INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Office of Medicaid Policy and Planning

Home- and Community-Based Services: Indiana PathWays for Aging Waiver

Note: For updates to the information in this module, see the following Indiana Health Coverage Programs (IHCP) bulletins, accessible from the IHCP Bulletins webpage at in.gov/medicaid/providers:

- *BT202687 – IHCP announces document delivery requirements for Medicaid HCBS waiver providers*
- *BT202609 – OMPP further clarifies TB test requirements for direct care HCBS, adding SFC to example list*
- *BT202603 – FSSA implements extraordinary care allowance for Attendant Care and Participant Assistance and Care*
- *BT2025190 – IHCP revises previously announced changes to HCBS assisted living billing policy*
- *BT2025173 – IHCP updates the billing policy for HCBS assisted living providers*
- *BT2025169 – IHCP and DDARS announce changes to waiver services, effective Jan. 1, 2026*

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Revision History

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1.1	Policies and procedures as of July 1, 2024 Published: Sept. 9, 2024	Correction	FSSA and Gainwell
1.2	Policies and procedures as of July 1, 2024 Published: April 4, 2025	Correction	FSSA and Gainwell
1.3	Policies and procedures as of July 1, 2024 Published: July 3, 2024	Interim update	FSSA and Gainwell
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1.7	Policies and procedures as of July 1, 2024 Published: Jan. 20, 2026	Interim update	FSSA and Gainwell
2.0	Policies and procedures as of Aug. 1, 2025 Published: April 30, 2026	Scheduled update: • Edited text as needed for clarity • Updated the *PathWays Waiver Overview* section • Added the *Managed Care Delivery System* subsection • Updated the *Services Available Under the PathWays Waiver* section • Updated the *Eligibility for PathWays Waiver Services* section • Updated the *Level of Care* section • Updated the *Service Plan Requirements* section	FSSA and Gainwell

Version	Date	Reason for Revision	Completed By
		• Updated the *FSSA Provider Enrollment Application and Certification* section • Updated the *PathWays Waiver Provider Certification* section • Updated the *IHCP Provider Type and Specialty* section • Updated the *IHCP Application Submission and Processing* section • Added the *MCE Provider Enrollment* section • Updated the *Background Checks* section • Added the *TB Test Requirement for Direct Care Employees* section • Added the *CPR/First Aid Requirements for Direct Care Employees* section • Updated the introductory text of *Section 3: Claim Billing and Reimbursement* • Updated the *Verifying Eligibility for HCBS Waiver Services* section • Updated the *Service Authorization Requirements* section • Included information about the IHCP Provider ID in the *Billing Instructions* section • Updated the *Electronic Visit Verification System Required for Personal Care Services* section • Updated *Section 6: Care Coordination* • Added the *Claim Note Required for Attendant Care* section • Added a note in the *Activities Not Allowed* section under Attendant Care • Updated the *Documentation Standards* and *Limitations* sections under Community Transition	

Version	Date	Reason for Revision	Completed By
		• Added a note in the *Activities Not Allowed* section under Home and Community Assistance • Updated the *Activities Not Allowed* section under Home-Delivered Meals • Updated the *Activities Not Allowed* section under Home Modification Assessment • Added a note about medication dispensers in the *Allowable Activities* under Specialized Medical Equipment and Supplies • Updated the *Service Coordination* section and subsections • Added the *Claim Note Required for Structured Family Caregiving* section • Added a note in the *Activities Not Allowed* section under Structured Family Caregiving • Added the *Allowable Activities* section and updated the *Service Standards* section under Transportation • Updated the *Helpful Contact Numbers* section	
2.1	Policies and procedures as of Aug. 1, 2025 Published: May 28, 2026	Interim update: • Added note on title page pointing to *IHCP Bulletin BT202687*	FSSA and Gainwell
2.2	Policies and procedures as of Aug. 1, 2025 Published: June 15, 2026	Correction: • On *Table 1,* corrected rate for Assisted Living – Level 2 Daily to $112.13	FSSA and Gainwell

Table of Contents

Section 1: Introduction

Section 1915(c) of the *Social Security Act* permits states to offer, under a waiver of statutory requirements, an array of home- and community-based services (HCBS) that an individual needs to avoid institutionalization. These waiver programs allow the Indiana Health Coverage Programs (IHCP), Indiana's Medicaid program, to provide services in an individual's home or other community setting that would ordinarily be provided only in an institution. The term "waiver" refers to waiving of certain federal requirements that otherwise apply to Medicaid program services. HCBS waivers are not Medicaid entitlement programs. Waiver services complement and supplement the services available to participants through the Indiana Medicaid State Plan and other federal, state and local public programs, as well as the support that families and communities provide.

The Indiana Family and Social Services Administration (FSSA) has overall responsibility for the waiver programs. Day-to-day administration and operation of individual waiver programs are delegated to divisions within the FSSA.

The FSSA Office of Medicaid Policy and Planning (OMPP) supports the Indiana PathWays for Aging (PathWays) program and the associated PathWays Waiver.

PathWays Waiver Overview

The PathWays Waiver is designed to provide an alternative to nursing facility (NF) admission for Medicaid-eligible persons ages 60 and older who meet nursing facility level of care. The services available through this waiver are designed to help members remain in their own homes, as well as to help individuals residing in NFs to transition back to community settings, such as their own homes, apartments, assisted living, structured family caregiving or adult family care.

Managed Care Delivery System

Indiana PathWays for Aging (PathWays) is a managed long-term services and supports (mLTSS) program. This means individuals enrolled in the PathWays program are assigned to a managed care entity (MCE) that manages the member's Medicaid benefits and coordinates member care. When a member also receives HCBS through the PathWays Waiver, their assigned MCE administers their PathWays Waiver benefits. For MCE contact information, see the *IHCP Quick Reference Guide*.

Exception: There are some specific exceptions and situations where automatic enrollment might not apply or where certain rules regarding eligibility might be waived from enrollment in an mLTSS program like Indiana PathWays for Aging. These exempted groups include American Indians and Alaska Natives, as well as IHCP members who are receiving hospice services under the FFS Traditional Medicaid program at the time that they become eligible for PathWays. When an individual is exempt from enrolling in PathWays mLTSS but is eligible and receives PathWays Waiver services, the waiver services are administered by FFS.

Through the competitive bid process, the FSSA contracts with managed care health plans to administer the PathWays program, including the PathWays Waiver. More information regarding the contracted MCEs, see the PathWays Health Plan Comparison.

The MCE is responsible for assigning a service coordinator to coordinate all waiver services. Service coordinator is used to reference waiver case management delivered by the MCEs. The service coordinator will develop the service plan, directed by the member, through the person-centered planning and Interdisciplinary Care Team (ICT) process. The MCE authorizes waiver services in accordance with the state-approved service authorization policies and procedures. The policies and procedures address how new

and continuing authorizations of services are approved and denied. More information regarding authorization of services can be found in *Section 6: Care Coordination*.

Services Available Under the PathWays Waiver

The following services are available under the PathWays Waiver (see *Section 7* for service definitions):

- Adult Day Services
- Adult Family Care
- Assisted Living
- Attendant Care
- Caregiver Coaching
- Case Management – Only applicable for exempt population receiving waiver services under FFS
- Community Transition – Provided by the MCE when member is enrolled in Medicaid managed care
- Home and Community Assistance
- Home-Delivered Meals
- Home Modification Assessment
- Home Modifications
- Integrated Health Care Coordination
- Nutritional Supplements
- Participant-Directed Home Care Service
- Participant-Directed Attendant Care
- Personal Emergency Response System
- Pest Control
- Respite Care Services
- Service Coordination – Provided by the MCE
- Specialized Medical Equipment and Supplies
- Structured Family Caregiving
- Transportation
- Vehicle Modifications

All services should be compliant with the Centers for Medicare & Medicaid Services (CMS) HCBS final rule settings requirements, as outlined in Indiana's Statewide Transition Plan (STP).

Participants must be authorized for individual services within the waiver, as described in the *Service Plan Requirements* section.

Eligibility for PathWays Waiver Services

Individuals must qualify for a nursing facility level of care (NF LOC) and must be enrolled in the IHCP to be eligible for HCBS coverage through the PathWays Waiver.

Beginning July 1, 2025, the Area Agencies on Aging (AAAs), the PathWays MCEs and the Indiana Level of Care Assessment Representative (LCAR) contractor, Maximus, serve as entry points for the PathWays Waiver. The LCAR contractor determines initial functional eligibility and LOC as described in the *Level of Care* section.

Before the PathWays Waiver benefit plan is assigned in *Core*MMIS, the member must have PathWays Full Medicaid coverage, the waiver benefit plan and the initial service plan must be approved, and a start date must be established. The waiver benefit plan with the start date is then entered into *Core*MMIS by the FSSA.

Level of Care

Persons must meet the criteria for nursing facility level of care (NF LOC) as a key component of eligibility for the PathWays Waiver. The criteria necessary to qualify for NF LOC are outlined in *Indiana Administrative Code* *405 IAC 1-3-1* through *405 IAC 1-3-3*.

Effective July 1, 2025, the NF LOC process will be coordinated by the Indiana LCAR contractor. Data elements from the interRAI suite of instruments will be collected in AssessmentPro – a web-based assessment platform developed by the LCAR contractor, Maximus – as follows:

- For individuals not currently enrolled in the PathWays managed care program, a request to have an LOC assessment performed should be submitted to the Indiana LCAR – Maximus Help Line at 833-597-2777 or (for registered users) by submitting an Assessment Request form on AssessmentPro.
- For currently enrolled PathWays members, the assigned MCE will submit interRAI data elements to AssessmentPro using the member's full comprehensive health assessment tool (CHAT).
- Area Agencies on Aging (AAAs) may submit interRAI data elements to AssessmentPro for individuals they already support in nonwaiver programs, when the individuals' needs change and they begin to seek services that require an NF LOC. However, effective July 1, 2025, AAAs will no longer conduct LOC assessments for the general public and will no longer be making LOC determinations.

> *Note: If the individual seeking PathWays Waiver services has been in a nursing facility for at least 90 days and has already received a long-term LOC designation for the nursing facility stay, then that determination will serve as the initial LOC assessment for the waiver eligibility.*

The LCAR contractor must ensure that the Level of Care outcome letter is sent to the applicant or participant within 10 working days of the determination.

The LCAR provides intake counseling for those aged 60 or older who qualified for a long-term approval as the outcome of their NF LOC assessment. Intake counseling is a person-centered process that provides individuals with unbiased information about the HCBS and long-term services and supports (LTSS) options available to them because they were determined to be eligible for an NF LOC.

Medicaid Eligibility and Disability Determinations

To receive PathWays Waiver services, an individual must be enrolled in the IHCP. For overall IHCP eligibility requirements, including for the PathWays program, see the *Member Eligibility and Benefit Coverage* provider reference module. Financial eligibility is determined by the Division of Family Resources (DFR).

PathWays Waiver members must be age 60 or older. The following information applies to those ages 60 through 64. Disability verification is not required for individuals age 65 and older.

If an individual has a disability determination from the Social Security Administration (SSA), the state uses the SSA determination for Medicaid eligibility purposes. Individuals considered disabled by the SSA are considered disabled by the IHCP. However, by law, the IHCP determines eligibility for individuals who apply to Indiana Medicaid without having received SSA disability determination. The following conditions apply:

- For those between ages 18 through 64 years, the IHCP requires an approval, active application or appeal to the SSA on file with FSSA as part of the eligibility process.
- Individuals age 18 through 64 years who are found eligible for Indiana Medicaid are required to have an approval, active application or appeal to SSA on file with FSSA.
- If the SSA's disability determination differs from the IHCP's, the SSA determination is considered final. As a 1634 state, Indiana is required to defer to all SSA disability determinations. For example, if the Medicaid agency's MRT deemed an individual to be nondisabled but the SSA later determined that same individual to be disabled and eligible for Supplemental Security Income (SSI), the IHCP would automatically enroll the individual. Individuals later found eligible for Social Security Disability Income (SSDI) would need to reapply, but the SSA disability determination would be accepted, and the member would be eligible if they met the other eligibility requirements.

Waiver Liability

Individuals who qualify for PathWays Waiver services but who have income in excess of the Medicaid limits may be enrolled with a waiver liability, which they must meet each month before their HCBS services will be covered. For more information, see the *Member Eligibility and Benefit Coverage* provider reference module.

Service Plan Requirements

PathWays case managers/service coordinators are responsible for preparing a written individualized care plan (ICP) utilizing strengths-based, person-centered processes. The ICP is developed using data from multiple sources. The service coordinator/case manager will identify gaps in care. This ICP is developed with the ICT.

A member in the PathWays waiver will also have a person-centered service plan (PCSP). The PCSP must describe the following:

- The setting in which the individual resides and that it is chosen by the individual
- The individual's strengths and preferences
- Clinical and support needs as identified through an assessment of functional need
- Individually identified goals and desired outcomes
- The services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports

- Risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed
- Services and supports in a manner that is comprehensible to the individual, written in plain language and in a manner that is accessible to individuals with disabilities and persons who have limited English proficiency
- Identity of the individual and/or entity responsible for monitoring the plan
- That the plan be finalized and agreed upon, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation
- That the plan be distributed to the individual and other people involved in the plan
- Services that the individual elects to self-direct, and how to prevent the provision of unnecessary or inappropriate services and supports
- Medical and other services to be furnished, regardless of funding source (such as medical transportation under prior authorization [PA], respite care under HCBS waiver, in-home hospice through the Indiana Medicaid State Plan PA process)
- Frequency of each service the member is receiving
- Type of provider (home health provider under Medicaid PA, waiver provider or family member) that will furnish each service

All services must be furnished pursuant to a written service plan. The service plan is subject to the approval of the MCE and may be subject to the approval of the FSSA.

The PathWays service coordinator/case manager is responsible for completing the service plan.

MCE or FSSA service plan approval results in an approved service authorization. The service authorization provides the following details for each waiver-funded service that is approved for the member:

- Number of units to be provided
- Name of the authorized waiver provider
- Approved billing code with the appropriate modifiers
- Unit cost
- Dates covered under the authorization
- Contact information for the service coordinator

The PathWays service coordinator/case manager transmits this information to the waiver database of MCE provider portal. Claims deny if no authorization exists in the database or if a code other than the approved code is billed. Providers are not to render or bill services without an approved service authorization. It is the provider's responsibility to contact the service coordinator/case manager if there is any discrepancy in the services authorized or rendered on the approved service authorization.

Section 2: Waiver Provider Requirements

The following sections describe the process for becoming a provider of home- and community-based services (HCBS) for the Indiana PathWays for Aging (PathWays) Waiver, as well as related requirements. Providers using this process will also be eligible to provide services to individuals enrolled in the Traumatic Brain Injury (TBI) and Health & Wellness (H&W) waivers, which are administered by the Division of Disability, Aging and Rehabilitative Services (DDARS).

FSSA Provider Enrollment Application and Certification

To provide PathWays Waiver services, a provider must be certified by the Indiana Family and Social Services Administration (FSSA) Office of Medicaid Policy and Planning (OMPP), enrolled in the Indiana Health Coverage Programs (IHCP), and enrolled with one or more PathWays managed care entities (MCEs), as described in the following sections. For some waiver services, providers may be required to become a licensed personal services agency through the Indiana Department of Health (IDOH), prior to applying for waiver provider certification.

PathWays Waiver Provider Certification

The FSSA OMPP is responsible for enrolling and certifying providers for the PathWays Waiver, Health & Wellness (H&W) Waiver and the Traumatic Brain Injury (TBI) Waiver as of July 1, 2024. Information on the application process, including the required documentation, are located on the *Medicaid HCBS Certification* webpage at in.gov/fssa/ompp. Providers wishing to provide services under these waivers must complete an application through the OMPP HCBS Certification Portal. Providers must submit all required documentation for each service in which they wish to be certified. This portal is used to certify new providers, add services for existing providers and make a change in ownership. An application for certification can be denied if the screening process determines that the provider does not meet the requirements for participation, or an application can be rejected if required supporting documentation or information is missing from the submission. A letter is sent to notify applicants of this decision and advise them of the necessary actions needed for resubmission of the rejected application. An application for certification will be approved by a Provider Certification team member after a determination is made that conditions of participation have been met. Upon approval, a provider will be advised of the next steps, which will include the following: enrolling with Gainwell, enrolling in MCE provider networks, and completing settings rule compliance if applicable. Providers must be approved or certified through the OMPP and IHCP.

When a provider submits an HCBS application (as a brand-new enrollment, a change of ownership or add services), the application will be placed into the provider applications queue. A notification will be sent to the group email address for the Provider Certification manager to assign each application record. The provider certification manager will be responsible for assigning all applications to a provider certification specialist. Applications are to be assigned within two business days of submission.

> *Note: Because PathWays Waiver services mirror Health and Wellness (H&W) Waiver services, separate certification is not required to deliver the same service under both waivers.*

If a provider has more than one service location, a separate certification application must be submitted for each location. For facility-based services (such as Adult Day Services, Adult Family Care, Assisted Living or Structured Day Program), each location where a given service is provided must be individually certified. For non-facility-based services, each location where HCBS business is conducted for a given service must be individually certified. Each individually certified service location will need to be separately enrolled in the IHCP and assigned its own unique IHCP Provider ID.

Multiple certification applications may be submitted under a single account in the OMPP HCBS Certification Portal, as long as the services and locations are all under a single provider entity.

Applications will be reviewed within four business days of submission. Providers will have five business days to make corrections for returned documents that may be incorrect or require more information. For all requests submitted, providers will receive communication from the OMPP Provider Certification Team.

For required background checks, the background check needs to be completed within 90 days of the certification application submission date. See the *Background Checks* section for details.

The *Waiver Service Certification Letter* directs the provider to contact the fiscal agent to complete the IHCP provider enrollment process. A copy of the FSSA OMPP waiver certification letter will need to be included with the IHCP provider enrollment application. After completing the IHCP enrollment process, the provider then must also enroll with the PathWays MCEs in which they wish to participate.

Waiver agencies are required to recertify with the OMPP every three years. All HCBS provider certification renewal requests for PathWays waivers must be submitted through the OMPP HCBS Certification Portal. Provider compliance reviews are required by all HCBS waiver providers every three years. Noncompliance with this process will result in corrective action and ultimately decertification. Providers will receive notification of their renewal three months prior to their due date. Providers that have not created an account through the OMPP HCBS Certification Portal will be contacted via the email address provided to the IHCP to initiate the process.

> *Note: Existing waiver providers can also use the OMPP HCBS Certification Portal to request certification for additional services (Add Service) or additional locations (New Application). When a currently certified provider completes the application to add a service, they should include all their current services, as well, to ensure that all services (existing as well as newly added) are reflected within the OMPP HCBS Certification Portal. Providers that use the OMPP HCBS Certification Portal for any changes to their certification will receive a new certification letter, and they will then need to update their provider enrollment information on the IHCP Portal.*

IHCP Enrollment as a PathWays Waiver Provider

After a prospective provider receives the FSSA OMPP *Waiver Service Certification Letter,* the enrollment process with the IHCP begins. **The IHCP enrollment application MUST be submitted within 90 calendar days of certification.**

The prospective provider can enroll online or by mail, as follows:

- Prospective providers may enroll online through the IHCP Provider Healthcare Portal (IHCP Portal), accessible from the homepage at in.gov/medicaid/providers. Click the **Provider Enrollment** link to begin the enrollment process.
- To enroll by mail, a prospective provider may obtain an IHCP provider enrollment packet by downloading it from the *Complete an IHCP Provider Enrollment Application* webpage at in.gov/medicaid/providers.

> *Note: Providers are strongly encouraged to use the IHCP Portal, accessible from the homepage at in.gov/medicaid/providers, for provider enrollment applications, revalidations and profile updates whenever possible, as electronic transactions can be processed more efficiently than paper submissions. Not only is the IHCP Portal designed to reduce errors in initial submissions, but it also provides a tracking number that is helpful in tracking subsequent submissions if follow-up is needed for missing information or documents. However, providers unable to use the IHCP Portal do have the option to submit paper enrollment applications.*

> *All applications for enrollment as a PathWays Waiver provider must include the FSSA OMPP Waiver Service Certification Letter.*

For detailed enrollment instructions, see the *Provider Enrollment* provider reference module at in.gov/medicaid/providers.

IHCP Provider Classification

When applying for enrollment in the IHCP, providers must select a provider classification based on their business structure. HCBS waiver providers must be enrolled under one of the following classifications:

- Billing provider (sole practitioner)
- Group provider (must have members linked to the group)
- Rendering provider (must be linked to a group)

Rendering providers cannot bill for services; the group bills for services, identifying the rendering provider as the performer of the service. For group enrollments, all rendering providers linked to the group must be certified by the FSSA OMPP.

When applying by mail rather than online, the provider classification determines which enrollment packet the waiver provider should complete:

- *IHCP Waiver Billing Provider Enrollment and Profile Maintenance Packet*
- *IHCP Waiver Group Provider Enrollment and Profile Maintenance Packet*
- *IHCP Waiver Rendering Provider Enrollment and Profile Maintenance Packet*

IHCP Provider Type and Specialty

Each prospective waiver provider must designate a "type" and "specialty," as well as one or more secondary specialties, during IHCP enrollment.

The IHCP provider type for HCBS waiver providers is 32 – *Waiver Provider*. PathWays Waiver providers must be enrolled under specialty 350 – *PathWays / Health and Wellness Waiver*. The provider's secondary specialties must be the same ones it is certified for by the OMPP. If a provider does not wish to enroll with a certified service, the provider must contact the OMPP to have that service removed from their certification. See the *IHCP Provider Enrollment Type and Specialty Matrix* for a complete list of waiver specialties and secondary specialties.

> *Note: When enrolling in the IHCP as a PathWays Waiver provider, providers will automatically also be enrolled for the Money Follows the Person (MFP) demonstration grant specialties corresponding to the PathWays Waiver specialties for which they are certified, even if the certification letter does not indicate MFP services.*

IHCP Application Submission and Processing

The enrollment application must be signed and submitted with the requested documentation, including form *W-9*, electronic funds transfer (EFT) form and a copy of the FSSA OMPP *Waiver Service Certification Letter*. An *IHCP Provider Agreement* is also included in the enrollment application. Enrollments submitted via the IHCP Portal allow electronic signatures and electronic attachments.

All paper enrollment forms and attachments must be sent to the following address, to ensure proper processing:

IHCP Provider Enrollment
PO Box 50443
Indianapolis, IN 46250-0418

Enrollment documents are logged into a document tracking system and issued an application tracking number (ATN).

The IHCP Provider Enrollment Unit has dedicated staff members assigned to coordinate and handle all HCBS waiver provider enrollments and updates. These staff members work closely with the FSSA OMPP to ensure timely and accurate maintenance of HCBS waiver provider enrollment processes.

The IHCP staff members review the IHCP provider enrollment packet to ensure completeness according to the Provider Enrollment guidelines:

- If a provider enrollment packet needs correcting or is missing required documentation, the IHCP Provider Enrollment Unit will contact the applicant by telephone, email or mail. This contact is intended to communicate what needs to be corrected, completed and submitted before the IHCP can process the enrollment transaction. If an application is rejected for missing or incomplete information, a letter will be sent indicating what needs to be corrected or attached, and a copy of this letter must be included when submitting the corrected or missing information.
- If the information is completed accurately and approved, the IHCP Provider Enrollment Unit then enters the provider's information into the IHCP Core Medicaid Management Information System (*Core*MMIS). For enrollment applications submitted via the IHCP Portal, the provider's information transfers automatically into *Core*MMIS. A provider letter is generated from the IHCP notifying the provider agency that it is now a Medicaid-enrolled HCBS waiver provider. This letter is sent to the provider detailing the assigned IHCP Provider ID and enrollment information entered into *Core*MMIS. Providers are encouraged to review this letter to ensure enrollment accuracy.

The provider's IHCP enrollment effective date with the IHCP will automatically match the certification date, by service, for each certified service.

MCE Provider Enrollment

After completing the IHCP enrollment process, providers wishing to participate in the PathWays program and waiver will be directed to contact the MCEs with whom the provider wishes to participate. For more information about enrolling with an MCE, see the *Enrolling as a Managed Care Program Provider* webpage.

PathWays Waiver service providers are encouraged to enroll with each of the PathWays MCEs and to register their agency on the MCE provider portals, in addition to the IHCP Portal.

IHCP Provider Responsibilities

Complete information on IHCP provider enrollment, eligibility and responsibilities is available in the *Provider Enrollment* provider reference module at in.gov/medicaid/providers.

IHCP Provider Agreement

Medicaid-enrolled HCBS waiver providers are enrolled in the IHCP and have executed an *IHCP Provider Agreement* with the FSSA. This agreement states that the provider will comply, on a continuing basis, with all the federal and state statutes and regulations pertaining to the IHCP, including the waiver programs' rules and regulations. The *IHCP Provider Agreement* is included in the IHCP enrollment application; see

the *IHCP Enrollment as a PathWays Waiver Provider* section for details. By signing the agreement, the provider agrees to follow the information provided in the IHCP provider reference modules (including this module), as amended periodically, as well as all provider bulletins and notices. All amendments to the IHCP provider reference modules (including this module), and all applicable *Indiana Administrative Code* (IAC) rules and regulations are binding on publication. This provider reference module and all IHCP publications are accessible online from the *Bulletins and Reference Modules* webpage at in.gov/medicaid/providers.

The information is made available to assist all those who administer, manage and participate in the PathWays program and the PathWays Waiver. Current HCBS waiver requirements can be found in the Centers for Medicare & Medicaid Services (CMS) approved applications and the *Aging Rule, 455 IAC 2*.

Office of Inspector General Exclusionary List

The U.S. Health and Human Services Office of Inspector General (HHS-OIG) excludes certain providers (both individuals and entities) from participation in Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP) and all federal healthcare programs (as defined in Section 1128B[f] of the *Social Security Act* – the Act). When the HHS-OIG has excluded a provider, federal healthcare programs – including Medicaid and SCHIP programs – are generally prohibited from paying for any items or services furnished, ordered or prescribed by the excluded individual or entity (see *Section 1903[i][2]* of the Act and *Code of Federal Regulations 42 CFR 1001.1901[b]*). This payment ban applies to any items or services reimbursable under a Medicaid program that are furnished by an excluded individual or entity. The prohibition applies to payments for any items or services directed or prescribed by an excluded physician or other authorized person when the individual or entity furnishing the services knew or should have known of the exclusion, even when the payment itself is made to another provider, practitioner or supplier that is not excluded.

The HHS-OIG maintains the List of Excluded Individuals and Entities (LEIE), a database that provides information about parties excluded from participation in Medicare, Medicaid and all other federal healthcare programs. The LEIE database is accessible to the general public from the *Exclusions Program* webpage at oig.hhs.gov, for online searching or to be downloaded. The online searchable Exclusions Database identifies currently excluded individuals or entities by name. When a match is identified, it is possible for the searcher to verify the accuracy of the match using a Social Security number (SSN) or employer identification number (EIN). The downloadable version of the database may be compared against an existing database maintained by a provider. However, unlike the online format, the downloadable database does not contain SSNs or EINs.

All current IHCP providers and providers applying to participate in the IHCP are required to take the actions outlined in this section to determine whether their employees and contractors are excluded individuals or entities. Providers are required to agree to comply with these obligations as a condition of enrollment:

- Screen all employees and contractors to determine whether any of them have been excluded. Providers can access the LEIE database on the HHS-OIG website at oig.hhs.gov and search by the names of any individual or entity.
- Search the HHS-OIG website monthly to capture exclusions and reinstatements that have occurred since the last search.
- Report to the state any exclusion information discovered by contacting the Provider and Member Concerns Line toll free at 800-457-4515.

Because it is prohibited by federal law, no payments can be made for any amount expended for items or services (other than an emergency item or service not provided in a hospital emergency room) by an individual or entity while being excluded from participation (unless the claim for payment meets an exception listed in *42 CFR section 1001.1901[c]*). Any such payments actually claimed for federal financial participation (FFP) constitute an overpayment and are therefore subject to recoupment. The amount of the Medicaid overpayment for such items or services is the actual amount of Medicaid dollars

that were expended for those items or services. When Medicaid funds have been expended to pay an excluded individual's salary, expenses or fringe benefits, the amount of the overpayment is the amount of those expended Medicaid funds. Civil monetary penalties may be imposed against Medicaid providers and managed care entities (MCEs) that employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid recipients.

For examples of types of items or services that, when provided by excluded parties, are not reimbursable and would constitute an overpayment subject to recoupment, see the *Provider and Member Utilization Review* provider reference module at in.gov/medicaid/providers.

Provider Record Updates

When enrollment record information changes, PathWays Waiver providers must notify the FSSA OMPP, the IHCP and all applicable MCEs, to ensure timely communication of all information. Provider information is stored in several FSSA systems, including *Core*MMIS. Each of the Indiana PathWays for Aging MCEs maintain their own claim-processing and case management systems. *Core*MMIS is maintained by the FSSA's fiscal agent.

The fiscal agent is responsible for maintaining *Core*MMIS; therefore, the fiscal agent must have accurate information on file for all providers, including the current pay-to, mail-to, service location and home office (legal) address. It is the provider's responsibility to ensure that the information on file with the fiscal agent is correct. As described in the *Provider Enrollment* provider reference module, providers are required to submit updated information to the IHCP within 10 business days of any applicable change. Provider profile maintenance forms are available at the *Update Your Provider Profile* webpage at in.gov/medicaid/providers, or updates can be made via the IHCP Provider Healthcare Portal, accessible from the homepage of in.gov/medicaid/providers.

> *Note: For waiver providers, many types of updates must first be submitted to the FSSA OMPP and require a new Waiver Service Certification Letter before they can be submitted to the IHCP. See the FSSA OMPP Waiver Provider Information Updates section for details.*

If the provider is licensed through the Indiana Department of Health (IDOH), the provider must also notify the IDOH of any changes to the provider's name, address or telephone number.

Provider Responsibilities Specific to the Waiver Program

The following sections describe responsibilities applicable to all waiver providers.

Background Checks

Pursuant to *455 IAC 2,* the OMPP HCBS certification team must obtain a current background check for each employee or agent involved in the direct management, administration or provision of services. The background check must not show any evidence of acts, offenses or crimes affecting the applicant's character or fitness to care for waiver participants in their homes or other locations.

The minimum accepted background is a limited history check. A report may be requested through the Indiana State Police *Get Limited Criminal History* webpage at in.gov/isp. A report from a third party would also be accepted. A copy of the individual's driver license must be provided with this background check. National background checks, as well as fingerprint-based background checks, are acceptable.

Additionally, for entities seeking certification for services that the IHCP has assigned to the **high-risk** enrollment category, all owners and managing individuals are required to undergo a national fingerprint-based background check. For the PathWays Waiver, this mandate includes entities enrolling to provide the following services:

- Attendant Care
- Specialized Medical Equipment and Supplies

This requirement applies to all individuals who have at least 5% ownership or controlling interest in the enrolling business entity, including the board of directors if the enrolling entity is not-for-profit. Instructions for the fingerprinting registration process are available on the *Provider Enrollment Risk Levels and Screening* webpage at in.gov/medicaid/providers.

If any background check returns with a conviction, the provider will identify whether the conviction falls under any of the statutes referenced in *455 IAC 2-15-2*. If there is a conviction that falls under any of the categories in A-I below, the corresponding code reference in parenthesis will need to be examined to see if the conviction type is named in that code and if so, the employee will not be eligible for hire.

(A) A sex crime (*Indiana Code IC 35-42-4*)

(B) Exploitation of an endangered adult (*IC 35-46-1-12*)

(C) Abuse or neglect of a child (*IC 35-42-2-1*)

(D) Failure to report battery, neglect, or exploitation of an endangered adult or dependent (*IC 35-43-4*), except as provided in *IC 16-27-2-5(a)(5)*

(E) Theft (*IC 35-43-4*), except as provided in *IC 16-27-2-5(a)(5)*

(F) Murder (*IC 35-42-1-1*)

(G) Voluntary manslaughter (*IC 35-42-1-3*)

(H) Involuntary manslaughter (*IC 35-42-1-4*)

(I) Battery (*IC 35-42-2*)

Background checks are maintained in agency files and are available upon request.

Licensed professionals are checked for findings through the Indiana Professional Licensing Agency (IPLA). Direct care staff is also checked against the nurse aide registry at the IPLA to verify that each unlicensed employee or agent involved in the direct provision of services has no finding entered into the registry in order to qualify to provide direct care to members receiving services.

The IPLA is responsible for maintaining the nurse aide registry. Pursuant to *455 IAC 2, General Requirements*, the provider must obtain and submit a current document from the nurse aide registry of the IPLA, verifying that each unlicensed employee involved in the direct provision of services has no finding entered into the registry before providing direct care to members receiving services. The FSSA OMPP waiver certification specialist verifies receipt of documentation as part of provider certification.

Nurse aide registry documents are maintained in agency files and are available upon request.

Waiver providers must understand the service definitions and parameters for each service authorized on a participant's service authorization. All waiver providers are subject to audit and potential recoupment if the services provided are not in agreement with the services authorized as indicated on the approved service authorization. If the needs of a member change, the provider must contact the service coordinator/case manager to discuss revising the service plan.

Providers are required to furnish at least 30 calendar days' written notice before terminating waiver services to a member. This notice must be made to the member, the legal representative (if applicable), the member's service coordinator/case manager and the FSSA OMPP.

TB Test Requirement for Direct Care Employees

To be certified for direct care HCBS, providers must meet the following requirements:

- A tuberculosis (TB) test is required for all direct care employees upon hire prior to face-to-face interaction with clients. The TB test is to be stored in the employee's personnel file.
- The provider's personnel policy will include that the agency will provide yearly TB education to direct care employees.
- The provider's personnel policy will include that an employee will be required to have an updated TB test upon known TB exposure. If the TB test is positive, a negative X-ray is required.

CPR/First Aid Requirements for Direct Care Employees

The FSSA requires direct service staff to receive training in first aid and cardiopulmonary resuscitation (CPR), which includes topics such as emergency precautions and injury and medical emergencies. The FSSA also requires direct service staff to have demonstrated competency in CPR through CPR certification from an approved entity, such as the American Heart Association or the American Red Cross. The certification should be updated in accordance with these entities. To certify as a provider of direct services for the HCBS waivers, providers must meet the following requirements:

- CPR/first aid training and certification are required for all direct service staff upon hire, prior to face-to-face interaction with clients. The CPR and first aid training certification documents are to be stored in the employee's personnel file.
- The provider's personnel policy will include that the agency requires updated training and certification in accordance with an approved entity.
- The provider's personnel policy will include that all direct service staff are required to have CPR certification and first aid training current and documented in the employee's personnel file.

The FSSA expects direct service staff – direct support professionals and patient care aides – to be trained in CPR/first aid and to administer it, if needed. The IDOH does not regulate direct service staff in HCBS waivers; however, in alignment with IDOH oversight in the state licensed residential care facilities (licensed assisted living), home health agencies and personal service agencies, the FSSA expects CPR/first aid to be provided if needed.

FSSA OMPP Waiver Provider Information Updates

Updates to the following information must be submitted within 10 calendar days of the change to the FSSA OMPP through the OMPP HCBS Certification Portal at omppproviders.fssa.in.gov:

- Name changes
- Tax identification changes
- Additional service locations (additional service location addresses)
  - Requires new OMPP waiver service certification
- Changes to counties served
- Specialty changes (all specialties must be certified by the FSSA OMPP)
  - Requires new OMPP waiver provider application
  - Requires new OMPP waiver service certification

- Changes in ownership (CHOWs)
  - Requires new OMPP waiver provider application
  - Requires new OMPP waiver service certification

After update certification requirements for the provider have been met, the FSSA OMPP sends a new *Waiver Service Certification Letter* to the provider detailing the approved services and instructing the provider to begin the update process with the IHCP.

Providers can then update their information with the IHCP using the IHCP Portal or by mail using the appropriate enrollment packet or profile maintenance form, available from the *Update Your Provider Profile* webpage at in.gov/medicaid/providers. The new *Waiver Service Certification Letter* must be included with the update.

Section 3: Claim Billing and Reimbursement

Providers become eligible for reimbursement of Indiana PathWays for Aging (PathWays) Waiver services after all the following have occurred:

- They have received a letter of certification from the FSSA for the applicable services.
- They have enrolled in the Indiana Health Coverage Programs (IHCP) under the applicable provider type, specialty and secondary specialty, and have received their IHCP Provider ID.
- They have enrolled with one or more PathWays managed care entity (MCE) (required to deliver services to most PathWays members).
- They have been activated in the waiver provider database.
- They have received a service authorization for the provision of services for which they are certified to a particular member (whose MCE they are enrolled with).
- They have delivered the authorized services to the member in accordance with all service requirements. (The dates of service must be on or after the date of the provider's certification.)

This section provides general billing instructions for reimbursement of PathWays Waiver services. Specific claim completion and submission instructions may vary depending on the member's MCE. For MCE contact information, see the *IHCP Quick Reference Guide*.

Verifying Eligibility for HCBS Waiver Services

All Home- and Community-Based Services (HCBS) waiver participants must be enrolled in the IHCP with Full Medicaid coverage. PathWays Waiver participants are generally enrolled with a PathWays MCE, as described in the *Managed Care Delivery System* section.

All service providers must verify IHCP eligibility for each member before initiating services. If a member does not have an active waiver benefit plan and/or is not currently enrolled in an appropriate IHCP program on the date on which services were provided, any claim submitted may not be paid. For information about verifying eligibility, see the *Member Eligibility and Benefit Coverage* provider reference module at in.gov/medicaid/providers.

> *Note: The fiscal agent cannot add or correct a waiver benefit plan assignment in CoreMMIS.*

It is important to remember that, for members with a waiver liability, the IHCP does not reimburse for HCBS waiver services until their waiver liability is met for the month (see the *Waiver Liability* section). The IHCP eligibility verification process indicates if a PathWays member has a monthly waiver obligation; providers will need to refer to the member's MCE to verify the monthly obligation amount and the amount remaining for the month (based on paid claims). Providers may not bill the member for their liability amount until after the claim has been submitted to the IHCP and adjudicated.

Service Authorization Requirements

All services must be furnished pursuant to a written service plan, as described in the *Service Plan Requirements* section.

MCE or FSSA service plan approval results in an approved service authorization. The service authorization provides the following details for each waiver-funded service that is approved for the member:

- Number of units to be provided
- Name of the authorized waiver provider
- Approved billing code with the appropriate modifiers
- Unit cost
- Dates covered under the authorization
- Contact information for the service coordinator

The PathWays service coordinator/case manager transmits this information to the waiver database of MCE provider portal. Claims deny if no authorization exists in the database or if a code other than the approved code is billed. Providers are not to render or bill services without an approved service authorization. It is the provider's responsibility to contact the service coordinator/case manager if there is any discrepancy in the services authorized or rendered on the approved service authorization.

The MCE's prior authorization processes should support the provision of timely services to members and administrative efficiencies for providers with less duplication of effort and more coordinated and integrated processes and systems. The MCE shall authorize long-term services and supports (LTSS) and HCBS based on an enrollee's current needs assessment and consistent with the person-centered service plan in accordance with *Code of Federal Regulations 42 CFR 438.210(b)(2)(iii)*. The MCE shall alert the relevant provider of the services approved in the person-centered service plan using the timelines specified below:

- Complete and submit a service plan within five business, not to exceed seven calendar days, from the time the MCE is notified of one of the following:
  - The member is approved and meets eligibility criteria for Medicaid and PathWays Waiver.
  - The member or member's representative has requested a change to the service plan, including increase, decrease or removal of waiver services.
- After services are authorized, the service coordinator must ensure services are in place to start within 20 business days.
- When a member signs their service plan indicating disapproval of the service plan, the service coordinator must provide the member with a denial notice within two business days.
- For decisions to terminate, suspend or reduce previously authorized covered services, the MCE is required to allow at least 10 business days before the date of action.

Billing Instructions

PathWays waiver services are billed as **professional** claims, using applicable managed care entity (MCE) claim portal, 837P electronic transaction or *CMS-1500* paper claim form:

- Each PathWays MCE has its own provider portal that allows providers to submit claims and attachments, check eligibility and check status of claims.
- Professional claims can also be submitted via the 837P electronic transaction. To use this transaction, the provider must become a trading partner with the MCE.
- Paper copies of the *CMS-1500, Version 02/12* form are available from the U.S. Government Bookstore or other online retailers. Providers wishing to bill using the paper copies, must use an original *CMS-1500* form; black-and-white copies of the form are not accepted.

Providers should reach out to the appropriate MCE for specific instructions on submitting claims for PathWays Waiver services. See the *IHCP Quick Reference Guide* for MCE contact information, including mailing addresses and portal links.

Waiver providers are considered atypical providers and must bill using their IHCP-assigned Provider ID, even if the provider maintains a separate National Provider Identifier (NPI) for an additional enrollment type (such as a home health agency). The IHCP does not allow waiver (type 32) providers to add an NPI to their provider profile. As a result, billing with an NPI will result in claim denials for the IHCP-enrolled waiver provider.

Providers bill services based on an approved service authorization for the individual member, using an appropriate procedure code and the pricing method associated with the procedure code, such as per unit, per day, or per month. Additional pricing information is available on the Professional Fee Schedule, accessible from the *IHCP Fee Schedules* webpage at in.gov/medicaid/providers. General guidelines include:

- Do not bill for services before they are provided.
- If a unit of service equals 15 minutes, a minimum of eight minutes must be provided to bill for one unit.
- Activities requiring less than eight minutes may be accrued to the end of that date of service.
- At the end of the day, partial units may be rounded as follows: units totaling eight or more minutes may be rounded up and billed as one unit.
- Partial units totaling less than eight minutes may not be billed.
- Monthly units are billed at the end of the month.
- Daily units may be billed daily, weekly or monthly.

Assisted Living Billing Instructions

Assisted living facility (ALF) providers are now able to bill monthly or daily for services up to 29 days. Monthly billing can still be done even when a resident is out of the facility, as long as their time out of the facility does not exceed 30 consecutive days.

Example 1: The ALF provider normally bills monthly. During the month, the facility's resident, Mary, discharged to the hospital on Feb. 13, 2024, with plans to return to the ALF. She was at the hospital for four days and then discharged to a skilled nursing facility (SNF). Mary remained in the SNF for 14 days. While in the SNF, Mary's family decided to move her to another ALF when she discharged from the SNF. On the date of discharge from the SNF (March 2, 2024), Mary's family informed her ALF provider that she would not be returning and that they wanted her to go to a different ALF.

In this scenario, the original ALF provider would need to bill daily only for the days that Mary was in the facility. If the ALF provider had already submitted monthly billing for Mary, the provider would need to void the original claim and rebill the claim for only the dates of services (DOS) that Mary was in its facility. The new ALF provider would also need to bill the first month using the daily method.

Example 2: The ALF provider normally bills monthly. During the month, the facility's resident, Mary, discharged to the hospital on Feb. 13, 2024, with plans to return to the ALF. She was in the hospital for four days and then discharged to a SNF for seven days. She returned to the ALF on Feb. 24, 2024. The ALF can still bill the monthly rate for the entire month because Mary was not out of the ALF for 30 consecutive days. The ALF provider would need to choose a single DOS from Feb. 1, 2024, through Feb. 12, 2024, ***or*** from Feb. 24, 2024, through Feb. 29, 2024. The provider can bill for one date in the date range, for 1 unit (for example, From Date of Service [FDOS] Feb. 2, 2024 – To Date of Service [TDOS] Feb. 2, 2024), and bill for T2031 U7 with either U1, U2 or U3 modifiers and UA for one unit.

> *Note: The modifiers determine the reimbursement rate and the LOC for the member. Providers receive a service authorization via email before the member is admitted to the facility (and whenever there are changes to the service authorization). The service authorization lists the procedure code and basic modifiers, as well as the total dollar amount that the provider may bill. The service authorization does not list modifier UA for monthly billing. However, the provider **may** choose monthly billing instead of daily.*

Example 3: The ALF provider normally bills monthly. During the month, the facility's resident, Mary, discharged to the hospital on Feb. 3, 2024. Mary remained in the hospital for 10 days and then discharged to a SNF for 21 days. She returned to the ALF on March 5, 2024. In this scenario, Mary was out of the facility for more than 30 consecutive days. The ALF would need to bill daily only for the days that Mary was in the facility during February and March. If the monthly billing had already been completed for February, then the ALF would need to void the original claim and rebill for only Feb. 1, 2024, through Feb. 2, 2024. For the month of March, the provider would bill daily for the DOS March 5, 2024, through March 31, 2024.

> *Note: The service authorization will **not** list the **UA** modifier. The service authorization will list the daily rate as done previously. However, the maximum dollar amount will equal the monthly rate amounts for each LOC. If the ALF chooses to continue to bill for the daily rate, **29** is the maximum number of days that can be billed in any given month.*

Claim Tips and Reminders

When billing IHCP waiver claims, the provider must consider the following:

- The IHCP does not reimburse HCBS claims for time spent by office staff billing claims.
- Providers may bill only for services that were authorized (as indicated in the service authorization email) and that were delivered to the member.
- A claim should include dates of service within the same month. Do not submit a claim with dates of service that span more than one month on the same claim.
- The units of service as billed to the IHCP must be substantiated by documentation in accordance with the appropriate *Indiana Administrative Code* (IAC) regulations and the waiver documentation standards issued by the FSSA and be supported by the member's individual person-centered plan of care.
- Services billed to the IHCP must meet the service definitions and parameters, as published in the aforementioned rules and standards.
- Updated information is disseminated through IHCP provider bulletins, available on the *IHCP Bulletins* webpage at in.gov/medicaid/providers. Each provider is responsible for obtaining the information and implementing new or revised policies and procedures, as outlined in these notices.

Third-Party Liability Exemption

The IHCP will not bill private insurance carriers through the third-party liability (TPL) or reclamation processes for claims containing any HCBS benefit modifier codes. This billing practice includes modifiers specific to claims for the PathWays Waiver.

Electronic Visit Verification System Required for Personal Care Services

The *21st Century Cures Act* requires Medicaid providers of personal care services to use an electronic visit verification (EVV) system to document services rendered.

Affected providers may use an EVV system of their choice (either the state's EVV system [Sandata] or an alternate EVV system that can integrate with the Sandata system); however, providers are responsible for ensuring that the system selected complies with federal requirements, including documentation of the following information:

- Type of service performed
- Individual receiving the service
- Date of the service
- Location of service delivery
- Individual providing the service
- Time the service begins and ends

Providers are required to use EVV to document all personal care services (procedure code and modifier combinations) indicated in *Service Codes That Require Electronic Visit Verification*, accessible from the *Code Sets* webpage at in.gov/medicaid/providers. For more information, see the *Electronic Visit Verification* webpage at in.gov/medicaid/providers.

PathWays HCBS Waiver Rates

Table 1 identifies procedure codes and modifiers for each service available through the PathWays Waiver, and the associated payment methodology.

Table 1 – Indiana PathWays for Aging HCBS Waiver Rates and Coverage

Service	Code	Mod 1	Mod 2	Mod 3	Rate	Notes
Nutritional Supplements	B4150	U7			Individual	$1,200 Per Year
Caregiver Coaching	H0004	U7	U4		$15.75	0.25 Hour Max 32 quarter hours (8 hours)/ month; cap $320/month per member
Adult Day Services – Level 1 (Category 1)	S5100	U7	U1	UC	$3.32	0.25 Hour
Adult Day Services – Level 2 (Category 1)	S5100	U7	U2	UC	$3.74	0.25 Hour
Adult Day Services – Level 3 (Category 1)	S5100	U7	U3	UC	$4.76	0.25 Hour
Adult Day Services – Level 1 (Category 2)	S5100	U7	U1		$2.93	0.25 Hour

Service	Code	Mod 1	Mod 2	Mod 3	Rate	Notes
Adult Day Services – Level 2 (Category 2)	S5100	U7	U2		$3.30	0.25 Hour
Adult Day Services – Level 3 (Category 2)	S5100	U7	U3		$4.20	0.25 Hour
Attendant Care (Agency)	S5125	U7	UA		$8.59	0.25 Hour
Attendant Care (Non-Agency)	S5125	U7			$8.21	0.25 Hour
Attendant Care (Nonemergency Medical Transportation/Companion)	S5125	U7	UA	UC	$8.59	0.25 Hour
Attendant Care (Consumer-Directed)	S5125	U7	U1		$8.21	0.25 Hour
Attendant Care (Consumer-Directed Overtime)	S5125	U7	U1	TU	$1.81	0.25 Hour
Participant Directed Home Care – Skilled	S5125	U7	U2	UA	$14.97	0.25 Hour
Participant Directed Home Care – Unskilled	S5125	U7	U2	U9	$8.59	0.25 Hour
Home and Community Assistance (Agency)	S5130	U7	UA		$7.93	0.25 Hour
Home and Community Assistance (Non-Agency)	S5130	U7			$7.68	0.25 Hour
Structured Family Caregiving (Level 1)	S5140	U7	U1		$77.54	Per Day
Structured Family Caregiving (Level 2)	S5140	U7	U2		$99.71	Per Day
Structured Family Caregiving (Level 3)	S5140	U7	U3		$133.44	Per Day
Adult Family Care (Level 1)	S5141	U7	U1		$67.93	Per Day
Adult Family Care (Level 2)	S5141	U7	U2		$72.34	Per Day
Adult Family Care (Level 3)	S5141	U7	U3		$90.64	Per Day
Respite Care Services, Home Health Aide (HHA)	S5150	U7	UA	U9	$9.23	0.25 Hour
Personal Emergency Response System – Install	S5160	U7			$54.41	One Time
Personal Emergency Response System – Maintenance	S5161	U7			$54.41	Monthly
Home Modifications – Install	S5165	U7	NU		Individual	$20,000 Lifetime Cap

Service	Code	Mod 1	Mod 2	Mod 3	Rate	Notes
Home Modifications – Maintenance	S5165	U7	U8		Individual	$1,000 Per Year
Home-Delivered Meals	S5170	U7			$7.76	Per Meal
Respite Care Services, Licensed Practical Nurse (LPN)	T1005	U7	UA	TE	$13.69	0.25 Hour
Respite Care Services, Registered Nurse (RN)	T1005	U7	UA	TD	$17.10	0.25 Hour
Home Modifications – Assessment	T1028	U7			$628.00	Per Project
Transportation Nonassisted (Base Trip)	T2003	U7	U1	UB	$12.12	Base Trip
Transportation Nonassisted (Mileage)	T2003	U7	U1		$1.06	Mileage
Transportation Assisted (Base Trip)	T2003	U7	U2	UB	$20.19	Base Trip
Transportation Assisted (Mileage)	T2003	U7	U2		$1.54	Mileage
Care Management	T2022	U7			$189.56	Monthly
Integrated Health Care Coordination	T2022	U7	U1		$14.21	0.25 Hour (16 Hours/Month)
Pest Control	T2025	U7	U1		Individual	$4,000 Per Year
Specialized Medical Equipment and Supplies – New DME	T2029	U7	NU		Individual	$15,000 Cap; no limit; subject to review
Specialized Medical Equipment and Supplies – Replacement or Repair	T2029	U7	U8		Individual	$1,000 Per Year
Assisted Living – Level 1 Monthly	T2031	U7	U1	UA	$3,028.81	Monthly
Assisted Living – Level 2 Monthly	T2031	U7	U2	UA	$3,330.26	Monthly
Assisted Living – Level 3 Monthly	T2031	U7	U3	UA	$3,922.18	Monthly
Assisted Living – Level 1 Daily	T2031	U7	U1		$101.98	1 Day
Assisted Living – Level 2 Daily	T2031	U7	U2		$112.13	1 Day
Assisted Living – Level 3 Daily	T2031	U7	U3		$132.06	1 Day
Community Transition	T2038	U7			$2,500.00	Lifetime Cap
Vehicle Modifications	T2039	U7			Individual	$15,000.00 every 10 Years

Service	Code	Mod 1	Mod 2	Mod 3	Rate	Notes
Vehicle Modifications – Maintenance	T2039	U7	U8		Individual	$1,000 Per Year

Section 4: Quality Assurance/Quality Improvement

The Office of Medicaid Policy and Planning (OMPP) Clinical Operations Quality Improvement (QI) Team is responsible for oversight of each managed care entity (MCE) Quality Assurance and Performance Improvement (QAPI) program. This includes oversight of complaints, grievances, appeals and investigations of potential quality of care or service complaints.

MCEs will work with providers to resolve provider noncompliance as detailed in *Indiana Administrative Code 455 IAC 2.* Noncompliance with provider standards may result in corrective action plans or other sanctions, up to and including termination as a waiver provider. Providers are contracted directly with the MCE and as such will be subject to MCE processes to review potential quality of care or service concerns as well as the processes for complaints, grievances and appeals. The OMPP QI Team monitors and helps ensure program integrity, clinical and service excellence, and cost-effectiveness of programs administered by the MCEs. The role of OMPP QI is to:

- Oversee MCE monitoring of all waiver enrolled providers that are delivering waiver services to enrolled members.
- Oversee MCEs to help ensure that services to all members are delivered in accordance with the member's person-centered service plan, the specifications identified in the approved waiver and *Indiana Administrative Code 455 IAC 2*.
- Collect and analyze data to implement sound remediation of problems at the individual, organization and systemic levels.
- Oversee monitoring of MCEs' policies and procedures that all providers, including case managers/service coordinators, must follow to ensure compliance with Indiana Administrative Code (IAC) and Centers for Medicare & Medicaid Services (CMS) assurances, and to protect members' health and welfare.

The OMPP QI program encompasses the following components:

- Incident monitoring
- Complaint monitoring
- Mortality review
- Coordination of External Quality Review (EQR) activities
- Coordination with Adult Protective Services (APS)
- Quality reviews – National Core Indicators survey for the aged and disabled population (NCI-AD); Consumer Assessment of Healthcare Providers and Systems, Home- and Community-Based Services (CAHPS HCBS); and Healthcare Effectiveness Data and Information Set (HEDIS)
- Coordination with the Indiana Department of Health (IDOH)
- Implementation of the Indiana Quality Improvement Strategy (QIS)
- Monitoring health plan Quality Assurance and Performance Improvement (QAPI) activities

Incident Reporting

Indiana's *455 IAC 2* requires all providers of PathWays Waiver services, including care coordinators and case managers/service coordinators, submit notifications when specific events occur. The nature of these events is defined as an unusual occurrence affecting the health and safety of a Home- and Community-Based Services (HCBS) waiver participant.

Events that must be reported include but are not limited to:

- Alleged, suspected, reported, or observed abuse/battery, neglect or exploitation of a participant
- The death of a participant
- Significant injuries to the participant requiring emergent medical intervention
- Any threat or attempt of suicide made by the participant
- Any unusual hospitalization due to a significant change in health and/or mental status that may require a change in service provision
- Participant elopement or missing person
- Inadequate formal or informal support for a participant, including inadequate supervision, which endangers the participant
- Medication error occurring in a 24/7 or day setting
- A residence that compromises the health and safety of a participant
- Suspected or observed criminal activity committed by any of the following:
  - Provider's staff when it affects or has the potential to affect the participant's care
  - A family member of a participant receiving services when it affects or has the potential to affect the participant's care or services
  - The participant receiving services
- Police arrest of the member or any person responsible for the care of that participant
- A major disturbance or threat to public safety created by the participant
- Any use of restraints
- Fall with injury

All waiver service providers, including care coordinators and case managers/service coordinators, with knowledge of a reportable event are required to submit an incident report through the web-based Incident and Follow-Up Reporting (IFUR) tool. If IFUR web access is unavailable, incidents can be reported to the OMPP QI Team by email at OMPPQualityImprovement@fssa.in.gov.

> *Note: Recent changes to the incident reporting tool allow for incident submission with less required information. This enhancement makes the system more accessible to participants, family members and direct caregivers. For more information on the waiver incident reporting tool, see the Incident Reporting webpage at in.gov/fssa.*

Additionally, *455 IAC 2* requires reporting of known or suspected abuse, neglect or exploitation of an adult to the Adult Protective Services (APS). A 24-hour hotline connected to the statewide APS system is available for this reporting, or reports can be made to the local APS or county prosecutor's office through the APS State Hotline: 800-992-6978. Additional information about APS may be obtained at the *Adult Protective Services* webpage at in.gov/fssa.

Providers are required to suspend from duty any staff suspected, alleged or involved in incidents of abuse, neglect or exploitation of a participant, pending the provider's investigation of the incident. If needed, the service coordinator/case manager coordinates replacement services for the participant. If the service coordinator/case manager is the alleged perpetrator, the participant will be given a new pick list from which a new service coordinator/case manager will be selected.

Providers of HCBS are required to submit an incident report for any reportable unusual occurrence within 48 hours of the time of the incident or becoming aware of the incident. However, if an initial report involves a participant death, or an allegation or suspicion of abuse, neglect or exploitation, it is required to be submitted within 24 hours of "first knowledge" of the incident.

Incidents are received by the OMPP QI Team via a secure web-based reporting system that links to the electronic incident database. Incident reports are forwarded within one business day to the MCE responsible for the PathWays member. The MCE will conduct investigations as needed and report details of case closure back to the OMPP QI Team, which tracks and trends incidents and monitors investigation closure by the MCE. If the incident report is submitted to the APS, the MCE will work with APS as needed to provide care management/service coordination to meet the health and welfare needs of the participant, and APS will be responsible for the investigation.

Required actions may include:

- Notification to the APS if the incident involves abuse, neglect or exploitation, and notification is not documented in the report
- Submission of a new report when the first report was inadequate or incomplete

HCBS providers are expected to follow individual MCE policy and procedures on incident reporting and work with the MCE to resolve the incident.

Complaint Resolution

The OMPP QI Team monitors complaint, grievance and appeals reports submitted by the MCE to the state. The OMPP QI Team tracks and trends complaint, grievance and appeals data received. The MCE is responsible for complaint, grievance and appeal resolution.

Mortality Review

As part of its quality oversight process, participant deaths are reviewed by the OMPP QI Team, along with any previously filed incident reports involving the participant. Additional information, including provider's records of service delivery, may be requested from the MCE for further review of any unexpected deaths. If additional review is indicated, it is referred for review by the OMPP Mortality Review Committee (MRC).

Incident reporting of all PathWays participant deaths happens electronically via the IFUR tool, which is the OMPP QI Team's incident reporting system. The OMPP QI Team determine the "apparent cause" of death, as classified in this section, and monitor and close incident reviews for all PathWays participants. When additional information is needed to determine cause of death, the OMPP QI Team will classify the death as "Apparent Cause/Unexpected: Unknown – Further Information Needed."

Apparent cause/unexpected death causes may include:

- Accident (for example, motor vehicle)
- Alleged abuse
- Alleged neglect
- Misuse or use of controlled substances
- Refused care or treatment
- Suicide

- Unknown
  - Care transition prior seven days (for example, hospital or nursing facility to home, home to assisted living or nursing facility, and so forth)
  - Choking/aspiration
  - Emergency room visit and/or hospital admission prior seven days
  - Fall with injury
  - Further information needed
  - Homicide
  - Incident reports prior 90 days
  - Medication error or adverse drug effect
  - Sudden death

Apparent cause/expected deaths may include:

- Medical condition or illness
  - Hospice
  - Known chronic illness
  - Known terminal illness
  - Nursing facility more than seven days
- Natural cause
  - Died in sleep
  - Found deceased in home

All waiver participant deaths are required to be reported to the OMPP QI Team. The Critical Incident Workgroup reviews all reported deaths after preliminary review by the OMPP QI Team that are found to be "unexpected." The Critical Incident Workgroup identifies cases for MRC review. The MCE will be notified to gather and present case summaries to the MRC. Case summaries include the following:

- Summary of the member's death and related circumstances
- Identified quality concerns
- Actions taken to address quality concerns or mitigate any health and welfare impact to future participants

The MRC then conducts a comprehensive review of deaths identified by the Critical Incident Workgroup as warranting further investigation and review through a review of case summaries and relevant records and documents for circumstances and events that contributed to or were associated with deaths. The MRC will:

- Make recommendations to the MCE for "opportunities to correct" and/or "corrective actions" that may reduce the risk of death and other adverse outcomes for service recipients.
- Make recommendations for systemic interventions for quality improvement for implementation by all MCE.
- Track MCE implementation of recommendations.
- Track corrective actions that MCEs impose against service providers and support coordination agencies with delayed or failed implementation of recommendations.
- Review aggregate information about deaths and assess trends and identify areas of opportunity to further protect the health and welfare of PathWays participants.

The MRC is chaired by an OMPP medical director and quality director. MRC participants include but are not limited to Office of General Counsel (OGC) representative, OMPP Case Management manager, OMPP Quality Improvement manager, Provider Relations director and MCE representatives.

The Quality Improvement director or delegated staff prepares the final MRC recommendations and presents them at the Quality Improvement Committee.

The OMPP Quality Improvement Committee will:

- Evaluate effectiveness of implemented recommendations to reduce death rate, hospitalizations and critical incidents.
- Review trend analysis of deaths and issue systemic interventions as appropriate.
- Provide public reporting on deaths of individuals receiving services, including the trends and patterns identified by mortality reviews.

The Critical Incident Workgroup meets monthly. The MRC meets at least four times a year, and an MRC Summary Review is reported to the Quality Improvement Committee at least annually.

Provider Compliance Reviews

The FSSA OMPP or its designee through MCE or contractor conducts provider compliance reviews for all nonlicensed waiver service providers, as well as licensed providers that also offer services that fall outside the scope of the license. The provider compliance review includes a review of provider policies and adherence to state and federal requirements, as well as the provider's own policies. Site visits are conducted as part of the compliance review for all congregate settings, such as adult day centers, adult family care homes and assisted living facilities.

The FSSA OMPP or its designees administer compliance reviews that include an extensive review of provider and service coordinator/case manager documentation, service delivery records, policies and procedures, and compliance with other waiver and state requirements.

For licensed providers, this review is conducted by the Indiana Department of Health (IDOH). Nonlicensed providers are reviewed by the FSSA OMPP. Both the IDOH and FSSA OMPP have formal review and corrective action procedures submitted by the provider with approval or denial by the FSSA. If denied, the provider is required to resubmit the corrective action plan within a two-week time frame. After it is approved, the FSSA OMPP verifies successful implementation of the corrective action plan. Any provider not successfully completing the corrective action process is decertified as a provider.

A provider's failure to cooperate with the review procedure or to complete the corrective action process results in a referral to the Provider Relations director as a formal complaint, which may result in sanctions up to and including termination as a waiver provider.

Any provider decertified as a result of noncompliance with the provider agreement or failing to complete corrective actions is notified of the decision, and of the provider's right to appeal. Documentation of all corrective actions taken with providers is maintained in the OMPP HCBS Certification Portal. Prior to taking action to suspend or terminate a provider, alternative service options will be provided to any affected participants through their service coordinator/case manager.

Review of Waiver Process Outcomes

The PathWays managed care entities aggregate and analyze data from all waiver processes to identify incidents of noncompliance with waiver requirements and opportunities to achieve more positive outcomes. Findings are reviewed for viable remediation options at the individual and systemic levels. A provider's failure to complete requirements may result in sanctions up to and including termination as a waiver provider.

The OMPP reviews reports on waiver process outcomes from each MCE that may require systemic improvements and assesses the performance of the QA/QI components.

Section 5: Program Integrity and Financial Oversight

The state of Indiana employs a hybrid program integrity approach to overseeing waiver programs, incorporating oversight and coordination by the Office of Medicaid Policy and Planning (OMPP) Program Integrity, as well as engaging the full array of technology and analytic tools available through the Fraud and Abuse Detection System (FADS) contractor arrangements.

Waiver Audits

The Family and Social Services Administration (FSSA) has expanded its program integrity activities using a multifaceted approach to program integrity activity that includes provider self-audits, desk audits and on-site audits. The Program Integrity Unit analyzes claim data, allowing them to identify providers and claims that indicate aberrant billing patterns and other risk factors. Based on this information, audits are completed as needed.

The program integrity audit process uses data mining, research, identification of outliers, problematic billing patterns, aberrant providers and issues that are referred by other divisions and state agencies. The Program Integrity Unit also meets with all waiver divisions and receives referrals on an ongoing basis to maintain open lines of communication and understanding in specific areas of concern, such as policy clarification.

The Program Integrity Unit offers education regarding key program initiatives and audit issues at waiver provider meetings to promote ongoing compliance with federal and state guidelines, including all IHCP and waiver requirements is available in the *Provider and Member Utilization Review* provider reference module at in.gov/medicaid/providers.

FSSA Audit Oversight

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

The Audit Division of the FSSA reviews waiver audit team schedules and findings to reduce redundancy and ensure use of consistent methodology.

Medicaid Fraud Control Audit Overview

The Indiana Medicaid Fraud Control Unit (MFCU) is an investigative branch of the Attorney General's Office. MFCU conducts investigations in the following areas:

- Medicaid provider fraud
- Misuse of Medicaid members' funds
- Patient abuse or neglect in Medicaid facilities

When the MFCU identifies a provider that has violated regulations in one of these areas, the provider's case is presented to the state or federal prosecutors for appropriate action. Providers can access information about the MFCU on the *Medicaid Fraud & Patient Abuse* webpage at in.gov/attorneygeneral.

Section 6: Care Coordination

This section provides information about care coordination services under the Indiana PathWays for Aging (PathWays) Waiver.

Care coordination aims to create a person-centered approach to care, where individuals receive the support they need to live independently and maintain their health and well-being. Care coordination involves assessing needs, developing care plans, coordinating services and connecting individuals to community resources. All PathWays members are eligible to receive care coordination services from the managed care entity (MCE). Members receiving Home- and Community-Based Services (HCBS) through the PathWays Waiver are automatically enrolled in the MCE 's Complex Case Management (CCM) level-of-care (LOC) coordination, unless the individual is enrolled in a Medicare Advantage Duals Special Needs Plan (D-SNP). Members enrolled in a D-SNP receive their care coordination activities, including CCM, from their D-SNP health plan. Members will have an assigned complex case manager or a D-SNP care manager who is responsible for all the care coordination activities.

In addition to care coordination services, all members who are determined to have nursing facility level of care (NF LOC) and are receiving PathWays Waiver services will also have an assigned service coordinator to support member waiver services and related environmental and social services. Service coordinators and care coordinators work together with the member to ensure cohesive, holistic service delivery.

Levels of PathWays Coordination

This section provides the different levels of coordination involved in the care of a PathWays member.

Care Coordination

MCEs are required to offer care coordination to all members enrolled in the PathWays program. Members receiving HCBS through the PathWays Waiver are stratified into CCM LOC coordination and assigned a complex case manager. This does not apply to members enrolled in a Medicare Advantage D-SNP health plan. Members enrolled in a D-SNP health plan are assigned to a Medicare care manager, who is integrated into the PathWays Medicaid health plan.

Care coordination level of service, whether delivered by the PathWays health plan or the D-SNP health plan, is intended to provide members with assistance in making preventive care appointments, accessing care and improving health outcomes.

Members receiving HCBS and enrolled with an MCE are automatically enrolled in the MCE's CCM level-of-care coordination. This LOC coordination includes coordination of care across providers and direct member contact to assist with scheduling appointments, locating providers and specialty services, and assistance with disease specific conditions. CCM includes the completion of a comprehensive health assessment tool (CHAT) and development and implementation of an individualized care plan (ICP), which outlines specific objectives, goals and action protocols to meet the member's identified needs as established through a person-centered planning process. The complex case manager works closely with the member's assigned service coordinator to collaborate on the member's care plan and service plan, and is part of the member's Interdisciplinary Care Team (ICT).

Dual eligible members, enrolled in the Indiana PathWays for Aging Medicaid program with an MCE and enrolled in the aligned companion Medicare D-SNP plan, are not automatically enrolled in CCM. These members receive care coordination support through the companion D-SNP plan. For more information, see the *PathWays and Dual Eligible Care Coordination Alignment* section.

Members have a choice to opt out of CCM. For members who are unable or unwilling to participate in CCM, the MCE is required to provide care coordination services through communication and coordination with the member's providers, individual care team and support team, service coordinator, and the member's natural support system.

Role of the Complex Case Manager

Complex case managers are required to live in Indiana and be licensed, as applicable, in Indiana. Complex case managers must:

- Be an Indiana licensed registered nurse
- Have an Indiana licensed master's degree in social work or therapy, and have training, expertise and experience in providing case management and care coordination services for individuals, including specialized populations such as older adults and/or individuals with physical or developmental disabilities and/or individuals determined to have a serious mental illness (SMI).

The complex case manager is required to be face to face with the member at least one time annually and is required to contact the member monthly. All contact with the member shall be coordinated with the service coordinator.

Service Coordination

Each member receiving HCBS is required to have an assigned service coordinator. Service coordination is used to reference waiver case management delivered by the MCEs. Service coordination is a process of assessment, discovery, planning, facilitation, advocacy, collaboration and monitoring of the holistic long-term services and supports (LTSS) and related environmental and social needs of each member on the PathWays Waiver. The service coordinator is responsible for the development and implementation of the LTSS-specific person-centered support plan (referred to as service plan) and for assisting members in gaining access to LTSS, as well as medical, social, housing, educational and other services, regardless of the funding source for the services, to ensure the member's health, safety and welfare, and as applicable, to delay or prevent the need for institutional placement. The service coordinator must collaborate with the member's complex case manager and provide for the regular review and modification of the members LTSS-specific service plan with the member, their caregiver with the consent of the member, and the member's ICT.

Members do not have a choice to opt out of service coordination. Should individuals (or their legal representative, when indicated) choose not to participate actively and responsibly in the administration and management of their Medicaid HCBS waiver supports and services, the OMPP may terminate the individual's HCBS waiver participation. If the OMPP decides to terminate the individual's HCBS waiver, the OMPP must provide the individual (or the individual's legal representative, when indicated) with written notice of intent to terminate the individual's waiver services.

Role of the Service Coordinator

Service coordinators are required to be located in Indiana while performing job responsibilities. Service coordination is a vital service to members and the service coordinators should be engaged in the communities they serve. MCEs must employ service coordinators experienced in meeting the needs of people with disabilities regardless of age and vulnerable populations with chronic and/or complex conditions. A service coordinator must have an undergraduate and/or graduate degree in social work or a related field, or be a registered nurse, licensed practical nurse, advanced nurse practitioner, or a physician assistant.

The member's service coordinator shall monitor the member's person-centered service plan and conduct LTSS-specific assessments based on the member's needs and goals in a face-to-face contact every 90 days

from initial service plan activation. The quarterly in-person assessments must also include a screening for abuse, neglect and exploitation as well as a loneliness assessment.

When the initial service plan is activated, the service coordinator must either call or visit the member within 30 days from initial service plan activation to ensure initial implementation of services.

Members shall be contacted by their service coordinator at least monthly either in person or by telephone unless the member specifically requests to opt out or otherwise reduce the frequency of these monthly contacts. At least two of these face-to-face contacts per year will be in the member's home setting. The service coordinator may also meet more frequently with the member when appropriate based on the member's needs and/or request. The member's choice of service coordinator contact frequency and mode must be captured in their person-centered service plan.

The member/guardian/designated representative must be able to contact the member's service coordinator between the regularly scheduled visits to ask questions, discuss changes/needs and/or to request a meeting with the service coordinator. The service coordinator must respond to the questions and/or requests made by the member/guardian/designated representative, within 48 hours (not including weekends and holidays).

The service coordinator is responsible for documenting evidence of any and all communications, which may include, but are not limited to face-to-face meetings, phone calls, emails, electronic messages and text messages. Communications may be with the member, informal caregivers, other staff, other professionals, as well as healthcare professionals that render services to the members. Communication documentation must include the complete date and signature.

HCBS Waiver Case Management

Some populations who meet Medicaid eligibility and NF LOC criteria for waiver services may voluntarily enroll with an MCE or can opt to remain in FFS. This includes American Indians/Alaska Natives (AI/AN) and individuals who are receiving hospice services at the time they become eligible for PathWays. Waiver services available to these enrollees who opt to remain in FFS are identical to those available to enrollees served by an MCE. Waiver case management services are delivered through a certified case management entity, such as Area Agencies on Aging (AAA) or independent case management organizations.

The case manager is responsible for the implementation and monitoring of the service plan. Waiver case managers are required to meet the requirements outlined in the *Role of the Service Coordinator* section and in the *Service Coordination* section.

PathWays and Dual Eligible Care Coordination Alignment

Members receiving PathWays Waiver services include members in one of three categories based on Medicaid and Medicare eligibility and Medicare D-SNP alignment:

- *Medicaid Only*: Includes members who are solely Medicaid eligible and enrolled in only PathWays
- *Dual Eligible – Aligned*: Includes dually eligible members who are enrolled in both the contractor's PathWays program and the contractor's exclusively aligned companion D-SNP
- *Dual Eligible – Unaligned*: Includes dually eligible members who are enrolled in the contractor's PathWays program and any unaligned Medicare service delivery system. This would include enrollment in traditional Medicare, any non-SNP Medicare Advantage Plan, Chronic Condition Special Needs Plans (C-SNPs), and Institutional Special Needs Plans (I-SNPs).

Dual eligible aligned members are exempt from enrolling in CCM with the PathWays MCE. Dual eligible members enrolled in an aligned companion D-SNP, receive care coordination support through the Medicare D-SNP health plan. D-SNP staff are responsible for coordinating the full range of Medicaid, including LTSS, and Medicare benefits, and have access to all the information needed to do so. The PathWays MCE

and aligned companion D-SNP shall support an integrated approach to care coordination and service delivery to avoid administrative duplication.

Comprehensive Health Assessment

In accordance with *Code of Federal Regulations 42 CFR 438.208(b)(3)* and *42 CFR 438.208(c)(1)-(2)*, the MCE conducts a comprehensive health assessment using a state-developed comprehensive health assessment tool (CHAT) of all members receiving HCBS, to identify the member's risks, level of support needed to address risks and overall needs. The CHAT is all-inclusive and identifies the clinical, psychosocial, functional and financial needs of the member to ensure appropriate referrals to providers, programs and community-based organizations.

The state-developed CHAT is a functional assessment based on the interRAI suite of assessment instruments. The MCE is required to administer the CHAT face to face, within the first 30 days of the member's enrollment and annually thereafter. The CHAT can either be completed by the complex case manager or the service coordinator. The complex case manager and the service coordinator must have a coordinated approach to work with members, including administering assessments and developing the member's individual care plan and individual service plan.

Level-of-Care Assessments

Effective July 1, 2025, the Indiana Level of Care Assessment Representative (LCAR) contractor, Maximus, also serves as a point of entry, and performs all nursing facility level of care (NF LOC) assessments. After an applicant has been determined to meet the eligibility criteria and approved to receive PathWays Waiver services, the LCAR contractor will support the member in enrolling in PathWays and selecting a PathWays managed care entity. After the MCE is selected, the member will be assigned a care coordinator.

If the FSSA OMPP identifies a systemic problem with Care Coordination services, the coordinator must obtain training on the topics recommended by the FSSA OMPP.

Care Coordination may not be conducted by any organization, entity or individual that also delivers other in-home and community-based services under the FSSA OMPP waiver programs, or any organization, entity or individual with common ownership or control in any other organization, entity or individual that also delivers other in-home and community-based services under the Medicaid waiver program. The FSSA OMPP uses the following definitions in determining common ownership, control or relation:

- *Common Ownership* exists when an individual, individuals or any legal entity possesses ownership or equity of at least 5% in the provider entity, as well as the institution or organization serving the provider.
- *Control* exists where an individual or organization has the power or the ability, directly or indirectly, to influence or direct the actions or policies of an organization or institution, whether or not the control is actually exercised.
- *Related* means associated or affiliated with, or having the ability to control, or be controlled by.

Service Coordination, as defined in this provider reference module, may not be reimbursed unless and until the client becomes eligible for waiver service. Care Coordination provided to individuals who are not eligible for FSSA OMPP waiver services will not be reimbursed as a waiver service.

Ongoing Medicaid HCBS Waiver Care Management Standards

HCBS waiver case managers/service coordinators need to maintain the following standards:

- Maintain the highest professional and ethical standards in the conduct of their business.

- Comply with all FSSA OMPP-issued documents, as well as all federal, state and local law, and all FSSA policy, rules, regulations and guidelines, including the *Health Insurance Portability and Accountability Act* (HIPAA).
- Complete The Learning Community Person-Centered Thinking (PCT) training.
- Complete required annual training as follows:
  - The following components of the online orientation must be reviewed annually by all active case managers/service coordinators:
    - LOC modules – general, narrative, skilled needs and activities of daily living
    - Incident reporting module
    - Service definition module
  - The following will ***not*** be accepted as part of the required training:
    - Care management orientation
    - Required annual retraining
    - Vendor fairs
    - Staff meetings (unless there is an outside speaker or expert speaking on a relevant topic, or someone who attended a state training as a trainer is sharing that information)
    - Presentations related to employment issues; for example, performance appraisal process and retirement
    - Communications that are part of supervisory oversight; for example, reinforcement of or retraining on job requirements, review of state guidelines, informational or training, sessions specific to a case, and so on
  - Required training hours are prorated in a care management first year and are in addition to new care manager orientation.
  - Individuals will choose their service provider, from a list furnished by the state, including their care manager, and have the right to change any provider, including their care manager.
  - A maximum response time between implementation of the initial service plan and the first monitoring contact will be no more than 30 calendar days.
  - Case managers/service coordinators will have face-to-face contact with each individual a minimum of every 90 days to assess the quality and effectiveness of the service plan. At least two of these face-to-face contacts per year will be in the home setting.
  - Case managers/service coordinators will document, in the chronological narrative, each contact with the individual and each contact with providers within seven days of activity.
  - Case managers/service coordinators will assist with facilitating and monitoring the formal and informal supports that are developed to support the individual's health and welfare in the community.
  - Case managers/service coordinators will provide each individual or guardian with clear and easy instructions for contacting the care manager or care manager agency. The care manager will also provide additional information and procedures for individuals who may need assistance or have an emergency that occurs before or after business hours. This information will be located in the home in a location that is visible from the telephone.
  - Case managers/service coordinators will complete face-to-face annual assessments and update the service plan as needed, in collaboration with the individual, in a timely and appropriate manner to avoid gaps in service authorization.
  - Case managers/service coordinators will support the individual communicating their needs, strengths and preferences to the support team.
  - Case managers/service coordinators will ensure that person-centered planning is occurring on an ongoing basis.
  - Case managers/service coordinators will monitor the ongoing services to ensure that they meet the individual's needs and preferences.

- Case managers/service coordinators will base the service plan upon the individual's needs, strengths and preferences.
- Case managers/service coordinators will ensure that the individual and all providers have a current, comprehensive service plan a copy of relevant documentation, including instructions on how to request an appeal.
- Case managers/service coordinators will review and explain to the individual or guardian the services that will be provided, and the individual or their designated representative will sign the service plan to show understanding of, and agreement with, the plan. The service plan will not be implemented prior to receiving MCE approval.
- Case managers/service coordinators will initiate timely follow-up of identified problems, whether self-identified or referred by others. Critical or crisis issues, including incident reports, will be acted upon immediately, as specified by the FSSA OMPP. All follow-up and resolution will be documented in the activities under the case record in the MCE's care coordination system.
- Case managers/service coordinators will comply with all automation standards and requirements as prescribed by the FSSA OMPP for documentation and processing of care management activities.
- Case managers/service coordinators will maintain privacy and confidentiality of all individual records. No information will be released or shared with others without the individual or guardian's written consent.
- Case managers/service coordinators will provide to the state upon request, ready access to all care manager documentation, either electronic or hard copy.
- Case managers/service coordinators documentation will demonstrate that the safety and welfare of the individual are being monitored on a regular basis.

Section 7: Service Definitions and Requirements

This section lists service definitions and related information for the services currently approved for the Indiana PathWays for Aging (PathWays) Waiver. Each service listed includes the following information as appropriate:

- Service definition
- Allowable activities
- Service standards
- Documentation standards
- Limitations if applicable
- Activities not allowed
- Provider qualifications
  - A provider qualifications table identifies the waiver, the license or certification requirements, and any additional standards that apply.

Table 1 shows procedure (billing) codes and modifiers, as well as unit rates.

All settings must be compliant with the Centers for Medicare & Medicaid Services (CMS) final rule on Home- and Community-Based Services (HCBS) settings requirements as outlined in Indiana's Statewide Transition Plan.

Adult Day Services

The following subsections provide information and requirements for Adult Day Services.

Service Definition

Adult Day Services are community-based group programs designed to meet the needs of individuals who need structured, social integration through comprehensive and nonresidential programs. The service plan will identify the need through the person-centered assessment (PCA) process and evident through the assessment tool. The purpose for Adult Day Services is to provide health, social, recreational, supervision, support services and personal care. Meals, specifically, and as appropriate, breakfast, lunch, and nutritious snacks are required. Participants attend Adult Day Services on a planned basis. The three levels of Adult Day Services are Basic, Enhanced and Intensive.

Allowable Activities

Basic Adult Day Services (Level 1) services include the following activities:

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

- Monitoring of medication or medication administration
- Minimum staff ratio: One staff for each eight individuals
- RN consultant available

Enhanced Adult Day Services (Level 2) includes: Level 1 service requirements must be met. Additional services include:

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

Intensive Adult Day Services (Level 3) includes: Level 1 and Level 2 service requirements must be met. Additional services include:

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

Recommended Facility Standards

To promote best practices in facility standards for adult day physical spaces, the FSSA OMPP will provide additional reimbursement for providers that meet the following requirements (Adult Day Services Category 1):

- Each adult day health care program, when it is co-located with another facility, must have its own separate designated space during operational hours.
- The indoor space for an adult day center must be at least 100 square feet per participant including office space for staff and must be 60 square feet per participant excluding office space for staff.

- Each program will need to design and partition its space to meet its own needs, but the following functional areas must be available:
  - A dividable multipurpose room or area for group activities, including dining, with adequate table setting space
  - A kitchen area for refrigerated food storage, the preparation of meals and/or training participants in activities of daily living
  - An examination and/or medication room
  - A quiet room (with at least one bed), which functions to isolate participants who become ill or disruptive, or who require rest, privacy, or observation
    - This room should be separate from activity areas, near a restroom and supervised.
  - Bathing facilities adequate to facilitate bathing of participants with functional impairments
  - Toilet facilities and bathrooms easily accessible to people with mobility problems, including participants in wheelchairs
    - There must be at least one toilet for every 10 participants.
    - The toilets must be equipped for use by persons with limited mobility, easily accessible from all program areas, preferably within 40 feet from the program area, designed to allow assistance from one or two staff, and barrier free.
  - Adequate storage space
    - There should be space to store arts and crafts materials, personal clothing and belongings, wheelchairs, chairs, individual handiwork, and general supplies.
    - Locked cabinets must be provided for files, records, supplies and medications.
  - An individual room for counseling and interviewing participants and family members
  - A reception area
  - An outside space that is used for outdoor activities and is safe, accessible to indoor areas and accessible to those with a disability
    - This space may include recreational space and a garden area.
    - It should be easily supervised by staff.
- Furnishings must be available for all participants. This requirement includes functional furniture appropriate to the participants' needs.

Service Standards

Adult Day Services must follow a written service plan addressing specific needs determined by the client's assessment. The Adult Day Services provider is responsible for sharing the client's service plan with the client's service coordinator/case manager to ensure continuity of care.

Documentation Standards

Case managers/service coordinators must maintain the following documentation:

- Justification for the service is documented.
  - The documented need for the service is to include, but not be limited, to the following:
    - Describe the structure needed for the participant (medical, social, recreational)
    - Types of ADL care the participant may require and level of assistance needed
- Level of service as determined in the PCA, which is given to provider.

Limitations

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

Activities Not Allowed

The following activities are not allowed for Adult Day Services:

- Services provided to participants receiving the Assisted Living waiver service
- Therapies that duplicate therapies provided under any other service
- Services provided by the spouse of a participant (also known as a legally responsible individual [LRI])

Provider Qualifications

Provider qualifications for Adult Day Services are presented in Table 2.

Table 2 – Provider Qualifications for Adult Day Services

Waiver	Provider	Licensure/ Certification	Other Standards
PathWays	Adult Day Services provider	All adult-day providers, both new and existing providers, are given the option of receiving accreditation from the Indiana Association of Adult Day Services as part of the adult-day provider credentialing through the FSSA.	Must comply with the Adult Day Services Provision and Certification Standards FSSA approved *455 IAC 2* Provider qualifications: Becoming an approved provider; maintaining approval *455 IAC 2* Provider qualifications: General requirements *455 IAC 2* Provider qualifications: General requirements for direct care staff *455 IAC 2* Procedures for protecting individuals *455 IAC 2* Unusual occurrence; reporting *455 IAC 2* Transfer of individual's record upon change of provider *455 IAC 2* Notice of termination of services *455 IAC 2* Provider organizational chart *455 IAC 2* Collaboration and quality control *455 IAC 2* Data collection and reporting standards *455 IAC 2* Quality assurance and quality improvement system *455 IAC 2* Financial information *455 IAC 2* Liability insurance *455 IAC 2* Maintenance of personnel records *455 IAC 2* Adoption of personnel policies *455 IAC 2* Operations manual *455 IAC 2* Maintenance of records of services provided *455 IAC 2* Individual's personal file; site of service delivery

Adult Family Care

The following subsections provide information and requirements for Adult Family Care.

Service Definition

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

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

The breakdown is as follows:

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

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

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

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

Participants selecting the Adult Family Care service may also receive the following services through the PathWays Waiver:

- Care Management
- Adult Day Services
- Specialized Medical Equipment and Supplies
- Integrated Health Care Coordination

> *Note: Participants living in Adult Family Care settings are entitled to retain at least their personal needs allowances (PNAs) as established by the state of Indiana. The PNA is currently $52.00 per month per Indiana Code IC 12-15-7-2.*
>
> *A provider, after ensuring that the participants retain their PNAs, may bill participants up to the current maximum federal Supplemental Security Income (SSI). Providers may not charge Medicaid waiver participants a room-and-board rate that exceeds the maximum SSI rate.*

Allowable Activities

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

- Attendant care related to ADLs
- Home and community assistance care related to instrumental activities of daily living (IADLs)
- Medication oversight (to the extent permitted under state law)

Service Standards

These service standards must be followed for Adult Family Care:

- Adult Family Care services must follow a written service plan addressing specific needs determined by the participant's PCA.
- Services must address the participant's level of service needs.
- Provider must live in the Adult Family Care home, unless another provider-contracted primary caregiver, who meets all provider qualifications, lives in the Adult Family Care home.
- Backup services must be provided by a qualified participant familiar with the participant's needs for those times when the primary caregiver is absent from the home or otherwise cannot provide the necessary level of care (LOC).
- Adult Family Care provides an environment that has the qualities of a home, including the following:
  - Privacy
  - Safe place that is free of environmental hazards, such as pests
  - Habitable environment
  - Comfortable surroundings
  - Opportunity to modify one's living area to suit one's participant preferences
- Rules managing or organizing the home activities in the Adult Family Care home must be provided to the participant prior to the start of Adult Family Care services and may not be so restrictive as to interfere with a participant's rights under state and federal law; these rules are developed by the provider, the provider-contracted primary caregiver, or both and approved by the Medicaid waiver program.
- Participant-focused activity plans are developed by the provider with the participant or the participant's representative.
- Providers or provider's employees who provide medication oversight, as addressed in the *Allowable Activities* section, must receive necessary instruction from a doctor, nurse or pharmacist on the administration of controlled substances prescribed to the participant.

Documentation Standards

Level of service is determined in the PCA. The service coordinator/case manager must follow these documentation standards:

- Document the medical need for Adult Family Care and types of ADL and IADL care the participant may require.
- Document the expected Adult Family Care activity to meet the individual's needs, which is accurately shown in the intermediate LOC assessment.

- If the participant requires skilled care, the service coordinator/case manager must justify how the skilled-care need will be met and by whom with the required documentation, describing:
  - Reason to use attendant care services
  - Who will be providing this service
  - Activities that are expected to be performed and frequency
- Give the completed PCA to the provider.

The provider must follow these documentation standards:

- Daily documentation to support services rendered by the Adult Family Care provider to address needs identified in the PCA:
  - Participant's status, including health, mental health, medication, diet, sleep patterns, social activity
  - Updates, including health, mental health, medication, diet, sleep patterns, social activity
  - Participation in consumer-focused activities
  - Medication management records, if applicable
- Monthly updated service plans provided to the participant's service coordinator/case manager from the Adult Family Care caregiver
  - Notification to the participant's service coordinator/case manager within 48 hours of any changes in the participant's care plan
- Maintenance of participant's personal records to include:
  - Social Security number
  - Medical insurance number
  - Birth date
  - Emergency contacts
  - All medical information available including all known current prescription and nonprescription drug medication
  - Most recent prior residence
  - Hospital preference
  - Primary care physician
  - Mortuary (if known)
  - Religious affiliation and place of worship, if applicable
- Participant's personal records must contain copies of all the applicable documents, which the Adult Family Care caregiver will also provide to the participant's service coordinator/case manager on an ongoing basis if there are changes to these documents:
  - Advance directive
  - Living will
  - Power of attorney
  - Health care representative
  - Do not resuscitate (DNR) order
  - Letters of guardianship

Note: If applicable, copies of personal record must be:

- *Placed in a prominent place in the participant's file*
- *Sent with the participant when transferred for medical care or upon moving from the residence and in accordance with state law*

Activities Not Allowed

The following activities are not allowed or reimbursed under Adult Family Care:

- Services provided in the home of a caregiver who is related by blood or related legally to the participant
- Services provided when the owner of the service organization is one of the following:
  - Spouse of a participant
  - Attorney-in-fact (POA) of a participant
  - Health care representative (HCR) of a participant
  - Legal guardian of a participant
- Payments for room and board or the costs of facility maintenance, upkeep or improvement
- Personal care services provided to medically unstable or medically complex participants as a substitute for care provided by a registered nurse, licensed practical nurse, licensed physician or other health professional
- Separate payment will not be made for the following services furnished to a participant selecting Adult Family Care services, as these activities are integral to and inherent in the provision of the Adult Family Care services:
  - Home and Community Assistance
  - Respite Care Services
  - Home Modifications
  - Attendant Care
  - Home-Delivered Meals
  - Pest Control
  - Community Transition
  - Structured Family Caregiving

Provider Qualifications

Provider qualifications for Adult Family Care services are presented in Table 3.

Table 3 – Provider Qualifications for Adult Family Care

Waiver	Provider	Licensure/ Certification	Other Standards
PathWays	Adult Family Care individual	Not required	Provider and home must meet the requirements of the *Indiana Adult Family Care Service Provision and Certification Standards*. FSSA approved *455 IAC 2* Becoming an approved provider; maintaining approval *455 IAC 2* Provider qualifications: General requirements *455 IAC 2* General requirements for direct care staff *455 IAC 2* Procedures for protecting individuals *455 IAC 2* Unusual occurrence; reporting *455 IAC 2* Transfer of individual's record upon change of provider *455 IAC 2* Notice of termination of services *455 IAC 2* Provider organizational chart *455 IAC 2* Collaboration and quality control *455 IAC 2* Data collection and reporting standards *455 IAC 2* Quality assurance and quality improvement system *455 IAC 2* Financial information *455 IAC 2* Liability insurance *455 IAC 2* Transportation of an individual *455 IAC 2* Documentation of qualifications *455 IAC 2* Maintenance of personnel records *455 IAC 2* Adoption of personnel policies *455 IAC 2* Operations manual *455 IAC 2* Maintenance of records of services provided *455 IAC 2* Individual's personal file; site of service delivery
PathWays	Adult Family Care agency	Not required	Provider and home must meet the requirements of the *Indiana Adult Family Care Service Provision and Certification Standards*. FSSA approved *455 IAC 2* Becoming an approved provider; maintaining approval *455 IAC 2* General requirements *455 IAC 2* General requirements for direct care staff *455 IAC 2* Procedures for protecting individuals *455 IAC 2* Unusual occurrence; reporting *455 IAC 2* Transfer of individual's record upon change of provider *455 IAC 2* Notice of termination of services *455 IAC 2* Provider organizational chart *455 IAC 2* Collaboration and quality control *455 IAC 2* Data collection and reporting standards *455 IAC 2* Quality assurance and quality improvement system *455 IAC 2* Financial information *455 IAC 2* Liability insurance

Waiver	Provider	Licensure/ Certification	Other Standards
			455 IAC 2 Transportation of an individual *455 IAC 2* Documentation of qualifications *455 IAC 2* Maintenance of personnel records *455 IAC 2* Adoption of personnel policies *455 IAC 2* Operations manual *455 IAC 2* Maintenance of records of services provided *455 IAC 2* Individual's personal file; site of service delivery

Assisted Living

The following subsections provide information and requirements for Assisted Living services.

Service Definition

The Assisted Living service is defined as the following services provided in a congregate residential setting in conjunction with the provision of participant-paid room and board:

- Personal care and services
- Home and community assistance
- Chore, attendant care and companion services
- Medication oversight (to the extent permitted under state law)
- Therapeutic social and recreational programming.

This service includes 24-hour, on-site response staff to meet scheduled and unpredictable needs. The participant retains the right to assume risk.

Participants selecting the Assisted Living service may also receive the following services through the PathWays Waiver:

- Care Management
- Specialized Medical Equipment and Supplies

> *Note: Under 455 IAC 3-1-12, participants living in assisted living facilities are entitled to retain at least their PNAs, as established by the state of Indiana. The PNA is currently $52.00 per month per IC 12-15-7-2.*
>
> *A provider, after ensuring that the participants retain their PNAs, may bill participants up to the current maximum federal SSI. Providers may not charge Medicaid eligible individuals a room-and-board rate that exceeds the maximum SSI amount for a studio apartment. A participant who wishes to select a larger room, may pay extra for any unit exceeding the size of a studio based on the monthly amount determined by the facility.*

Allowable Activities

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

- Attendant care related to ADLs

- Home and community assistance care related to IADLs
- Medication oversight (to the extent permitted under state law)
- Nonemergency nonmedical transportation
- Therapeutic social and recreational programming

Service Standards

The Assisted Living service must follow a written service plan addressing specific needs determined by the participant's PCA.

If the participant requires skilled care, the service coordinator/case manager must justify how the skilled need will be met and by whom. The documentation must describe the reason to use Assisted Living services, who will be providing this service, the activities that are expected to be performed and the frequency.

Documentation Standards

The service coordinator/case manager must follow these documentation standards for the Assisted Living service:

- Document the need for, types of, and frequency of ADL and/or IADL care the participant may require, which is identified in the PCA.
- If the participant requires skilled care, the service coordinator/case manager must justify how the skilled-care need will be met and by whom. The documentation must describe the following:
  - Reason to use the Assisted Living service
  - Who will be providing this service
  - Activities that are expected to be performed and frequency of the activities

The service coordinator/case manager must give the completed PCA to the Assisted Living provider. The provider must follow these documentation standards:

- Complete and accurate documentation to support daily services rendered by the Assisted Living service to address needs identified in the person-centered service plan:
  - Participant's status, including health, mental health, medication, diet, sleep patterns and social activity
  - Updates, including health, mental health, medication, diet, sleep patterns, social activity
  - Participation in consumer-focused activities
  - Medication management records, if applicable
  - Quarterly updated service plans provided to the participant's service coordinator/case manager from the AL service
  - Notification to the participant's service coordinator/case manager within 48 hours of any changes in participant's care plan
- Maintenance of participant's personal records to include:
  - Social Security number
  - Medical insurance number
  - Birth date
  - Emergency contacts
  - Available medical information, including known current prescription and nonprescription drug medication
  - Hospital preference

  - Primary care physician
  - Mortuary (if known)

- Participant's personal records must include copies of the following documents, if available, which the Assisted Living caregiver will also provide to the participant's service coordinator/case manager on an ongoing basis if there are changes to these documents:
  - Advance directive
  - Living will
  - Power of attorney
  - Health care representative
  - Do not resuscitate (DNR) order
  - Letters of guardianship
  - Fully executed lease agreement with the Assisted Living service

> *Note: If applicable, copies of personal record must be:*
>
> - *Placed in a prominent place in the participant's file*
> - *Sent with the participant when transferred for medical care or upon moving from the residence and in accordance with state law*

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

Activities Not Allowed

The following activities are not allowed under the Assisted Living service:

- Personal care services cannot be provided to medically unstable or medically complex participants as a substitute for care provided by a registered nurse, licensed practical nurse, licensed physician or other health professional.
- The Assisted Living service per diem or monthly rate does not include room and board.
- Separate payment will not be made for the following services furnished to a participant selecting the Assisted Living service, as these activities are integral to and inherent in the provision of the Assisted Living service:
  - Adult Day Services
  - Adult Family Care
  - Attendant Care
  - Home Modification Assessment
  - Home Modifications
  - Home-Delivered Meals
  - Home and Community Assistance
  - Personal Emergency Response System
  - Pest Control
  - Respite Care Services
  - Structured Family Caregiving
  - Transportation

Provider Qualifications

Provider qualifications for the Assisted Living service are presented in Table 4.

Table 4 – Provider Qualifications for Assisted Living

Waiver	Provider	Licensure/ Certification	Other Standards
PathWays	Licensed Assisted Living Agencies	*IC 16-28-2*	FSSA approved *410 IAC 16.2-5*

Attendant Care

The following subsections provide information and requirements for Attendant Care services.

Service Definition

Attendant Care (ATTC) services are provided to participants with nursing facility level of care needs. Attendant Care services provide direct, hands-on care to participants for the functional needs with ADLs. The participant is the employer for Consumer-Directed Attendant Care or appoints a representative to be the employer on their behalf.

Allowable Activities

Attendant Care includes all nonskilled ADL care as identified in the PCA, which includes but is not limited to the following:

- Provides assistance with personal care, which includes:
  - Bathing, partial bathing
  - Oral hygiene
  - Hair care including clipping of hair
  - Shaving
  - Hand and foot care
  - Intact skin care
  - Application of cosmetics
  - Dressing
- Provides assistance with mobility, which includes:
  - Proper body mechanics
  - Transfers (including lifting with mechanical assistance with appropriate training)
  - Ambulation
  - Use of assistive devices
- Provides assistance with elimination, which includes:
  - Assistance with bedpan, bedside commode, toilet
  - Incontinent or involuntary care
  - Emptying urine collection and colostomy bags
- Provides assistance with nutrition, which includes:
  - Meal planning
  - Meal preparation
  - Clean-up

- Provides assistance with safety, which includes:
  - Use of the principles of health and safety in relation to self and individual
  - Identification and elimination of safety hazards
  - Practicing health protection and cleanliness by appropriate techniques of hand washing
  - Waste disposal and household tasks
  - Reminding the participant to self-administer medications
  - Providing assistance with correspondence and bill paying
  - Transportation of individuals to nonmedical community activities *(Note: Out-of-state transportation is limited to within 50 miles of state geographic limits. Escorting of participants does not include mileage or other costs that are not associated with the provision of personal care.)*

Service Standards

Attendant Care services may be provided from the following:

- Agency – An agency enrolled in the program is responsible to hire and render services
- Nonagency/solo provider – The solo provider classification refers to an individual (as opposed to an agency) operating under their Social Security number (SSN) and operating without employees.
- Consumer-directed – The participant is the employer and acts as the agency directing their own care.

If direct care or monitoring of care is not provided to the participant and the documentation of services rendered for the units billed reflects home and community assistance duties, an entry must be made to indicate why the direct care was not provided for that day. If direct care or supervision of care is not provided for more than 30 days and the documentation of services rendered for the units billed reflects home and community assistance duties, the service coordinator/case manager must be contacted to amend the service plan to do one of the following:

- Add the Home and Community Assistance service and eliminate the Attendant Care service.
- Reduce Attendant Care hours and replace with the appropriate number of hours of Home and Community Assistance service.

Documentation Standards

The service coordinator/case manager must follow these documentation standards:

- Document the medical need for Attendant Care and types of ADL support the participant may require.
- Document the type of Attendant Care service (attendant care or consumer-directed) determined to meet the needs of the individual or caregiver through the PCA.
- Document the Attendant Care activity that will meet the participant's needs and ensure it is accurately documented in the LOC assessment.
- If the participant has nursing facility level of care (NF LOC), document how the skilled need is being met and by whom. If Attendant Care is being requested for an individual with skilled care, documentation must describe the following:
  - Who will be providing Attendant Care
  - Frequency of care
  - Activities being performed
- If the Attendant Care is consumer-directed, documentation must describe the following:
  - Who the employer is

- Who the employee/direct worker is and their relationship to the participant (include POA, guardian status as well)

Attendant Care providers must follow these documentation standards:

- In addition to electronic visit verification (EVV), providers will record services provided, including:
  - Complete date and time of service (in and out)
  - Specific services/tasks provided
  - Signature of participant verifying the service was provided by agency
  - Signature of employee providing the service (minimally the last name and first initial) *(Note: If the person providing the service is required to be a professional, the title must also be included.)*
- Each staff member providing direct care or supervision of care to the participant must make at least one entry on each day of service.
- Documentation of service delivery is to be signed by the participant or designated participant representative.
- Notification to the participant's service coordinator/case manager within 48 hours of any changes in the participant's person-centered service plan.

> *Note: If applicable, copies of personal record must be:*
> - *Placed in a prominent place in the participant's file*
> - *Sent with the participant when transferred for medical care or upon moving from the residence and in accordance with state law*

Claim Note Required for Attendant Care

When billing for Attendant Care services, providers must include a claim note with information about who provided those services, including their relationship to the member receiving the service. The claim note must be accurate and complete for audit purposes. If the individual providing the service is the spouse of the member receiving the service, that relationship status should be reflected in the claim note.

Legally responsible individuals (LRIs) (a spouse or the parent of a minor child) may not provide Attendant Care services to that individual. Knowingly using an incorrect relationship status, such as "Other," for the spouse of the member receiving services may result in recoupment of these claims; it could also constitute a false claim in accordance with the False Claims Act. The OMPP Program Integrity staff is auditing claims, including the entry of claim notes.

For the structure required in the claim note, see the *Caregiver Name for Attendant Care or Structured Family Caregiving* section in the *Claim Submission and Processing* provider reference module.

Limitations

When provided by a legal guardian of an adult, Attendant Care services are limited to a maximum of 40 hours per week.

Activities Not Allowed

The following activities are not allowed and will not be reimbursed under Attendant Care services:

- Services provided for a participant regarding specialized feeding (such as has difficulty swallowing, refuses to eat or does not eat enough), unless permitted under law and not duplication of Indiana Medicaid State Plan services

- Services provided to a participant requiring management of the following (which must be considered for respite care nursing services unless permitted under law and not a duplication of Indiana Medicaid State Plan services):
  - Uncontrolled seizures
  - Infusion therapy
  - Venipuncture
  - Injection
  - Wound care for decubitus and incision
  - Ostomy care
  - Tube feedings
- Services provided as a substitute for care provided by a registered nurse, licensed practical nurse, licensed physician or other health professional
- Setting up and administering medications
- Assisting with catheter and ostomy care
- Services provided to household members other than to the participant
- Services provided by the spouse of a participant (also known as a legally responsible individual [LRI])
- Services provided to participants receiving any of the following waiver services:
  - Adult Family Care
  - Assisted Living
  - Structured Family Caregiving

> *Note: Attendant Care services will not be reimbursed if performed in the same calendar month as Structured Family Caregiving services.*

Provider Qualifications

Provider qualifications for Attendant Care services are presented in Table 5.

Table 5 – Provider Qualifications for Attendant Care

Waiver	Provider	Licensure/ Certification	Other Standards
PathWays	Licensed Home Health Agency	*IC 16-27-1 IC 16-27-4*	FSSA approved
PathWays	Licensed Personal Services Agency	*IC 16-27-4*	FSSA approved
PathWays	Attendant Care Individual	*IC 16-27-4*	FSSA approved *455 IAC 2* Provider qualifications: General requirements *455 IAC 2* General requirements for direct care staff *455 IAC 2* Liability insurance *455 IAC 2* Professional qualifications and requirements

Waiver	Provider	Licensure/ Certification	Other Standards
			455 IAC 2 Personnel records *455 IAC 2-6-1* Provider qualifications: becoming an approved provider; maintaining approval *455 IAC 2-6-2 (a)(1)(B)* Provider qualifications: general requirements *455 IAC 2-11-1* Property and personal liability insurance *IC 12-10-17.1-10* Registration; prohibition *IC 12-10-17.1-11* Registration requirement *IC 12-10-17.1-12* Registration by the division; duties of the division The division may reject any applicant with a conviction of a crime against persons or property, a conviction for fraud or abuse in any federal, state, or local government program, (*42 USC §1320a-7*) or a conviction for illegal drug possession. The division may reject an applicant convicted of the use, manufacture, or distribution of illegal drugs (*42 USC §1320a7*). The division may reject an applicant who lacks the character and fitness to render services to the dependent population or whose background check shows that the applicant may pose a danger to the dependent population. The division may limit an applicant with a criminal background to caring for a family member only if the family member has been informed of the criminal background. Compliance with *IC 16-27-4*, if applicable.

Caregiver Coaching

The following subsections provide information and requirements for Caregiver Coaching.

Service Definition

The purpose of Caregiver Coaching is to enable the stabilization and continued community tenure of a waiver participant by equipping the participant's lay caregivers with the necessary skills to manage the participant's chronic medical conditions and associated behavioral health needs related to a cognitive impairment and/or dementia.

Covered Services

The following services are covered under Caregiver Coaching:

- Initial consultation for assessment of the caregiver to determine initial coaching needs, and understand the caregiver's goals, values, needs and strengths.

- Caregiver Coaching provided in the community of the participant, virtually or telephonically, and through *Health Insurance Portability and Accountability Act* (HIPAA) secure communication platforms that allow for real time and asynchronous communication between caregivers and caregiver coaches and collaboration with waiver case managers/service coordinators.

Service Standards

These service standards must be followed for Caregiver Coaching:

- Caregiver Coaching services are family centered, individualized to the needs of the participant and caregiver, and informed by an assessment of each caregiver's goals, values, needs and strengths.
- A caregiver coach with expertise working with lay caregivers will conduct a caregiver assessment developed by the FSSA and deliver ongoing education and coaching that is informed by the assessment.
- Caregiver Coaching services may be delivered telephonically and through HIPAA secure electronic communication platforms that enable a caregiver coach and a caregiver to communicate efficiently and in a manner convenient to the caregiver.
- Provider agencies must capture any caregiver communications received through an electronic communication platform, such as an app or email, to facilitate the sharing of relevant information with case managers/service coordinators. Providers will communicate with case managers/service coordinators through traditional means to share any relevant information. The service does not require any specific percentage of in-person visits versus virtual visits.
- The service is designed to equip the participant's lay caregivers with the skills to manage the participant's medical conditions and associated behavioral health needs related to a cognitive impairment and/or dementia. Part of the caregiver assessment rendered by the caregiver coach will address areas of the caregiver's life that promote socialization and involvement within the community, but ultimately, the decision is based on where the caregiver needs support. If community integration is an area important to the participant, the caregiver coach will support the caregiver in ensuring the participant's goals with regards to community integration are met. Additionally, a caregiver's community integration and supporting a participant's community integration may change over time and will be consistently modified as necessary.
- A caregiver coach engages with a caregiver on a biweekly basis to understand the evolving needs of the participant and caregiver and deliver content, strategies and tools related to the management of the participant's needs and behaviors and the caregiver's self-care needs.
- Caregiver training will include how to address necessary precautions to prevent coronavirus disease 2019 (COVID-19) infections/spread in the home and address anxiety that participants may experience related to the crisis; behavior and triggering events; effective verbal and nonverbal communication strategies; strategies for managing challenging behaviors; and how to address home safety concerns. Coaching will also support a caregiver to apply stress reduction techniques and reduce caregiver isolation.
- A caregiver coach will assist the caregiver and participant in creation of a crisis management/emergency plan to address the person and environment. The plan will be reviewed and updated on a monthly basis (and more often as needed) and provided to the service coordinator/case manager and waiver/Indiana Medicaid State Plan/hospice providers as well as emergency contacts and backup caregiver. The plan shall include but is not limited to the following:
  - Health conditions
  - Advanced directives, will planning, physician orders for life sustaining treatment
  - Medications and medication management/assistance to prevent medication errors
  - Fall prevention interventions
  - Sundowning interventions
  - Healthcare providers including contact information

- Emergency contacts
- Identification and contact information for backup caregiver
- Contact information for caregiver coach and waiver service coordinator/case manager
- Caregiver resources available within the caregiver's/participant's community of choice.

Note: Initial rate is $10 per quarter hour unit.

Limitations

The following restrictions are made for Caregiver Coaching:

- Medicaid-participating Structured Family Caregiving agencies may be service providers; agencies must employ caregiver coaches with the experience and qualifications appropriate to the needs of each family.
- Educational content delivered by provider agencies to caregivers and delivery methods must be appropriate to the needs of lay caregivers.

Note: Maximum billable quarter hour units per month is 32.

Activities Not Allowed

The following activities are not allowed or reimbursed under Caregiver Coaching:

- Caregiver Coaching services will not duplicate services provided under the Indiana Medicaid State Plan or any other waiver service.
- Separate payment will not be made for Structured Family Caregiving.
- Caregiver Coaching service will not be reimbursed when provided by a spouse of the participant.

Provider Qualifications

Provider qualifications for Caregiver Coaching services are presented in Table 6.

Table 6 – Provider Qualifications for Caregiver Coaching

Waiver	Provider	Licensure/ Certification	Other Standards
PathWays	Structured Family Caregiving Provider	Not required	FSSA approved *455 IAC 2*
PathWays	Adult Day Provider	Not Required	FSSA approved *455 IAC 2*

Community Transition

The following subsections provide information and requirements for Community Transition services.

Service Definition

Community Transition services include reasonable setup expenses for participants who make the transition from an institution to their own home where the person is directly responsible for their own living expenses in the community. Community Transition services will not be reimbursable on any subsequent move.

> *Note: "Own home" is defined for this service as any dwelling – including a house, an apartment, a condominium, a trailer or other lodging – that is owned, leased or rented by the participant.*

Items purchased through Community Transition are the property of the participant receiving the service, and the participant takes the property with them when moving to another residence. For participants receiving this service under the waiver, approved Community Transition expenditures are reimbursed through the local Area Agency on Aging (AAA) or FSSA OMPP-approved provider that maintains all applicable receipts and verifies the delivery of services.

Allowable Activities

The following activities are allowed under Community Transition services:

- Security deposits and application fees that are required to obtain a lease on an apartment or home
- Essential (not luxury) furnishings and moving expenses required to occupy and use a community domicile, including a bed, table and chairs, assembly of flat-packed furniture when it is not included as part of the furniture purchase cost, window coverings, one land-line telephone, eating utensils, housekeeping supplies, food preparation items, microwave, and bed or bath linens
- Setup fees or deposits for utility or service access including telephone, electricity, heating, internet and water
- Health and safety assurances, including pest eradication, allergen control that would be used in instances where the participant is allergic to certain things that need to be removed from the residence (like animal hair), or one-time cleaning prior to occupancy

> *Note: If the participant lacks the required government-issued identification items to secure housing or utilities (including but not limited to birth certificate, Social Security card, state ID and state driver's license), costs related to obtaining these items are also covered under Community Transition services.*

Service Standards

Community Transition services must follow a written service plan addressing specific needs determined by the PCA.

Documentation Standards

The service coordinator/case manager must follow these documentation standards:

- Document the need for Community Transition services and reasonable furnishings or set-up expenses being requested by the participant (determined through the PCA) in the service plan.

- Maintain receipts for all expenditures, showing the amount and what item or deposit was covered.
- If a service coordinator/case manager requests the full $1,500 lifetime cap (described in the *Limitations* section) and not all funds are used, the service coordinator/case manager must complete a service plan update to reduce the amount to ensure Medicaid is not over-reimbursing for these services.

> *Note: If applicable, copies of personal record must be:*
>
> - *Placed in a prominent place in the participant's file*
> - *Sent with the participant when transferred for medical care or upon moving from the residence and in accordance with state law*

Limitations

The following restrictions are made for Community Transition services:

- Reimbursement for Community Transition is limited to a single use and lifetime cap for setup expenses of up to $1,500.
- When the participant is discharged from the facility, the Community Transition service must be identified, ordered, delivered and reimbursed within three months.
- Community Transition services are furnished only to the extent that they are reasonable and necessary as determined through the service plan development process, clearly identified in the service plan, and the person is unable to meet such expense or when the services cannot be obtained from other sources.
- The state will not bill for federal financial participation (FFP) until after the participant departs the institution and enters the waiver.

Activities Not Allowed

The following activities are not allowed through Community Transition services:

- Apartment or housing rental or mortgage expenses
- Food
- Regular utility charges
- Household appliances or items that are intended for purely diversional/recreational purposes
- Allergen control to fund the mitigating or removal of items that would be the responsibility of the landlord or homeowner
- Service provided by the spouse of a participant (also known as an LRI), relative or legal guardian

Provider Qualifications

Provider qualifications for Community Transition services are presented in Table 8.

Table 8 – Provider Qualifications for Community Transition

Waiver	Provider	Licensure/ Certification	Other Standards
PathWays	Community Transition Service Agency	Not required	FSSA approved *455 IAC 2* Becoming an approved provider; maintaining approval *455 IAC 2* Provider qualifications: General requirements *455 IAC 2* Transfer of individual's record upon change of provider *455 IAC 2* Financial information *455 IAC 2* Liability insurance *455 IAC 2* Transportation of an individual *455 IAC 2* Professional qualifications and requirements; documentation of qualifications *455 IAC 2* Maintenance of personnel records *455 IAC 2* Adoption of personnel policies *455 IAC 2* Operations manual *455 IAC 2* Maintenance of records of services provided *455 IAC 2* Individual's personal file; site of service delivery

Home and Community Assistance

The following subsections provide information and requirements for Home and Community Assistance services.

Service Definition

Home and Community Assistance services provide instrumental activities of daily living (IADL) for participants in their home. The services are provided when participants are unable to meet their needs or when their informal caregiver or helper is unable to perform these needs for the participant.

Allowable Activities

The following activities are allowed under the Home and Community Assistance services:

- IADL care that may include but are not limited to the following:
  - Dusting and straightening furniture
  - Cleaning floors and rugs by wet or dry mop and vacuum sweeping
  - Cleaning the kitchen, including washing dishes, pots and pans; cleaning the outside of appliances and counters and cupboards; cleaning ovens; and defrosting and cleaning refrigerators
  - Maintaining a clean bathroom, including cleaning the tub, shower, sink, toilet bowl and medicine cabinet; and emptying and cleaning commode chair or urinal
  - Laundering clothes in the home or laundromat, including washing, drying, folding, putting away, ironing, and basic mending and repair

  - Changing linen and making beds
  - Washing insides of windows
  - Removing trash from the home
- Assistance with meal planning and preparation, including special diets under the supervision of a registered dietitian or health professional
- Completing essential errands and/or unassisted transportation for nonmedical, community activities
- Assistance with correspondence and bill paying
- Simple pet care *(Note: This activity may be allowed at the discretion of the agency.)*
- Assistance with outdoor tasks including raking leaves, snow removal, lawn mowing and weeding

Service Standards

These service standards must be followed:

- The service coordinator/case manager will document through the PCA the need for Home and Community Assistance, the frequency of need, the required type of Home and Community Assistance activities.

Documentation Standards

The service coordinator/case manager will document the following through the PCA:

- Need for Home and Community Assistance
- Frequency of need
- Required type of Home and Community Assistance activities

Home and Community Assistance providers are responsible for the following documentation standards:

- Data record of services provided must include the following:
  - Complete date and time of service (in and out)
  - Specific services/tasks provided
  - Notification to the participant's service coordinator/case manager within 48 hours upon any changes in the participant's person-centered service plan
  - Time spent traveling and completing the errand as well as the specific tasks and necessity of the task being completed (for errands such as using a laundromat due to there not being a washer or dryer in the participant's home)

    Note: If Home and Community Assistance services take place outside the participant's home (such as errands being required due to no washer/dryer in home, or travel for other allowable tasks), travel expenses beyond the time spent on the errand are the responsibility of the agency providing Home and Community Assistance services.
  - Signature of employee providing the service (minimally the last name and first initial) *(Note: If the person providing the service is required to be a professional, that title must also be included.)*
- Each staff member providing direct care or supervision of care to the participant must make at least one entry on each day of service. All entries should describe an issue or circumstance concerning the participant.

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

> *Note: If applicable, copies of personal record must be:*
>
> - *Placed in a prominent place in the participant's file*
> - *Sent with the participant when transferred for medical care or upon moving from the residence and in accordance with state law*

Activities Not Allowed

The following services are not allowed under Home and Community Assistance services:

- Assistance with ADL hands-on care (*Note: Specifically, Home and Community Assistance services do not include any ADL assistance, such as eating, bathing, dressing, personal hygiene, or medication setup and administration.*)
- Hands-on and/or assisted transportation of participants to community activities or errands
- Home and Community Assistance services provided to household members other than to the participant
- Home and Community Assistance services when the owner of the service organization is one of the following:
  - Spouse of a participant
  - Attorney-in-fact (or POA) of a participant
  - HCR of a participant
  - Legal guardian of a participant
  - Any member of the participant's household
- Service provided by the spouse of a participant (also known as an LRI)
- Services provided to participants receiving any of the following waiver services:
  - Adult Family Care
  - Assisted Living
  - Structured Family Caregiving

> *Note: Home and Community Assistance services will not be reimbursed if performed in the same calendar month as Structured Family Caregiving services.*

Provider Qualifications

Provider qualifications for Home and Community Assistance services are presented in Table 9.

Table 9 – Provider Qualifications for Home and Community Assistance Services

Waiver	Provider	Licensure/ Certification	Other Standards
PathWays	Licensed Personal Services Agency	*IC 16-27-4*	FSSA approved
PathWays	Homemaker Individual	*IC 16-27-4*	FSSA approved *455 IAC 2* Provider qualifications: becoming an approved provider; maintaining approval *455 IAC 2* Provider qualifications: general requirements *455 IAC 2* Liability insurance *455 IAC 2* Professional qualifications and requirements *455 IAC 2* Personnel records Compliance with *IC 16-27-4*, if applicable

Home-Delivered Meals

The following subsections provide information and requirements for Home-Delivered Meals.

Service Definition

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

Allowable Activities

The Home-Delivered Meals service may include but is not limited to:

- Diet and nutrition counseling provided by a registered dietician
- Nutritional education based on needs of each participant
- Diet modification according to a physician's order, as required, meeting the individual's medical and nutritional needs

Service Standards

These service standards must be followed:

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

- All meals must meet state, local, and federal laws and regulations regarding the safe handling of food. The provider must also hold adequate and current Servsafe certification.
- All Home-Delivered Meals provided must contain at least one-third of the current daily recommended dietary allowance (RDA) as established by the Food and Nutrition Board of the National Academy of Sciences, National Research Council, including but not limited to the following foods:
  - A variety of vegetables (dark green, red and orange), legumes (beans and peas), and starchy and other vegetables
  - Fruits, especially whole fruit
  - Grains, at least half of which are whole grain
  - Fat-free or low-fat dairy, including milk, yogurt, cheese and/or fortified soy beverages
  - A variety of protein foods, including seafood, lean meats and poultry, eggs, legumes (beans and peas), soy products, and nuts and seeds
  - Oils, including those from plants: canola, corn, olive, peanut, safflower, soybean and sunflower. Oils also are naturally present in nuts, seeds, seafood, olives and avocados
- Meals shall contain less than 10% daily calories from added sugars unless prior FSSA OMPP or registered dietitian approval is received.
- Meals shall contain less than 10% of daily calories from saturated fats unless prior FSSA OMPP or registered dietitian approval is received.
- Meals shall contain less than 2,300 mg of sodium per day unless prior FSSA OMPP or registered dietitian approval is received.

Documentation Standards

These documentation standards must be followed:

- The service coordinator/case manager is responsible for documenting the need for Home-Delivered Meals and the amount being requested.
- The provider is responsible for the following:
  - Documenting the date of delivery, how many meals are included and the name of the care professional or service coordinator/case manager that involved the participant
  - Documenting any food allergies, food preferences, or gluten sensitivity for waiver participants
  - Ensuring date of expiration is included on all meals
  - Written or oral instruction for:
    - Appropriate storage of meal
    - Preparing meal

Note: If applicable, copies of personal record must be:

- *Placed in a prominent place in the participant's file*
- *Sent with the participant when transferred for medical care or upon moving from the residence and in accordance with state law*

Activities Not Allowed

The following activities are not allowed or reimbursed under Home-Delivered Meals:

- More than two meals per day
- Services provided to participants receiving either of the following waiver services:
  - Adult Family Care
  - Assisted Living
- Service provided by the spouse of a participant (also known as an LRI)

Provider Qualifications

Provider qualifications for Home-Delivered Meals services are presented in Table 10.

Table 10 – Provider Qualifications for Home-Delivered Meals

Waiver	Provider	Licensure/ Certification	Other Standards
PathWays	Home-Delivered Meals Agency	Not required	FSSA approved *455 IAC 2* Becoming an approved provider; maintaining approval *455 IAC 2* Provider qualifications: General requirements *455 IAC 2* Maintenance of records of services provided *455 IAC 2* Liability insurance *455 IAC 2* Maintenance of records of services provided Must comply with all state and local health laws and ordinances concerning preparation, handling and serving of food.

Home Modification Assessment

The following subsections provide information and requirements for Home Modification Assessment services under the PathWays Waiver.

Service Definition

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

The Home Modification Assessment will assess the home for physical adaptations to the home, including incidental structural repairs to facilitate modifications that, as indicated by the individual's service plan, are necessary to ensure the health, welfare, and safety of the individual and enable the individual to function with greater independence in the home. Without the modifications, the individual would require institutionalization.

The assessor will be responsible for writing the specifications, review of feasibility and the post-project inspection:

- Upon completion of the specifications and a review of feasibility, the assessor will prepare and submit the project specifications to the service coordinator/case manager and the participant for the bidding process. The assessor will be paid first installment for the completion of the home specifications.
- After the project is complete, the assessor, participant and service coordinator/case manager will each be present on an agreed-upon date and time to inspect the work and sign-off indicating that it was completed per the agreed-upon bid and be paid the final installment of the home modification work. In the event the participant, provider, assessor and/or care manager/service coordinator become aware of discrepancies for complaints about the work being completed, the provider shall stop work immediately and contact the care manager/service coordinator and the FSSA OMPP for further instruction. The FSSA OMPP also has the ability to request additional assessment visits to help resolve a disagreement between the Home Modifications provider and the participant. This payment is not included in the actual home modification cost category and shall not be subtracted from the participant's lifetime cap for Home Modifications. The case management provider/MCE will be responsible for maintaining related records that can be accessed by the state.

Allowable Activities

The Home Modification Assessment service includes the following activities:

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

Service Standards

These service standards must be followed for the Home Modification Assessment:

- The need for Home Modifications must be indicated in the participant's person-centered service plan.
- The modification must address the participant's level-of-service needs.
- Proposed specifications for the modification must conform to the requirements and limitations of the current approved service definition for Home Modifications.
- The assessment should be conducted by an approved, qualified individual who is independent of the entity providing the Home Modifications.
- The appropriate authority must be contacted regarding potential code violations.

Documentation Standards

These documentation standards must be followed:

- The need for Home Modifications must be indicated in the participant's person-centered service plan.
- The modification must address the participant's level-of-service needs.
- Any discrepancy noted by the provider, service coordinator/case manager and/or participant shall be detailed in the final inspection and addressed by the assessor.

> *Note: If applicable, copies of personal record must be:*
>
> - *Placed in a prominent place in the participant's file*
> - *Sent with the participant when transferred for medical care or upon moving from the residence and in accordance with state law*

Limitations

An annual cap of $628 is available for Home Modification Assessment services, unless the FSSA OMPP requests an additional assessment to help mediate disagreements between the home modification provider and the participant.

Activities Not Allowed

The following activities are not allowed:

- Home Modification Assessment services will not be performed by the same provider that performs the subsequent Home Modifications.
- Home Modification Assessment services will not be reimbursed when owner of the organization is any of the following:
  - Spouse of a participant
  - Attorney-in-fact (or POA) of a participant
  - HCR of a participant
  - Legal guardian of a participant
- This service must not be used for living arrangements that are owned or leased by providers of waiver services.
- Payment will not be made for Home Modifications under this service.
- Payment will not be made for a Home Modification Assessment for the maintenance, repair, or service of an existing home modification that was funded by an HCBS waiver.

Provider Qualifications

Provider qualifications for Home Modification Assessment services are presented in Table 11.

Table 11 – Provider Qualifications for Home Modification Assessment

Waiver	Provider	Licensure/ Certification	Other Standards
PathWays	Home Modification Assessment Individual	One of the following: • License: *IC 2520.2* Home Inspector • Certified Aging-In-Place Specialist (CAPS Certification – National Association of Home Builders) • Executive Certificate in Home Modifications (University of Southern California) Verification required every three years	FSSA approved *455 IAC 2* Becoming an approved provider; maintaining approval *455 IAC 2* Provider qualifications: General requirements *455 IAC 2* Financial information *455 IAC 2* Liability insurance *455 IAC* 2 Professional qualifications and requirements; documentation of qualifications *455 IAC* 2 Warranty required Compliance with applicable building codes and permits
PathWays	Architect	*IC 25-4*	FSSA approved *455 IAC 2* Becoming an approved provider; maintaining approval *455 IAC 2* Provider qualifications: General requirements *455 IAC 2* Financial information *455 IAC 2* Liability insurance *455 IAC 2* Professional qualifications and requirements; documentation of qualifications *455 IAC 2* Warranty required Compliance with applicable building codes and permits

Home Modifications

The following subsections provide information and requirements for the Home Modifications service.

Service Definition

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

Home Ownership

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

Choice of Provider

The participant chooses the certified providers to submit bids for the Home Modifications. If the participant chooses to continue with the Home Modifications after receiving the bids, then the lowest bid that meets the minimum requirements shall be chosen, such as, time frame to start service. There is a minimum requirement to gather two bids for any expected amount over $5,000.

Allowable Activities

Modifications allowed under the Home Modifications service may include but are not limited to the following:

- Adaptive door openers and locks
- Bathroom modification – including but not limited to:
  - Removal of existing bathtub, toilet and/or sink
  - Installation of roll-in shower, grab bars, toilet and sink
  - Installation of replacement incidental items (such as flooring, storage space and cabinets) that are necessary due to the bath modification
- Home control units − Adaptive switches and buttons to operate medical equipment, communication devices, heat and air conditioning, and lights for an individual living alone or who is alone without a caregiver for a substantial portion of the day.
- Kitchen modification, including but not limited to:
  - Removal of existing cabinets and sink
  - Installation of sink and cabinet
  - Installation of replacement incidental items (such as flooring, storage space and cabinets) if necessary due to kitchen modification
- Home safety devices such as:
  - Door alarms
  - Anti-scald devices
  - Hand-held shower head
  - Grab bars for the bathroom
- Ramp – including but not limited to portable (considered for rental property only) and permanent
- Single room air or portable conditioners/single room air purifiers
- Vertical lift and/or stair lift
- Widening of doorways, including:
  - Exterior or interior bedroom, bathroom, kitchen door or any internal doorway as needed to allow for access. Pocket doors may be requested.

- Windows – replacement of glass with Plexi-glass or other shatterproof material when there is a documented medical or behavioral reason
- Matching interior – Upon completion of the modification, the room being modified will be matched to the previous color/style/design to the degree possible with the same paint, wall texture, wall coverings, doors, trim, flooring and so on.

Items requested that are not listed in this section must be reviewed and a decision rendered by the state FSSA director or state agency designee.

Service Standards

The service coordinator/case manager must follow these service standards:

- Document the need for home modification assessment.
- Share expected modification requests identified by the participant determined through the PCA with the assessor.
- All home modifications must be approved by the waiver program prior to services being rendered.
- Collect two bids if the cost is over $5,000.
- If only one bid is obtained, the service coordinator/case manager must document the date of contact, the provider name and why a bid was not obtained from another provider.
- Notify the FSSA OMPP of any discrepancies or complaints about the work while it is being completed. Notice must be provided to the FSSA OMPP within 48 hours upon learning of the issues.
- Ensure that before and after drawings are submitted for bathroom, kitchen and ramps.
- Ensure that bid contains warranty information.
- If a home assessor is available in the county where the participant lives, then all participants must receive a home modification assessment if a provider is available in that county, with a certified waiver provider selected by the participant prior to any subsequent home modifications as well as a home modification inspection upon completion of the work.

The provider must meet these standards:

- The need for home modification must be indicated in the participant's service plan.
- Proposed specifications for modification must conform to the requirements and limitations of the current approved service definition for the Home Modifications service.
- Providers are required to provide a written warranty for a new product or service in the form of a binding document stating that, for a period of not less than one year, the service provider shall replace or repair any product or installation.
- If the state agency determines the provider is at fault for poor and/or incorrect work during the home modification, then the provider is responsible for correcting work at the cost of the provider.
- Bid must contain warranty information.
- Before and after drawings are required for bathroom, kitchen and ramps.
- Bid must be itemized with cost for each major component of the modification.
- Prohibited from placing residential liens.
- All home modifications must be approved by the waiver program prior to services being rendered.

- Home modification requests must be provided in accordance with applicable state and/or local building codes. Home modifications must be compliant with applicable building codes.
- A land survey may be required when exterior modifications approach the property line.
- Providers of services must maintain receipts for all incurred expenses related to the modification; must be in compliance with FSSA and FSSA-specific guidelines and/or policies.
- Notification to the participant's service coordinator/case manager and FSSA of any discrepancies or complaints about the work while it is being completed. Notice must be provided to the FSSA within 48 hours upon learning of the issues.

Documentation Standards

The service coordinator/case manager must provide documentation/explanation of the service within the service plan including the following:

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

> *Note: If applicable, copies of personal record must be:*
>
> - *Placed in a prominent place in the participant's file*
> - *Sent with the participant when transferred for medical care or upon moving from the residence and in accordance with state law*

Limitations

The following limits apply for the Home Modifications service:

- A lifetime cap of $20,000 is available for Home Modifications – Installation (procedure code and modifier S5165 U7 NU); however, the cap on any single project is $15,000. The cap represents a cost for basic modification of a participant's home for accessibility and safety and accommodates the participant's needs for housing modifications.
- The cost of a home modification includes all materials, equipment, labor and permits to complete the project. No parts of a home modification may be billed separately as part of any other service category (such as Specialized Medical Equipment and Supplies).
- In addition to the $20,000 lifetime cap, $1,000 is allowable annually for the repair, replacement or an adjustment to an existing home modification that was funded by an HCBS waiver.
- Home Modifications – Maintenance (procedure code and modifier S5165 U7 U8) is limited to $1,000 annually for the repair and service of home modifications that have been provided through an HCBS waiver. The following apply for these home modification maintenance services:
  - Requests for service must detail parts cost and labor cost.
  - If the need for maintenance exceeds $1,000, the service coordinator/case manager will work with other available funding streams and community agencies to fulfill the need. If service costs exceed the annual limit, those parts and labor costs funded through the waiver must be itemized clearly to differentiate the waiver service provision from those parts and labor funded through a nonwaiver funding source.

- Items requested that are not listed in the *Allowable Activities* section must be reviewed and decision rendered by the state FSSA director or state agency designee.
- Requests for modifications at two or more locations may only be approved at the discretion of the FSSA director or designee.
- Requests for modifications may be denied if the state FSSA director or state agency designee determines the documentation does not support residential stability and/or the service requested.

The services under Home Modifications are limited to additional services not otherwise covered under the Indiana Medicaid State Plan, but consistent with waiver objectives of avoiding institutionalization.

Activities Not Allowed

Activities not allowed under Home Modifications include but are not limited to the following:

- Adaptations or improvements that are not of direct medical or remedial benefit to the participant, such as:
  - Central heating and air conditioning
  - Routine home maintenance
  - Roof repair
  - Structural repair that is not incidental to the original modification
  - Driveways, decks, patios, publicly owned sidewalks and household furnishings
  - Swimming pools, spas or hot tubs
  - Outside storage spaces
  - Home security systems
- Modifications that create living space or facilities where they did not previously exist (for example, installation of a bathroom in a garage/basement, and so on)
- Modifications that will add non-incidental square footage to the home
- Home Modifications services for participants living in foster homes, group homes, assisted living facilities or homes for special services (any licensed residential facility)
  (*Note: The responsibility for Home Modifications rests with the facility owner or operator.*)
- Home Modifications services for participants living in a provider-owned or -controlled residence
  (*Note: The responsibility for Home Modifications rests with the facility owner or operator.*)
- Completion of, or modifications to, new construction or significant remodeling/reconstruction are excluded, unless there is documented evidence of a significant change in the participant's medical or remedial needs that now require the requested modification
- Home Modifications services will not be reimbursed when the owner of the service organization is one of the following:
  - Spouse of a participant
  - Attorney-in-fact (or POA) of a participant
  - HCR of a participant
  - Legal guardian of a participant

Provider Qualifications

Provider qualifications for Home Modifications are presented in Table 12.

Table 12 – Provider Qualifications for Home Modifications

Waiver	Provider	Licensure/ Certification	Other Standards
PathWays	Home Modifications Individual	Any applicable licensure must be in place	FSSA approved *455 IAC 2* Becoming an approved provider; maintaining approval *455 IAC 2* Provider qualifications: General requirements *455 IAC 2* Maintenance of records of services provided *455 IAC 2* Liability insurance *455 IAC 2* Professional qualifications and requirements; documentation of qualifications *455 IAC 2* Warranty required Compliance with applicable building codes and permits
PathWays	Home Modifications Agency/ Contractor	Any applicable licensure *IC 25-20.2* Home inspector *IC 25-28.5* Plumber *IC 25-4* Architect	FSSA approved *455 IAC 2* Becoming an approved provider; maintaining approval *455 IAC 2* Provider qualifications: General requirements *455 IAC 2* Maintenance of records of services provided *455 IAC 2* Liability insurance *455 IAC 2* Professional qualifications and requirements; documentation of qualifications *455 IAC 2* Warranty required Compliance with applicable building codes and permits
PathWays	Plumber	*IC 25-28.5*	FSSA approved *455 IAC 2* Becoming an approved provider; maintaining approval *455 IAC 2* Provider qualifications: General requirements *455 IAC 2* Financial information *455 IAC 2* Liability insurance *455 IAC 2* Professional qualifications and requirements; documentation of qualifications *455 IAC 2* Warranty required Compliance with applicable building codes and permits

Waiver	Provider	Licensure/ Certification	Other Standards
PathWays	Architect	*IC 25-4*	FSSA approved *455 IAC 2* Becoming an approved provider; maintaining approval *455 IAC 2* Provider qualifications: General requirements *455 IAC 2* Financial information *455 IAC 2* Liability insurance *455 IAC 2* Professional qualifications and requirements; documentation of qualifications *455 IAC 2* Warranty required Compliance with applicable building codes and permits

Integrated Health Care Coordination

The following subsections provide information and requirements for Integrated Health Care Coordination for the PathWays Waiver.

Service Definition

Integrated Health Care Coordination is to promote improved health status and quality of life, delay/prevent deterioration of health status, manage chronic conditions in collaboration with the physicians, and integrate medical and social services.

Allowable Activities

Integrated Health Care Coordination may include the following activities:

- Development and oversight of a healthcare support plan that includes coordination of medical care and proactive care management of both chronic diseases and complex conditions such as recurring falls, depression and dementia. (*Note: Skilled nursing services are provided within the scope of the Indiana State Nurse Practice Act*.)
- Collaboration across all service providers: waiver, Indiana Medicaid State Plan, mental health, dental and medical
- Collaboration across social supports: housing, food, Medicare/Medicaid system navigation, finances and transportation
- Medication review
- Transitional support from hospital or nursing facility to home/assisted living
- Advance care planning

Service Standards

These service standards must be followed for Integrated Health Care Coordination:

- Weekly consultations or reviews

- Face-to-face visits with the participant; including a minimum of one face-to-face visit per month
- No duplication of services provided under the Indiana Medicaid State Plan or under any other waiver service
- Services must address needs in the plan of care
- Current Indiana RN license for each nurse
- Current Indiana license for LPN
- Current Indiana license for social worker (LSW) with master's degree in social work with additional documentation of at least two years of experience providing health care coordination

The service coordinator/case manager is expected to coordinate and collaborate with other case managers/service coordinators, other organizations, community partners, healthcare professionals and FSSA OMPP staff to ensure quality care management is being delivered and options are being discovered and presented to the individual to optimize their overall functioning capability.

Documentation Standards

These documentation standards must be followed for Integrated Health Care Coordination:

- Evidence of a consultation, including complete date and signature (*Note: Consultation can be with the participant, informal caregivers, other staff, other professionals, as well as healthcare professionals.*)
  - Weekly consultations or reviews
  - Minimum of one face-to-face visit with the participant per month.
- Services required to address needs identified in the plan of care or PCA
- Written report provided to pertinent parties at least quarterly by the Integrated Health Care Coordination provider
  (*Note: Pertinent parties include the participant, guardian, waiver service coordinator/case manager, all waiver service providers including mental health providers, Indiana Medicaid State Plan services and physicians.*)

> *Note: If applicable, copies of personal record must be:*
>
> - *Placed in a prominent place in the participant's file*
> - *Sent with the participant when transferred for medical care or upon moving from the residence and in accordance with state law*

Limitations

Integrated Health Care Coordination services will not duplicate services provided under the Indiana Medicaid State Plan or any other waiver service.

Integrated Health Care Coordination services are:

- A minimum of one face-to-face visit per month
- Not to exceed 16 hours of healthcare coordination per month, including travel time

Activities Not Allowed

The following activities are not allowed under Integrated Health Care Coordination:

- Skilled nursing services that are available under the Indiana Medicaid State Plan
- Any other service otherwise provided by the waiver

Provider Qualifications

Provider qualifications for Integrated Health Care Coordination are presented in Table 13.

Table 13 – Provider Qualifications for Integrated Health Care Coordination

Waiver	Provider	Licensure/ Certification	Other Standards
PathWays	Adult Day Facility	*IC 25-23-1* RN *IC 25-23-1* LPN *IC 25.23.6* LSW	FSSA approved
PathWays	Assisted Living Facility	*IC 25-23-1* RN *IC 25-23-1* LPN *IC 25.23.6* LSW	FSSA approved
PathWays	Physician Practice	*IC 25-23-1* RN *IC 25-23-1* LPN *IC 25.23.6* LSW	FSSA approved

Nutritional Supplements

The following subsections provide information and requirements for the Nutritional Supplements service.

Service Definition

Nutritional (dietary) supplements include liquid supplements, such as Boost or Ensure, to support people in maintaining an individual's health, so they are able to remain in the community.

Supplements must be ordered by a physician, physician assistant or nurse practitioner.

Approved Nutritional Supplements expenditures are reimbursed through the local AAA or an approved FSSA OMPP provider that maintains all applicable receipts and verifies the delivery of services. Providers can directly relate with the state Medicaid agency at the provider's election.

Allowable Activities

The Nutritional Supplements service includes enteral formulae, category 1, such as Boost or Ensure.

Service Standards

Nutritional Supplements services must follow a written service plan addressing specific needs determined by the individual's PCA.

Documentation Standards

The service coordinator/case manager must complete these documentation tasks:

- Document the need for nutritional supplements and amount being requested.
- Identify the amount requesting from the annual cap of $1,200 for Nutritional Supplements services.

The provider must document the following:

- Date of delivery
- How many meals were provided
- Care professional or service coordinator/case manager that involved the participant

> *Note: If applicable, copies of personal record must be:*
>
> - *Placed in a prominent place in the participant's file*
> - *Sent with the participant when transferred for medical care or upon moving from the residence and in accordance with state law*

Limitations

The following limits apply for Nutritional Supplements services:

- An annual cap of $1,200 is available for Nutritional Supplements services.
- The services under Nutritional Supplements are limited to additional services not otherwise covered under the Indiana Medicaid State Plan, but consistent with waiver objectives of avoiding institutionalization.
- The meals provided as part of these services shall not constitute a full nutritional regimen.

Activities Not Allowed

The following activities are not allowed under Nutritional Supplements:

- Services available through the Indiana Medicaid State Plan (an Indiana Medicaid State Plan PA denial is required before reimbursement is available through the Medicaid waiver for this service)
- Service provided by the spouse of a participant (also known as an LRI)

Provider Qualifications

Provider qualifications for the Nutritional Supplements service are presented in Table 14.

Table 14 – Provider Qualifications for Nutritional Supplements

Waiver	Provider	Licensure/ Certification	Other Standards
PathWays	Nutritional Supplements Agency	Not required	FSSA approved *455 IAC 2* Becoming an approved provider; maintaining approval *455 IAC 2* Provider qualifications: General requirements *455 IAC 2* Transfer of individual's record upon change of provider *455 IAC 2* Maintenance of records of services provided *455 IAC 2* Liability insurance

Participant-Directed Home Care Service

The following subsections provide information and requirements for Participant-Directed Home Care Service under the PathWays Waiver.

Service Definition

The Participant-Directed Home Care Service is a health-related service under the PathWays Waiver that can be performed by either licensed medical or trained nonmedical personnel. This service is provided for the primary purpose of meeting the chronic personal needs of the participant to maintain a level of function that will allow for a participant to avoid unnecessary institutionalization. This service can provide skilled or attendant care activities or both. In conjunction with the Indiana Medicaid State Plan, the Participant-Directed Home Care Service may be provided 24 hours per day, seven days a week.

Initially, the Participant-Directed Home Care Service will be limited to the 46260, 46143, 46202 and 46204 ZIP codes. This is a new service and, if successful, then the expectation would be to make it available in more areas of the state.

> *Note: The Participant-Directed Home Care Service has a limit of five slots, and services must be approved by the FSSA OMPP.*

Service Standards

The Participant-Directed Home Care Service has the following service standards:

- A participant shall hire either a licensed professional through a home health agency, an independent, licensed professional or a nonclinical competency trained unlicensed profession.
- Home care service requires individual and continuous services when there is no person available outside of these services to assume the role of caregiver.
- The Participant-Directed Home Care Service requires a participant to be diagnosed with a chronic medical condition that may require up to 24 hours of continuous care, as evidenced through a physician's order that can be safely provided outside of an institution. The participant must also receive Indiana Medicaid State Plan home health services.
- Home care attendant service is provided according to the participant's service plan/plan of care which documents the participant's specific health-related need for individual and continuous care.

- Participant must be willing to accept risks and responsibilities associated with employing the caregiver and directing their own care.

Limitations

The Participant-Directed Home Care Service has the following limitations:

- Is offered to individuals in a noncongregate setting.
- Is offered to individuals living without family or other informal supports willing and able to be trained to care for the participant and assume a portion of the participant's care.
- Is offered to individuals residing in postal codes 46260, 46143, 46202 and 46204.
- Does not include administration of level II, III, IV and V medications.

Documentation Standards

Case managers/service coordinators are an integral part of the success of the Participant-Directed Home Care Service. The service coordinator/case manager must maintain these documentation standards:

- Provide a current assessment, including scope, frequency, duration and activities of the Participant-Directed Home Care Service, which documents the participant's needs.
- Complete the participant-directed checklist before the service may be added to the service plan and at the initial, quarter review, annual and reentry assessments.
- Assess the needs of the participant through a person-centered planning process. The service coordinator/case manager is required to develop a person-centered plan to meet those needs and create a service request (expressed in service units and cost reimbursement services); the service coordinator/case manager must document the budget process and review with the participant.
- Document the medical need for a skilled service and types of skilled care the participant may require.
- Document the frequency, duration and types of appropriate skilled activities.
- Document the skilled activity that will meet the participant's needs and ensure it is accurately documented in the skilled level of care assessment.
- Monitor the service delivery every month. The service coordinator/case manager will coordinate service delivery (frequency, activities) with the employee/direct worker and also contact the fiscal intermediary agency to verify.
- Conduct monthly face-to-face visits with participants.
- Complete face-to-face assessments, including the Person-Centered Monitoring Tool (PCMT) every quarter and annually.
- Document the backup plan for the participant for when the direct worker is unavailable to deliver skilled care.
- Have participant sign a waiver liability form.
- Document who is the employer, who is the employee/direct worker, and their relationship to the participant.
- Monitor the enrollment process for the participant and their employee/direct worker.
- Collect all training paperwork containing signatures for the file.

> *Note: If applicable, copies of personal record must be:*
>
> - *Placed in a prominent place in the participant's file*
> - *Sent with the participant when transferred for medical care or upon moving from the residence and in accordance with state law*

Activities Not Allowed

The following activities are not allowed under the Participant-Directed Home Care Service:

- Home care service shall not be reimbursed when provided by any of the following:
  - Attorney-in-fact (POA) of a participant
  - Health care representative (HCR) of a participant
  - Legal guardian of a participant
  - Spouse of a participant
- Participant must be able to direct their own care.

Provider Standards

The caregiver applicant must enter into the IHCP agreement to become a paid caregiver. The caregiver is authorized to provide home care attendant services to participants if the caregiver:

- Either meets the personnel qualifications specified in *IC.16-27-1* or successfully completed at least one of the following, as applicable (verified by the fiscal intermediary):
  - If applicable, a competency evaluation program or training and competency evaluation program approved or conducted under section 10.2.2 of the American Association of Respiratory Care (AARC) Clinical Practice Guideline
  - A program that includes cardiopulmonary resuscitation (CPR), basic first aid and any applicable durable medical equipment (DME) training
- Identifies and documents participant need in the provider service plan:
  - Services must be outlined in the provider service plan.
  - Data record of services must be provided and maintained, including:
    - Complete date and time of service (in and out)
    - Specific services or tasks provided
    - Signature of paid caregiver providing the service (minimally the last name and first initial)
  - Each paid caregiver providing direct care or supervision of care to the participant must make at least one entry on each day of service. All entries must describe an issue or circumstance offered to the individual.
  - Daily documentation of service delivery is to be signed by the participant. If the participant cannot sign, then the paid caregiver must self-attest and sign in lieu of the participant.
  - The paid caregiver is required to coordinate information about the participant's care, including backup plan, with any and all other providers and service coordinator/case manager rendering services to the participant. Provider coordination shall occur among providers/paid caregivers during shift changes for the participant and at any other time where the participant experiences a healthcare change.

Provider Qualifications

Provider qualifications for the Participant-Directed Home Care Service are presented in Table 15.

Table 15 – Provider Qualifications for Participant Directed Home Care Service

Waiver	Provider	Licensure/ Certification	Other Standards
PathWays	Aide/Paid Caregiver	Not required	FSSA approved
PathWays	Home Health Agency	*IC 16-27-1*	FSSA approved provider

Personal Emergency Response System

The following subsections provide information and requirements for the Personal Emergency Response System service.

Service Definition

The Personal Emergency Response System is an electronic device that enables certain participants at high risk of institutionalization to secure help in an emergency. The participant may also wear a portable help button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center after a button is activated. The response center is staffed 24 hours a day, seven days a week by trained professionals.

Allowable Activities

The following activities are allowed under the Personal Emergency Response System service:

- Device installation
- Ongoing monthly maintenance of the device
- Electronic service that is usually a portal help button; however, it can also be an electronic device that includes, but is not limited to, Global Positioning System (GPS) or video monitoring service (*Note: Remote monitoring will not be placed in participant bedrooms or bathrooms.*)

Service Standards

The Personal Emergency Response System service must follow a written service plan addressing specific needs determined by the individual's assessment.

The service coordinator/case manager is required to contact the waiver participant if contacted by the Personal Emergency Response System provider that waiver participant experienced a fall.

Documentation Standards

The service coordinator/case manager is responsible for the documenting the following:

- The need for Personal Emergency Response System
- The need for Personal Emergency Response System maintenance
- Whether the person is residing alone or alone for significant parts of the day without a caregiver present

The provider is responsible for documenting the following:

- Date of installation
- Expense for installation
- Monthly rental fee
- Ongoing monthly maintenance of device
- Monthly written notification to case managers/service coordinators of any participant who experienced a fall within a one-month time frame

The monitor positions would be determined during the person-centered service planning process.

Persons responsible for monitoring would be determined during the person-centered service planning process.

The mainframe location would be determined by the provider.

The MCE confirms there is a backup plan in the event of equipment failure.

The service coordinator/case manager is the central vehicle for the state to provide information to the participant, their family and the entire circle of support. This is part of the person-centered planning process, which would include the provider.

Note: If applicable, copies of personal record must be:

- *Placed in a prominent place in the participant's file*
- *Sent with the participant when transferred for medical care or upon moving from the residence and in accordance with state law*

Activities Not Allowed

The following activities are not allowed under the Personal Emergency Response System service:

- Replacement cost of lost or damaged equipment
- Services provided to participants receiving the Assisted Living or Adult Family Care waiver services
- Service provided by the spouse of a participant (also known as an LRI)

Provider Qualifications

Provider qualifications for the Personal Emergency Response System service are presented in Table 16.

Table 16 – Provider Qualifications for Personal Emergency Response System

Waiver	Provider	Licensure/ Certification	Other Standards
PathWays	Personal Emergency Response System Agency	Not required	FSSA approved *455 IAC 2* Becoming an approved provider; maintaining approval *455 IAC 2* Provider qualifications: General requirements *455 IAC 2* Maintenance of records of services provided *455 IAC 2* Liability insurance *455 IAC 2* Professional qualifications and requirements; documentation of qualifications *455 IAC 2* Warranty required Compliance with applicable building codes and permits

Pest Control

The following subsections provide information and requirements for Pest Control services.

Service Definition

Pest Control services are designed to prevent, suppress or eradicate anything that competes with humans for food and water, injures humans, spreads disease to humans, or annoys humans, and is causing or is expected to cause more harm than is reasonable to accept. Pests include but are not limited to insects such as roaches, mosquitoes, bed bugs and fleas; insect-like organisms, such as mites and ticks; and vertebrates, such as rats and mice.

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

Reimbursement for approved Pest Control expenditures is through the local AAA or other approved FSSA OMPP provider, which maintains all applicable receipts and verifies the delivery of services. Providers can directly communicate with the state Medicaid agency at the provider's election.

Allowable Activities

Pest Control services are added to the service plan when the service coordinator/case manager determines – either through direct observation or by participant report – that a pest is present and is causing or is expected to cause more harm than is reasonable to accept.

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

Service Standards

Pest Control services must follow a written service plan addressing specific needs determined by the individual's PCA.

Documentation Standards

The service coordinator/case manager is responsible for documenting the following through the PCA:

- Need for pest control
- Types of pests to eradicate through the PCA

> *Note: If applicable, copies of personal record must be:*
>
> - *Placed in a prominent place in the participant's file*
> - *Sent with the participant when transferred for medical care or upon moving from the residence and in accordance with state law*

Limitations

An annual cap of $4,000 is available for Pest Control services.

Activities Not Allowed

The following activities are not allowed under the Pest Control service:

- Services used solely as a preventative measure (*Note: There must be documentation of a need for this service either through the service coordinator/case manager's direct observation or participant report that a pest is causing or is expected to cause more harm than is reasonable to accept.*)
- Services provided to participants receiving either of the following waiver services:
  - Adult Family Care
  - Assisted Living
- Preventive measures or ongoing need for service
- Eradication or prevention of mold or mold-like substances
- Service provided by the spouse of a participant (also known as an LRI)

Provider Qualifications

Provider qualifications for Pest Control services are presented in Table 17.

Table 17 – Provider Qualifications for Pest Control

Waiver	Provider	Licensure/ Certification	Other Standards
PathWays	Pest Control Agency	*IC 15-3-3.6*	FSSA approved *455 IAC 2* Becoming an approved provider; maintaining approval *455 IAC 2* Provider qualifications: General requirements *455 IAC 2* Maintenance of records of services provided *455 IAC 2* Liability insurance *455 IAC 2* Professional qualifications and requirements; documentation of qualifications *455 IAC 2* Warranty required

Waiver	Provider	Licensure/ Certification	Other Standards
			Pesticide applicators must be certified or licensed through the Purdue University Extension Service and the Office of the Indiana State Chemist.

Respite Care Services

The following subsections provide information and requirements for Respite Care Services.

Service Definition

Respite Care Services are those services that are provided temporarily or periodically in the place of the usual caregiver. Respite can occur in home- and community-based settings.

Allowable Activities

The following activities are allowed under Respite Care Services:

- Respite care home health aide (HHA) services
- Respite care nursing services

Service may be provided in home- and community-based settings.

Service Standards

The level of professional care provided under Respite Care Services depends on the needs of the participant and caregiver determined in the PCA. The service standards under Respite Care Services are as follows:

- Agency providing Respite Care Services is responsible for tracking participant's respite hours and notifying participant and case manager of hours used as well as hours remaining.
- RHHA: A participant who is eligible for Indiana Medicaid State Plan home health services (HOHE) should be considered for respite home health aide (RHHA) services under the supervision of a registered nurse.

  RHHA-authorized hours will roll over month-to-month through the duration of the annual service plan. If a request for an increase in RHHA during the annual care plan is needed, the service coordinator/case manager must coordinate with the agency to verify unused hours before requesting the additional hours. If there are unused hours, those hours must be used first before requesting additional hours.
- RNU: A participant who is eligible for Indiana Medicaid State Plan nursing services (SKNU) must be considered for respite care nursing services (RNU) provided by an RN or LPN.

  RNU authorized hours will roll over month to month through the duration of the annual service plan. If a request for an increase in RHHA during the annual care plan is needed, the service coordinator/case manager must coordinate with the agency to verify unused hours before requesting the additional hours. If there are unused hours, those hours must be used first before requesting additional hours.

Documentation Standards

The service coordinator/case manager is responsible for the following documentation standards:

- Identify the primary caregiver being relieved; identify that the primary caregiver is not being paid by the agency to respite themselves during this time.
- Document needs and activities that require skilled respite.

The provider is responsible for the following documentation standards:

- Complete a data record of staff to participant service, documenting the complete date and time in and time out, and the number of units of service delivered that day.
- Ensure that each staff member providing direct care or supervision of care to the participant makes at least one entry on each day of service describing an issue or circumstance concerning the participant.
- Include date and time, and at least the last name and first initial of the staff person making the entry in documentation. *(Note: If the person providing the service is required to be a professional, include that title – for example, if a nurse is required to perform the service, the RN or LPN title would be included with the name.)*
- Document any significant issues involving the participant that require intervention by a healthcare professional; also document the service coordinator/case manager that involved the participant.
- Include the following elements: the reason for the respite and the type of respite rendered.
- Specify applicable (if any) limits on the amount, frequency or duration of this service.
- Provide notification to the participant's service coordinator/case manager and other unskilled provider within 48 hours upon changes to the participant's person-centered service plan.

Note: If applicable, copies of personal record must be:

- *Placed in a prominent place in the participant's file*
- *Sent with the participant when transferred for medical care or upon moving from the residence and in accordance with state law*

Activities Not Allowed

The following activities are not allowed under Respite Care Services:

- Replacing services that should be provided under the Indiana Medicaid State Plan
- Provided when the owner of the service organization is one of the following:
  - Spouse of a participant
  - Attorney-in-fact (or POA) of a participant
  - HCR of a participant
  - Legal guardian of a participant
- Duplication of any other service being provided under the participant's service plan
- Services provided to participants receiving any of the following waiver services:
  - Adult Family Care
  - Assisted Living

Provider Qualifications

Provider qualifications for Respite Care Services are presented in Table 18.

Table 18 – Provider Qualifications for Respite Care Services

Waiver	Provider	Licensure/ Certification	Other Standards
PathWays	Licensed Home Health Agency	*IC 16-27-1*	FSSA approved

Service Coordination

The following subsections provide information and requirements for the Service Coordination service.

Service Definition

Service Coordination is a process of assessment, discovery, planning, facilitation, advocacy, collaboration and monitoring of the holistic needs of each individual participant, regardless of funding sources.

Allowable Activities

The following activities are allowed under Service Coordination:

- Person-centered assessment and planning:
  - Includes but is not limited to discovering the participant's strengths, needs, goals and preferences.
  - Appropriate facilitation of the assessment process through utility of person-centered discovery tools and practice engaging the participant and their circle of support. The assessment and planning phase can include, but is not limited to, brokering community resources, action and/or service planning, and eligibility for funded services.
- Development and implementation of a person-centered support plan, including action and/or service plans:
  - Action planning is a process to determine community resources to meet the participant's functional and social needs.
  - Service planning is a process to determine funded services and eligibility to appropriately meet the participant's needs.
- Monitoring and evaluating all action and/or service plans:
  - Service coordinators are responsible to monitor progress for all services displayed on the action and/or service plans.
  - The Service coordinator will provide and coordinate high quality services to the participant, while promoting seamless, integrated, coordinated care.
  - The service coordinator will monitor person-centered support plans in a face-to-face contact every 90 days from the initial service plan activation. When the initial care plan is activated, the service coordinator will either call or visit the participant within 30 days from initial service plan activation to ensure implementation of services.
  - The service coordinator/case manager is responsible for completing annual person-centered assessments, including eligibility and service planning.
  - The service coordinator/case manager is responsible for coordinating changes in the service plan that include but are not limited to, notifying all providers about the change and when they are to

begin or end services, and notifying all providers when a care plan is in terminated or restart status.

- The service coordinator/case manager will be responsible for evaluating the effectiveness of all services. Evaluation is demonstrated through but not limited to the following:
  - Monitoring the progress from identifying need to meeting goals and/or preferences identified by the participant
  - Direct collaboration and coordination with providers to ensure services are within the participant's preferences
  - Adjusting action and service plans appropriately to identify changing needs that meet the participant's needs

- Termination of plans
  - The service coordinator/case manager will follow the nursing facility level of care (NF LOC) HCBS waiver's termination procedures when a participant is no longer to receive services under the waiver program. This includes providing a 30-day notice to any participant the care manager/service coordinator is terminating.

- Transition follow-up
  - The service coordinator/case manager must ensure that participants fully understand their ability to make choices concerning all services they receive, including Service Coordination services.
  - In the event the participant chooses another MCE/care management agency, the current MCE/care management agency fully assists the participant in their transition to the new organization or individual service coordinator/case manager of choice. The goal is to ensure a seamless transition for the participant.

Service Standards

These service standards must be followed for Service Coordination:

- Service Coordination services must be reflected in the participant's service plan.
  - Case managers/service coordinators enhance the participant's functional and social well-being.
  - Case managers/service coordinators broker community resources that align with the participant's unique needs.

- Case managers/service coordinators will engage the participant and their circle of support in all aspects of the Service Coordination process and tailor the person-centered support plan to the participant's needs, preferences, goals and strengths.

- The service coordinator/case manager is expected to coordinate and collaborate with the MCE care coordinator, other organizations, community partners and FSSA staff to ensure quality Service Coordination is being delivered and options are being discovered and presented to the participant to optimize their overall functioning capability.

- A service coordinator/case manager's maximum Medicaid waiver caseload is not to exceed 65 participants at any time.

> *Note: If a mixed caseload is assigned, the following PathWays-specific weighted caseload requirements are followed: [# of members in an institutional setting × 1.0] + [# of members identified as candidates for transition to the community × 2] + [# of members in an HCBS setting × 1.5] = 100 or Less*

- Case managers/service coordinators are responsible for the following:
  - Identifying when a participant is residing in a provider-owned or -controlled setting

- Monitoring HCBS characteristics
- Monitoring person-centered modifications to HCBS characteristics and documenting them in the person-centered service plan as such

Documentation Standards

The service coordinator/case manager must follow these documentation standards:

- Person-centered assessment and planning:
  - Includes but is not limited to discovering the participant's strengths, needs, goals and preferences.
  - Appropriate facilitation of the assessment process to engage the participant and their circle of support. The assessment and planning phase can include but is not limited to, brokering community resources, action and/or service planning, and eligibility for funded services.
  - To meet the HCBS settings final rule, case managers/service coordinators must support the person to lead and direct their planning process as much as possible, and to the extent the person wants. The circle of support must include people the participant wishes to include.
- Development and implementation of a person-centered support plan, including action and/or service plans:
  - Action planning is a process to determine community resources to meet the participant's functional and social needs.
  - Service planning is a process to determine funded services and eligibility to appropriately meet the participant's needs.
- Monitoring and evaluating all action and/or service plans:
  - Case managers/service coordinators are responsible to monitor progress for all services displayed on the action and/or service plans.
  - The service coordinator/case manager will provide and coordinate high quality services to the individual, while promoting seamless, integrated and coordinated care.
  - The service coordinator/case manager will monitor person-centered support plans in a face-to-face contact every 90 days from the initial service plan activation. When the initial care plan is activated, the care manager/service coordinator will either call or visit the individual within 30 days and no more than 40 days from initial service plan activation to ensure implementation of services.
  - The service coordinator/case manager is responsible to complete annual person-centered assessments including eligibility and service planning.
  - The service coordinator/case manager is responsible to complete all assessment tools including but not limited to timely submission of incident reports.
  - The service coordinator/case manager will be responsible to evaluate the effectiveness of all services. Evaluation is demonstrated through, but is not limited to, the following:
    - Monitoring the progress from identifying needs to meeting goals and/or preferences identified by the participant
    - Direct collaboration and coordination with providers to ensure services are within the participant's preferences
    - Adjusting action and service plans appropriately to identify changing needs that meet the participant's needs

Note: If applicable, copies of personal record must be:

- *Placed in a prominent place in the participant's file*
- *Sent with the participant when transferred for medical care or upon moving from the residence and in accordance with state law*

Activities Not Allowed

The following activities are not allowed under the Service Coordination service:

- Service Coordination may not be conducted by any organization, entity, or participant that also delivers other in-home and community-based services, or by any organization, entity, or participant related by common ownership or control to any other organization, entity, or participant who also delivers other in-home and community-based services, unless the organization is an Area Agency on Aging (AAA) that has been granted permission by the FSSA OMPP to provide direct services to participants. Prior to billing, a service coordinator/case manager must have completed The Learning Community Person-Centered Thinking (PCT) training to become a Medicaid certified service coordinator/case manager.

> *Note: Common ownership exists when a participant, or any legal entity, possesses ownership or equity of at least 5% in the provider as well as the institution or organization serving the provider. Control exists where a participant or organization has the power or the ability, directly or indirectly, to influence or direct the actions or policies of an organization or institution, whether or not actually exercised. "Related" means associated or affiliated with, or having the ability to control, or be controlled by.*

- Independent service coordinator/case manager and independent care management agencies may not provide initial applications for Medicaid waiver services.
- Reimbursement of Service Coordination under Medicaid waivers may not be made unless and until the participant becomes eligible for Medicaid waiver services. Service Coordination provided to participants who are not eligible for Medicaid waiver services will not be reimbursed as a Medicaid waiver service.
- Service Coordination services will not be reimbursed when the owner of the service organization is one of the following:
  - Spouse of a participant
  - Attorney-in-fact (or POA) of a participant
  - HCR of a participant
  - Legal guardian of a participant

Provider Qualifications

Provider qualifications for Service Coordination services are presented in Table 7. Prior to billing, a service coordinator/case manager must have completed The Learning Community PCT training to become a Medicaid certified service coordinator/case manager.

Table 7 – Provider Qualifications for Service Coordination

Waiver	Provider	Licensure/ Certification	Other Standards
PathWays	Service Coordination Individual	Not required	FSSA, or its designee, approved *455 IAC 2* Documentation of qualifications *455 IAC 2* Care management liability Insurance Training in the nursing facility LOC process by the FSSA or designee Education and work experience (must meet one of the following): • Be continuously employed as a care manager by an Area Agency on Aging (AAA) since June 30, 2018 • Be an Indiana registered nurse • Have a bachelor's degree in social work, psychology, counseling, gerontology, nursing, or health and human services • Have a bachelor's degree in any field with a minimum of two years full-time, direct service experience with the elderly or disabled (this experience includes assessment, care plan development, and monitoring) • Have a master's degree in social work, psychology, counseling, gerontology, nursing, or health and human services, which may substitute for the required minimum of two full time direct services experience • Have an associate degree in nursing • Have an associate degree in any field with a minimum of four-year, full-time direct service experience with the elderly or disabled (this experience includes assessment, care plan development and monitoring)
PathWays	Care Management Agency	Not required	FSSA, or its designee, approved *455 IAC 2* Provider Qualifications: General requirements *455 IAC 2* Procedures for protecting individuals *455 IAC 2* Unusual occurrence; reporting *455 IAC 2* Transfer of individual's record upon change of provider *455 IAC 2* Notice of termination of services *455 IAC 2* Provider organizational chart *455 IAC 2* Collaboration and quality control *455 IAC 2* Data collection and reporting standards *455 IAC 2* Quality assurance and quality improvement system *455 IAC 2* Financial information *455 IAC 2* Liability insurance *455 IAC 2* Documentation of qualifications *455 IAC 2* Maintenance of personnel records *455 IAC 2* Adoption of personnel policies *455 IAC 2* Operations manual *455 IAC 2* Maintenance of records of services provided *455 IAC 2* Case Management

Waiver	Provider	Licensure/ Certification	Other Standards
			Training in the nursing facility level of care process by the FSSA or designee Education and work experience (one of the following): • An individual continuously employed as a care manager by an AAA since June 30, 2018 • A qualified intellectual disability professional (QIDP) who meets the QIDP requirements at *42 CFR 483.430* • A registered nurse, licensed practical nurse, bachelor's degree or associate degree with one year of experience delivering health care/social services or care management, or at least two or more years in care planning, care management or delivering health care or social services *Note: A master's degree in a related field may substitute for the required experience.*

Specialized Medical Equipment and Supplies

The following subsections provide information and requirements for Specialized Medical Equipment and Supplies.

Service Definition

The Specialized Medical Equipment and Supplies service includes medically prescribed items required by the participant's service plan, which assist the participant in maintaining their health, welfare and safety, and enable the participant to function with greater independence in the home. The Specialized Medical Equipment and Supplies service provides therapeutic benefits to a participant in need, because of certain medical conditions and/or illnesses. Specialized Medical Equipment and Supplies primarily and customarily are used to serve a medical purpose and are not useful to a person in the absence of illness or injury.

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

- Participants requesting authorization for this service through an HCBS waiver must first exhaust eligibility of the desired equipment or supplies through the Indiana Medicaid State Plan, which may require PA. The applicable MCE will deny any provider claim that did not follow the correct Medicaid billing practices:
  - There should be no duplication of services between HCBS waiver and Indiana Medicaid State Plan.
  - The refusal of a Medicaid vendor to accept the Medicaid reimbursement through the Indiana Medicaid State Plan is not a justification for waiver purchase.
  - Preference for a specific brand name is not a medically necessary justification for waiver purchase. The Indiana Medicaid State Plan often covers similar equipment but may not cover the specific brand requested. When this occurs, the participant is limited to the service/brand covered by the Indiana Medicaid State Plan.
  - Reimbursement is limited to the Indiana Medicaid State Plan fee schedule, if the requested item is covered under Indiana Medicaid State Plan.

- All requests for items to be purchased through a Medicaid waiver must be accompanied by documentation of Indiana Medicaid State Plan PA request and decision, if requested item is covered under the Indiana Medicaid State Plan.

- Requests will be denied if the FSSA director or designee determines the documentation does not support the service requested.

Allowable Activities

The services under Specialized Medical Equipment and Supplies are limited to additional services not otherwise covered under the Indiana Medicaid State Plan, but consistent with waiver objective of avoiding institutionalization.

Justification and documentation are required to demonstrate that the request is necessary to meet the participant's identified needs.

The following are allowable activities under Specialized Medical Equipment and Supplies:

- Lift chairs – The HCBS program will cover the chair. The Indiana Medicaid State Plan should be pursued first for prior approval of the lift mechanism.
- Medication dispensers

> *Note: Filling the medication dispenser is not currently an allowable activity. If a participant needs assistance with the filling of medication dispensers, Indiana Medicaid State Plan prior authorization services could be sought, and this task could be completed by a registered nurse (RN). Participants could also use informal supports if available. As a reminder, "pill packs," where the pharmacy is packaging together an individual's medications, is not a medication dispenser. Any service plans that include pill packs will not be approved. If a member is receiving pill packs, work with them to update their service plan. Case managers can use their local Aging and Disability Resource Center (ADRC) and options counselors to identify pharmacies that may offer pill packs through other resources.*

- Toileting and/or incontinence supplies that do not duplicate Indiana Medicaid State Plan Services
- Slip-resistant socks
- Self-help devices – including over-the-bed tables, reachers, adaptive plates, bowls, cups, drinking glasses and eating utensils
- Strollers – when needed because participant's primary mobility device does not fit into the participant's vehicle/mode of transportation, or when the participant does not require the full-time use of a mobility device, but a stroller is needed to meet the mobility needs of the participant outside of the home setting.
- Voice active smart devices
- Interpreter service – provided in circumstances where the interpreter assists the individual in communication during specified scheduled meetings for service planning (such as waiver case conferences or team meetings) and is not available to facilitate communication for other service provision.

> *Note: Items requested that are not listed in this section will be submitted in the service plan and reviewed by the state FSSA director.*

Service Standards

The following service standards must be met for the Specialized Medical Equipment and Supplies service:

- All items must be of direct medical or remedial benefit to the participant.
- All items must meet applicable standards of manufacture, design and service specifications.

Documentation Standards

The care manager/service coordinator is responsible for the following documentation standards:

- Document the need for medical specialized equipment.
- Describe how the equipment is expected to improve the participant's quality of ADL.
- Collect two bids if over $1,000; if only one bid is obtained, the care manager/service coordinator must document the date of contact, the provider name and why the bid was not obtained from another provider.
- Ensure that bid contains warranty information and picture of the equipment.
- Submit Indiana Medicaid State Plan denial information for the equipment and/or supplies.

The provider must follow these document standards:

- Document date of installation.
- Document expense for installation.
- Document the identified direct benefit or need within the following:
  - Person-centered service plan
  - Physician prescription and/or clinical evaluation as deemed appropriate
- Obtain Indiana Medicaid State Plan PA request and the decision rendered, if applicable.
- Obtain signed and approved person-centered service plan.
- Maintain receipts for all incurred expenses related to this service.
- Must be in compliance with FSSA OMPP-specific guidelines and/or policies.
- At the time of renewal or when this section of the waiver is opened/edited in an amendment prior to the renewal, the state will create a separate, standalone interpreter service.

> *Note: If applicable, copies of personal record must be:*
>
> - *Placed in a prominent place in the participant's file*
> - *Sent with the participant when transferred for medical care or upon moving from the residence and in accordance with state law*

Limitations

Maintenance is limited to $1,000 annually for the repair and service of items that have been provided through an HCBS waiver:

- Requests for service must detail parts and labor costs.
- If the need for maintenance exceeds $1,000, the care manager/service coordinator works with other available funding streams and community agencies to fulfill the need. If service costs exceed the annual limit, parts and labor costs funded through the waiver must be itemized clearly to

differentiate parts the waiver service provision from parts and labor provided through a nonwaiver funding source.

- The services under Specialized Medical Equipment and Supplies are limited to additional services not otherwise covered under the Indiana Medicaid State Plan, but consistent with waiver objectives of avoiding institutionalization.

Activities Not Allowed

The following activities are not allowed under Specialized Medical Equipment and Supplies:

- Unallowable items including, but not limited to the following:
  - Hospital beds or air fluidized suspension mattresses/beds
  - Therapy mats
  - Parallel bars
  - Scales
  - Paraffin machines or baths
  - Therapy balls
  - Books, games or toys
  - Electronics such as CD players, radios, cassette players, tape recorders, television, VCRs/DVDs, camerasor film, videotapes, and other similar items
  - Computers and software
  - Exercise equipment such as treadmills or exercise bikes
  - Furniture
  - Appliances such as refrigerator, stove or hot water heater
  - Indoor and outdoor play equipment such as swing sets, swings, slides, bicycles adaptive tricycles, trampolines, playhouses or merry-go-rounds
  - Swimming pools, spas, hot tubs or portable whirlpool pumps
  - Adjustable mattresses (such as, but not limited to, Tempur-Pedic), positioning devices or pillows
  - Motorized scooters
  - Barrier creams, lotions or personal cleaning cloths
  - Essential oils
  - Totally enclosed cribs and barred enclosures used for restraint purposes
  - Manual wheelchairs
  - Vehicle modifications
- Any equipment or items that can be authorized through the Indiana Medicaid State Plan
- Any equipment or items purchased or obtained by the participant, their family members or other nonwaiver providers
- Service provided by the spouse of a participant (also known as an LRI)

Provider Qualifications

Provider qualifications for Specialized Medical Equipment and Supplies are presented in Table 19.

Table 19 – Provider Qualifications for Specialized Medical Equipment and Supplies

Waiver	Provider	Licensure/ Certification	Other Standards
PathWays	Licensed Home Health Agency	*IC 16-27-1*	FSSA approved *455 IAC 2-18* Warranty required
PathWays	Specialized Medical Equipment and Supplies Agency	*IC 25-26-21* *Certification IC 6-2.5-8-1*	FSSA approved *455 IAC 2* Becoming an approved provider; maintaining approval *455 IAC 2* Provider qualifications: general requirements *455 IAC 2* Maintenance of records of services provided *455 IAC 2* Liability insurance *455 IAC 2* Professional qualifications and requirements; documentation of qualifications *455 IAC 2* Warranty required

Structured Family Caregiving

The following subsections provide information and requirements for Structured Family Caregiving under the PathWays Waiver.

Service Definition

Structured Family Caregiving means a caregiving arrangement in which a participant lives with a primary caregiver who provides daily care and support to the participant based on the participant's daily care needs. The primary caregiver may be a nonfamily member or a family member who lives with the participant in the private home of the participant or the primary caregiver.

Necessary support services are provided by the primary caregiver (family caregiver) as part of Structured Family Caregiving service. Primary caregivers must be qualified to meet all federal and state regulatory guidelines-and be able to provide care and support to a participant based on the participant's assessed needs. Primary caregivers receive training based on the participant's assessed needs and are paid a per diem stipend for the care and support they provide to participants.

Structured Family Caregiving preserves the dignity, self-respect and privacy of the participant by ensuring high-quality care in a noninstitutional setting. The goal of this service is to provide necessary care while fostering and emphasizing the participant's independence in a home environment that will provide the participant with a range of care options as the needs of the participant change. The goal is reached through a cooperative relationship between the participant (or the participant's legal guardian), the primary caregiver, HCBS Medicaid waiver care manager/service coordinator and the Structured Family Caregiving provider. Participant needs will be addressed in a manner that supports and enables the individual to maximize abilities to function at the highest level of independence possible, while primary caregivers receive initial and ongoing support so they can provide high quality care. The service is designed to provide options for alternative long-term care to persons who meet nursing facility level of care and whose needs can be met in Structured Family Caregiving.

Only agencies may be Structured Family Caregiving providers, with the home settings being assessed and accessible, and all paid caregivers (including primary caregivers) being qualified as able to meet the participant's needs. The provider agency must conduct a minimum of two quarterly home visits. Additional home visits and ongoing communication with the caregiver is based on the assessed needs of the participant

and the caregiver. Home visits are conducted by a registered nurse and/or a caregiver coach as determined by a person-centered plan of care. The provider agency must make a substitute caregiver available to allow opportunities for primary caregiver wellness and skill development in alignment with the needs of the primary caregiver as identified by the caregiver coach, up to 15 days per year. The provider agency must capture daily notes that are completed by the primary caregiver in an electronic format, and use the information collected to monitor participant health and caregiver support needs. The agency provider must make such notes available to waiver care managers/service coordinators and the state upon request.

Allowable Activities

Structured Family Caregiving includes the following activities (Levels 1-3):

- Services provided by a primary caregiver who is the spouse of the participant (also known as an LRI)
- Home and Community Assistance care services related to needed IADLs
- Attendant Care services related to needed ADLs
- Medication oversight (to the extent permitted under state law)
- Escorting to necessary appointments, whenever possible, such as transporting individuals to doctor *(Note: When provided, such transportation is incidental and not duplicative of any other Indiana Medicaid State Plan or waiver service.)*
- Appointments and community activities that are therapeutic in nature or assist with maintaining natural supports
- Other appropriate supports as described in the individual's service plan

Service Standards

These service standards must be followed for Structured Family Caregiving:

- Structured Family Caregiving provider agencies must demonstrate three years of delivering services to older adults and adults with disabilities, and their caregivers must be in Indiana or be a Medicaid participating provider in another state or have a national accreditation.
- Structured Family Caregiving must be reflected in the participant's service plan and address specific needs determined by the participant's person-centered planning process.
- Structured Family Caregiving provider agencies develop, implement and provide ongoing management and support of a person-centered service plan that addresses the participant's level of service needs.
- The supports provided within the home are managed and completed by the primary caregiver throughout the day based on the participant's daily needs.
- Structured Family Caregiving is provided in a private residence and affords all the rights, dignity and qualities of living in a private residence including privacy, comfortable surroundings and the opportunity to modify one's living area to suit one's individual preferences.
- Provider agencies must conduct, at a minimum, two home visits per quarter based on the participant's assessed needs and caregiver coaching needs, but the actual frequency of visits should be based on the participant's assessed needs and caregiver coaching needs.
- The provider agency must identify the skill development and wellness needs of the primary caregiver and provide access to a qualified substitute caregiver as needed for up to 15 days per year.

- Primary caregivers receive a minimum of eight hours in-person annual training that reflects the participant's and primary caregiver's assessed needs. Training may be delivered during quarterly home visits, or in another manner that is flexible and meaningful for the caregiver.
- Provider agencies must work with participants and primary caregivers to establish backup plans for emergencies and other times when the primary caregiver is unable to provide care.
- Structured Family Caregiving emphasizes the participant's independence in a setting that protects and encourages the participant's dignity, choice and decision-making while preserving self-respect.
- Provider agencies that provide medication oversight, as addressed in the *Allowable Activities* subsection, must receive necessary instruction from a doctor, nurse or pharmacist regarding medications prescribed to the participant.

Documentation Standards

These documentation standards must be followed for Structured Family Caregiving:

- Identified need for Structured Family Caregiving in the service plan
- Services outlined in the service plan
- Completed PCA given to the provider by the care manager/service coordinator
- Documentation to support service rendered, including:
  - Electronic caregiver notes that record and track the participant's status, updates or significant changes in the participant's health status or behaviors, and participation in community-based activities and other notable or reportable events
  - Medication management records, if applicable
- Regular review of caregiver notes by provider agency to:
  - Understand and respond to changes in the participant's health status and identify potential new issues in an effort to better communicate changes with the participant's doctors or healthcare providers and avoid unnecessary hospitalizations or emergency room use
  - Document, investigate, and refer reportable events to the waiver care manager/service coordinator
- Documentation of home visits conducted by the registered nurse and caregiver coach
- Documentation of education, skills training and coaching conducted with the caregiver
- Documentation demonstrating collaboration and communication with other service providers and healthcare professionals (as appropriate), waiver care managers/service coordinators, and other caregivers or individuals important to the participant regarding changes in the participant's health status and reportable events
- Documentation of all qualified caregivers (including paid respite caregivers)

> *Note: If applicable, copies of personal record must be:*
>
> - *Placed in a prominent place in the participant's file*
> - *Sent with the participant when transferred for medical care or upon moving from the residence and in accordance with state law*

Claim Note Required for Structured Family Caregiving

When billing for Structured Family Caregiving services, providers must include a claim note with information about who provided those services, including their relationship to the member receiving the service. The claim note must be accurate and complete for audit purposes. This requirement helps the IHCP obtain better information on the legally responsible individuals (LRIs) providing services to a member.

When completing the claim note, providers should ensure that the most accurate relationship status is being used. If the individual providing the service is an LRI (spouse of the member receiving services), that relationship status should be reflected in the claim note. Knowingly using the incorrect relationship status, such as "Other" for the spouse or parent of the member receiving services may result in recoupment of these claims if an LRI received payment for services when they otherwise should not have; it could also constitute a false claim in accordance with the *False Claims Act*. OMPP Program Integrity staff is auditing claims, including the entry of claim notes.

For the structure required in the claim note, see the *Caregiver Name for Attendant Care or Structured Family Caregiving* section in the *Claim Submission and Processing* provider reference module.

Activities Not Allowed

Separate payment will not be made for any of the following waiver services furnished to a participant receiving Structured Family Caregiving services:

- Adult Family Care
- Assisted Living
- Attendant Care
- Home and Community Assistance

> *Note: Attendant Care or Home and Community Assistance services will not be reimbursed if performed in the same calendar month as Structured Family Caregiving services.*

Provider Qualifications

Provider qualifications for Structured Family Caregiving are presented in Table 20.

Table 20 – Provider Qualifications for Structured Family Caregiving

Waiver	Provider	Licensure/ Certification	Other Standards
PathWays	Structured Family Caregiving Agency	Not required	Provider and home must meet the requirements of the Indiana Adult Family Care Service Provision and Certification Standards. FSSA approved *455 IAC 2* Becoming an approved provider; maintaining approval *455 IAC 2* Provider qualifications: general requirements *455 IAC* 2 General requirements for direct care staff *455 IAC 2* Procedures for protecting individuals *455 IAC 2* Unusual occurrence; reporting

Waiver	Provider	Licensure/ Certification	Other Standards
			455 IAC 2 Transfer of individual's record upon change of provider *455 IAC 2* Notice of termination of services *455 IAC 2* Provider organizational chart *455 IAC 2* Collaboration and quality control *455 IAC 2* Data collection and reporting standards *455 IAC 2* Quality assurance and quality improvement system *455 IAC 2* Financial information *455 IAC 2* Liability insurance *455 IAC 2* Transportation of an individual *455 IAC 2* Documentation of qualifications *455 IAC 2* Maintenance of personnel records *455 IAC 2* Adoption of personnel policies *455 IAC 2* Operations manual *455 IAC 2* Maintenance of records of services provided *455 IAC 2* Individual's personal file; site of service delivery

Transportation

The following subsections provide information and requirements for nonmedical Transportation services.

Service Definition

Transportation services are offered to enable participants served under the waiver to gain access to waiver and other nonmedical community services, activities and resources, specified by the service plan.

Allowable Activities

The following activities are allowed for Transportation waiver services:

- Attendance at Adult Day Services
- Visits to community centers or senior centers
- Participation in volunteer work or employment
- Trips to grocery stores, pharmacies and other essential errands
- Social outings, such as visiting friends or family, attending religious services, or participating in community events

Service Standards

These service standards must be followed for Transportation waiver services:

- Transportation services must follow a written service plan addressing specific needs determined by the participant's PCA.

- This service is offered in addition to medical transportation required under *42 CFR 431.53* and transportation services under the Indiana Medicaid State Plan, defined at *42 CFR 440.170(a)* (if applicable), and shall not replace them.
- Whenever possible, family, neighbors, friends or community agencies that can provide this service without charge will be used.

Transportation services are reimbursed as these types of service:

- Level 1 – Nonassisted Transportation: The participant does not require mechanical assistance to transfer in and out of the vehicle.
- Level 2 – Assisted Transportation: The participant requires mechanical assistance to transfer into and out of the vehicle.
- Adult Day Service Transportation – The participant requires round-trip transportation to access Adult Day Services.

Documentation Standards

These documentation standards must be followed for Transportation waiver services:

- Identified need in the service plan
- Services outlined in the service plan
- Documentation, maintained by the provider or its agent, that the provider meets and maintains the requirements for providing services under *455 IAC 2*
- Specify applicable (if any) limits on the amount, frequency or duration of this service.

> *Note: If applicable, copies of personal record must be:*
>
> - *Placed in a prominent place in the participant's file*
> - *Sent with the participant when transferred for medical care or upon moving from the residence and in accordance with state law*

Limitations

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

Activities Not Allowed

The following activities are not allowed under the Transportation waiver service:

- Services available through the Indiana Medicaid State Plan *(Note: An Indiana Medicaid State Plan prior authorization [PA] denial is required before reimbursement is available through the Medicaid waiver for this service.)*
- Services provided to participants receiving any of the following waiver services:
  - Adult Family Care
  - Assisted Living
- Services provided by the spouse of a participant (also known as an LRI)

Provider Qualifications

Provider qualifications for Transportation waiver services are presented in Table 21.

Table 21 – Provider Qualifications for Transportation

Waiver	Provider	Licensure/ Certification	Other Standards
PathWays	Licensed Home Health Agency	*IC 16-27-1*	FSSA approved Compliance with applicable vehicle/driver licensure for vehicle being utilized
PathWays	Transportation Agency	Not required	FSSA approved *455 IAC 2* Becoming an approved provider; maintaining approval *455 IAC 2* Provider qualifications: general requirements *455 IAC 2* Procedures for protecting individuals *455 IAC 2* Unusual occurrence; reporting *455 IAC 2* Transfer of individual's record upon change of provider *455 IAC 2* Notice of termination of services *455 IAC 2* Provider organizational chart *455 IAC 2* Collaboration and quality control *455 IAC 2* Data collection and reporting standards *455 IAC 2* Quality assurance and quality improvement system *455 IAC 2* Financial information *455 IAC 2* Liability insurance *455 IAC 2* Transportation of an individual *455 IAC 2* Documentation of qualifications *455 IAC 2* Maintenance of personnel records *455 IAC 2* Adoption of personnel policies *455 IAC 2* Operations manual *455 IAC 2* Maintenance of records of services provided Compliance with applicable vehicle/driver licensure for vehicle being utilized

Vehicle Modifications

The following subsections provide information and requirements for the Vehicle Modifications service, which includes vehicle modifications and vehicle modifications maintenance.

Service Definition

Vehicle Modifications are the addition of adaptive equipment or structural changes to a motor vehicle that will empower a participant to have safe transportation in a motor vehicle.

Allowable Activities

Justification and documentation are required to demonstrate that the modification is necessary to meet the participant's identified needs.

The following are allowable under the Vehicle Modifications service:

- Wheelchair lifts
- Wheelchair tie-downs (if not included with lift)
- Wheelchair/scooter hoist
- Wheelchair/scooter carrier for roof or back of vehicle
- Raised roof and raised door openings
- Power transfer seat base

Maintenance is limited to $1,000 annually for repair and service of items that have been funded through an HCBS waiver:

- Requests for service must differentiate between parts and labor costs.
- If the need for maintenance exceeds $1,000 the care manager/service coordinator will work with other available funding streams and community agencies to fulfill the need. If service costs exceed the annual limit, those parts and labor costs funded through the waiver must be itemized clearly to differentiate the waiver service provision from those parts and labor provided through a nonwaiver funding source.

> *Note: Items requested that are not listed in this section, must be reviewed and decision rendered by the state division director or state agency designee.*

Service Standards

These service standards must be followed:

- The vehicle to be modified must meet all the following:
  - The participant or primary caregiver is the titled owner.
  - The vehicle is registered and/or licensed under state law.
  - The vehicle has appropriate insurance as required by state law.
  - The vehicle is the participant's sole or primary means of transportation.
  - The vehicle is not registered to or titled by an FSSA-approved provider.
  - Only one vehicle per a participant's household may be modified.
- Many automobile manufacturers offer a rebate of up to $1,000 for participants purchasing a new vehicle requiring modifications for accessibility. To obtain the rebate, the participant is required to submit to the manufacturer documented expenditures of modifications. If the rebate is available, it must be applied to the cost of the modifications.
- Requests for modifications may be denied if the FSSA director or designee determines the documentation does not support the service requested.
- All Vehicle Modifications must be approved by the waiver program prior to services being rendered.

Documentation Standards

The care manager/service coordinator is responsible for the following documentation standards:

- Document the medical need for Vehicle Modifications determined to meet the needs of the participant through the PCA.
- Describe the specific modification being requested to the vehicle.
- Collect two bids if over $1,000; if only one bid is obtained, the care manager/service coordinator must document the date of contact, the provider name and why the bid was not obtained from another provider.
- Submit warranty information from the provider to the FSSA OMPP.
- Ensure that a picture of vehicle modification is included with the bid.

The provider is responsible for the following documentation standards:

- Maintain receipts for all incurred expenses related to the modification.
- Itemize all bids.
- Be in compliance with FSSA OMPP-specific guidelines and/or policies.

> *Note: If applicable, copies of personal record must be:*
>
> - *Placed in a prominent place in the participant's file*
> - *Sent with the participant when transferred for medical care or upon moving from the residence and in accordance with state law*

Limitations

A lifetime cap of $15,000 is available for one vehicle per every 10-year period for a participant's household. In addition to the applicable lifetime cap, $1,000 will be allowable annually for repair, replacement or an adjustment to an existing modification that was funded by an HCBS waiver.

Activities Not Allowed

Examples or descriptions of modifications or items not covered under this service include but are not limited to, the following:

- Repair or replacement of modified equipment damaged or destroyed in an accident
- Alarm systems
- Auto loan payments
- Insurance coverage
- Driver's license, title registration or license plates
- Emergency road service
- Routine maintenance and repairs related to the vehicle itself
- Specialized Medical Equipment and Supplies or Home Modifications items
- Leased vehicles
- Service provided by the spouse of a participant (also known as an LRI)

Provider Qualifications

Provider qualifications for Vehicle Modifications are presented in Table 22.

Table 22 – Provider Qualifications for Vehicle Modifications

Waiver	Provider	Licensure/ Certification	Other Standards
PathWays	Vehicle Modification Agency	Not required	FSSA approved *455 IAC 2* Becoming an approved provider; maintaining approval *455 IAC 2* Provider qualifications: general requirements *455 IAC 2* Liability insurance *455 IAC 2* Professional qualifications and requirements; documentation of qualifications *455 IAC 2* Maintenance of records of services provided *455 IAC 2* Warranty required

Helpful Websites

Consult the following websites for more information:

- FSSA homepage – Find information by type of person in need: children, seniors, families, those with intellectual disabilities (ID) and so forth. All programs and services available are listed on this site.
- Medicaid HCBS Certification webpage – Find information about how to become a provider of FSSA Office of Medicaid Policy and Planning (OMPP) services.
- Indiana Level of Care Assessment Representative (LCAR) website – Find information about requesting a level of care (LOC) assessment for individuals seeking a nursing facility level of care (NF LOC) determination.
- Incident And Follow-Up Reporting (IFUR) Tool – Submit initial incident reports and care manager/service coordinator follow-up reports for waiver and Money Follows the Person (MFP) services via the IFUR Tool.
- IHCP Providers website – Find Indiana Health Coverage Programs (IHCP) provider bulletins and the IHCP provider reference modules. Telephone contact information for providers is also available on this website.
- Indiana PathWays for Aging website – Find information about the Indiana PathWays for Aging (PathWays) program, including information for members and caregivers, agency advocates, and PathWays providers. PathWays resources and informational webinars are also available.

Helpful Contact Numbers

Contact Indiana LCAR – Maximus Help Line at 833-597-2777 to request an LOC assessment, register for the AssessmentPro web-based assessment platform, or find out more information about the LCAR process.

See *Indiana's Area Agencies on Aging* for information on local Area Agency on Aging (AAA) offices. To contact your local AAA office toll-free, call 800-713-9023.

Communications

The IHCP publishes IHCP bulletins and provider reference modules for providers, which are accessible from the *Bulletins and Reference Modules* webpage at in.gov/medicaid/providers.

Providers may also subscribe to the Email Notification Service, accessible from the homepage at in.gov/medicaid/providers. This service sends emails to subscribers when new communications are posted on the IHCP website.