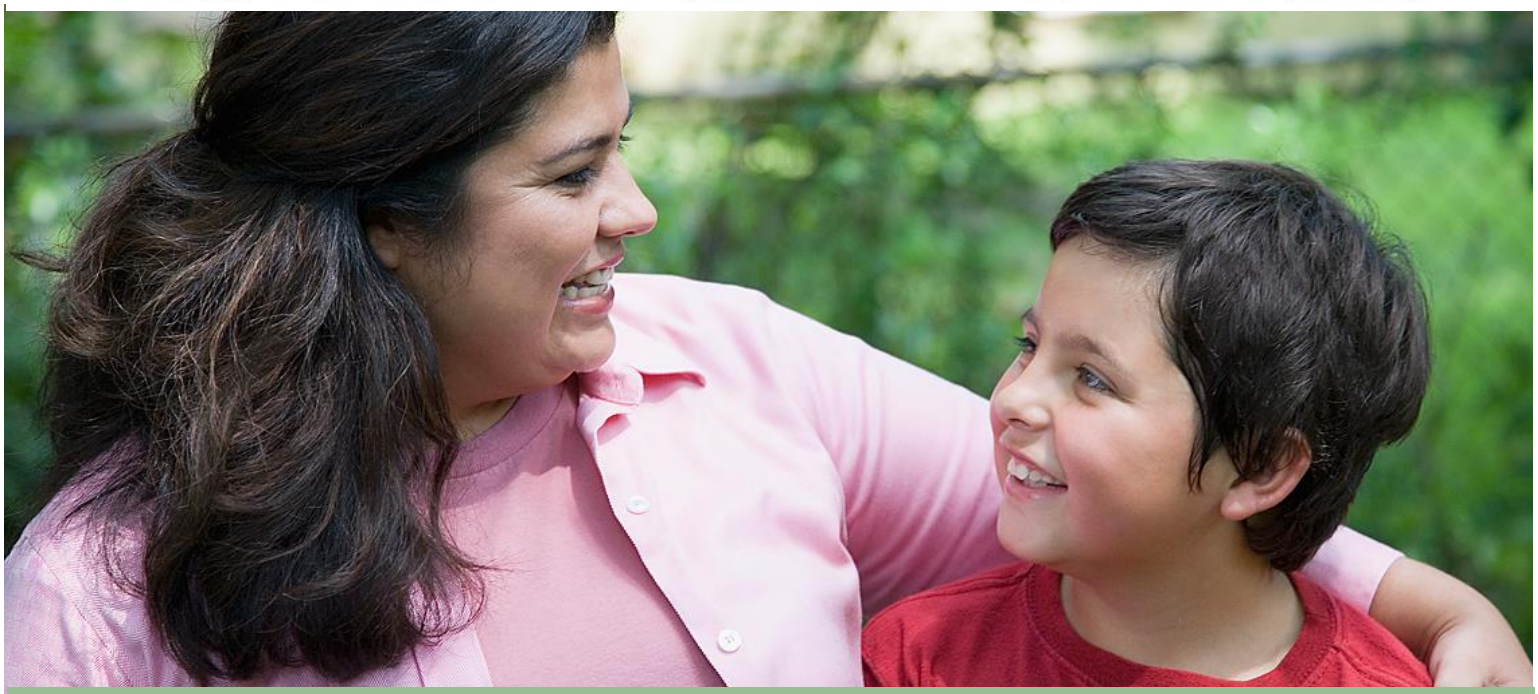
Indiana Family and Social Services Administration

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

April 2016

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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
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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 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) had 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 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 this time. Through guidance from CMS, Indiana is submitting a modified STP by April 30, 2016 that provides additional detail from systemic assessments and incorporates changes related to October 2015 guidance from CMS. Additionally, Indiana plans to submit an amended STP with the results of its site-specific assessments by September 30, 2016.

Overview of the Settings Provision

The 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 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 develops medical policy, ensures proper reimbursement of Medicaid services, and acts as the administrative authority for all home and community-based services programs. The remaining three divisions, listed below, operate multiple programs including Medicaid home and community-based service programs. The programs currently under review include 1915(c) HCBS Waivers and 1915(i) State Plan benefits operated by the following divisions within the Family and Social Services Administration:

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.
- Plans for 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 Statewide Transition Plan, as participants, members, beneficiaries, consumers, residents, 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: ASSESSMENT OF SETTINGS

From May through September 2014 the Division of Aging completed a review and analysis of all settings where HCBS provided. The analysis included:

- A preliminary crosswalk of Indiana Statute, Indiana Administrative Code, Home and Community Based Services 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.

The DA has determined the following waiver services 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 (A&D, TBI):** Short term relief for non-paid caregivers
- **Specialized Medical Equipment and Supplies (A&D, TBI):** Adaptive equipment and supplies to help participants live more independently
- **Structured Family Caregiving (A&D):** Around-the-clock residential support provided in a participant's own home; the Structured Family Caregiving (SFC) service is designed to provide services in the individual's home or the home of a caregiver selected by the individual, usually a close friend or relative. Typically the individual and the caregiver are living in the same residence. DA will clarify in an upcoming waiver amendment service description that the service cannot be offered in a provider-owned setting. To date, no waiver residents are being served in SFC in a provider owned setting and the service cannot currently be provided by an individual provider, only by a provider agency.
- **Supported Employment (TBI)** Supervision and training for participants requiring support to be able to perform in a work setting
- **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 four services

which are provided in provider owned settings. As such, additional assessment is required to determine if each site is compliant with the HCBS requirements. Based on initial provider self-survey results, at least some portion of these sites will require modification to become compliant and some may in fact be found to be institutional in nature. A number of sites, particularly assisted living sites, will fall into the presumed institutional categories and will be subject to heightened scrutiny.

- **Adult Family Care (A&D, TBI):** Residential services provided in a family-like setting; the Adult Family Care (AFC) homes are approved to serve not more than four residents 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 40 enrolled AFC homes. There are 48 current waiver consumers in 22 AFC sites. The remaining 18 homes have no current waiver consumers residing in them. 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
    - 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.

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

  Assisted Living (AL) facilities participating in HCBS waiver programs are governed by 455 IAC Section 3 and IC 12-10-15-3 which encompass many of the requirements of the HCBS rule. Among these requirements are lockable, private units with a refrigerator and a means to heat food, assures the resident the freedom to choose their roommate or choose to not have a roommate; and a Resident Contract which delineates resident rights and provider responsibilities. While the self-survey results indicate broad compliance with these requirements, there are isolated incidents of non-compliance with nearly all HCBS standards which will require remediation.

  Assisted Living 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 residents 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. DA does have some AL facilities which are co-located with nursing facilities, but does not allow them to be located within or adjacent to a public institution. The provider self-survey does indicate that some providers do limit visiting hours or have restrictions which limit access to the greater community and have implemented safety measures which include secured perimeters or delayed egress systems.
  There are currently 92 enrolled Assisted Living providers. There are 1912 current waiver consumers in 83 assisted living sites. 40% of the enrolled AL providers have 10 or fewer waiver residents; and 9 sites with no current waiver consumers. The overall assessment of AL providers indicates 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

- **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 Adult Day Service (ADS) providers to determine the level of compliance with the HCBS rule. The results of that 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. The 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 the their service plan.

There are currently 38 enrolled ADS providers. There are 532 current waiver consumers receiving services in these settings. The assessment and remediation strategies delineated below will be implemented to identify and correct deficiencies.

- **Structured Day Program** (TBI): Activities and rehabilitative services provided in a group setting outside the home. DA has not yet assessed Structured Day Program (SDP) settings to determine the level of compliance with the final rule. 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.

  There are currently 66 enrolled SDP providers. Twelve of these providers have active waiver consumers through the Traumatic Brain Injury (TBI) waiver program. There are 20 TBI waiver consumers receiving this service (12 in individual programs, 8 in group programs). DA will use an approach similar to that used to assess residential settings, but at this time we do not have enough information to identify any specific instances of non-compliance with HCBS rule requirements. The assessment and remediation strategies delineated below will be implemented to identify and correct deficiencies.

  The structured day programs under the TBI waiver provide 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 typically 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 ID/DD population.

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. The primary deficient area for the proposed DA rule was in relation to structured day programs and adult day services programs. The DA rule is in the rule making process but has not yet been promulgated. So, 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 service of assisted living. ISDH does not have licensure or regulations specific to the service of assisted living. Currently both the A&D and TBI waivers require providers of assisted living to be licensed by ISDH and so these providers are licensed as residential care facilities. There are some conflicts in this designation with waiver service provision. DA has considered removing the licensure requirement from the waivers and continues to discuss this option with provider groups. This is more than just a change in name. 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 does not in and of itself make these settings home and community based. However, it could 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. Currently a group of providers, advocates, and state staff from both the DA and ISDH are starting to meet to work on changes to the residential care facility licensure requirements and rules. DA believes this process can lead to a new rule that is aligned with the HCBS settings requirements.

From January to June 2016, the DA is conducting comprehensive site-specific assessments of waiver providers. In January 2016, documentation offering evidence of compliance with HCBS settings requirements was requested from all assisted living (AL) and adult day service (ADS) providers. This could include policies, procedures, handbooks, staff training schedules, lease agreement templates, client rights documents, etc. There was a 62% response rate in the case of ADS providers and a 56% response rate in the case of AL providers. This material was then reviewed in February 2016 by a contractor to the State to initially determine each site's level of compliance with the new HCBS requirements. Overall, over 90% of providers were determined to have at least partial evidence of compliance with the 13 HCBS setting standards identified in the CMS rule. Providers were most often determined to have "evidence of compliance" with standards related to legally enforceable tenant rights, ability to have visitors at any time, and giving individuals' choice regarding services, supports, and who provides them.

Documentation was not requested from Adult Family Care (AFC) sites as these sites serve no more than four participants and frequently do not have the same level of policy and procedure. They are not licensed through ISDH and so there is less consistency in this group. Documentation will be gathered by the contractor during onsite visits to these providers.

Provider site visits will be conducted between March 2016 and June 2016 to either validate initial compliance determinations from the documentation reviews (Assisted Living and Adult Day Services) or evaluate onsite compliance and gather information on policies, procedures, etc. to make subsequent compliance determinations (AFC). All AL, ADS, and AFC providers enrolled as Medicaid waiver providers across the state will receive visits from DA.

Individual participant experiences with HCBS will be used to validate the results of the site assessments. Waiver case managers visit participants at least every 90 days. During these visits, a person centered monitoring tool is completed. In July 2015, questions were added to this tool to capture participant experience relative to HCBS setting requirements. Data has been collected since July of 2015 on waiver participants.

The DA will use the results of this site-specific assessment to determine compliance. The results of these site visits will verify which sites are subject to heightened scrutiny. From the AL provider survey in the fall of 2014, DA believes at least 37% of assisted living sites are co-located with nursing facilities and are therefore subject to heighted scrutiny review by DA. Only those sites believed to be HCBS compliant will be submitted to CMS for review. About 36% of sites did not respond to the co-location question and so their status is unknown at this time. It is estimated that these known co-located sites serve about 26% of the waiver participants that receive assisted living services. There is not yet an estimate of how many of these sites will be found to be institutional in nature. The site surveys will provide information through which DA will make that determination.

In the 2014 provider survey, 24% of the respondents indicated they had a secured memory care unit. DA believes these units take a variety of forms. The site surveys will provide the necessary information to determine which sites do have secure units that have the effect of isolating participants. Such a characteristic would subject the site to the heightened scrutiny process. However, DA is currently working with provider organizations and advocacy groups such as the Alzheimer's Association to collaboratively identify alternatives to secure memory care units that isolate individuals. As part of this process, regulations will be added to the proposed, pending DA rule to cover what defines a secure unit including specific requirements for how door locks should function in order to permit participants to come and go from the site appropriately. It is possible that a number of sites that currently have secure units will be able to transition to more memory care services and modify their

current secure units to fit the proposed requirements. In that case, they would no longer have those characteristics that made them a setting that isolates and thus would not be subject to heightened scrutiny at that point.

No structured day, AFC or ADS provider sites are believed to be co-located. Some structured day and ADS providers do have secure perimeters. Again, DA is working with the provider community to establish regulations addressing this issue. If sites are found to have the effect of isolating participants, even with modifications to their secure perimeter, they will be subjected to heightened scrutiny by DA. Only those found to be HCBS compliant by DA would be submitted to CMS for review.
This table summarizes the four groups into which sites will be 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 are 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.

Setting Modifications

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 remediations must be completed no later than September 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, Indiana Administrative Code, 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.

Heightened Scrutiny Process

For all settings subject to heightened scrutiny, the DA will gather and review evidence and make a determination with regard to compliance with HCBS setting requirements. Such evidence will include documentation provided by provider, survey documentation from visits to the site by DA and contractor staff, public input, and any other information DA requires. 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. DA will submit to CMS for review the evidence and documentation for those settings that have HCBS characteristics. To the extent that this setting can be grouped and submitted as similar sites, DA will do so and work with CMS to facilitate the review of such groupings of sites.

Transition of Beneficiaries from Noncompliant Settings

The DA has not yet determined the number of individuals who may be affected by relocation. This will be determined as a result of the systemic assessment and site visit verifications. 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 insure the individuals is transitioned to a compliant setting no later than December 2018 provided they wish to remain in the waiver program. Beginning in late summer of 2016, training will be provided to case managers and providers to ensure a smooth transition for the participant(s) requiring transition.

Ongoing Monitoring

The Division of Aging currently monitors providers and service delivery through a variety of activities. Two of these are 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 we move 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.

The Provider Compliance Review is conducted every three years for all waiver providers not licensed by the Indiana State Department of Health (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.

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 will crosswalk to the characteristics of a HCBS setting.

Additionally 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. 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.

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? *(Can you have time to yourself?)*	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	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?

	have)? To clarify, we are not talking about general repairs to the house, but rather specialized modifications.	NRS-6) Are all program and personal service areas physically accessible to the participant?

SECTION 2: PROPOSED REMEDIATION STRATEGIES

Service/ Setting	Areas in Need of Remediation to Comply with HCBS Characteristics	Validation/Remediation Strategies	Timeline for Start/Completion	Assuring Ongoing Compliance
General Affects all settings	Changes are needed to Indiana Administrative Code 455 IAC 2 to incorporate and reinforce the requirements of the HCBS Final Rule	DA cross-walk of existing rules, 455 IAC 3-1-8, 410 IAC 16.2-5-0.5, A&D, TBI, and MFP approved waiver documents, IHCP Provider Bulletin dated 6/17/09 and proposed rule 455 IAC 2.1 Legal review of existing State legislation and the HCBS rule to identify s necessary changes to State code Development and adoption of policies allowing enforcement of HCBS Final Rule requirements prior to finalization of legislation. Finalization of legislative action amending state code to incorporate the requirements of the HCBS Final Rule.	9/2014 1/2016 7/2016 09/2018	
General Affects all settings	Changes are needed to both 1915(c) Medicaid Waivers (A&D and TBI), the initial and on-going assessment tools, and the HCBS Waiver Provider Manual to incorporate and reinforce the requirements of the HCBS Final Rule	Identify needed changes to service definitions of all residential and facility-based services. Create a work group, including waiver participants and advocates, to more clearly define requirements for privacy, choice, and other quality of life components as well as safeguards for privacy and freedom from coercion and restraint as specified in final rule for all HCBS program services Open and submit modifications for TBI waiver Open and submit modifications for A&D waiver	07/2016 03/2016 09/2016 09/2016	
	The individual can have visitors at any time The individual controls his/her own schedule including access to food at any time	Conduct a provider self-survey to determine general compliance with the HCBS Final Rule Conduct onsite visits to all AFC settings to determine compliance with the HCBS Final Rule	10/2014 3/2016 - 06/2016	Verify continuing compliance through Provider Compliance Reviews conducted for all AFC providers every three years and

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) 40 service sites; 48 waiver consumers	The setting is integrated in and supports full access to the greater community The individual has choice of roommates Optimizes autonomy and independence in making life choices;	DA will partner with key AFC stakeholders in a collaborative effort to develop and communicate expectations of standards to provider and consumer communities Communicate expectations to specific AFC providers identified to be out of compliance through the self-assessment process, requiring a response indicating a corrective action plan. The participant's waiver case manager will conduct PCMT reviews with the individual AL resident to identify any concerns indicating provider non-compliance with HCBS characteristics. Review of provider-specific corrective action plans, either approving or requiring additional actions Verify implementation of approved corrective actions through on-site reviews conducted by state or contracted personnel DA will issue decertification notices to providers unable/unwilling to complete corrective actions. Affected participants will be offered assistance if they choose to transition to a new provider	7/2016 9/2016 Beginning 07/2015 09/2017 12/2017 09/2018 At least by 09/2018	Person-Centered Compliance Reviews, as well as NCI-AD surveys and Person Centered Monitoring Tool reviews.
Adult Family Care 40 service sites; 48 waiver consumers	The individual has a lease or other legally enforceable agreement providing similar protections	DA will communicate this standard to all AFC providers Conduct site visits to all AFC providers to assess setting for compliance with HCBS Final Rule Require all providers to submit a representative sample of a lease or residency agreement that conforms to local standards DA will issue decertification notices to providers unable/unwilling to provide an acceptable representative sample Affected participants will be offered assistance if they choose to transition to a new provider	12/2015 3/21016 - 06/2016 By 06/2016 06/2017 At least by 09/2018	Verify continuing compliance through Provider Compliance Reviews conducted for all AFC providers every three years and Person-Centered Compliance Reviews, as well as NCI-AD surveys and Person Centered Monitoring Tool reviews.
	The individual controls his/her own schedule including access to food at any time	Conduct a provider self-survey to determine general compliance with the HCBS Final Rule Conduct documentation review of all AL providers' policies, procedures, staff training, sample lease agreements,	10/2014	To assure on-going compliance, DA will develop and implement a provider compliance review process

Service/ Setting	Areas in Need of Remediation to Comply with HCBS Characteristics	Validation/Remediation Strategies	Timeline for Start/Completion	Assuring Ongoing Compliance
Assisted Living (AL) 92 service sites; 1912 active waiver consumers	The individual has privacy in their unit including lockable doors The individual has choice of roommates Optimizes autonomy and independence in making life choices;	etc. and assess for compliance with HCBS Final Rule Conduct site visits to all AL providers to assess setting for compliance with HCBS Final Rule DA will partner with key stakeholders in a collaborative effort to develop and communicate expectations of standards to provider and consumer communities Communicate expectations to specific providers identified to be out of compliance through the self-assessment process, requiring a response indicating a corrective action plan The participant's waiver case manager will conduct reviews with the individual AL resident to identify any concerns indicating provider non-compliance with HCBS characteristics. Review of provider-specific corrective action plans, either approving or requiring additional actions Verify implementation of approved corrective actions through on-site reviews conducted by state or contracted personnel DA will issue decertification notices to providers unable/unwilling to complete corrective actions. Affected participants will be offered assistance if they choose to transition to a new provider	02/2016 3/2016 - 06/2016 Beginning in fall 2015 9/2016 Beginning in 7/2015 11/2016 Beginning in 09/2017 Beginning in 12/2017 At least by 09/2018	similar to that used to review non-licensed providers, in addition to the Person-Centered Compliance Reviews, as well as NCI-AD surveys and Person Centered Monitoring Tool reviews.
Assisted Living 92 service sites; 1912 active waiver consumers	The individual has a lease or other legally enforceable agreement providing similar protections	DA will communicate this standard to all AL providers Require all providers to submit a representative sample of a lease or residency agreement that conforms to local standards Conduct documentation review of all AL providers' policies, procedures, staff training, sample lease agreements,	12/2015 06/2016 02/2016	Verify continuing compliance through Person-Centered Compliance Reviews conducted for a statistically valid random sample of waiver participants, determined annually, as well as Person

Service/ Setting	Areas in Need of Remediation to Comply with HCBS Characteristics	Validation/Remediation Strategies	Timeline for Start/Completion	Assuring Ongoing Compliance
		etc. and assess for compliance with HCBS Final Rule Conduct site visits to all AL providers to assess setting for compliance with HCBS Final Rule DA will issue decertification notices to providers unable to provide an acceptable representative sample Affected participants will be offered assistance if they choose to transition to a new provider	06/2016 Beginning in 12/2107 At least by 9/2018	Centered Monitoring Tool reviews.
Assisted Living 92 service sites; 1912 active waiver consumers	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	DA will partner with key stakeholders in a collaborative effort to develop and communicate expectations of standards to provider and consumer communities Conduct documentation review of all AL providers' policies, procedures, staff training, sample lease agreements, etc. and assess for compliance with HCBS Final Rule Conduct site visits to all AL providers to assess setting for compliance with HCBS Final Rule Communicate expectations to specific providers identified to be out of compliance through the self-assessment process, requiring a response indicating a corrective action plan The participant's waiver case manager will conduct reviews with the individual AL resident to identify any concerns indicating provider non-compliance with HCBS characteristics. Review of provider-specific corrective action plans, either approving or requiring additional actions Verify implementation of approved corrective actions through on-site reviews conducted by state or contracted personnel DA will issue decertification notices to providers unable/unwilling to complete corrective actions. Affected participants will be offered assistance if they choose to transition to a new provider.	12/2016 02/2016 06/2016 12/2016 Beginning in 7/2015 09/2017 9/2017 Beginning in 12/2017	Verify continuing compliance through Person-Centered Compliance Reviews, as well as NCI-AD surveys and Person Centered Monitoring Tool reviews.

Service/ Setting	Areas in Need of Remediation to Comply with HCBS Characteristics	Validation/Remediation Strategies	Timeline for Start/Completion	Assuring Ongoing Compliance
			At least by 09/2018	
Adult Day Services (ADS) 38 service sites; 532 waiver consumers	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;	DA will require a self-survey for all ADS providers to identify both facility-specific and systemic areas of non-compliance. Conduct documentation review of all ADS providers' policies, procedures, staff training, sample lease agreements, etc. and assess for compliance with HCBS Final Rule Conduct site visits to all ADS providers to assess setting for compliance with HCBS Final Rule DA will partner with key stakeholders in a collaborative effort to develop and communicate expectations of standards to provider and consumer communities The participant's waiver case manager will conduct reviews with the individual ADS participant to identify any concerns indicating provider non-compliance with HCBS characteristics. DA will communicate expectations to specific providers identified to be out of compliance through the assessment processes, requiring a response indicating a corrective action plan Review of provider-specific corrective action plans, either approving or requiring additional actions Verify implementation of approved corrective actions through on-site reviews conducted by state or contracted personnel DA will issue decertification notices to providers unable/unwilling to complete corrective actions. Affected participants will be offered assistance if they choose to transition to a new provider	2/2015 Beginning in 7/2015 9/2016 04/2017 9/2017 06/2017 09/2017 Beginning in 12/2017 At least by 09/2018	Verify continuing compliance through Provider Compliance Reviews conducted for all ADS providers every three years and Person-Centered Compliance Reviews, as well as NCI-AD surveys and Person Centered Monitoring Tool reviews.

Service/ Setting	Areas in Need of Remediation to Comply with HCBS Characteristics	Validation/Remediation Strategies	Timeline for Start/Completion	Assuring Ongoing Compliance
Structured Day Program (SDP) 66 service sites; 20 TBI waiver consumers	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;	DA will require a self-survey for all SDP providers to identify both facility-specific and systemic areas of non-compliance. DA will partner with key stakeholders in a collaborative effort to develop and communicate expectations of standards to provider and consumer communities The participant's waiver case manager will conduct reviews with the individual SDP participant to identify any concerns indicating provider non-compliance with HCBS characteristics. DA will communicate expectations to specific providers identified to be out of compliance through the assessment processes, requiring a response indicating a corrective action plan Review of provider-specific corrective action plans, either approving or requiring additional actions Verify implementation of approved corrective actions through on-site reviews conducted by state or contracted personnel DA will issue decertification notices to providers unable/unwilling to complete corrective actions. Affected participants will be offered assistance if they choose to transition to a new provider	1/2016 12/2016 Beginning in 7/2015 06/2017 09/2017 12/2017 09/2018 09/2018	Verify continuing compliance through Provider Compliance Reviews conducted for all SDP providers every three years and Person-Centered Compliance Reviews, as well as NCI-AD surveys and Person Centered Monitoring Tool reviews.

Crosswalk of CMS Final Rule on Home and Community Based Services Settings to Division of Aging and Indiana State Department of Health Rules, current and proposed

Home and Community Based Services Requirement	Current Rule DA Provider Rule 455 IAC 2	Current DA AL Rule 455 IAC 3	Current ISDH Health Facilities Rule 410 IAC 16.2-5-1.2	Proposed ISDH Rule Amendments	General Provisions Proposed Rule 455 IAC 2.1	Adult Family Care Proposed Rule 455 IAC 2.1-6-5	Assisted Living Proposed Ruled – 455 IAC 2.1-6-6 and 455 IAC 2.1-6-7	Structured Day Program	Adult Day Program
Services provided under a person-centered service plan	Not referenced	455 IAC 3-1-2 (32) "Service plan" means a written plan for services to be provided by the provider, developed by the provider, the recipient, and others, if appropriate, on behalf of the recipient, consistent with the services needed to ensure the health and welfare of the recipient. It is a detailed description of the capabilities, needs, choices, measurable goals, and if applicable the measurable goals and managed risk issues, and documents the specific duties to be performed for the recipient, including who will perform the task, when, and the frequency of each task based on the individual's assessed needs and preferences. 455 IAC 3-1-8(d)-(e)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;	410 IAC 16.2-5-1.2(b) Residents have the 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. 410 IAC 16.2-5-1.2(j) (1) – Residents have the right to "Participate in the development of his or her service plan and in any updates of that service plan."	Not Applicable	**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." **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). **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)." **455 IAC 2.1-6-4** - General Direct Care Service Standards: A provider shall: (1) Develop person-centered service plan specific to participants' assessed needs; (2) Allow decision-making and self-determination to the fullest extent possible; (3) 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. (b) SFC, AFC, and AL providers shall maintain a safe, clean, and comfortable living environment.	Addressed in the general provisions of proposed rule 455 IAC 2.1	**455 IAC 2.1 -6-4 (a)(4)** - Assisted living facilities shall: "Provide living units that include access to the following in accordance with the resident's person-centered service plan: (A) A bedroom; (B) A private bath; (C) A living area; (D) A kitchenette that contains: (i) a refrigerator; (ii) a food preparation area; (iii) a microwave or stovetop for hot food preparation; and (E) Individual thermostat." **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 resident's person centered service plan."	Addressed in the general provisions of proposed rule 455 IAC 2.1	Addressed in the general provisions of proposed rule 455 IAC 2.1

Home and Community Based Services Requirement	Current Rule DA Provider Rule 455 IAC 2	Current DA AL Rule 455 IAC 3	Current ISDH Health Facilities Rule 410 IAC 16.2-5-1.2	Proposed ISDH Rule Amendments	General Provisions Proposed Rule 455 IAC 2.1	Adult Family Care Proposed Rule 455 IAC 2.1-6-5	Assisted Living Proposed Ruled – 455 IAC 2.1-6-6 and 455 IAC 2.1-6-7	Structured Day Program	Adult Day Program
		(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. (e) The service plan shall support the principles of dignity, privacy, and choice in decision making, individuality, and independence. **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			**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 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. (c) All case managers must: Coordinate services; Share information on the participant's well-being as required by the participant's person-centered plan; Collaborate with the participant's other providers; and Collaborate with other authorized entities. (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.				

Home and Community Based Services Requirement	Current Rule DA Provider Rule 455 IAC 2	Current DA AL Rule 455 IAC 3	Current ISDH Health Facilities Rule 410 IAC 16.2-5-1.2	Proposed ISDH Rule Amendments	General Provisions Proposed Rule 455 IAC 2.1	Adult Family Care Proposed Rule 455 IAC 2.1-6-5	Assisted Living Proposed Ruled – 455 IAC 2.1-6-6 and 455 IAC 2.1-6-7	Structured Day Program	Adult Day Program
		recipients to select where and how to spend time and receive personal assistance. **455 IAC 3-1-2(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.							
Setting is integrated in and supports access to the greater community	Not Referenced	**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	**410 IAC 16.2-5-1.2 (b)** "Residents have the 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."	Not Applicable		**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 resident; … and therapeutic social and recreational programming." **455 IAC 2.1-6-5(d)** Adult Family Care providers must ensure that a resident has the ability to: come	**455 IAC 2.1-6-6 (b)** Assisted living facilities are require to ensure that a resident 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 **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,	Not Referenced	Not Referenced

Home and Community Based Services Requirement	Current Rule DA Provider Rule 455 IAC 2	Current DA AL Rule 455 IAC 3	Current ISDH Health Facilities Rule 410 IAC 16.2-5-1.2	Proposed ISDH Rule Amendments	General Provisions Proposed Rule 455 IAC 2.1	Adult Family Care Proposed Rule 455 IAC 2.1-6-5	Assisted Living Proposed Ruled – 455 IAC 2.1-6-6 and 455 IAC 2.1-6-7	Structured Day Program	Adult Day Program
		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. **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.				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 .	age and condition of the individual; and therapeutic social and recreational programming.		

Home and Community Based Services Requirement	Current Rule DA Provider Rule 455 IAC 2	Current DA AL Rule 455 IAC 3	Current ISDH Health Facilities Rule 410 IAC 16.2-5-1.2	Proposed ISDH Rule Amendments	General Provisions Proposed Rule 455 IAC 2.1	Adult Family Care Proposed Rule 455 IAC 2.1-6-5	Assisted Living Proposed Ruled – 455 IAC 2.1-6-6 and 455 IAC 2.1-6-7	Structured Day Program	Adult Day Program
Includes 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 as individual not receiving Medicaid HCBS	Not Referenced	**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. **455 IAC 3-1-2 (18)** "Homelike" means an environment that has the qualities of a home, including	**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." **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	Not Applicable		**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 resident; … and therapeutic social and recreational programming." **455 IAC 2.1-6-5(d)** Adult Family Care providers must ensure that a resident 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 .	**455 IAC 2.1-6-6 (b)** Assisted living facilities are require to ensure that a resident 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 **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.	Not Referenced	Not Referenced

Home and Community Based Services Requirement	Current Rule DA Provider Rule 455 IAC 2	Current DA AL Rule 455 IAC 3	Current ISDH Health Facilities Rule 410 IAC 16.2-5-1.2	Proposed ISDH Rule Amendments	General Provisions Proposed Rule 455 IAC 2.1	Adult Family Care Proposed Rule 455 IAC 2.1-6-5	Assisted Living Proposed Ruled – 455 IAC 2.1-6-6 and 455 IAC 2.1-6-7	Structured Day Program	Adult Day Program
		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. 455 IAC 3-1-8(1) Provide is required to "Promote the ability of residents 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."	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. Management does not include the safekeeping of personal items…" (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." (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."						
Setting is selected by the individual from amount setting options including non-	Not Referenced	455 IAC 3-1-6 (g) "The physical environment and the delivery of assisted living Medicaid waiver services shall	410 IAC 16.2-5-1.2(b) Residents have the right to a dignified existence, self-determination, and communication with and access to		**455 IAC 2.1-6-4** - General Direct Care Service Standards: A provider shall: (1) Develop person-centered service plan specific to participants' assessed needs;	Addressed in the general provisions of proposed rule 455 IAC 2.1	**455 IAC 2.1 -6-4 (a)(4) -** Assisted living facilities shall:	Addressed in the general provisions of proposed rule 455 IAC 2.1	Addressed in the general provisions of proposed rule 455 IAC 2.1

Home and Community Based Services Requirement	Current Rule DA Provider Rule 455 IAC 2	Current DA AL Rule 455 IAC 3	Current ISDH Health Facilities Rule 410 IAC 16.2-5-1.2	Proposed ISDH Rule Amendments	General Provisions Proposed Rule 455 IAC 2.1	Adult Family Care Proposed Rule 455 IAC 2.1-6-5	Assisted Living Proposed Ruled – 455 IAC 2.1-6-6 and 455 IAC 2.1-6-7	Structured Day Program	Adult Day Program
disability specific settings		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."	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.		(2) Allow decision-making and self-determination to the fullest extent possible.		"Provide living units that include access …in accordance with the resident's person-centered service plan."		
Option for a private unit in a residential setting	Not Referenced	**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 the other occupant	**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	Amend to state that the individual has choice of whether to have a private room or roommate of their choosing.		**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	**455 IAC 2.1-6-6(b)(2)** The assisted living facility must assure that the resident has a private room.	Not Applicable	Not Applicable

Home and Community Based Services Requirement	Current Rule DA Provider Rule 455 IAC 2	Current DA AL Rule 455 IAC 3	Current ISDH Health Facilities Rule 410 IAC 16.2-5-1.2	Proposed ISDH Rule Amendments	General Provisions Proposed Rule 455 IAC 2.1	Adult Family Care Proposed Rule 455 IAC 2.1-6-5	Assisted Living Proposed Ruled – 455 IAC 2.1-6-6 and 455 IAC 2.1-6-7	Structured Day Program	Adult Day Program
		consent to the arrangement."	the right to live as a family in a suitable room or quarters and may occupy a double bed unless contraindicated 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 allowed to occupy a bedroom, if such an arrangement is agreeable to the residents or the residents' legal representative."	Delete reference to housing assignment		adult family care provider. The provider must assure that the resident has a private room.			
Setting options are identified and documented in the person-centered plan and are based on the individual's needs, preferences and for residential settings, resources available for room and board.	Not Referenced	**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	**410 IAC 16.2-5-1.2(b)** (b) Residents have the 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. (j) Residents have the right to the following: (1) Participate in the development of his or her service plan		**455 IAC 2.1-6-4** - General Direct Care Service Standards: A provider shall: (1) Develop person-centered service plan specific to participants' assessed needs; (2) Allow decision-making and self-determination to the fullest extent possible.	Addressed in the general provisions of proposed rule 455 IAC 2.1	**455 IAC 2.1 -6-4 (a)(4)** - Assisted living facilities shall: "Provide living units that include access …in accordance with the resident's person-centered service plan."	Addressed in the general provisions of proposed rule 455 IAC 2.1	Addressed in the general provisions of proposed rule 455 IAC 2.1

Home and Community Based Services Requirement	Current Rule DA Provider Rule 455 IAC 2	Current DA AL Rule 455 IAC 3	Current ISDH Health Facilities Rule 410 IAC 16.2-5-1.2	Proposed ISDH Rule Amendments	General Provisions Proposed Rule 455 IAC 2.1	Adult Family Care Proposed Rule 455 IAC 2.1-6-5	Assisted Living Proposed Ruled – 455 IAC 2.1-6-6 and 455 IAC 2.1-6-7	Structured Day Program	Adult Day Program
		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."	and in any updates of that service plan.						
Freedom from restrain, coercion, interference and discrimination	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"	Not addressed	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."		**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 -6-5 (d) (10)** The adult family care provider must assure that the resident has freedom from coercion and restraint.	**455 IAC 2.1-6-6 (b) (11)** The assisted living facility must assure that the resident has freedom from coercion, restraint and seclusion. **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 resident."	Addressed in the general provisions of proposed rule 455 IAC 2.1	Addressed in the general provisions of proposed rule 455 IAC 2.1

Home and Community Based Services Requirement	Current Rule DA Provider Rule 455 IAC 2	Current DA AL Rule 455 IAC 3	Current ISDH Health Facilities Rule 410 IAC 16.2-5-1.2	Proposed ISDH Rule Amendments	General Provisions Proposed Rule 455 IAC 2.1	Adult Family Care Proposed Rule 455 IAC 2.1-6-5	Assisted Living Proposed Ruled – 455 IAC 2.1-6-6 and 455 IAC 2.1-6-7	Structured Day Program	Adult Day Program
			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." 410 IAC 16.2-5-1.2(v)(6) – "Residents have the right to be free from …involuntary seclusion."						
Optimizes individual initiative, autonomy, and independent in making life choices	Not Referenced	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;	410 IAC 16.2-5-1.2(b) "Residents have the 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." 410 IAC 16.2-5-1.2(j) "Residents have the right to the following: (1) Participate in the development of his or her service plan and in any updates of that service plan."		**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."	Addressed in the general provisions of proposed rule 455 IAC 2.1	**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 resident's right to take responsibility for the risks associated with decision making."	Addressed in the general provisions of proposed rule 455 IAC 2.1	Addressed in the general provisions of proposed rule 455 IAC 2.1

Home and Community Based Services Requirement	Current Rule DA Provider Rule 455 IAC 2	Current DA AL Rule 455 IAC 3	Current ISDH Health Facilities Rule 410 IAC 16.2-5-1.2	Proposed ISDH Rule Amendments	General Provisions Proposed Rule 455 IAC 2.1	Adult Family Care Proposed Rule 455 IAC 2.1-6-5	Assisted Living Proposed Ruled – 455 IAC 2.1-6-6 and 455 IAC 2.1-6-7	Structured Day Program	Adult Day Program
		(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. **455 IAC 3-1-8(d)** "(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:							

Home and Community Based Services Requirement	Current Rule DA Provider Rule 455 IAC 2	Current DA AL Rule 455 IAC 3	Current ISDH Health Facilities Rule 410 IAC 16.2-5-1.2	Proposed ISDH Rule Amendments	General Provisions Proposed Rule 455 IAC 2.1	Adult Family Care Proposed Rule 455 IAC 2.1-6-5	Assisted Living Proposed Ruled – 455 IAC 2.1-6-6 and 455 IAC 2.1-6-7	Structured Day Program	Adult Day Program
		(A) the recipient; (B) the provider; (C) the licensed nurse; (D) the case manager; and (4) includes the date the plan was approved."							
Specific physical place that can be owner/rent or occupied under a legally enforceable agreement;	Not Referenced	Not addressed	**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. (2) A written notice of the facility's basic daily or monthly rates. (3) A written statement of all facility services (including those offered on an as needed basis). (4) Information on related charges, admission, readmission, and discharge policies of the facility. (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			**455 IAC 2.1-6-5** The adult family care provider must assure that the resident 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."	**455 IAC 2.1-6-6** The assistant living service provides must assure that the resident 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."	Not Applicable	Not Applicable

Home and Community Based Services Requirement	Current Rule DA Provider Rule 455 IAC 2	Current DA AL Rule 455 IAC 3	Current ISDH Health Facilities Rule 410 IAC 16.2-5-1.2	Proposed ISDH Rule Amendments	General Provisions Proposed Rule 455 IAC 2.1	Adult Family Care Proposed Rule 455 IAC 2.1-6-5	Assisted Living Proposed Ruled – 455 IAC 2.1-6-6 and 455 IAC 2.1-6-7	Structured Day Program	Adult Day Program
			those items provided for in IC 12-10-15-9.						
Privacy in sleeping or living unit	Not Referenced	**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."	**410 IAC 16.2-5-1.2(y)** (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: (1) Bathing. (2) Personal care. (3) Physical examinations and treatments. (4) Visitations.	Amend to add that the individual have a right to privacy in their sleeping or living unit.		**455 IAC 2.1-6-5 (d)(2)** The adult family care provider must assure that the resident has a private room.	**455 IAC 2.1-6-6 (b)(2)** The assisted living facility must assure that the resident has a private room.	Not Applicable	Not Applicable
Unit have locking doors; with only appropriate staff having keys	Not Referenced	**455 IAC 3-1-5 (f)** "Residential units provided to recipients shall be able to be 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."	Not addressed.	Amend to add that resident must have ability to lock room with only appropriate staff having keys.		**455 IAC 2.1-6-5 (d) (1)** The adult family care provider must assure that residents have the ability to lock their room.	**455 IAC 2.1-6-6 (b) (1)** The assisted living facility must assure that residents have the ability to lock their room.	Not Applicable	Not Applicable
Individuals sharing units have choice of roommates	Not Referenced	**455 IAC 3-1-5 (e)** "Residential units provided to recipients must be	**410 IAC 16.2-5-1.2(m)** "The facility must promptly notify the resident and, if	Amend to delete references to		Not Referenced	**455 IAC 2.1-6-6(b)(3)** The assisted living facility must assure that the	Not Applicable	Not Applicable

Home and Community Based Services Requirement	Current Rule DA Provider Rule 455 IAC 2	Current DA AL Rule 455 IAC 3	Current ISDH Health Facilities Rule 410 IAC 16.2-5-1.2	Proposed ISDH Rule Amendments	General Provisions Proposed Rule 455 IAC 2.1	Adult Family Care Proposed Rule 455 IAC 2.1-6-5	Assisted Living Proposed Ruled – 455 IAC 2.1-6-6 and 455 IAC 2.1-6-7	Structured Day Program	Adult Day Program
		single units unless the recipient chooses to live in dual-occupied unit and the recipient and other occupant consent to the arrangement."	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.	roommate assignments and provide that individuals have choice of roommates. Delete specific references to how individuals may occupy beds or bedroom.			individual has the ability to choose whether to have a roommate and a choice of roommates, if desired.		
Freedom to furnish and decorate sleeping or living units within lease or written agreement	Not Referenced	**455 IAC 3-1-8 (b)(4)** "A provider shall: (4) provide a safe, clean, and comfortable homelike environment allowing recipients	**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			**455 IAC 2.1-6-5 (d) (6)** The adult family care provider must assure that residents have the ability to decorate or furnish their	**455 IAC 2.1-6-6 (b) (7)** The assisted living facility must assure that residents have the ability to decorate or furnish their rooms as they choose.	Not Applicable	Not Applicable

Home and Community Based Services Requirement	Current Rule DA Provider Rule 455 IAC 2	Current DA AL Rule 455 IAC 3	Current ISDH Health Facilities Rule 410 IAC 16.2-5-1.2	Proposed ISDH Rule Amendments	General Provisions Proposed Rule 455 IAC 2.1	Adult Family Care Proposed Rule 455 IAC 2.1-6-5	Assisted Living Proposed Ruled – 455 IAC 2.1-6-6 and 455 IAC 2.1-6-7	Structured Day Program	Adult Day Program
		to use their personal belongings to the extent possible."	would infringe upon the rights of others or would create a health or safety hazard."			rooms as they choose.			
Freedom and support to control own schedule and activities	Not Referenced	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; (3) provide services for recipients in a manner and in an environment that encourages maintenance or enhancement of each recipient's quality of life and promotes the recipient's: (A) privacy; (B) dignity; (C) choice; (D) independence; (E) individuality; and (F) decision making ability; and (4) provide a safe, clean, and comfortable homelike	410 IAC 16.2-5-1.2 (ff) "Residents have 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."			**455 IAC 2.1-6-5 (d) (7)** The adult family care provider must assure that residents 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 residents have the ability to control their own schedule and to choose whether to participate in activities.	Not Referenced	Not referenced

Home and Community Based Services Requirement	Current Rule DA Provider Rule 455 IAC 2	Current DA AL Rule 455 IAC 3	Current ISDH Health Facilities Rule 410 IAC 16.2-5-1.2	Proposed ISDH Rule Amendments	General Provisions Proposed Rule 455 IAC 2.1	Adult Family Care Proposed Rule 455 IAC 2.1-6-5	Assisted Living Proposed Ruled – 455 IAC 2.1-6-6 and 455 IAC 2.1-6-7	Structured Day Program	Adult Day Program
		environment allowing recipients to use their personal belongings to the extent possible."							
Access to food at any time	Not Referenced	Not addressed	Not addressed	Amend to state residents have right to access food at all times.		**455 IAC 2.1-6-5 (d) (5)** The adult family care provider must assure that residents 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 residents have the ability to have access to food at all times.	Not Applicable	Not Applicable
Ability to have visitors of choosing at any time	Not Referenced	Not addressed	**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." **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	Amend to remove the 12 hour limitation on visiting hours.		**455 IAC 2.1-6-5 (d) (4**) The adult family care provider must assure that residents have the ability to have guest when they choose.	**455 IAC 2.1-6-6 (b) (5)** The assisted living facility must assure that residents have the ability to have guests when they choose.	Not Applicable	Not Applicable

Home and Community Based Services Requirement	Current Rule DA Provider Rule 455 IAC 2	Current DA AL Rule 455 IAC 3	Current ISDH Health Facilities Rule 410 IAC 16.2-5-1.2	Proposed ISDH Rule Amendments	General Provisions Proposed Rule 455 IAC 2.1	Adult Family Care Proposed Rule 455 IAC 2.1-6-5	Assisted Living Proposed Ruled – 455 IAC 2.1-6-6 and 455 IAC 2.1-6-7	Structured Day Program	Adult Day Program
			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. **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						

Home and Community Based Services Requirement	Current Rule DA Provider Rule 455 IAC 2	Current DA AL Rule 455 IAC 3	Current ISDH Health Facilities Rule 410 IAC 16.2-5-1.2	Proposed ISDH Rule Amendments	General Provisions Proposed Rule 455 IAC 2.1	Adult Family Care Proposed Rule 455 IAC 2.1-6-5	Assisted Living Proposed Ruled – 455 IAC 2.1-6-6 and 455 IAC 2.1-6-7	Structured Day Program	Adult Day Program
			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."						
Setting is physically accessible to the individual	Not Referenced	Not addressed	Not addressed	Amend to state resident living unit must be physically accessible to the individual.		**455 IAC 2.1-6-5 (d) (2)** The adult family care provider must assure that residents have a room that is physically accessible to them.	**455 IAC 2.1-6-6 (b) (2)** The assisted living facility must assure that residents have the ability to have a room that is physically accessible to them.	Not Referenced	Not References
Modifications of additional conditions under §441.301(c)(4)(vi)(A) through (D) must be supported by specific assessed need and justified in the person-centered service plan	Not referenced	Not addressed	410 IAC 16.2-5-1.2(j) (1) – Residents have the right to "Participate in the development of his or her service plan and in any updates of that service plan."		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 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. (c) All case managers must: Coordinate services;	Addressed in the general provisions of proposed rule 455 IAC 2.1	Addressed in the general provisions of proposed rule 455 IAC 2.1	Not Applicable	Not Applicable

Home and Community Based Services Requirement	Current Rule DA Provider Rule 455 IAC 2	Current DA AL Rule 455 IAC 3	Current ISDH Health Facilities Rule 410 IAC 16.2-5-1.2	Proposed ISDH Rule Amendments	General Provisions Proposed Rule 455 IAC 2.1	Adult Family Care Proposed Rule 455 IAC 2.1-6-5	Assisted Living Proposed Ruled – 455 IAC 2.1-6-6 and 455 IAC 2.1-6-7	Structured Day Program	Adult Day Program
					Share information on the participant's well-being as required by the participant's person-centered plan; Collaborate with the participant's other providers; and Collaborate with other authorized entities. (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.				

SECTION 3: 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, 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 residents 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.
- More stakeholder engagement is planned through the spring and summer of 2016.
- 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 Protection and Advocacy Services (IPAS) more directly in this process.

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: SYSTEMIC ASSESSMENT

From May through September 2014 the Division of Disability and Rehabilitative Services (DDRS), completed a systemic review and analysis of settings where HCBS services are provided. The analysis included review of National Core Indicators (NCI) Data, Indiana Statute, Indiana Administrative Code and Home and Community Based Services policy. Through this initial review process the DDRS has identified areas which may need to have additional scrutiny and possible remediation. DDRS' intent throughout this process was to utilize currently available data to determine where systemic improvements or changes would need to be made to meet CMS' Home and Community Based Services Standards.

This initial systemic analysis was 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 may 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.

Below are brief narratives of each activity DDRS undertook to complete a preliminary analysis of HCBS settings. Following the narratives there is a table which more clearly outlines each area, the sources of information, the key stakeholders and the outcome of the analysis.

Systemic review of standards, rules, regulations, and/other requirements

The HCBS requirements and DDRS' current standards, rules, regulations, and requirements were reviewed and analyzed in order to determine if DDRS' current internal requirements meet/support the federal HCBS requirements. Once assessments and validity checks occurring in the next phase are completed, the DDRS transition plan will be updated to include the full results.

Systemic Assessment -Preliminary Landscape of Settings

The systemic assessment examines the HCBS requirements and DDRS' initial level of compliance with the HCBS requirements. The systemic assessment was constructed utilizing Indiana's NCI data, 90 Day Check List data and an initial review of DDRS' current standards, rules, regulations, and other requirements.

SYSTEMIC ASSESSMENT						
Item	**Description**	**Start Date**	**End Date**	**Sources/ Documents**	**Key Stake-holders**	**Outcome**
Systemic Setting Crosswalk: Initial review of standards, rules, regulations, and other requirements	DDRS has chosen to review its current standards, rules, regulations, and requirements in order to ascertain DDRS' level of compliance with the HCBS requirements	9/2014	12/2014	Crosswalk of HCBS requirements and DDRS' standards, rules, regulations, and other requirements	DDRS/BDDS internal staff, OMPP, and the FSSA Office of General Council	A review of the HCBS requirements and DDRS' current standards, rules, regulations, and requirements were evaluated and revealed areas of vulnerability and areas that need further exploration as outlined in the systemic setting analysis.
Setting Assessment based on requirements	The Setting Assessment examines the HCBS requirements and DDRS' initial level of compliance with the HCBS requirements	9/2014	10/2014	Crosswalk of HCBS requirements and Indiana's NCI	DDRS/BDDS internal staff, OMPP, and the FSSA Office of	The Preliminary settings assessment revealed areas of vulnerability and areas that need further exploration in order to

SYSTEMIC ASSESSMENT						
Item	**Description**	**Start Date**	**End Date**	**Sources/ Documents**	**Key Stake-holders**	**Outcome**
	The Setting Assessment was constructed utilizing Indiana's NCI data and an initial review of DDRS' current standards, rules, regulations, and other requirements. This initial setting analysis is general in nature and does not imply that any specific provider or location in non-compliant solely by classification in this analysis. Final determination will depend upon information gathered through all assessment activities outlined in the comprehensive transition plan, including but not limited to onsite reviews, provider annual self-assessments, internal programmatic data, and provider/participant surveys.			Data and 90 Day Check List Data	General Council In order to receive comprehensive stakeholder feedback, the preliminary assessment will be reviewed by stakeholders during the public comment period.	ascertain DDRS' level of compliance.

Systemic Settings Crosswalk

The table below outlined DDRS' systemic setting crosswalk. This initial systemic assessment was general in nature and did not imply that any specific provider or location was 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 annual self-assessments, internal programmatic data, and provider/participant surveys.

To ascertain DDRS' initial level of compliance with the HCBS rules an initial review of Indiana Administrative Code (IAC 460), policies, procedures, provider agreements, and ongoing monitoring forms was completed.

The initial review was completed by DDRS/BDDS internal staff, OMPP, and the FSSA Office of General Council.

In addition to ascertaining DDRS' initial level of compliance with the HCBS rules, the systemic setting crosswalk was also used with the goal of identifying specific policies requiring updates, documents and processes requiring modifications in order to more appropriately represent compliance.

SYSTEMIC SETTINGS CROSSWALK				
CMS Criteria	**IAC / IC Reviewed**	**Policy and Procedures Reviewed**	**Waiver Manual /Forms Reviewed**	**Outcome of Review**
Is integrated in and supports access to the greater community	460 IAC 6-20-2 "community-based employment services shall be provided in an integrated setting." *Needs to be modified in order to meet HCBS standards* 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 460 IAC 6-3-32 ISP *Needs to be modified in order to meet HCBS standards*	Individual Rights and Responsibilities (NEW) (4600221014) ***In process of being updated to enhance support of CMS regulations*** Transition Policy (4600316031)	90-day Checklist Does the individuals' routine outlined in ISP include participation in community activities and events? Pre-Post Monitoring Checklist Transportation available to meet all community access needs	**Residential** An analysis of existing state standards show silence with respect to the federal regulation **Non-Residential** An analysis of existing state standards show silence with respect to the federal regulation
Provide opportunities to seek employment and work in competitive integrated settings	460 IAC 6-20-2 (community-based employment services shall be provided in an integrated setting). *Needs to be modified in order to meet HCBS standards*	Intentionally left blank.	90-day 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?	**Residential** An analysis of existing state standards show silence with respect to the federal regulation **Non-Residential** An analysis of existing state standards show silence with respect to the federal regulation
Control Personal Resources	460 IAC 6-17-3 Individuals Personal File 460 IAC 6-24-3 Management of Individuals Financial Resources *Needs to be modified in order to meet HCBS standards* 460 IAC 6-9-4 Personal Possessions and Clothing	Individual Rights and Responsibilities (NEW) (4600221014) ***In process of being updated to enhance support of CMS regulations***	90-day Checklist Unrestricted access to their personal possessions? -Free to receive and open own mail? -Free to receive and make phone calls without restrictions? Fiscal Issues (money, accounts, etc.) ISP Are the Individuals' Property/Financial resources being properly managed?	**Residential** An analysis of existing state standards show silence with respect to the federal regulation **Non-Residential** An analysis of existing state standards show silence with respect to the federal regulation

SYSTEMIC SETTINGS CROSSWALK				
CMS Criteria	**IAC / IC Reviewed**	**Policy and Procedures Reviewed**	**Waiver Manual /Forms Reviewed**	**Outcome of Review**
Ensures the individual receives services in the community with the same degree of access as individuals not receiving Medicaid HCBS	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. 460 IAC 6-20-2 community-based employment services shall be provided in an integrated setting *Needs to be modified in order to meet HCBS standards*	BQIS Complaints: Supported Living Services & Supports (BQIS 4600221005) Individual Rights and Responsibilities (NEW) (4600221014) ***In process of being updated to enhance support of CMS regulations***	90-day Checklist **Does the individual's routine outlined in the ISP include participation in community activities and events?**	**Residential** An analysis of existing state standards show conflict with, or are silent with respect to the federal regulation **Non- Residential** An analysis of existing state standards show conflict with, or are silent with respect to the federal regulation
Allow full access to the greater community/Engaged in community life	460 IAC 6-9-4System 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. ACCESS TO THE COMMUNITY 460 IAC 6-20-2 "community-based employment services shall be provided in an integrated setting." *Needs to be modified in order to meet HCBS standards* 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 460 IAC 6-3-32 ISP *Needs to be modified in order to meet HCBS standards*	Individual Rights and Responsibilities (NEW) (4600221014) ***In process of being updated to enhance support of CMS regulations***	ISP Is adequate Transportation being provided? 90-day Checklist Does the individual's routine outlined in the ISP include participation in community activities and events? Pre-Post Monitoring Checklist Transportation	**Residential** An analysis of existing state standards show silence with respect to the federal regulation **Non- Residential** An analysis of existing state standards show silence with respect to the federal regulation

SYSTEMIC SETTINGS CROSSWALK				
CMS Criteria	**IAC / IC Reviewed**	**Policy and Procedures Reviewed**	**Waiver Manual /Forms Reviewed**	**Outcome of Review**
Setting is chosen among setting options including non-disability specific settings and options for a private unit in residential settings	460 IAC 6-4 Rule 4. Types of Supported Living Services and Supports 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 appropriate devices or home modifications, or both 460 IAC 6-9-6 Transfer of individual's records upon change of provider	Intentionally left blank.	(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. AND When priority access has been deemed appropriate and a priority waiver slot in the specific reserved capacity category met by the applicant remains open, participants may choose to live in their own home, family home, or community setting appropriate to their needs.	**Residential** An analysis of existing state standards show silence with respect to the federal regulation **Non- Residential** An analysis of existing state standards show silence with respect to the federal regulation
Ensures right to privacy, dignity, and respect and freedom from coercion and restraint	460 IAC 13-3-12 (IST Membership) 460 IAC 6-8-2 - Constitutional and statutory rights IC 12-27-4 – Seclusion and Restraint laws 460 IAC 6-8-3 Promoting the exercise of rights 460 IAC 7-5-6 - Statement of agreement section 460 IAC 6-10-8 - Resolution of disputes 460 IAC 6-9-4 – Systems for protecting individuals 460 IAC 6-9-3 Prohibiting violations of individual rights	Aversive Techniques (BDDS 4601207003) BMR-ANE (BDDS 4601207002) Environmental Requirements (BDDS 460 1216039) Use of Restrictive Interventions, Including Restraint (BDDS 460 0228 025) Human Rights Committee (BDDS 460 0221 012) Protection of Individual Rights (4600228022) Incident Reporting and Management (BQIS 460 0301 008) – TRAINING IS REQUIRED FOR ALL DSPs (4600228027) – Annual Training on the protection of individual rights and respecting dignity of individual (4600228021-Professional Qualifications and Requirements) Individual Rights and Responsibilities (NEW) (4600221014)	Provider Agreement Checklist 12. Prohibiting Violations of Individual Rights Provider Agreement Checklist 14 Individual Freedoms Provider Agreement Checklist 15 Personnel Policy- Safeguards that ensure compliance with HIPAA and all other Federal and State Privacy Laws. 90-day 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? Pre-Post Monitoring Checklist Transportation	**Residential** An analysis of existing state standards show compliance with respect to the federal regulation **Non- Residential** An analysis of existing state standards show compliance with respect to the federal regulation

SYSTEMIC SETTINGS CROSSWALK				
CMS Criteria	**IAC / IC Reviewed**	**Policy and Procedures Reviewed**	**Waiver Manual /Forms Reviewed**	**Outcome of Review**
		In process of being updated to enhance support of CMS regulations IST (4600228016) Identifies other persons identified by the individual AND requires the individual to be present at all meetings Pre-Post Transition Monitoring (BDDS 4600530032) Health and Welfare is protected Provider Code of Ethics Conduct all practice with honest, integrity and fairness DDRS Policy: Personnel Policies and Manuals		
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)	460 IAC 7-3-12 (PCP) *Needs to be modified in order to meet HCBS standards* 460 IAC 7-4-1 (Development of ISP) 460 IAC 6-3-32 "Individualized support plan" or "ISP" defined 460 IAC 6-3-38.5 "Person centered planning" defined (A) based on the individual's preferences, dreams, and needs; 460 IAC 6-3-38.6 "Person centered planning facilitation services" defined 460 IAC 6-5-36 Person centered planning facilitation services provider qualifications 460 IAC 6-14-4 Training	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 Professional Qualifications and Requirements (4600228021) Provider shall ensure that services provided to individual meet the needs of the individual	(Part 4.5 and 4.6 of Manual- FSW/CIH) Participants develop an Individual Service Plan (ISP) using a person centered planning process guided by an Individual Support Team (IST). 90-day Checklist Does CCB/POC, ISP address the needs of the individual, implemented appropriately?	**Residential** An analysis of existing state standards show silence with respect to the federal regulation **Non-Residential** An analysis of existing state standards show silence with respect to the federal regulation

SYSTEMIC SETTINGS CROSSWALK				
CMS Criteria	**IAC / IC Reviewed**	**Policy and Procedures Reviewed**	**Waiver Manual /Forms Reviewed**	**Outcome of Review**
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.	IC 12-27 (Seclusion and Restraint) 460 IAC 6-3-29.5 Independence assistance service 460 IAC 6-24-1 Coordination of training services and training plan (be designed to enhance skill acquisition and increase independence). 460 IAC 6-8-2 Constitutional and statutory rights 460 IAC 6-8-3 promoting the exercise of rights 460 IAC 6-36-2 Code of ethics 460 IAC 6-3-54 "Support team" defined are designated by the individual;	Provider Code of Ethics A provider shall provide professional services with objectivity and with respect for the unique needs and values of the individual being provided services. Individual Rights and Responsibilities (NEW) (4600221014) ***In process of being updated to enhance support of CMS regulations***	Intentionally left blank	**Residential** An analysis of existing state standards show compliance with respect to the federal regulation **Non- Residential** An analysis of existing state standards show compliance with respect to the federal regulation

SYSTEMIC SETTINGS CROSSWALK				
CMS Criteria	**IAC / IC Reviewed**	**Policy and Procedures Reviewed**	**Waiver Manual /Forms Reviewed**	**Outcome of Review**
Facilitates choice of services and who provides them	460 IAC 7-4-3 Composition of the support team 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. 460 IAC 7-5-5 (Outcome section) (4) Proposed strategies and activities for meeting and attaining the outcome, including the following: (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.	Individual Rights and Responsibilities (NEW) (4600221014) ***In process of being updated to enhance support CMS regulations*** IST (4600228016) Coordinate the provision and monitoring of needed supports for the individual	(Part 4.5 and 4.6 of Manual- FSW/CIH) 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 90-day Checklist Provided information on their right to choose and change providers and case managers?	**Residential** An analysis of existing state standards show compliance with respect to the federal regulation **Non- Residential** An analysis of existing state standards show compliance with respect to the federal regulation
A lease or other legally enforceable agreement to protect from eviction (Provider owned or controlled residential setting)	460 IAC 6-24-3 Management of Individual's financial resources 460 IAC 6-9-4 Systems for protecting individuals	Intentionally left blank	90-day Checklist Has the provider obtained a rental agreement in the individuals' name? ISP Are the Individuals' Property/Financial resources being properly managed?	**Residential** An analysis of existing state standards show silence with respect to the federal regulation **Non- Residential** Non applicable

SYSTEMIC SETTINGS CROSSWALK				
CMS Criteria	**IAC / IC Reviewed**	**Policy and Procedures Reviewed**	**Waiver Manual /Forms Reviewed**	**Outcome of Review**
Privacy in their unit including entrances lockable by the individual	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. (1) the opportunity to communicate, associate, and meet privately with persons of the individual's choosing; (2) the means to send and receive unopened mail; and (3) access to a telephone with privacy for incoming and outgoing local and long distance calls at the individual's expense	Individual Rights and Responsibilities (NEW) (4600221014) ***In process of being updated to enhance support of CMS regulations*** Protection of Individual Rights (4600228022)	Intentionally left blank	**Residential** An analysis of existing state standards show silence with respect to the federal regulation **Non- Residential** Non applicable
Freedom to furnish and decorate their unit	460 IAC 9-3-7 - Physical environment 460 IAC 6-9-4 Systems for protecting individuals	Individual Rights and Responsibilities (NEW) (4600221014) ***In process of being updated to enhance support of CMS regulations***	Additional participant and family feedback is requested to measure this area.	**Residential** An analysis of existing state standards show compliance with respect to the federal regulation **Non-Residential** Non applicable

SYSTEMIC SETTINGS CROSSWALK				
CMS Criteria	**IAC / IC Reviewed**	**Policy and Procedures Reviewed**	**Waiver Manual /Forms Reviewed**	**Outcome of Review**
Control of schedule and activities	460 IAC 6-3-38.5 "Person centered planning" defined 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; 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. 460 IAC 6-36-2 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.	Intentionally left blank.	90-day Checklist Does the individual's routine outlined in the ISP include participation in community activities and events?	**Residential** An analysis of existing state standards show silence with respect to the federal regulation **Non- Residential** An analysis of existing state standards show silence with respect to the federal regulation
Access to food at any time	460 IAC 6-3-36 (Neglect -"Neglect" means failure to provide supervision, training, appropriate care, food, medical care, or medical supervision to an individual." 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	Individual Rights and Responsibilities (NEW) (4600221014) ***In process of being updated to enhance support of CMS regulations*** Protection of Individual Rights (4600228022)	90-day Checklist Individualized dining plan, does it include food restrictions?	**Residential** An analysis of existing state standards show silence with respect to the federal regulation **Non- Residential** An analysis of existing state standards show silence with respect to the federal regulation

SYSTEMIC SETTINGS CROSSWALK				
CMS Criteria	**IAC / IC Reviewed**	**Policy and Procedures Reviewed**	**Waiver Manual /Forms Reviewed**	**Outcome of Review**
Visitors at any time	460 IAC 6-9-4 (1) the opportunity to communicate, associate, and meet privately with persons of the individual's choosing; 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.	Intentionally left blank	90-day Checklist Free to receive visitors with no restrictions?	**Residential** An analysis of existing state standards show silence with respect to the federal regulation **Non- Residential** An analysis of existing state standards show silence with respect to the federal regulation
Setting is physically accessible to the individual	460 IAC 9-3-7 - Physical environment 460 IAC 6-29-2 Safety of individuals environment 460 IAC 6-29-3 Monitoring an individual's environment	Environmental Requirements (BDDS 460 1216039) Transition Activities (4600316031)	Pre-Post Monitoring Checklist	**Residential** An analysis of existing state standards show compliance with respect to the federal regulation **Non- Residential** An analysis of existing state standards show compliance with respect to the federal regulation
Individuals sharing units have a choice of roommates in that setting	Intentionally left blank	Intentionally left blank	Intentionally left blank	**Residential** An analysis of existing state standards show silence with respect to the federal regulation **Non-Residential** Non applicable

SECTION 2: SITE SPECIFIC SETTING ASSESSMENT

The National Core Indicators (NCI) Data and existing 90 Day Check List Data were reviewed to determine initial 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 other data collected from the 90 day check list, the need for further review was determined due to inconsistencies in the data outcomes. DDRS also confirmed that NCI data was not inclusive of all HCBS requirements. A more in depth analysis is being conducted via the Individual Experience Survey (IES) that targets the specific requirements. Upon review of IES data, DDRS will determine compliance with the specific HCBS Settings requirements. For these reasons, the NCI data will not be used moving forward **for purposes of measuring compliance with the settings rule, however, DDRS will use NCI data for purposes of triangulating data as a way to validate ongoing compliance with the rule.**

National Core Indicators (NCI) Data Review

In order to ascertain the level of compliance with the HCBS requirements, DDRS had chosen to utilize the National Core Indicators (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 National Core Indicators (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.

In reviewing NCI data, DDRS set a clear standard of 85% or greater compliance in each point reviewed in order to guide the analysis. In March 2014, CMS also issued modifications to Quality Measures and Reporting on 1915(c) Home and Community Based Waivers. Specific to Improvements in 1915(c) Waiver Quality Requirements (June 15, 2014), CMS issued guidance to the States indicating that any level of performance measuring "less than 86%" compliance indicated a need for improvement and further analysis to determine the cause(s) of the performance problem. DDRS chose to use that same percentage (less than 86%, or 85%) as the threshold for low level compliance within our National Core Indicator and 90-Day Checklist data findings. National Core Indicator findings, including those specific to Indiana, are available at http://www.nationalcoreindicators.org/states/

The breakdown of NCI data was utilized as supplemental data in preparing the setting assessment. Based on the NCI analysis, Indiana consistently demonstrated that it did not meet this standard in the majority of the HCBS requirement areas.

The breakdown of the NCI was incorporated into the waiver specific Transition Plans.

90 Day Check List Data Review

The 90 day check list is used as a monitoring tool for case managers to ensure supports are provided consistent with BDDS policies and procedures. The 90 day checklist will be modified by 12/2017 as part of the remediation strategy "revisions to forms" outlined in the STP to ensure ongoing compliance with the final rule with the addition of specific questions addressing the delivery of services in each setting. If the response to any question on the 90 day check list related to HCBS requirements is evaluated to be out of compliance, the case managers will notify **the responsible party that a corrective action plan 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, 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 (see below response). The 90 day check list is an ongoing monitoring tool that will be used to ensure ongoing compliance after the March 2019 deadline.

Individual Experience Survey

The DDRS has developed a high quality, comprehensive survey that targets the specific HCBS requirements and provides additional data to determine DDRS' compliance status. DDRS has contracted with The Indiana Institute on Disability and Community (IIDC) to design, develop, and administer a survey to be completed by participants when able or the person who knows them best. This survey was administered by the participant's **waiver case manager** to ensure all participants were reached. 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.

Site Specific Assessment

Based on the results of the Individual Experience Survey, DDRS will identify specific sites that will need further review prior to the completion of the comprehensive setting results document in order to validate the information obtained through the comprehensive survey.

Validation of the compliance of the specific sites will be 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 will utilize this guidance in developing and establishing criteria for engaging in site specific assessments.

During the site-specific assessments, **DDRS or its contracted agents** will review the results of the assessments to validate the results. Prior to the assessment review, DDRS will conduct a comprehensive training for all case management providers in order to ensure consistency of all reviews.

Results of the site-specific assessments will be used to identify specific settings that do not meet the HCBS requirements.

The table below outlined DDRS' initial setting assessment analysis. This initial assessment was general in nature and did not imply that any specific provider or location was 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 annual self-assessments, internal programmatic data, and provider/participant surveys.

SETTING ASSESSMENT			
CMS Criteria	**NCI Data Analysis**	**90 Day Check List Data Analysis**	**Outcome of Review**
Is integrated in and supports access to the greater community	Identified as 85% and below the low level of compliance threshold.	The data analysis indicated that 85% of the time or better this area is checked yes on the 90 day checklist	While the DDRS does have policies and procedures that support the HCBS rules, a more in-depth analysis will be completed in order to ensure full compliance due to inconsistencies in NCI data between 90 day check list data.
Provide opportunities to seek employment and work in competitive integrated settings	Identified as 85% and below the low level of compliance threshold.	The data analysis indicated that 85% of the time or better this area is checked yes on the 90 day checklist	While DDRS does have policies and procedures that support the HCBS rules, a more in-depth analysis will be completed in order to ensure full compliance due to inconsistencies in inconsistencies in NCI data and 90 day check list data.
Control Personal Resources	Identified as 85% and below the low level of compliance threshold.	The data analysis indicated that 85% of the time or better this area is checked yes on the 90 day checklist	While DDRS does have policies and procedures that support the HCBS rules, a more in-depth analysis will be completed in order to ensure full compliance due to inconsistencies in NCI data and 90 day check list data.
Ensures the individual receives services in the community with the same degree of access as individuals not receiving Medicaid HCBS	No NCI data	The data analysis indicated that 85% of the time or better this area is checked yes on the 90 day checklist	While DDRS does have policies and procedures that support the HCBS rules, a more in-depth analysis will be completed in order to ensure full compliance.
Allow full access to the greater community/Engaged in community life	Identified as 85% and below the low level of compliance threshold.	The data analysis indicated that 85% of the time or better this area is checked yes on the 90 day checklist	While DDRS does have policies and procedures that support the HCBS rules, a more in-depth analysis will be completed in order to ensure full compliance due to inconsistencies in NCI data and 90 day check list data.
Setting is chosen among setting options including non-disability specific settings and options for a private unit in residential settings	Identified as 85% and below the low level of compliance threshold.	This information is not obtained through the 90 day checklist	A review of policies, procedures and data assume vulnerability in this area.
Ensures right to privacy, dignity, and respect and freedom from coercion and restraint		The data analysis indicated that 85% of the time or better this area is checked yes on the 90 day checklist	A review of policies, procedures and data assume compliance in this area.

SETTING ASSESSMENT			
CMS Criteria	**NCI Data Analysis**	**90 Day Check List Data Analysis**	**Outcome of Review**
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 is not obtained through the 90 day checklist	Due to lack of data a more in-depth analysis will be completed in order to determine compliance in this area
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.	Identified as 85% and below the low level of compliance threshold	This information is not obtained through the 90 day checklist	A review of policies, procedures and data assume vulnerability in this area.
Facilitates choice of services and who provides them	Identified as 85% and below the low level of compliance threshold	The data analysis indicated that 85% of the time or better this area is checked yes on the 90 day checklist	While DDRS does have policies and procedures that support the HCBS rules, a more in-depth analysis will be completed in order to ensure full compliance due to inconsistencies in NCI data and 90 day check list data.
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 check list being "n/a" validity of the data is unable to be determined	A more in-depth analysis will be completed in order to ensure full compliance.
Privacy in their unit including entrances lockable by the individual	Identified as 85% and below the low level of compliance threshold	This information is not obtained through the 90 day checklist	A review of policies, procedures and data assume vulnerability in this area.
Freedom to furnish and decorate their unit	No NCI Data Available	This information is not obtained through the 90 day checklist	Due to lack of data a more in-depth analysis will be completed in order to determine compliance in this area.
Control of schedule and activities	Identified as 85% and below the low level of compliance threshold	The data analysis indicated that 85% of the time or better this area is checked yes on the 90 day checklist	While DDRS does have policies and procedures that support the HCBS rules, a more in-depth analysis will be completed in order to ensure full compliance due to inconsistencies in NCI data and 90 day check list data.
Access to food at any time	No NCI Data Available	The data analysis indicated that 85% of the time or better this area is checked yes on the 90 day checklist	While the DDRS does have policies and procedures that support the HCBS rules, a more in-depth analysis will be completed in order to ensure full compliance.

SETTING ASSESSMENT			
CMS Criteria	**NCI Data Analysis**	**90 Day Check List Data Analysis**	**Outcome of Review**
Visitors at any time	Identified as 85% and below the low level of compliance threshold	The data analysis indicated that 85% of the time or better this area is checked yes on the 90 day checklist	While the DDRS does have policies and procedures that support the HCBS rules, a more in-depth analysis will be completed in order to ensure full compliance due to inconsistencies in NCI data and 90 day check list data.
Setting is physically accessible to the individual	No NCI Data available	This information is not obtained through the 90 day checklist	While DDRS does have policies and procedures that support the HCBS rule, a more in-depth analysis will be completed in order to ensure full compliance due to lack of data.
Individuals sharing units have a choice of roommates in that setting	Identified as 85% and below the low level of compliance threshold	Intentionally left blank	A review of policies, procedures and data assume weakness in this area.

SECTION 3: VALIDATION OF PRELIMINARY SETTINGS INVENTORY

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 Individual Experience Survey and site visit verifications. **The table below references the number of individuals in each service description and the approximate number of settings provided through the DDRS waivers**. DDRS has not presumed compliance in any setting type at this time.

The data derived from the Individual Experience Survey will be used to determine compliance of settings with assessment results analyzed by 4/01/16 and site specific assessment results submitted in an amended Statewide Transition Plan by 9/30/16.

PRELIMINARY SETTING INVENTORY		
Service Description	**Number of Individuals**	**Number of Settings**
Living in Own Home or with Family	1900	
Living in Shared Setting	4753	1716
Living in Structured Family Caregiving	202	155
Living Alone	1056	
Participant Assistance and Care	2440	
Facility Habilitation Group*	5357	NOTE - Number of individuals who received the service in 2014
Pre-Vocational Services*	4344	NOTE - Number of individuals who received the service in 2014
Adult Day Services*	254	NOTE - Number of individuals who received the service in 2014
Community Hab - Group*	3286	NOTE - Number of individuals who received the service in 2014
Community Hab Individual*	6945	NOTE - Number of individuals who received the service in 2014
*Duplicative Counts		

SECTION 4: PROPOSED 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 CMS 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 will use the results of the Individual Experience Survey (IES) to identify settings that **may** not be in compliance. Once these settings have been identified and the findings verified through an onsite visit, a corrective action plan will be developed and monitored to ensure the setting comes into compliance within a specified time period. Specific corrective action(s) will be based on the noncompliance findings. For instance, if a person does not have a key to their home, the corrective action would be for the provider to supply one and to ensure that the provider's practice is amended to ensure keys are routinely provided. Or if there is a restriction in place for health or safety reasons that are not documented in the Person Centered Service Plan, the corrective action would be for the Person Centered Service Plan to be updated to include the required information consistent with DDRS policy.

- If a setting has not achieved compliance even after remedial strategies have been employed; by 2018 as outlined in the waiver specific transition plans, a transition plan for relocation will be developed and will include: Identification of the participant(s) requiring transition;
- Reasonable notice to participant(s) and the Individual Support Team regarding the noncompliance, action steps, and procedural safeguards;
- Information, and supports for the participant to make an informed choice of an alternate setting that complies with, or will comply with the HCBS settings requirements;
- Assurances that the participants' services/supports are in place prior to the individual's transition; Identify timeline for participant transitions; and
- Training provided to local districts, case managers, and providers to ensure a smooth transition for the participant(s) requiring transition

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 a corrective action plan, 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 a corrective action plan shall be submitted to the Division or its designee and the time period in which the corrective action plan 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.

Completion and results of the survey are expected by April 2016. Following an analysis and ensuring a public comment period, the updated Statewide Transition Plan will be submitted to CMS to include results of the survey, a detailed description of the setting types, and a description of the assessment activities, how the assessment determined compliance, remedial steps necessary, and time frames of corrective action plans required for providers identified as being out of compliance.

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 the Bureau of Developmental Disabilities Services; 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.

Relocation of Beneficiaries

Reasonable notice will be given to the participant and the Individual Support Team regarding any setting found to be noncompliant. 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 chosing to remain in their current location.

Per 460 IAC 6-29-9 Change in location of residence, when no emergency exists but an individual will need to move, providers are to notify the individual's BDDS service coordinator at least twenty days before any contemplated change of the individual's residence. As outlined in the BDDS Transition Activities Policy, 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 noncompliant 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.

BDDS will ensure reasonable notice and procedural safeguards are provided to anyone needing to transition. Notice will be provided to individuals allowing time to choose a HCBS compliant setting or locate an alternative funding source in order to remain in the HCBS noncompliant setting.

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. Transition activities include transition planning, Person Centered Planning, updating of the Individualized Support Plan, referrals to providers, selection of providers, safety inspections, home visits, as well as the pre and post monitoring process . 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.

Additionally, per **460 IAC 6-7-6 Administrative review**, the provider has 15 days to request Administrative Review, preserving the right to appeal.

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

Heightened Scrutiny

Any residential or non-residential setting that is found to not have the qualities of a home and community based setting will require a site visit to validate heightened scrutiny. These settings may presumptively meet the HCBS requirements and would require DDRS to present evidence to CMS as to how the setting has the qualities of a home and community based setting and not the qualities of an institution. DDRS is looking at 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 so, the setting would not be considered to be compliant with the regulation.

This will require a visit by DDRS to verify that the setting characteristics are community based and having the team provide evidence to DDRS as to how they can ensure the independence and autonomy of the individual(s) in the setting where services are delivered.

In these situations if DDRS believes it can present an indication that the setting meets the requirements, evidence will be submitted to CMS for approval. If DDRS determines the setting cannot meet the requirements with modifications, the relocation process/timelines outlined above will commence.

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

PROPOSED REMEDIATION STRATEGIES – DDRS

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. 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. 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. Once the survey has been validated IIDC will disseminate it electronically to providers throughout Indiana to complete with the individuals they serve. 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. The aggregate results will be disseminated to stakeholders throughout the system.	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 Survey: 01/2015 Comprehensive Survey: 01/2016 Survey Results: 04/2016	Survey Document Aggregate and site specific survey results	DDRS/BDDS internal staff, OMPP, DDRS Advisory Council, IIDC, Pilot group. Providers, Individuals Served
Site Specific Assessment	Based on the results of the preliminary settings inventory and statewide survey, DDRS will identify specific sites that will need further review prior to the completion of the comprehensive setting results document. In addition, specific sites will be identified for data validation.	Validation of the compliance of the specific sites will be determined by CMS guidance as to what is and is not a community setting. 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. DDRS will utilize this guidance in developing and establishing criteria for engaging in site specific assessments.	7/31/2016	Not yet available	DDRS or its contracted entity.

Action Item	Description	Remediation Strategies	Timeline for Completion	Source Document	Key Stakeholders
Evaluation of Collected Data	After completion of the site specific surveys, DDRS will evaluate all collected data	The information gathered will be utilized to develop a Comprehensive Settings Result Document	8/15/2016	Aggregate and site specific survey results	DDRS/BDDS/ IIDC
Comprehensive Setting Results	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.	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.	8/31/2016	Not yet available	DDRS/BDDS internal staff, OMPP, DDRS Advisory Council, IIDC, Advocacy groups, Providers, Participants, Self-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	04/2018	Review of current enrollment/re-enrollment process	DDRS/BDDS internal staff, OMPP, Providers
Development of a Corrective Action Process	The development of a provider corrective action process/plan is to ensure providers are in compliance with HCBS requirements. Once a provider has been identified as non-compliant,	Provider training on the HCBS requirements Deadlines for completion & periodic status update	04/2018	To Be Determined	DDRS/BDDS internal staff, OMPP

Action Item	Description	Remediation Strategies	Timeline for Completion	Source Document	Key Stakeholders
	DDRS will work to develop a provider remediation process and framework of plans:	requirements for significant remediation activities			
Develop process for Provider Sanctions and Disenrollment 's	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.	3/2017	To be determined	DDRS/BDDS staff, Self-Advocates, individuals served, Providers, Advocacy groups

SECTION 5: KEY STAKEHOLDERS AND OUTREACH

As DDRS moves forward in further assessing the system's compliance with HCBS rules DDRS intends 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 posted the CMS approved preliminary transition plan specific to the Community Integration and Habilitation Waiver renewal online with a notation that the comprehensive plan would be posted for public comment. In addition, announcements of the public comment period are 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 other stakeholders such as the ARC of Indiana, INARF, and providers to promote public input though various public meetings including quarterly provider meetings.

DDRS is committed to a high level transparency moving forward and will 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 ADDICITION - YOUTH (DMHA-Y)
HCBS Programs
Psychiatric Residential Treatment Facility (PRTF) Transition Waiver – 1915(c)
Child Mental Health Wraparound (CMHW) – 1915(i)

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.

SECTION 1: ASSESSMENT OF SETTINGS

From May through September 2014 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 analysis included a crosswalk of Indiana Statute, Indiana Administrative Code, reviews of Home and Community Based Services policy, provider manuals, provider trainings, and review of licensing rules and regulations.

Through this process, DMHA has identified areas where specific setting criteria are stated, and in these areas are compliant with federal regulation; but also areas where state standards are silent or only imply requirement of compliance:

IAC

- In the general provisions section of IAC (**405 IAC 5-21.7-1 General provisions)** related to the HCBS program, it is stated that the purpose of the program is to "enable (the participant) to benefit from receiving intensive wraparound services within their home and community with natural family supports."
- In the definitions(**405 IAC 5-21.7-2 Definitions**), IAC goes on to describe eligible participants in the program as "living in their family in the community" and
- One of the purposes of the plan of care (**405 IAC 5-21.7-6 Individualized plan of care)** is to assist the participant to "remain in the home or community."
- The IAC sections of Habilitation, and Training and Support for the Unpaid Caregiver services, it is plainly stated that services must take place "in the participant's home or other community-based setting."

While these implications are present, IAC will be updated to include:

- Specifying that living with their family in a compliant community setting as a requirement for eligibility for the program,
- The reasons for denials (non-compliant living setting);
- Documentation of a compliant setting required as a part of the initial assessment, and
- On-going verification of settings compliance as relates to the consumer/applicants living situation, both annually, and as part of the ad hoc documentation of any change in the consumers living situation.
- An addition will be made to the section of code addressing coverage requirements and limits, and
- General service provisions.

The Application for Eligibility and Approval Process

A review was conducted of the application for eligibility and approval process including the DMHA approved behavioral assessment tool. The application for eligibility (**405 IAC 5-21.7-3)** includes the submission of the behavioral assessment tool by the Access Site (initial application for CMHW) and/or the Wraparound Facilitator (semi-annual reevaluation for eligibility for CMHW and PRTF Transition Waiver). As a part of this assessment, the evaluator meets with the family "face-to-face." Demographic data is collected as part of the assessment, and includes a description of the residential setting. This is reviewed by DMHA as part of the eligibility for services. Participants enrolled in these programs must reside in a community based setting. The application process for both programs, require the living situation is clearly documented for

the potential applicant. Any applicant that is not currently living in a community based setting is not eligible for these services. Group Homes and residential facilities are licensed by Indiana Department of Child Services as a child caring institution; therefore, individuals living in these environments are not eligible for home and community based services.

The only setting in which an applicant/consumer may reside and be approved for services is:

- In the family home in the community, or
- In a single family type foster home in the community.

Applicants in any other type of residential setting are denied based on the setting. A denial based on a non-compliant setting supports and demonstrates DMHA's compliance with federal standards, the standard needs to be made more explicit. To address this in the eligibility process, DMHA will update the attestation form.

At the time of application, initially and at the time of renewal, the family is given the choice of either institutional or home and community-based options, which includes the evaluator's explanation of these options. This and other assurances, such as choice of providers and of services, is documented through a signed document referred to as the attestation form.

DMHA will update this form to include the assurance that the participant understand the differences in settings options and resides and receives services in compliant settings.

Regarding the residential setting of the home of a licensed foster family, the Indiana Department of Child Services licenses all family foster homes, this includes standard foster care homes, special needs foster care homes and therapeutic foster care homes as defined in Indiana Code 31-27-4, Regulation of Foster Homes. According to the DCS Indiana Child Welfare Policy Manual, Chapter 12: Foster Family Home Licenses, the policy requires that foster homes meet the following requirements related to the foster care setting; 1)own or rent your own home that meets physical safety standards, and 2) permit initial and on-going home visits from the Regional Licensing Specialist. The Department of Child Services, its designee, or a licensing worker conducts a minimum of two (2) visits to each foster family for the purpose of assessing the physical environment of the home and engaging in a thoughtful dialogue with all members of the household about foster parenting or adoption.

DMHA and DCS have regular, ongoing meetings to discuss relevant policy changes affecting both agencies. Should the Indiana Code relating to DCS be modified, DMHA will work closely with DCS to ensure that the changes are consistent with the HCBS settings final rule.

Policy, Provider Manuals, Provider Training, and Licensing Rules and Regulations

A review of these materials (**PRTF Transition Waiver Provider Manual**; **Child Mental Health Wraparound Services Provider Manual**; **DMHA Home and Community Based Wraparound Services Provider Orientation Presentation**; **Wraparound Service Habilitation Training materials; Training and Support for the Unpaid Caregiver Training materials; Respite Trainings; and Wraparound Facilitator Training materials**) found language generally reflective of IAC as noted above, with strong emphasis on settings where services may be provided, including specifying home and community settings, and also prohibiting service delivery in settings which are institutional and/or segregated in nature, among other things.

In the areas of service definitions, manuals, and training materials, DMHA is in full compliance with the federal requirements.

Additionally, it is specifically noted in the manuals and training materials that any out of home placement of a little as 24-hours, including among other things acute hospital stays, result in the suspension of services and the submission of documentation to DMHA suspending services until the participant returns home. If the participant does not return home and resume services within 30-days, participation in the program is terminated.

Services

The following services are available through one or both of these programs:

- **Consultative Clinical and Therapeutic Services** (PRTF): Improve participant's independence and inclusion in his or her community. These services are provided in the participants own home or in the community at large, as specified in the CMS approved applications, IAC, provider manuals, and Training materials, and are in full compliance with federal requirements.

- **Flex Funds** (PRTF): Purchase variety of one time or occasional goods that is supported by rationale as to how that expenditure will assist the participant to remain in the home and/or community.

- **Habilitation** (PRTF, CMHW): Enhance a participant's level of functioning through one-on-one support. These services are provided in the participants own home or in the community at large, as specified in the CMS approved applications, IAC, provider manuals, and Training materials, and are in full compliance with federal requirements.

- **Non-Medical Transportation** (PRTF): Transportation for participants to gain access to community services or activities. These services are provided in the participants own home or in the community at large, as specified in the CMS approved applications, IAC, provider manuals, and Training materials, and are in full compliance with federal requirements.

- **Respite**[1] (PRTF, CMHW): Short-term relief for person who normally provides care for the participant.

- **Training and Support for Unpaid Caregivers** (PRTF, CMHW): Provide education and support to the unpaid caregiver of a participant. These services are provided in the participants own home or in the community at large, as specified in the CMS approved applications, IAC, provider manuals, and Training materials, and are in full compliance with federal requirements.

- **Wraparound Facilitation/Care Coordination** (PRTF, CMHW): Comprehensive service that follows a series of steps and is provided in the community through a Child and Family Wraparound Team. These services are provided in the participants own home or in the community at large, as specified in the CMS approved applications, IAC, provider manuals, and Training materials, and are in full compliance with federal requirements.

- **Wraparound Technician** (PRTF): Monitor progress and assist participant or their family with gaining knowledge or access to community based resources, services or activities. These services are provided in the participants own home or in the community at large, as specified in the CMS approved applications, IAC, provider manuals, and Training materials, and are in full compliance with federal requirements.

All services offered by PRTF and CMHW are individualized services provided in one of the following settings;

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

Services in these settings are individualized according to the participant's needs as outlined in the plan of care. 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 are approximately 20 participants receiving services through the PRTF Waiver and approximately 200 through the CMHW.

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.

[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 Wraparound process includes four phases: engagement, plan development, plan implementation and transition. The wraparound facilitator participates in extensive training to ensure that family voice and choice is consistent throughout all four phases of the wraparound process.

- The engagement phase includes discussion of the family's needs, hopes, dreams, concerns and strengths. This phase includes telling the family story and developing a vision for their future. The Wraparound Facilitator assists the family with identifying potential participants of their child and family team that will guide and support them through the entire process.
- The plan development phase includes developing a mission statement that will help the child and family team with agreeing on what they will be working on together, reviewing the family's needs and beginning discussions about how to utilize strengths to overcome the needs.
- The implementation phase involves reviewing accomplishments, assessing what is or is not working, adjusting items that are not working in the current plan and assigning new tasks to the child and family team participants.
- The transition phase is occurring throughout the life of the plan and the family's involvement with wraparound. The child and family team will consistently review and support the family to ensure that a transition off of services is appropriate. The family will end the wraparound process with more knowledge and access to community based resources as well as emergency services should they be needed in the future.

SECTION 2: VALIDATION OF STATE ASSUMPTION

To further validate compliance with the rule regarding HCBS settings, DMHA conducted a survey 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. The survey will be required for completion for each active participant by the Wraparound Facilitator (conflict free case coordinator) at a child and family team meeting. The development of the youth member survey has been finalized and the completed surveys were submitted to DMHA on March 11, 2016. These surveys will be used to validate the results of DMHA's systemic assessments and linked to specific sites. DMHA will complete a detailed review of each member survey and the final results will be available by May 31, 2016.

The development of the survey to make it appropriate for youth required consideration. 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 family home should only be living in single family type foster homes if enrolled in the program. In the case of child in a 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. Additionally, questions were included to be answered by the conflict-free Wraparound Facilitator, such as descriptor of the living and school environments. Since DMHA anticipates that most, if not all, participants will be found to live in single family homes in the community with a minimal number of youth in foster care, DMHA will analyze and compare the findings of youth living in family homes with youth living in foster homes to determine if there are fundamental differences between the settings. Any systemic differences between these populations will be reviewed for indicators of institutional qualities, and if found so, considered as potentially requiring heightened scrutiny.

If, as a result of this survey, a setting is found to be potentially out of compliance, DMHA staff would conduct an on-site review of the setting to determine if the setting required remediation to bring it into compliance. If the setting involved a licensed DCS foster care setting that could potentially be institutional in nature, it would be out of compliance with DCS standards as well. DMHA would work in conjunction with DCS to review the setting. 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. The review of any potentially non-compliance settings will be completed by June 30, 2016.

The results of the review would be analyzed and communicated to the interested parties no by July 29, 2016. 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 compliance setting within 90-day of receipt of notification of non-compliance. DMHA worked in

cooperation with DCS to determine 90-days as a reasonable timeframe for remediation and relocation if necessary of participants.

In the event that the youth resides with family, but the family is living in a setting that does not fully comply with federal and state requirements, 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 discharged no later than July 31, 2017.

Ongoing Compliance

DMHA currently conducts field audits that include a review of the participant's current living arrangement to ensure compliance. The field audits can occur in the participant's home, at the provider's office or at DMHA. The audits include at least one of the following: a review of the case file, participation in a child and family team meeting or supervision between the Wraparound Facilitator and DMHA consultant. These reviews included a review of settings where services are provided as well as settings where participants reside. If compliance issues are found, DMHA consultant issues an informal adjustment or corrective action depending on the situation. In addition, 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.

DMHA will continue its current compliance reviews and monitoring activities beyond March 2019 to ensure continued compliance with the HCBS settings requirements.

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.

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

On-site audit reviews by DMHA will also continue and confirmation of the setting's compliance will continue to be included.

Finally, 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. In order to ensure ongoing review of setting compliance, the Wraparound Facilitators are in the participants' home at least once per month; if the participant is discovered to be in an institutional setting, the Wraparound Facilitator will immediately notify DMHA. 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.

DMHA plans to modify IAC and draft a policy that states that eligible participants must live and be served in compliant HCBS settings in order to strengthen the ongoing compliance with HCBS rules as noted in the system analysis.

SECTION 3: REMEDIATION STRATEGIES AND ONGOING COMPLIANCE

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.	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.	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	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 of notification of non-compliance.	Communications distributed by July 29, 2016.	Aggregate and site specific survey results	Participants and families; Foster parents; Child Placement Agencies; Providers; Conflict free Wraparound Facilitators, DMHA and DCS staff.
Site Specific Remediation and/or Beneficiary Relocation	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	To be determined by the Corrective Action Plan with no less often than monthly monitoring by DMHA.	Corrective Action Plans submitted by provider must come into compliance no later than 90-days from the date of the plan's acceptance by DMHA. Where the non-	Corrective Action Plans; Monthly Child and Family Team meeting notes.	Participants and families; Foster parents; Child Placement Agencies; Providers; Conflict free Wraparound Facilitators, DMHA and DCS staff.

	requirements, DMHA will require the participant modify their setting or relocate to a compliant setting, or be transitioned to appropriate services.		compliance involves the family living in a setting that does not fully comply, 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 discharged no later than July 31, 2017.		
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.	December 31, 2017	Updated, promulgated IAC.	Participants and families; Foster parents; Child Placement Agencies; Providers; Conflict free Wraparound Facilitators, State Medicaid DMHA and DCS staff.
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.	December 31, 2017	Updated, promulgated IAC.	Participants and families; Foster parents; Child Placement Agencies; Providers; Conflict free Wraparound Facilitators, State

					Medicaid DMHA and DCS staff.
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.	December 31, 2017	Updated, promulgated IAC.	Participants and families; Foster parents; Child Placement Agencies; Providers; Conflict free Wraparound Facilitators, State Medicaid DMHA and DCS staff.
Update Indiana Administrative Code 405 IAC 5-21.7, cont.	On-going verification of settings compliance as relates to the consumer/applicants living situation, both annually, and as part of the ad hoc documentation of any change in the consumers living situation.	Work with state agencies and lawmakers with public input to draft updated language.	December 31, 2017	Updated, promulgated IAC.	Participants and families; Foster parents; Child Placement Agencies; Providers; Conflict free Wraparound Facilitators, State Medicaid DMHA and DCS staff.
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.	July 1, 2016	Updated Attestation form	DMHA
Ongoing Compliance	Field audits that include a review of the participant's current living arrangement 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, participation in a child and family team meeting or supervision between the Wraparound Facilitator and DMHA consultant. These reviews included a review of settings where services are provided as	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.	Site review reports.	Participants and families; Foster parents; Child Placement Agencies; Providers; Conflict free Wraparound Facilitators, DMHA and DCS staff.

		well as settings where participants reside.			
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 concept 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.	Implemented by September 30, 2016. On-going indefinitely. 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; training certificates.	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 afterward to ensure understanding.	Implemented by September 30, 2016.	Webinar recording and training certificates.	DMHA, DMHA HCBS Providers.

SECTION 4: KEY STAKEHOLDERS AND OUTREACH

DMHA is posting a copy of the Statewide Transition Plan upon revision to its website and sending an email to notify stakeholders that it is 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.

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 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 Request for Additional Information (RAI) 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 providers.

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.

Settings Included in the Statewide Transition Plan

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.

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.

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 1: 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)** 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 federal HCBS final rule.

DMHA-A Systemic Assessment Crosswalk

Final Rule Setting Type	Final Rule 42 CFR 441.710(a)(1)	Applicable Indiana Code and Program Policy	Compliance with Final Rule? Y/N/Silent	Remediation Timeline	Ongoing Compliance Assurances
All settings (residential and non-residential)	(i) The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.	**AMHH:** IC 12-8-6.5-5; IC 12-15 405 IAC 5-21.6 Section 4(a)(6) Adult Mental Health Habilitation Provider Module: Section 2 and Section 6	Y	Systemically complies. Remediation strategy not needed.	Review policies every 6 months for compliance.
		BPHC: IC 12-8-6.5-5; IC 12-15 405 IAC 5-21.8 Section 4(A) Behavioral and Primary Healthcare Coordination Services Provider Module: Section 4 and Section 12	Y	Systemically complies. Remediation strategy not needed.	Review policies every 6 months for compliance.
All settings (residential and non-residential)	(ii) The setting is selected by the individual from among setting options, including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.	**AMHH:** IC 12-8-6.5-5; IC 12-15 405 IAC 5-21.6 Section 4(a)(6) Adult Mental Health Habilitation Provider Module: Section 2 and Section 6	Y	Systemically complies. Remediation strategy not needed.	Review policies every 6 months for compliance.
		BPHC: IC 12-8-6.5-5; IC 12-15 405 IAC 5-21.8, Section 3(d) Behavioral and Primary Healthcare Coordination Services Provider Module: Section 4 and Section 12	Y	Systemically complies. Remediation strategy not needed.	Review policies every 6 months for compliance.
All settings (residential and non-residential)	(iii) Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.	**AMHH:** IC 12-8-6.5-5; IC 12-15 405 IAC 5-21.6 Section 4(6)(A) Adult Mental Health Habilitation Provider Module: Section 2 and Section 6	Y	Systemically complies. Remediation strategy not needed.	Review policies every 6 months for compliance.
		BPHC: IC 12-8-6.5-5; IC 12-15 405 IAC 5-21.8 Section 4(4)(A) Behavioral and Primary Healthcare Coordination Services Provider Module: Section 4 and Section 12	Y	Systemically complies. Remediation strategy not needed.	Review policies every 6 months for compliance.
All settings (residential and non-residential)	(iv) Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.	**AMHH:** IC 12-8-6.5-5; IC 12-15 405 IAC 5-21.6 Section 4(6)(A) Adult Mental Health Habilitation Provider Module: Section 2 and Section 6	Y	Systemically complies. Remediation strategy not needed.	Review policies every 6 months for compliance.
		BPHC: IC 12-8-6.5-5; IC 12-15 405 IAC 5-21.8 Section 4(4)(A) Behavioral and Primary Healthcare Coordination Services Provider Module: Section 4 and Section 12	Y	Systemically complies. Remediation strategy not needed.	Review policies every 6 months for compliance.

Final Rule Setting Type	Final Rule 42 CFR 441.710(a)(1)	Applicable Indiana Code and Program Policy	Compliance with Final Rule? Y/N/Silent	Remediation Timeline	Ongoing Compliance Assurances
All settings (residential and non-residential)	(v) Facilitates individual choice regarding services and supports, and who provides them.	**AMHH:** IC 12-8-6.5-5; IC 12-15 405 IAC 5-21.6 Section 3(d) Adult Mental Health Habilitation Provider Module: Section 7	Y	Systemically complies. Remediation strategy not needed.	Review policies every 6 months for compliance.
		BPHC: IC 12-8-6.5-5; IC 12-15 405 IAC 5-21.8 3(d)(2) Behavioral and Primary Healthcare Coordination Services Provider Module: Section 6	Y	Systemically complies. Remediation strategy not needed.	Review policies every 6 months for compliance.
(vi) In a provider-owned or controlled residential setting, in addition to the above qualities at paragraphs (a)(1)(i) through (v) of this section, the following additional conditions must be met:					
All provider owned, controlled, or operated residential settings	(A) The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law;	**AMHH:** IC 12-8-6.5-5; IC 12-15 405 IAC 5-21.6 Section 4(6)(A) Adult Mental Health Habilitation Provider Module: Section 2 and Section 6	Y	Systemically complies. Remediation strategy not needed.	Review policies every 6 months for compliance.
		BPHC: IC 12-8-6.5-5; IC 12-15 405 IAC 5-21.8 Section 4(4)(A) Behavioral and Primary Healthcare Coordination Services Provider Module: Section 4 and Section 12	Y	Systemically complies. Remediation strategy not needed.	Review policies every 6 months for compliance.
All provider owned, controlled, or operated residential settings	(B) 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; and (*3*) Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.	**AMHH:** IC 12-8-6.5-5; IC 12-15 405 IAC 5-21.6 Section 4(6)(A) Adult Mental Health Habilitation Provider Module: Section 2 and Section 6	Y	Systemically complies. Remediation strategy not needed.	Review policies every 6 months for compliance.
		BPHC: IC 12-8-6.5-5; IC 12-15 405 IAC 5-21.8 Section 4(4)(A) Behavioral and Primary Healthcare Coordination Services Provider Module: Section 4 and Section 12	Y	Systemically complies. Remediation strategy not needed.	Review policies every 6 months for compliance.

Final Rule Setting Type	Final Rule 42 CFR 441.710(a)(1)	Applicable Indiana Code and Program Policy	Compliance with Final Rule? Y/N/Silent	Remediation Timeline	Ongoing Compliance Assurances
All provider owned, controlled, or operated residential settings	(C) Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time;	**AMHH:** IC 12-8-6.5-5; IC 12-15 405 IAC 5-21.6 Section 4(6)(A) Adult Mental Health Habilitation Provider Module: Section 2 and Section 6	Y	Systemically complies. Remediation strategy not needed.	Review policies every 6 months for compliance.
		BPHC: IC 12-8-6.5-5; IC 12-15 405 IAC 5-21.8 Section 4(4)(A) Behavioral and Primary Healthcare Coordination Services Provider Module: Section 4 and Section 12	Y	Systemically complies. Remediation strategy not needed.	Review policies every 6 months for compliance.
All provider owned, controlled, or operated residential settings	(D) Individuals are able to have visitors of their choosing at any time;	**AMHH:** IC 12-8-6.5-5; IC 12-15 405 IAC 5-21.6 Section 4(6)(A) Adult Mental Health Habilitation Provider Module: Section 2 and Section 6	Y	Systemically complies. Remediation strategy not needed.	Review policies every 6 months for compliance.
		BPHC: IC 12-8-6.5-5; IC 12-15 405 IAC 5-21.8 Section 4(4)(A) Behavioral and Primary Healthcare Coordination Services Provider Module: Section 4 and Section 12	Y	Systemically complies. Remediation strategy not needed.	Review policies every 6 months for compliance.
All provider owned, controlled, or operated residential settings	(E) The setting is physically accessible to the individual	**AMHH:** IC 12-8-6.5-5; IC 12-15 405 IAC 5-21.6 Section 4(6)(A) Adult Mental Health Habilitation Provider Module: Section 2 and Section 6	Y	Systemically complies. Remediation strategy not needed.	Review policies every 6 months for compliance.
		BPHC: IC 12-8-6.5-5; IC 12-15 405 IAC 5-21.8 Section 4(4)(A) Behavioral and Primary Healthcare Coordination Services Provider Module: Section 4 and Section 12	Y	Systemically complies. Remediation strategy not needed.	Review policies every 6 months for compliance.

SECTION 2: SITE SPECIFIC SETTING 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) SPA 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 is implementing separate site-specific assessment plans for POCO residential settings, non-POCO residential settings, and other non-residential settings.

Section 2-A: Estimated Number of Settings That Fall Into Each HCBS Compliance Category

DMHA initially identified 164 POCO residential settings throughout the state of Indiana, based on a provider self-assessment conducted between September 2015 and January 2016. The number of identified POCO residential settings statewide has grown to 177, as a result of ongoing data collection since January 2016. From a preliminary review of the provider self-assessment data, DMHA estimates that most of these settings will require some degree of remediation to come into full compliance with HCBS final rule. The provider self-assessment data has not been validated, and on-site assessments are scheduled to begin in July 2016. The final determination as to which existing POCO residential settings fall into each of the four HCBS compliance categories (fully complies, needs modifications to comply, cannot comply, presumed institutional but targeted for heightened scrutiny) will be made no later than May 15, 2016, and the results communicated to provider agencies no later than May 30, 2016.

DMHA estimates that there are 2528 non-POCO settings where AMHH and BPHC members are currently residing. DMHA cannot provide firm estimates at this time, but expects that the overwhelming majority (90% or greater) of the non-POCO residential settings in which these members live are already fully compliant with the federal HCBS requirements. The remainder is expected to require some degree of remediation in order to become fully compliant with federal HCBS requirements. DMHA will be implementing a comprehensive screening, assessment, and remediation plan for non-POCO settings beginning in April 2016. A revised estimate of how many existing non-POCO residential settings fall into each of the four HCBS compliance categories (fully complies, needs modifications to comply, cannot comply, presumed institutional but targeted for heightened scrutiny), if required, will be able to be made after approximately six months of non-POCO setting data has been collected.

DMHA has identified at least 143 provider-operated non-residential settings throughout the state of Indiana where HCBS services may be delivered, all of which are expected to already be fully compliant with the federal HCBS final rule for non-residential settings.

Section 2-B: Methodology and Milestones for Site-Specific Assessments: POCO Residential Settings

All identified POCO residential settings are being initially assessed for 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 will also be screened for institutional qualities by a combination of DMHA desk audit and on-site assessments.

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. Provider self-assessments were completed between September 3, 2015 and January 25, 2016. 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 177), and features of those settings as they pertain to HCBS requirements were reported.

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. Resident surveys were distributed and returned between February 1, 2016 and March 15, 2016. An on-line survey tool was accessible by agency staff at each of the 25 CMHCs in Indiana. 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.

Validation of the provider self-assessment will occur by cross-walking the resident survey responses with the provider self-assessments. The responses will be 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. 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) will be accepted as valid. Compliance categories for which the provider response and the resident response are not in agreement that the federal HCBS final rule requirement is met will be further investigated through desk audit, follow-up contact with the provider, and/or DMHA site visits (to include resident interviews) beginning July 1, 2016.

Screening for institutional qualities will be completed for each identified POCO residential setting prior to or during the validation cross-walk for the provider self-assessments and resident surveys, but in all cases no later than May 15, 2016. DMHA staff will enter the physical address for each identified POCO residential setting into MapQuest, Google Maps, or another Internet open-source mapping and satellite imaging service. The locations will be cross-referenced with the street addresses of known publicly or privately operated facilities that provide inpatient institutional treatment. This will preliminarily identify settings which may be presumed institutional, as defined in 42 CFR 441.710(a)(2)(v).

Preliminary Compliance Category Assignment for POCO Residential Settings

Each identified POCO residential setting will be preliminarily assigned to one of three HCBS compliance categories (Fully Compliant, Needs Modifications, and Potential Presumed Institutional) no later than May 15, 2016, and the results communicated to provider agencies no later than May 30, 2016.

POCO residential settings will be initially preliminarily assigned to the category "Fully Compliant" if:

1. There are no qualities of the setting that render it presumptively institutional, as defined in 42 CFR 441.710 (a)(2)(v)
2. The provider self-assessment and the resident survey(s) must be in agreement that each of the five qualities of home and community-based settings specified in 42 CFR 441.705(a)(1)(i-v) are present (5 out of 5)
3. The provider self-assessment and the resident survey(s) must be in agreement that each of the five additional conditions for POCO residential settings specified in 42 CFR 441.705(a)(1)(vi) are present (5 out of 5)

POCO residential settings will be preliminarily assigned to the category "Needs Modifications" if:

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) are not in agreement that each of the five qualities of home and community-based settings specified in 42 CFR 441.705(a)(1)(i-v) are present (less than 5 out of 5), OR
3. The provider self-assessment and the resident survey(s) are not in agreement that each of the five additional conditions for POCO residential settings specified in 42 CFR 441.705(a)(1)(vi) are present (less than 5 out of 5)

POCO residential settings preliminarily assigned to the category "Potential Presumed Institutional" will be scheduled for a joint DMHA/provider agency on-site assessment to definitively establish whether the setting is presumed institutional, and to determine whether DMHA will submit evidence for heightened scrutiny or allow the institutional presumption to stand. The on-site assessments and final determination for all "Potential Presumed Institutional" POCO residential settings will be made and communicated to the provider agency no later than February 1, 2017.

Section 2-C: Methodology and Milestones for Site-Specific Assessments: Non-POCO Residential Settings

Non-POCO residential settings began to be assessed 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. Using this method, initial assessment of all non-POCO residential settings will have been completed no later than March 31, 2017. For non-POCO residential settings which are identified through this process as not being fully compliant with the federal HCBS final rule, DMHA will initiate the remediation process.

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 the screening tool has been completed with the member, before the application may be submitted (all AMHH and BPHC applications are submitted online). The consumer-signed 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 screening tool 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 will be 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 will be required to select from the following list of community-based residential setting descriptions:

(1) Homeless
(2) Private/Independent Home
(3) A non-POCO residential setting that is fully compliant with the HCBS final rule
(4) A non-POCO residential setting that is not fully compliant with the HCBS final rule
(5) A POCO residential setting that is fully compliant with the HCBS final rule
(6) A POCO residential setting that is not fully compliant with the HCBS final rule
(7) 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 4.

Section 2-D: Methodology and Milestones for Site-Specific Assessments: Provider-Operated Non-Residential Settings

Non-residential settings in which some HCBS services are or are expected to be provided (for example, CMHC outpatient clinics, community rooms, etc.) will be assessed by provider self-report no later than May 31, 2016. For all provider-operated, 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. The timeframe for POCO non-residential assessment was changed from April 1-30, 2016, to May 1-31, 2016, based on public comment from providers expressing concern about the compressed assessment schedule.

A combined identification and provider self-assessment tool will be 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 medicaid.gov HCBS website. The self-assessment tool will be made available to each of the 25 CMHCs via an open-source online data collection service (link forthcoming) no later than May 1, 2016. CMHCs will be 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. CMHCs will be required to attest that each of the identified settings is fully compliant with the federal HCBS final rule, or, if not fully compliant, to indicate which HCBS characteristics are not present at the site. The self-assessments will be due to DMHA no later than May 31, 2016.

Based on the results of the provider self-assessment, each of the identified settings will be preliminarily designated "Assessed as Fully Compliant" or "Assessed as Not Fully Compliant". Designations will be made by DMHA no later than June 30, 2016, and results communicated to providers no later than July 15, 2016. For settings designated "Assessed as Not Fully Compliant", DMHA will initiate the remediation process. Settings designated "Assessed as Fully Compliant" will be validated on-site by the DMHA 1915(i) State Evaluation Team during scheduled SFY2017 QA/QI site visits.

For all setting types, final HCBS compliance designations will be made once all remediation activities (if required) are completed, and/or a determination has been made by CMS for "Presumed Institutional" settings which have been submitted for heightened scrutiny.

SECTION 3: 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.

All existing POCO residential settings that are preliminarily assessed to belong to an HCBS compliance category associated with a need for remediation (Needs Modifications and Potential Presumed Institutional) will be identified no later than May 15, 2016, and the results will be communicated to provider agencies no later than May 30, 2016. All existing provider-operated, non-residential, non-institutional settings that are initially assessed to belong to an HCBS compliance category associated with a need for remediation (Needs Modifications and Potential Presumed Institutional) will be identified no later than June 30, 2016, and the results will be communicated to provider agencies no later than July 15, 2016. Non-POCO residential settings which may not be fully compliant with federal HCBS requirements will be identified on an ongoing basis beginning April 1, 2016 and will be complete for all existing settings no later than March 31, 2017.Proposed remedial actions for all identified settings will be 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, in partnership between DMHA, members and provider agencies. 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, Indiana chapter (including the Mental Health Ombudsman program staff).

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, will be issued an HCBS Setting Action Plan. DMHA will issue a preliminary HCBS Setting Action Plan to the CMHC providing AMHH/BPHC services at that setting, identifying the areas of non-compliance for the setting and establishing up to a 6-month deadline for completion of remediation activities. 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 must be submitted to DMHA for review no later than 30 calendar days from the date the CMHC was issued the preliminary plan.

Member Transition Plan: Some members may choose to make changes in their living setting or service plans, 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 collaboratively with the member, their family/guardian/caretakers, and the AMHH/BPHC provider agency. 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 Customer Service Line, Indiana Protection and Advocacy Services, and the Mental Health America (Indiana chapter) Mental Health Ombudsman program. 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 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. The provider is required to assist the member in identifying other possible living settings that are HCBS compliant and available to the member, as well as other treatment options that may meet their needs if they choose to discontinue HCBS services. 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 be HCBS compliant.

POCO Residential Settings Designated as "Needs Modifications"

DMHA will inform the responsible CMHC of a POCO residential setting's designation as "Needs Modifications" to become fully compliant with federal HCBS requirements within 15 calendar days of the DMHA determination. (For the initial roll out of the assessment /remediation process, all notifications will be made no later than May 30, 2016.) The notification will identify areas of non-compliance with federal HCBS requirements as indicated by the validated site-specific assessment and specify required actions of the CMHC to be completed within 30 calendar days from date of notification. The required actions will 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.

If at any time the provider decides not to complete modifications to bring the setting into full HCBS compliance, or does not complete remediation by the end of the designated timeframe, the HCBS Setting Action Plan will end and the CMHC, together with the member and their family/guardian/caretaker, will initiate a Member Transition Plan for all affected members.

POCO Residential Settings Designated as "Potential Presumed Institutional"

POCO residential settings assigned to the category "Potential Presumed Institutional" will be scheduled for a joint DMHA/provider agency on-site assessment. The purpose of this on-site assessment is 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 for heightened scrutiny or allow the institutional presumption to stand. The on-site assessment will be completed no later than December 31, 2016, either in conjunction with regularly scheduled DMHA 1915(i) State Evaluation Team QA/QI visits or via a site visit specifically to address the "Potential Presumed Institutional" designation. The final determination for all "Potential Presumed Institutional" POCO residential settings will be made by DMHA and communicated to the provider agency no later than 15 calendar days from the date of the site visit.

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 Complies" 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 will assess how heightened scrutiny will be addressed once more information from assessments and validation of results is available.

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 will be identified on a case-by-case basis, using the screening and assessment process embedded in the AMHH and BPHC application process beginning April 1, 2016. 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 confirm 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 Settings 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. 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 at any time the SOA becomes unable or unwilling to make necessary remediation, or does not complete remediation by the end of the designated timeframe, the HCBS Setting Action Plan will end and the CMHC, together with the affected member(s) and their family/guardian/caretaker, will initiate a Member Transition Plan.

If the consumer chooses to live in the HCBS non-compliant setting, and/or does not relocate to an HCBS-compliant setting within the timeframe specified in the Member Transition Plan, the SET will end the member's program eligibility status in AMHH and/or BPHC HCBS programs. The consumer may 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.

Oversight of Remediation Activities and Milestones

DMHA will monitor HCBS Setting Action Plans and Member Transition Plans 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) SPA, 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.

SECTION 4: MONITORING OF SETTINGS

Ongoing monitoring of and compliance with HCBS requirements beyond the March 2019 implementation deadline will be facilitated by integrating HCBS compliance activities with required 1915(i) quality assurance/quality improvement (QA/QI)

on-site assessments. 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 will involve:

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 provider-controlled non-residential settings. Beginning in July 2016, during each scheduled CMHC QA/QI site visit, at least one provider-operated 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 5: 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 has 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 host webinars for providers, members, and stakeholders such as NAMI, Key Consumers, Indiana Council of CMHC's, and Mental Health America, to educate on the transition plan pieces specific to the DMHA adult population. 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 comments. DMHA will also continue working in partnership with members and advocates, providers and other stakeholders beyond March, 2019 to ensure communication and compliance with the HCBS settings rules.

PUBLIC INPUT

This modified Statewide Transition Plan was open for public comment for **30 days, March 7, 2016 through April 6, 2016.** The comment period allows all HCBS members, potential members, providers and other stakeholders an opportunity to provide input to the plan.

This modified 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 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. The modified Statewide Transition Plan is due to CMS by April 30, 2016. Once submitted, the updated Statewide Transition Plan will be posted on FSSA's Home and Community-Based Services Final Rule website.

The Statewide Transition Plan will be posted online and available for review for the duration of the transition period.

States must be in full compliance with the federal requirements by the time frame approved in the Statewide Transition Plan but no later than March 17, 2019.

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 two adult 1915(c) programs; the Aged and Disabled (A&D) Waiver and the Traumatic Brain Injury (TBI) Waiver. The comments resulted in changes on pages 9, 11, 12, 15, and 39.

PUBLIC COMMENTS:

Comment: A letter was received from an Indiana advocacy agency with comments regarding Section 1: Assessment of Settings, Section 2: Proposed Remediation Strategies, and Section 3: Key Stakeholders and Outreach. Below are the responses from DA regarding each comment contained in the letter.

Comments: Section 1: Assessment of Settings

The commenter wrote that the Division declares in blanket fashion that 19 of its waiver services fully comply with the new federal home- and community-based services (HCBS) regulations. However, there is no indication that the Division evaluated these services for compliance beyond stating that they are "individualized services provided in a residential setting that is not provider owned or controlled." The commenter finds this position overly conclusive, as service delivery in a setting neither owned nor controlled by a provider does not guarantee that a consumer will be integrated and have access to the greater community. Further, the concept of "provider control" is vague and undefined in the STP. A participant's selection and ability to terminate services of a particular provider does not equate to control over the provision of that provider's services. This is especially true in rural areas where participants have limited provider choices. The commenter urges the Division to critically examine all services provided under the Waiver and identify those chosen for further assessment.

Additionally, the Traumatic Brain Injury (TBI) Waiver offers supported employment services, described as "[s]upervision and training for participants requiring support to be able to perform in a work setting." The commenter fears that supported employment services may currently be delivered in sheltered, non-competitive, or provider-owned/controlled settings. The commenter suggested that these settings be assessed for compliance with the new HCBS regulations.

Similarly, while the Division does admit that the TBI Waiver's Structured Day Program providers "typically … serve individuals … in congregate community-based settings," it states that these settings have not been assessed for compliance with the new HCBS regulations. Although the Division indicates that it "will use an approach similar to that used to assess residential settings," The commenter recommends that the assessment criteria be explicitly articulated and available for public comment.

The Division notes that, in regard to assisted living, the Indiana State Department of Health (ISDH) plays a regulatory role. Currently, the Aged & Disabled (A&D) and TBI Waivers both require assisted living facilities to be licensed by ISDH, which licenses such facilities as residential care facilities. The Division notes that it has considered removing the requirement that ISDH license assisted living facilities, but has not decided whether it has the necessary capacity to oversee assisted living independently for Waiver purposes. The commenter believes that simply removing the "residential" designation from assisted living facilities is a semantic, rather than substantive, solution. More than phrasing will need to be altered before assisted living facilities comply with the new HCBS regulations.

The Division notes that "a group of providers, advocates, and state staff" have been engaged in conversations regarding the designation of assisted living facilities. Though discussions should certainly occur, the commenter requests more information regarding both the composition of this group and how participants were selected. It is not clear that people with disabilities, nor actual Waiver participants, have been invited to the discussion table.

Lack of Waiver participant engagement throughout the transition process is a predominant concern of the commenter. For example, while describing its proposed heightened scrutiny process, the Division indicates that it will review "documentation provided by [the] provider, survey documentation from visits to the site by [the Division] and contractor staff, public input, and any other information the [Division] requires." Notably absent from that list is individuals receiving services. The commenter also encourages that people with disabilities are included in the review process, either as Division employees or as contractors.

In a later section of the STP, the Division indicates that it monitors services through activities such as Provider Compliance Reviews (PCRs) and Participant-Centered Compliance Reviews (PCCRs). PCRs appear to be conducted only for those providers not licensed by ISDH. Therefore, the commenter is curious whether those providers licensed by ISDH are ever asked similar questions and, if so, how frequently. The Division indicates that PCCRs are "conducted for a statistically significant random sample of waiver participants each year." The commenter would like to know the size of the sample, whether the number of respondents are statistically significant across Division-implemented Waivers and across the provider network, and how the samples are selected.

The commenter further questions the usefulness of the Person Centered Monitoring Tool (PCMT) and National Core Indicators (NCI) survey questions for purposes of measuring provider adequacy. The problem is, in large part, due to yes-or-no responses demanded by the questions. For example, to assess whether a Waiver participant is given choice in services and service providers, the Division proposes asking the following questions from the NCI survey: "Can you choose or change what kind of services you get and determine how often and when you get them? Can you choose or change who provide their services if you want to? Do you feel in control of your life?" Respondents don't have the opportunity to discuss services they may feel are missing from their care plan or to describe situations where services that were requested may have been denied by the State, case manager, or provider in question. Relatedly, the PCMT denies Waiver participants the opportunity to provide any feedback whatsoever, in that the questions are posed to case managers rather than participants (e.g., "Does the individual have choices in what food is available and when to eat?").

Additionally, the commenter is concerned that the Division has not fully considered due process rights of individuals that may be receiving services in noncompliant settings. The Division indicates that transition plans will be developed for participants residing in Group 1 sites that will include "appropriate notice" and "procedural safeguards available to them." The commenter asserts that the details of the notice and procedural safeguards that will be provided to affected participants should be specified in the STP. Moreover, it is problematic that the Division has not yet determined the number of individuals that will be potentially affected, nor has it developed timelines for doing so, given that the exercise of appeal rights can be a significantly lengthy process. (In Section 2, the Division indicates that Waiver participants will be offered assistance transitioning from noncompliant providers by September 2018. The commenter believes this assistance should be offered much sooner.)

Response: The DA appreciates the thoughtful comments offered by the commenter on the STP. In the Assessment of Settings section, DA would first note that the Final Rule allows for a presumption that services provided in the individual's home are in fact home and community-based. That does not relieve the State of any obligation to monitor such services and settings for HCBS characteristics but as presumed HCBS settings DA does not believe private family homes should be part of the transition plan.

With regard to the TBI services of supported employment and structured day services, these are providers that also provide similar services under the DDRS waiver programs. As such, DA will coordinate with DDRS in the assessment of these settings so as to be consistent with these providers. DA certainly recognizes the issues the commenter has raised here with regard to these services. As very few TBI waiver participants utilize these services, DDRS will be the lead on issues with these providers and settings.

The commenter correctly points out that "more than phrasing will need to be altered before assisted living facilities comply with the new HCBS regulations." DA is very aware of this. DA will clarify some of the language in the STP to explain the consideration being given to removal of the residential care facility licensure is about much more than changing the name or phrasing associated with these settings. The licensure rules can be in direct conflict with the requirements of an HCBS setting. Removing the licensure requirement will not in any way make these settings HCBS compliant. But it removes barriers to that compliance and makes it more likely that they can become compliant.

The commenter expressed some concern regarding DA's monitoring tools the PCR and PCCR. They are correct in observing that the PCR is only administered to unlicensed providers but no PCR questions are used in the crosswalk as elements of monitoring HCBS settings characteristics. That process may be enhanced and expanded to more adequately address those issues. This is part of the consideration of whether or not to require assisted living providers to be licensed by ISDH. That licensure and survey process does not monitor for HCBS setting compliance so DA will have additional monitoring responsibilities either way. The PCCR is administered across all settings and providers, licensed and unlicensed so there is some DA monitoring of licensed providers through this survey process. 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 a total population of 200. A&D Waiver is approximately 375 using the above formula and a total population of 15,000.

With respect to the NCI-AD and PCMT questions that have been cross-walked to the HCBS characteristics, DA offers a couple clarifications. First, the NCI-AD is NOT a yes or no response. DA included only the questions in the cross-walk and not the available responses. Second, on the PCMT, the commenter raises two primary issues. One is the case manager is asked these questions. That is not strictly accurate. The case manager is responsible for completing the checklist but they do so through a person centered interview with the participant and anyone else they identify in their circle of support. The commenter raises a second issue on the yes/no response format to the questions. That format has traditionally been used with this tool to simplify reporting of data primarily. DA would note that for many of the questions a negative response requires additional documentation in the form a corrective action plan. However, DA thinks the commenter has a valid point here. DA will study a change to the format of the tool, perhaps implement a more evidence-based, person centered tool. DA also agrees that there needs to be a place to document the participant's input in their own words. The DA will work to add this to the PCMT process.

Comments: Section 2: Proposed Remediation Strategies

The Division indicates that it will "[c]reate a work group, including waiver participants and advocates, to more clearly define requirements for privacy, choice, and other quality of life components…" by March 2016. To date, the commenter is unaware of any invitation to the public to participate in such a group. The commenter requests additional clarification from the Division on how participants will be identified and chosen. The commenter also asks that the Division ensure that Waiver participants have at least equal representation to any provider members of the work group.

The Division also indicates that provider policies, procedures, training, and relevant other documentation will be assessed for compliance with the new HCBS regulations. Although this responsibility is not delineated within the STP, the commenter recommends that attorneys from the FSSA Office of General Counsel be thoroughly involved in this process. Because new regulations require providers to offer documents, including binding and enforceable residential leases, legal expertise is crucial in assessing provider compliance.

Next, the Division offers proposed State rule changes, several of which the commenter believes are contrary to the spirit and the letter of the new HCBS regulations. The Division proposes general direct care service standards, which would require a provider to "[a]llow decision- making and self-determination to the fullest extent possible…" The commenter believes that "to the fullest extent possible" is ambiguous; it is not clear whether the Division envisions autonomy being hampered by the participant's capacity or the provider's unwillingness to offer broad choice. The commenter recommends that the Division clarify the meaning of "possible."

The Division also proposes promulgating new rules regarding person centered service plans. The proposed rule would require case managers to use the 90-day monitoring tool, presumably the PCMT (an item with which the commenter raised concern above), to "review service deliverables." The Division requires that the case manager meet with the Waiver participant in his or her home for their first appointment and for at least 50% of the remaining assessments. The commenter would remind the Division that many Waiver participants are fully productive members of the community, holding jobs and otherwise committed during normal work hours. As such, if the Division keeps this proposed rule, the commenter recommends mandating that case managers be available to meet with Waiver participants at times convenient for those participants.

To meet the HCBS regulatory requirement that individuals have free access to the community, the Division proposes several rule changes. Generally, across services, the Division would require providers to "include transportation for community activities that are therapeutic in nature or assist with maintaining natural supports." It is not clear who determines whether an outing is therapeutic or essential to maintaining natural supports, but, in accordance with federal regulations, the Waiver participant should be permitted to go wherever he or she wishes. The Division further runs afoul of federal regulations when it proposes adult family care service providers offer activities "appropriate to the needs, preferences, age, and condition of the individual resident…" Again, who is the arbiter of what is "appropriate"? It should be the individual.

Relatedly, the Division proposes rules that are narrower than the new federal regulations. For example, the Division plans to promulgate a rule that would require adult family care and assisted living providers to "assure that residents have the ability to control their own schedule and to choose whether to participate in activities." This proposed rule is not as broad as new federal regulations which permit participants to choose not just whether they participate in offered activities, but to actually select activities. Similarly, the Division would require the same providers to "assure that residents have a room that is physically accessible to them." Residents should not be limited to just a room; the overall facility should be accessible. The commenter believes the Division should amend its proposed rules to match the intent of the federal regulations.

New HCBS regulations require bedrooms to have locking doors. However, the Division indicates that it will amend existing State rules to provide that "only appropriate staff" will have keys. Permitting staff to have keys negates the purpose of the regulations. Similarly, “appropriate” is an ambiguous term, meaning that potentially all staff could have keys.

Response: The commenter requests more details on the due process protections that will be afforded participants who receive waiver services at a site found not to be compliant with the Final Rule and cannot be made to be compliant. The commenter notes concern with the September 2018 date for offering assistance to these individuals. In fact, that assistance will be offered earlier whenever possible. That is to say as soon as a site is determined to be non-compliant and it is determined it cannot be made compliant, support will be provided to those participants right away. The September 2018 date is a final date by which all of those individuals need to be identified and in process for any required transition but we would expected most to be much sooner.

In terms of the safeguards participants will have in the remediation and any transition processes, DA will utilize existing systems in both waivers for review of decisions and access to administrative hearings and appeals. The commenter is critical of DA's inability to identify numbers of impacted consumers. DA has identified the numbers of participants in each setting in which DA has indicated Final Rule compliance issues. DA cannot yet determine how many of those sites will end up non-compliant either because the provider does not wish to make them compliant or they cannot be made compliant. Site surveys are being conducted now. Participants input and other information indicated in the plan will have to be considered for those sites subject to heightened scrutiny. It will simply take more time before DA can have exact numbers of individuals who may be impacted.

Comments: Section 3: Key Stakeholders and Outreach

The Division lists a number of outreach activities it has taken to date. Notably, all of these activities have been geared toward providers rather than participants. Although the Division indicates its desire to include participants "in the development and implementation" of the STP, the STP is already in the public comment period. The commenter recommends that the Division reach out to Waiver participants as quickly as possible to elicit critical input.

Response: DA would agree that input into the plan has largely come from providers. DA continues to struggle with ways to get more direct input from participants and their families. DA truly wishes to connect with the commenter and wishes DA had thought to include them as an important consumer advocacy voice. DA apologizes for that oversight. DA conducted consumer outreach sessions in assisted living settings through the state in the fall of 2014 but did not receive many comments during that process. DA has also included the Indiana Association of Area Agencies on Aging and the Alzheimer's Association in these processes to offer more of a participant focus. DA is currently engaging the assistance of the University of Indianapolis to aid DA in improved participant engagement including the creation of an HCBS Advisory Group. DA will absolutely include the commenter in these efforts and again wish DA had thought to do so earlier. The commenter also has concerns with the process and content of the draft Aging Rule, currently 455 IAC 2. The

FSSA Office of General Counsel has been very involved in this process. The OGC's office prepared the cross-walk of rules contained in the STP. DA continues to work closely with OGC in all elements of the efforts around Final Rule compliance and transition plan activities. The Rule is still in draft form and has not yet even been formally posted for public comment. DA is aware that a number of changes and additions still need to be made to the draft.

Comment: The same commenter requests that the Division disclose its plans to coordinate with the other State entities to ensure that individuals with "dual diagnoses" are not being unnecessarily served in settings that are non-compliant with or technically exempt from the HCBS Final Rule. Too often, the commenter hears reports from such individuals that they are essentially "punted" between Divisions and are unable to receive truly individualized treatment and services due to a lack of coordination among the Divisions.

Response: DA appreciates this concern expressed by the commenter. DA has been engaged with our sister divisions in FSSA in a planning process for a no wrong door system of access that addresses these concerns. DA will reach out to the commenter with information about this initiative and seek their participation in the process. DA also has a redesign of the State's Pre-Admission Screening Resident Review (PASRR) system for nursing facility placement in progress that DA can send the commenter information about. DA truly wishes to connect with the commenter and wish DA had thought to include them as an important consumer advocacy voice. DA apologizes for that oversight.

Comment: One commenter recommended that the expansion of Adult Family Care occur if the program contains nursing oversight. Adult Family Care can provide personalized options for long term care for Hoosiers in a small, intimate setting of a specialized home. However, since the recipients for this service meet nursing home level of care, more clinical oversight is needed to maintain positive outcomes for this aged and disabled population. Home health agencies have the skill and experience to teach and train caregivers, observe and assess clinical conditions, and manage and evaluate care provided by non-skilled caregivers. Since most of the Hoosiers in these homes most probably meet the requirements for Medicare covered home health services, Indiana Medicaid would not be responsible for payment for such services. Though long term skilled care would most probably not be covered or needed, this is an opportunity for new residents of adult family care homes. Though some recipients may not have Medicare, Medicaid could cover the initial oversight.

Response: DA appreciates this comment from the commenter. DA does not find it to be directly related to the STP but more a comment on DA's HCBS programs in general. DA will reach out to the commenter to discuss this and other issues outside of the STP process.

Comment: Indiana Medicaid should consider delegation of certain nursing services to home health aides under the fee-for-service and managed care programs. The services would be billed at the home health aide rate. Both the Indiana Nurse Practice Act and the Indiana State home Health regulations allow for nurse delegation to a trained and competent aide. Such procedures as in and out catheterization, bowel care, simple wound care, a simple G-tube feeding could be done by a certified home health aide under the supervision and training of a registered nurse. This process would allow the recipient to have one caregiver who could do all the required care. Not having to send a LPN to do a task that a trained and competency tested aide could do, would also be a cost savings to Medicaid.

Response: **DA appreciates this comment from the commenter. DA does not find it to be directly related to the STP but more a comment on DA's HCBS programs in general. DA will reach out to the commenter to discuss this and other issues outside of the STP process.**

Comment: Nursing practitioners should be able to sign primary plans of care. The commenter believes this would alleviate provider capacity concerns in rural areas. The Indiana home health statute and the federal Conditions of Participation only allow physicians to sign medical plans of care. Currently there is federal legislation to allow nurse practitioners and physician assistants to sign plan of care. For Indiana residents in rural and inner city, these practitioners are the primary care manager. It will be imperative that Indiana change its laws and regulations' to allow NPs and PAs to become the primary care provider.

Response: DA appreciates this comment from the commenter. DA does not find it to be directly related to the STP but more a comment on DA's HCBS programs in general. DA will reach out to the commenter to discuss this and other issues outside of the STP process.

Comment: Physical Therapy Assistants (PTAs) and Occupational Therapy Assistants (COTAs) under the supervision of a physical therapist and occupational therapist respectively should be covered services in the home setting. The commenter believes coverage should be consistent under Traditional Medicaid and the Medicaid managed care programs, such as Hoosier Care Connect and the Healthy Indiana Plan (HIP) 2.0. PTAs and COTAs can provide therapies under the Medicare program and this benefit and coverage should be covered under Indiana Medicaid. The use of PTAs and COTAs are important due to the shortage of physical therapists and occupational therapists, particularly in the rural areas. This would alleviate the access to service issues for individuals in need of timely therapy services to promote the individual's functioning and independence.

Response: **DA appreciates this comment from the commenter. DA does not find it to be directly related to the STP but more a comment on DA's HCBS programs in general. DA will reach out to the commenter to discuss this and other issues outside of the STP process.**

Comment: One commenter shared that presumptive eligibility is currently performed by the following entities under the Medicaid program: Hospitals, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), Community Mental Health Centers (CMHCs), Local Health Departments. At this time, the local Area Agencies on Aging are not identified as a qualified provider to make presumptive eligibility (PE) decisions. The commenter believes that there need to be procedures in place that allows for PE determinations for individuals when the home health nurse performs the nursing assessment and the individual has not received a PE determination in the hospital. FSSA should reach out to the Centers for Medicare and Medicaid Services (CMS) to consider the local Area Agencies on Aging as qualified providers.

Response: **DA appreciates this comment from the commenter. DA does not find it to be directly related to the STP but more a comment on DA's HCBS programs in general. DA will reach out to the commenter to discuss this and other issues outside of the STP process.**

Comment: OPTIONS counseling should be performed during the first 100 days of an individual's Medicare nursing facility care to promote informed consumer choice and prepare for adequate discharge planning from the nursing facility to the community. This practice affords an individual the opportunity to be in the least restrictive environment in a HCBS setting.

Response: **DA appreciates this comment from the commenter. DA does not find it to be directly related to the STP but more a comment on DA's HCBS programs in general. DA will reach out to the commenter to discuss this and other issues outside of the STP process.**

Comment: One commenter shared a concern that the managed care model may not be the most appropriate to provide the necessary comprehensive care for Medicaid home health recipients who have a skilled need or whose limitations in activities of daily living would make them eligible for the medical model waivers administered by the DA. There is a concern that comprehensive care will not be provided for this population under the managed care model. These individuals have been served well under the fee-for-service model. Currently, Medicaid waiver recipients are excluded from Hoosier Care Connect. It is important to note that many waiver recipients benefit from the combination of Traditional Medicaid home health services and waiver services.

Response: **DA appreciates this comment from the commenter. DA does not find it to be directly related to the STP but more a comment on DA's HCBS programs in general. DA will reach out to the commenter to discuss this and other issues outside of the STP process.**

Comment: The commenter expressed a concern that current reimbursement and administrative procedures set by Indiana Medicaid impact provider capacity and create lack of willing providers. Home health agencies have operated under a Medicaid rate cost reduction since SFY 2011. At this time, home health rates for SFY 2016 reflect a 3% reimbursement cut. In addition to cost reductions, home health agencies are faced with administrative burdens that impact their day to day operations. Indiana Medicaid has implemented Hoosier Care Connect and HIP 2.0 and awarded contracts to Anthem, MHS and MDWise. Each MCE is permitted to have its own prior authorization and claims billing procedures. Providers often encounter an administrative burden and possible slowdown of care provision when there is not a consistency in prior authorization guidelines or claims billing among health plans.

Reimbursement for licensed home health agencies that provide respite nursing and respite home health aides and licensed personal services agencies (PSAs) that provide services under the Aged and Disabled Waiver (A&D) Waiver, Traumatic

Brain Injury (TBI) Waiver, and Money Follow the Person (MFP) Grant is inadequate to hire staff as other industries are able to hire staff. An increase in waiver rates is necessary to promote hiring and staff retention for home health agencies and PSAs under these waiver programs

Response: **DA appreciates this comment from the commenter. DA does not find it to be directly related to the STP but more a comment on DA's HCBS programs in general. DA will reach out to the commenter to discuss this and other issues outside of the STP process.**

Comment: One commenter expressed a concern with the fairness to families who currently have loved ones in memory care units, requesting that the transition process allow for a grandfathering of patients who currently reside in those units to remain on the HCBS waiver and for those who become eligible for the waiver during this period of rule promulgation. The commenter also shared a concern with the Medicaid application process and that forcing an existing waiver recipient's family to find a new facility for their loved one is cruel.

Response: DA appreciates the concerns of the commenter regarding any potential that individuals would have to be moved from current settings that are perhaps both co-located with an institutional setting and/or have a secure memory care unit. DA acknowledges that these settings offer opportunities for spouses with different care needs to still be in close proximity to one another. It is certainly not the goal of the state to disrupt these or other participants of waiver programs. DA will work with providers to assure compliance with the Final Rule wherever possible. If there are instances where settings are simply found to not be home and community based, the state will work with providers, consumers, families, and advocates to explore all possible options providing individuals with person centered counseling in order to assist them with making their own well-informed decisions about their care options.

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 two adult 1915(c) programs; Community Integration and Habilitation (CIH) and Family Supports Waiver (FSW). The comments resulted in changes on pages 51, 55, 56, and 57.

PUBLIC COMMENTS:

Comment: A commenter suggested that strong language is needed to protect parents/guardians from provider agencies that threaten to issue a 60 day termination of services if the parents/guardians file a complaint or initiate an incident report related to their child's services.

> **Response: Thank you for the suggestion. This information is useful for the revisions/development of policies and procedures. While the STP will not be updated with this specific language, policies/procedures can be modified to incorporate additional protections.**

Comment: Another commenter suggested that familial services, if allowed, should be capped at no more than 40 hours a week across all services in total. The opportunity for exploitation occurs when family members, who are controlling the services, decide they will provide all the services and select Community Based Habilitation-Individual (CHIO) for all day funds rather than a mix of day programming and/or therapies. By capping the hours allowed by family, this issue will be mitigated.

> **Response: Thank you for your comment.**

Comment: One commenter provided a list of items (e.g. History of Consumer, Natural Supports, Diagnosis of Consumer, Short-term Goals, Long-term Goals, Services Receiving, Behaviors, and Incident Reports) and two questions: 1) What is working for this consumer? 2) What is not working for this consumer?

> **Response: Thank you for the suggestion. This information is useful for the revisions/development of forms.**

Comment: A comment was received regarding specific language in the STP as follows: 1) There is a reference to a new document titled "Individual Rights and Responsibilities." 2) There is a comment that says any question on the 90 Day checklist that is marked "no" will have remediation. The commenter pointed out that this is not true given the revision that is planned to be rolled out around 7/1/16. 3) Additional "in depth analysis" is noted as being needed in the majority of these comments. 4) The second paragraph ends with a sentence that references the PCP document, but I think you really mean the ISP document. 5) What role does the Waiver Case Manager play in the Site Specific Assessment?

> **Response: Thank you for the feedback. On page 51, the STP will be modified to read "*if the response to any questions related to HCBS requirements is evaluated to be out of compliance, the case managers will notify the responsible party that a corrective action plan is required to be completed and submitted.*" In regards to page 51, the "in depth analysis" refers to the results of the IES survey. Page 55 does reference the PCP. Language will be updated to the "Person Centered Service Plan" to reflect CMS criteria. Page 57 language will be updated to reflect "DDRS or its contracted entity". Case Managers may be involved in this process. Final determination of who will complete site visits has yet to be determined.**

Comment: A letter was received from an Indiana advocacy agency with comments regarding Section 1: Systemic Assessments, Section 2: Site Specific Setting Assessment, Section 4: Proposed Remediation Strategies, and Section 5: Key Stakeholders and Outreach. Below are the responses from DDRS regarding each comment contained in the letter.

Comments: Section 1: Systemic Assessment.

As requested by an October 8, 2015 letter from the Centers for Medicare and Medicaid Services (CMS) to State Medicaid Director Joe Moser, the Division has identified several sections of the Indiana Administrative Code that will need to be modified in order to comply with the new HCBS standards. However, no proposed modifications to these sections are provided. The commenter requests that the Division publish proposed amendments to the identified sections so that participants and others can provide meaningful feedback prior to federal STP approval.

> **Response: Through the Systemic Settings Crosswalk, the state has identified areas of within the Indiana Administrative Code that will necessitate modifications to assure the State's compliance with HCBS requirements. Specific language will be added to mirror HCBS requirements. Any proposed modifications will follow the Administrative Rules drafting procedure and will be published for a public comment period to ensure meaningful feedback from all stakeholders.**

Regarding employment services, the commenter is concerned that methods of collecting data (i.e., the 90-day Checklist) are inadequate to capture important evidence regarding the status of competitive, integrated employment. For example, the Checklist asks caseworkers to "[c]onfirm the individual is free from work without pay that benefits others." This question appears to forbid Waiver participants from engaging in volunteer work. The new HCBS regulations do not preclude Medicaid beneficiaries from volunteering in their communities. Instead, the Division should create a tailored survey tool designed to assess how many Waiver participants are actually engaged in competitive, integrated employment; how many would like to be, but have not yet become employed; barriers to employment in Indiana; etc. These findings should be made available, in accessible formats, on an annual basis.

> **Response: Thank you for the suggestions. The 90 day check list as an ongoing monitoring tool will be modified from the current content to measure HCBS Requirement on an ongoing basis. The information provided above will be helpful as the State incorporates the suggestions within specific policies and procedures.**

Further, the commenter asks that the Division include more specifics regarding its own role in helping Waiver participants achieve competitive, integrated employment. For example, the commenter recommends that the Division broaden the availability of individualized employment services, increase education and outreach to providers and Waiver participants about employment options and work incentives, and include other State agencies in achieving employment goals. The commenter also suggests that the STP explicitly forbid the use of Waiver funding for non-integrated employment settings, including sheltered workshops, and noncompetitive jobs, including those where individuals earn subminimum wage. To that end, the Division will need to address prevocational services, set measurable outcomes, create timelines, and change funding methodologies accordingly.

> **Response: DDRS appreciates the support expressed by commenters and will review the suggestions listed above. While the specific suggestions listed above will not be incorporated into the transition plan, the State will incorporate the suggestions within the specific processes to the greatest extent possible.**

In regard to the new HCBS regulation regarding the receipt of community services, the Division points to 460 IAC 7-3-12, which "empowers an individual and the individual's family to create a life plan and corresponding ISP for the individual…" the commenter believes the State rule needs to be amended to explicitly provide that the individual, rather than his or her family, leads the planning process. Certainly, a Waiver participant is free to include family members in the plan development process if he or she chooses, but any such inclusion should be at the option of the participant.

> **Response: Specific language will be added to mirror HCBS requirements. Any proposed modifications will follow the Administrative Rules drafting procedure and will be published for a public comment period to ensure meaningful feedback from all stakeholders. Additionally, policies and procedures will be updated timely and appropriately to comport to the HCBS requirements.**

The Division notes that measurables for determining if an individual has access to the community are captured by asking whether "adequate Transportation [is] being provided" and using the Checklist to determine if he or she participates in the community. These measures are insufficient to achieve compliance with the new HCBS regulations. The Waiver participant

should have the ability to leave his or her home as he or she wishes. The measuring tools only assess whether transportation is "adequate." The Division does not provide any definition for "adequate." Further, evidence of a presence outside the home does not guarantee that the participant is actually exercising choice in his or her daily agenda. Current Checklist inquiries for several other service criteria are similarly insufficient.

> **Response: The State agrees the current 90 day check list does not adequately address HCBS requirements. For this reason, the Individual Experience Survey was administered to give a clearer picture on how individuals experience their day to day life including accessing the community. The 90 day check list as an ongoing monitoring tool will be modified from the current content to measure HCBS Requirements on an ongoing basis. The information provided above will be helpful as the State incorporates the suggestions within specific policies and procedures.**

The Division also should amend the Indiana Administrative Code to reflect outings are at the discretion of the Waiver participant. Currently, 460 IAC 6-19-1(1) provides that the case manager should determine "[t]he wants and needs of an individual, including the health, safety and behavioral needs of an individual." The Division proposes that the current rule mandates that Waiver participants have control of their schedule. However, the existing rule falls short. A participant may wish to travel somewhere outside the scope of his or her health and safety needs. Similarly, providers are unlikely to interpret this rule as mandating that they assist clients with transportation and other services needed to obtain and maintain competitive, integrated employment.

> **Response: Specific language will be added to mirror HCBS requirements. Any proposed modifications will follow the Administrative Rules drafting procedure and will be published for a public comment period to ensure meaningful feedback from all stakeholders.**

The commenter is also concerned that such heavy reliance on the Checklist will have the result of excluding organic feedback from Waiver participants. First, the Checklist is completed by caseworkers rather than participants. Second, the Checklist does not mirror new HCBS regulatory requirements, but instead skirts around salient compliance information. The commenter recommends that the Division include Waiver participants and advocates in the planned redesign of the Checklist, targeted for completion in December 2017. Additionally, the Division should integrate regularly occurring face-to-face interviews with a statistically significant population of participants as an additional monitoring tool and means to verify data gathered through the Checklist. This should be carried out by an independent third party. The commenter is skeptical of any monitoring efforts that do not include strategic efforts to seek direct input from consumers themselves.

> **Response: Thank you for the comment. The information provided above will be helpful as the State incorporates the suggestions within specific policies and procedures. 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**.

Comments: Section 2: Site Specific Setting Assessment.

The commenter is concerned with the Division's proposed strategy for achieving compliance when noncompliance is determined through use of the 90-day Checklist. The Division proposes case managers require providers to submit a corrective action plan. Case managers are responsible for determining whether providers comply with these plans. If they do not, the Division will become involved. Importantly, no timelines are provided. How long will a Waiver participant be forced to forgo their rights while the provider may or may not attempt to take corrective action? How does the Division plan to achieve statewide continuity if individual case managers are making compliance determinations? How does the Division plan to limit managerial discretion? Who has due process rights during this process, and how are they invoked? Will the Division impose any sanctions on providers that continuously take advantage of the corrective action plan process and repeatedly violate participant rights?

> **Response: The state will review the suggestions listed above in order to identify areas inadequacy or weakness within the 90 day check list and develop necessary modifications to assure the State's compliance with HCBS requirements. Case Managers will continue to be trained and held accountable for following proper procedure in the completion of this task. While the specific suggestions will not be incorporated into the high level Transition Plan, the State will ensure stakeholders have an opportunity to review any**

policy/process changes listed above and, to the greatest extent possible, the State will incorporate the suggestions within the specific processes.

The commenter also requests the Division provide details regarding notice and procedural safeguards that will be provided to participants who will potentially face relocation. These details were explicitly requested by CMS in its October letter, but are not provided in the updated STP.

Response: The STP will be updated to incorporate the procedural safeguards provided to participants who would potentially face relocation. Thank you for the suggestion.

Comments: Section 4: Proposed Remediation Strategies.

The Division provides that an updated STP will be offered to CMS after survey results are examined. The commenter recommends that the Division provide its methodology and a timeline for evaluating data. These updated STP provisions should be made available for public comment.

Response: Thank you for the suggestion, the STP will be modified to include a timeline for evaluation of collected data. The updated STP is projected to be submitted in September 2016 and will include the results of the IES survey. Per CMS Requirements, any substantive changes to the STP will require a public comment period, and the addition of this information will be considered as substantive.

The commenter has substantial concerns regarding the manner in which the Division proposes administering the statewide survey created by the Indiana Institute on Disability and Community (IIDC). The STP provides that, "[o]nce the survey has been validated IIDC will disseminate it electronically to providers throughout Indiana to complete, with the individuals they serve." The commenter believes this methodology permits providers to severely bias survey results. Additionally, the Division provides no information regarding how it intends to protect the privacy of neither respondents nor potential retaliatory action by providers. The commenter proposes that the Division contract with an independent third party to assist individuals in completing their surveys.

Response: The IES Survey has been closed as of January 31st, 2016. It was completed by the individual or guardian during the individual's Quarterly meeting with the case manager presenting the survey and then entering the information into an electronic system. Dissemination of the summary of the survey will not include consumer or provider names, rather an overview of the results. Individuals and providers will be notified separately of site specific validations that result in the need for corrective action in order to protect privacy.

The Division also provides that survey results will be disseminated. The commenter questions how the results will be shared with Waiver participants, and suggests that the Division make a concerted effort to present survey data in an easily comprehensible format.

Response: Thank you for the suggestions. DDRS will work with IIDC to ensure presentation of the survey results are understandable and shared with all waiver participants and stakeholders via bulletins and postings, as well as providing printed copies upon request.

Finally, the commenter requests additional information regarding the plan to convene a "Transition Taskforce." How will members of the Taskforce be identified and selected? Does the Division plan to simply seek input from the listed key stakeholders or will there be designated outreach to and representation by self-advocates participants, providers, and advocacy groups?

Response: Members of the Transition Task force have yet to be determined. DDRS intent is to have representation of all stakeholders on the Taskforce including, but not limited to participants, family members, advocacy groups, providers, and State staff. DDRS plans to reach out to these groups via announcements, meetings, and other means of communication in order to ensure appropriate representation.

Comments: Section 5: Key Stakeholders and Outreach.

The Division states that its "intent is to engage in a collaborative process which will involve a high level of inclusion of all stakeholders." Yet, to date, the Division indicates that it has predominantly worked with the Arc of Indiana, INARF, and providers. The commenter believes the Division should strive to include both Waiver participants and consumer advocacy groups. The commenter believes participants are also being denied opportunity for public comment, in that the STP states announcements for public comment are provided on the BDDS Provider Portal and BDDS Case Management System. How are participants notified of opportunity for public comment?

Response: DDRS intent is to have all individuals provided an opportunity for feedback. In addition to a bulletin that went out to the DDRS list Serve of over 7,000 people, DDRS made a concerted effort to reach all waiver participants by an announcement to case managers requesting them to ensure individuals on their caseload were aware of the posting and encouraged to provide feedback. We also requested case managers assist individuals.

Comment: The same Indiana advocacy group also requests that the Division disclose its plans to coordinate with the other State entities to ensure that individuals with "dual diagnoses" are not being unnecessary served in settings that are non-compliant with or technically exempt from the HCBS Final Rule.

Response: FSSA divisions will work together to ensure each individual's needs are identified and met in the least restrictive most appropriate setting of their choice. FSSA has established cross-division meetings for this purpose.

DIVISION OF MENTAL HEALTH AND ADDICITION - 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 did not directly result in any changes to the Statewide Transition Plan.

PUBLIC COMMENTS:

Comment: One commenter requests that the Division disclose its plans to coordinate with the other State entities to ensure that individuals with "dual diagnoses" are not being unnecessarily served in settings that are non-compliant with or technically exempt from the HCBS Final Rule. Too often, the commenter hears reports from such individuals that they are essentially “punted” between Divisions and are unable to receive truly individualized treatment and services due to a lack of coordination among the Divisions.

Response: Thank you for your comments and the contributions your organization makes to persons with disabilities each day. The Division of Mental Health and Addiction is committed to securing the most effective and appropriate supports for Hoosier youth in need of services. For this reason several avenues currently exists to facilitation this, and are listed below:

MDT – Multidisciplinary Team consists of multiple state agencies that come together every other week to review and staff cases submitted by child welfare case managers. The cases submitted are usually involved in multiple systems and have already exhausted services that are readily available or known. The case manager and other family providers participate in the review. The MDT has the ability to support referrals to the Bureau of Developmental Disability Services (BDDS) waivers when there is a developmental diagnosis. In addition, the team can assist with referrals to residential or state operated facilities when appropriate. State agencies included are Division of Disability and Rehabilitative Services (DDRS), Division of Mental Health and Addiction (DMHA), Department of Child Services (DCS), Office of Medicaid Policy and Planning (OMPP), and Department of Corrections (DOC).

EMDT – Enhanced Multidisciplinary Team consists of the agencies listed above as well as the Department of Education (DOE), and meets every other week to discuss system level barriers. Most of the barriers discussed are brought to our attention through the MDT when an individual is in need of support but there is nothing available statewide. The Team works to develop solutions or implement policy change that will help to overcome barriers identified.

INConnect—an interactive web portal currently in development which will provide information for the public seeking services from all of the State’s Family and Social Services Administration programs. Included will be a survey for consumers which will gather information about their needs and guide them to the appropriate resources.

While individuals presenting with dual diagnoses are not eligible for DMHA’s Child Mental Health Wraparound (CMHW) Services program and the PRTF Transition Waiver accepts no new applicants, the

following features are in place to assure participants applying for or enrolled in our programs receive assistance to access resources and to successfully transition from services.

Access sites—Access sites, the point of entry to CMHW Services, are positioned in the community throughout the State and assist families to access services and supports appropriate to their needs, in addition to processing applications for the CMHW program.

Wraparound Facilitators—Wraparound Facilitators among many other responsibilities function as care coordinators for the CMHW program recipients, and assist families to access the services and supports within the family's System of Care as well as within the CMHW program. They assist families transitioning out of services. As part of the Wraparound Facilitator cohort training, Transition planning is covered throughout the entire curriculum. Wraparound is composed of Four Phases;

- **Phase 1- Engagement and Team Prep.**
- **Phase 2- Initial Plan Development.**
- **Phase 3- Implementation.**
- **Phase 4- Transition.**

The curriculum the State of IN uses has been developed by the National Wraparound Implementation Center. Training around Phase Four of Wraparound includes looking for the following benchmarks and progress made by families and youth.

- **Progress towards Underlying Needs being met**
- **Progress towards established outcome statements and behavior change**
- **Progress towards caregiver self-efficacy and empowerment**
- **Care Plans shifting to overtly monitor progress and changes in the plan to move towards sustainable supports, natural supports, and community supports.**
- **The development of a formalized transition plan that links families and youth to the most appropriate service level to meet their needs. This transition plan would include a transition to a lower level of care, or a transition to adult services upon the youth's 18 birthday. Wraparound Facilitators must start transition to adult services at least 90 days prior to the youth's 18 birthday.**
- **The development of a formalized transition crisis plan.**

Each transition plan is individualized to that person's needs and strengths.

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 changes on pages 76, 77, and 78.

PUBLIC COMMENTS:

Comment: One commenter has apartment buildings which are owned by an outside company, i.e. Volunteers of America, but the commenter has an office in that building to provide services to the clients. The commenter wanted to know if the lease is just for office space is it still considered to be [provider] owned/operated?

> **Response**: **Since the agency leases the office space, the offices would be "POCO non-residential" and must comply with the "Big 5" HCBS setting requirements, the same as any other community-based outpatient/clinic setting operated by the agency. If the member's apartment units are leased through [the agency], or if there is a requirement that members who live there receive services from [the agency], then it will likely meet criteria for a POCO residential setting.**

Comment: One commenter wanted to know if POCO [provider owned, controlled, or operated] is only for CMHC's or if they are also for nursing homes like some RCAPs?

> **Response: Provider owned, controlled or operated applies to any Medicaid enrolled HCBS provider who provides services to members utilizing HCBS programming. Each setting must be assessed based on CMS standards. Some setting types/categories (like RCAP) may or may not be fully compliant with the HCBS Settings Rule, and the relationship between an RCAP facility with a given CMHC may vary. Therefore, each must be assessed based on that setting and the relationship with the CMHC.**

Comment: One commenter wanted a list of settings DMHA has determined do not meet compliance for HCBS compliance.

> **Response: Initial compliance designations for POCO residential settings will be communicated to individual providers as they become available, no later than May 30, 2016 (for settings which need modifications to become fully HCBS compliant) or December 31, 2016 (for settings presumed institutional and will be referred for heightened scrutiny).**

Comment: One commenter wanted to know how to handle a coordination of transfer if a client is receiving services and meets HCBS requirements, however, medical health creates an (almost overnight) transition to nursing facility.

> **Response: As noted, coordination of transfers is a critical component of continuity of care and must be done. However, per the AMHH and BPHC 1915(i) State Plan Amendment 3.1-I and 405 IAC 5-21.6/405 IAC 5-21.8, HCBS are not reimbursable if provided in an institutional setting.**

Comment: One commenter wanted more information about clients who are on commitment to stay in a group home.

> **Response: Involuntary commitment does not affect the requirement that a member receiving HCBS lives in a fully compliant setting, and their participation in making informed choices about rights/responsibilities, and choosing to participate in HCBS services must be documented in all cases.**

Comment: One commenter wanted to confirm the April 1st is the date for implementing RSST and DARMHA modifications.

Response: Yes the April 1st date for implementation of HCBS Residential Setting Screening Tool (RSST) is firm, due to CMS's requirement for data collection before next STP submission (anticipated September 2016).

Comment: One commenter wanted to confirm if assisted living participants can get AMHH or BPHC if in a nursing home and also if the assisted living is on the same grounds as a nursing home but not in the nursing home. Does that also fall under presumed institutional?

Response: Whether the individual is eligible for AMHH or BPHC programs will depend on whether the assisted living facility is determined to be an HCBS compliant setting or an institutional setting. If the setting is assessed to have qualities of an institution (including being in or adjacent to an institutional setting), it may be referred for heightened scrutiny. The following is an excerpt from a CMS presentation in Nov 2015: "At a minimum, states should submit information clarifying that there is a meaningful distinction between the [institutional] 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. This could include documentation that the home and community-based setting is not operationally interrelated with the facility setting."

Comment: One commenter questioned if a presumed institution is receiving BPHC, will they be denied or eligible?

Response: Members receiving HCBS who live in a setting preliminary designated by DMHA as "Potential Presumed Institutional" are currently eligible to continue to receive services until a final determination is made. For settings which are presumed institutional and for which the presumption is allowed to stand, Member Transitions Plans will be initiated for any affected members. The Member Transition Plan process and any relocations or termination of HCBS will be guided by person-centered planning.

Comment: One commenter asked how county homes are identified on the application and if they would be identified as non-POCO.

Response: County homes like all other settings are considered non-POCO, as long as they are not owned/controlled/operated by an HCBS provider. However, if the setting is owned by a governmental unit (like the county), it meets criteria for "Potential Presumed Institutional" and needs to be referred for heightened scrutiny.

Comment: One commenter asked if homeless shelters are exempt from HCBS.

Response: During an HCBS conference call, a verbal response from CMS indicated homeless shelters are exempt from HCBS. However, FSSA/DMHA has not received this information in writing. Will advise as more information is available.

Comment: One commenter inquired if providers can scan surveys, such as the HCBS Resident Survey to DMHA through email.

Response: No. FSSA/DMHA needs the hard copies to protect member confidentiality.

Comment: One agency had a question regarding building compliance. Their agency has an inpatient unit, which they understand is considered an institution, and in a separate part of the building the agency providers skills in training groups. The agency wanted to know if they would be out of compliance even though these programs are separate from each other.

Response: If the setting is assessed to have qualities of an institution (including being in or adjacent to an institutional setting), it may be referred for heightened scrutiny. The following is an excerpt from a CMS presentation in Nov 2015: "At a minimum, states should submit information clarifying that there is a meaningful distinction between the [institutional] 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. This could include documentation that the home and community-based setting is not operationally interrelated with the facility setting."

Comment: One commenter asked how the application will be approved if the POCO 5 are not met, meaning the Screen Tool and application identify this, but there is justification in the Treatment Plan?

Response: If a modification(s) to one or more of the "POCO 5" requirements are substantiated through the person-centered treatment plan, then the setting will be considered compliant with that particular requirement.

Comment: One commenter wanted to know where the slides from the DMHA Webinar training would be posted and if they will include answers to the questions that were posed during the training.

Response: Slides from the 3/10/16 training were distributed on 3/21/16, and are posted on the DMHA AMHH and BPHC webpages. Responses to questions will be provided following the public comment period, which ends 4/6/16. The FSSA HCBS Final Rule Transition Plan website contains links to valuable information (www.in.gov/fssa/4917.htm).

Comment: One commenter asked if the surveys that providers completed online are different from the surveys that DMHA is requesting from the clients.

Response: Yes. The provider surveys completed on-line were the provider self-assessments of POCO residential settings. The surveys members are completing during February/March 2016 are resident surveys, which will be used to validate the results from the provider self-assessments of POCO residential settings.

Comment: One commenter asked if vignette examples will be given from which they can learn about applied classifications, (i.e. examples of specific cases of how someone in a certain situation would be classified).

Response: Good suggestion. DMHA will develop examples to help providers apply HCBS setting standards, to assist with the assessment process. In the meantime, refer to the HCBS Residential Setting Screening Tool for help in determining the setting type and the compliance requirements for a specific setting. Providers of HCBS are encouraged to review the medicaid.gov HCBS Final Rule page for additional information on settings as well.

Comment: One commenter asked if a group home is Joint Commission certified can it be assumed that it meets POCO 5?

Response: No. HCBS setting requirements are separate from and must be met whether or not a setting is Joint Commission certified.

Comment: One commenter asked what would happen if POCO-5 requirements violate Fire Marshal requirements.

Response: Conflicts between HCBS setting requirements and local fire marshal codes must be documented as a modification to the POCO 5 requirements on each individual resident's person-centered treatment plan.

Comment: One commenter asked if support staff could enter survey response into Survey Monkey.

Response: No. Member responses are to remain private.

Comment: One commenter asked how members will be informed about the HCBS Final Rule and new settings requirements.

Response: Providers are responsible for informing members about HCBS setting requirements and compliance status. The FSSA HCBS Final Rule page is a resource for providers as well for members. DMHA will develop an information handout for providers to be able to give to members, as well.

Comment: One commenter asked if there will be an information sheet available for staff to give the client about the new requirements.

Response: Good suggestion. DMHA will develop an information handout for providers to be able to give to members, explaining the requirements of the HCBS Settings Final Rule, its expected impact on members receiving AMHH and BPHC services, and the addition of the HCBS Residential Setting Screening Tool to the

application process. Providers are responsible for informing members about HCBS setting requirements and compliance status.

Comment: One commenter asked that in regard to the HCBS Residential Setting Screening Tool, if it would be possible to set up a form in our ECR that could be electronically signed to reduce the redundancy of a scanned form.

Response: Yes, as long as the electronic version of the RSST has all the same questions/information as the paper form, the signature is captured, and the outcome is entered correctly in DARMHA for applications beginning April 1st.

Comment: One commenter stated that they liked the changes to the flow of the RSST tool.

Response: Thank you for your feedback.

Comment: One commenter wanted know how "adjacent" would be defined in regards to how it relates to presumed institutions.

Response: CMS has not specifically defined "adjacent" as pertains to the HCBS Settings Rule, but DMHA is interpreting "adjacent" in this context to mean sharing a property boundary.

Comment: One commenter wanted to know how "operated" is defined as it relates to POCO residential sites.

Response: Each site must be assessed individually for compliance with the HCBS Settings Rule, including whether the setting has qualities of an institution. [The site] was previously identified by your agency as a POCO residential setting, which is accurate since the agency is involved in management of the property.

Comment: One commenter asked if assessments can be completed if the patient is in an inpatient unit or in a Crisis Respite outpatient unit.

Response: The assessments may be completed while the member is in an institutional setting, and are an important part of discharge planning and continuity of care. However, as with all home and community-based services, agencies will not be reimbursed for HCBS provided in an institutional setting.

Comment: One commenter asked if further guidance and clarification could be provided regarding how rules will apply to all settings where HCBS are delivered and not just to residential services.

Response: All home and community based services are required to be delivered in settings which fully comply with the HCBS Settings Rule. This applies to POCO non-residential settings, such as clinics, day service sites, etc. In May 2016, providers will complete self-assessments on their non-residential facilities to determine compliance with the HCBS Settings Rule.

Comment: One commenter asked if an exception to the requirement for the "locked bedrooms" requirement could be made since it is seen as a safety risk for patients.

Response: The intent is that a member's right to privacy is protected, as well as their right to choose whether to have visitors in their living space. Providers are reminded that all setting modifications must be based on an individual's specific assessed need, and documented in the individual's person-centered treatment plan. If a lockable bedroom door will not be provided for an individual member, that modification must be clearly supported by documentation in that member's person-centered treatment plan.

Comment: One commenter asked if it was acceptable to document checkpoints, which ensure modifications are still appropriate, at the time that the treatment plan is updated.

Response: Yes, at a minimum at least every 90 days. Review of modifications should also be done whenever there is a significant change in a member's status.

Comment: One commenter requested that the Division provide more details regarding how stakeholders will be identified and selected and encourages the Division to include a significant number of Waiver participants, as well as their advocates, as task force members.

> **Response: DMHA has received over 1,000 responses from members who completed the HCBS Resident Survey, many of whom reached out to family members, friends, and other natural supports to help them complete the survey. This was an incredibly robust response, and speaks to DMHA's commitment to engage members, their families, and other natural supports in an individual's ongoing person-centered treatment planning. DMHA is assessing the most appropriate avenues and anticipates engaging 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, Indiana chapter (including the Mental Health Ombudsman program staff).**

Comment: One commenter recommends, regarding the Division's proposed Member Transition Plan, that an independent facilitator be added to the plan development process. The commenter is concerned that the proposed team members will provide the potential for troubling conflicts of interest, especially for participants who lack natural supports and states that it is not enough that the Division will be reviewing the MTPs after they have been enacted. Lastly, the commenter requests greater detail regarding the notice and procedural protections that will be provided to participants needing to change their living settings or service plans.

> **Response: Per the CMS-approved 1915(i) SPA, members applying for or enrolled in AMHH/BPHC are required to be provided information about their rights and responsibilities, consisting of both written materials and a verbal explanation. DMHA ensures that members receive rights and responsibilities information through the established QA/QI process for 1915(i) programs. Among the information required to be included in the member's rights and responsibilities information are the phone numbers for the DMHA Consumer Support Line and Indiana Protection and Advocacy Services. In addition, the person-centered planning process ensures that an individual has the right to choose who will be a part of his or her treatment team, including family members, friends, natural supports, and advocates of the member's choosing. DMHA will explore changes to program policies and procedures to add that required HCBS information must include contact information of the State's Mental Health/Addiction Ombudsman program to ensure individuals without family or support systems have access to an independent party to assist and advocate for them if they choose**.

Comment: One commenter requests that the Division disclose its plans to coordinate with the other state entities to ensure that individuals with "dual diagnoses" are not being unnecessarily served in settings that are non-compliant with or technically exempt from the HCBS Final Rule. Too often, individuals are passed between Divisions and are unable to receive individualized treatment and services due to a lack of coordination.

> **Response: FSSA divisions will work together to ensure each individual's needs are identified and met in the least restrictive most appropriate setting of their choice. FSSA has established cross-division meetings for this purpose.**

Comment: Several questions were received about how the HCBS Settings Rule affects members who are homeless, specifically, how to document and assess the living situation for homeless members enrolled in or applying for HCBS programs.

> **Response: DMHA refers providers to the following guidance from CMS: "If a recipient is 'homeless,' that does not impact service delivery through the various authorities covered by the HCBS Settings Rule and transition process. The recipient has not been placed in a residential setting under the rule. Any nonresidential services would treat homeless and people with homes in the same manner. The additional requirements for provider owned and controlled residential settings do not apply as a homeless person is not served in that type of setting." To assist providers in documenting a member's homelessness, DMHA will establish a "Homeless" category on an updated version of the HCBS Residential Setting Screening Tool**

(RSST), and will add a "Homeless" choice to the available options in the "Current Living Situation" section of the DARMHA application for 1915(i) services. DMHA will also explore policy and procedural changes regarding ongoing residential assessment.

Comment: Several questions, comments and suggests were received from AMHH and BPHC providers regarding the HCBS Residential Setting Screening Tool (RSST). Providers requested further guidance on the implementation of this new tool, and made good suggestions for improving future versions of the tool.

Response: DMHA will develop and distribute an updated version of the RSST, to include a comprehensive definitions and instruction sheet. DMHA will compile and distribute an FAQ list for providers with responses to questions received about proper completion of the RSST, based on unique member residential situations encountered by provider agencies.