



**Balancing Incentive Program Application**  
**Office of Medicaid Policy and Planning**  
**State of Indiana**

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## Project Abstract

The Indiana Office of Medicaid Policy and Planning (OMPP), in partnership with its Family and Social Services Administration (FSSA) sister divisions and community partners throughout the state, proposes to leverage the Balancing Incentive Program (BIP) to expand the systems of home and community-based care that serve Hoosiers with behavioral health needs, physical and/or intellectual disabilities. The intent of the Indiana project is to realize the long-term goal of increasing the percentage of expenditures for long-term supports and services (LTSS) that are provided in home and community-based settings.

Indiana will comply with the BIP structural requirements in an effort to improve how LTSS are accessed and delivered throughout the state. The State will:

- Continue to implement the current Co-Location Pilot at Aging and Disability Resource Centers (ADRCs) and expand its existence statewide to enhance the existing No Wrong Door/Single Entry Point (NWD/SEP) model,
- Complete implementation of the Integrated Case Management System (ICMS), which will support the State's efforts to streamline the LTSS eligibility and assessment process and provide SEPs and community partners a broadly accessible database housing the Core Data Set, and
- Remediate all case management arrangements and policies that do not align with the BIP principles.

As outlined in the preliminary work plan, Indiana anticipates having the Co-Location Pilot project implemented in the initial area by December 2012. Expansion to additional ADRC sites will occur in the second project year, following evaluation of best practices and lessons learned from the pilot. The State anticipates the Co-Location project will be complete by the end of 2013. The implementation of ICMS is planned for Spring of 2013. Finally, conflicts related to case management for individuals with developmental disabilities, physical disabilities, or are aged will be remediated in the first year of the project. The State will be working on a long-term solution to Medicaid Rehabilitation Option case management conflicts with a goal of remediation by September 30, 2015.

Indiana will utilize the increased federal funding to continue current rebalancing efforts and adopt new home and community-based programming, including but not limited to:

- Reducing/eliminating waitlists on its home and community-based services (HCBS) waivers;
- Transitioning eligible nursing facility residents to the Developmentally Disabled Waiver;
- Expanding the Money Follows the Person (MFP) program to include children and adolescents with serious mental illness; and
- Implementing a 1915(i) state plan option for adults with serious mental illness.

**Preliminary Work Plan**

Issues highlighted in the application have been addressed in this preliminary work plan, with the expectation that a more comprehensive work plan will be produced according to schedule.

Category	Major Objective/Interim Tasks	Due Date from Work Plan Submission	Lead Person	Status of Task	Deliverables
General No Wrong Door/Single Point of Entry Structure	Standardize information so that all individuals experience the same eligibility determination and enrollment process.				
	Review current efforts to co-locate eligibility workers at the pilot single point of entry site.	December 2012			Policy and process documentation
	Plan and implement Phase II of pilot to integrate entry point for behavioral health services into SEPs.	March 2013			Project plan and timeline
	Identify points of entry to serve as NWDs.				NWD site list
	Develop standardized informational materials for use by SEPs and NWDs.	January 2013			Informational NWD/SEP materials
	Expand co-location of eligibility workers to additional SEPs statewide.	December 2013			Project plan and timeline
	Provide training to SEPs and NWDs on use of ICMS for all SEPs.	December 2013			NWD/SEP training materials and sign-in sheets
	Provide access to ICMS to SEPs and NWDs.	January 2014			ICMS guide

Category	Major Objective/Interim Tasks	Due Date from Work Plan Submission	Lead Person	Status of Task	Deliverables
Conflict-Free Case Management	Establish conflict of interest standards for the assessment and plan of care processes.				
	Describe current case management system.	December 2012			ICMS requirements
	Develop conflict-free policies applicable across departments and programs.	May 2013			Policy documents and administrative rules where applicable
	Identify areas of conflict of interest existing in the Medicaid Rehabilitation Option (MRO) program.	May 2013			Crosswalk of existing policies and conflict of interest requirements
	Engage stakeholders in MRO program to redesign system for conflict-free case management that best protects interests of consumers and meets the BIP standards.	December 2013			Meeting minutes
	Develop protocols and policies for conflict-free case management in MRO program.	December 2014			Policy documents and administrative rules where applicable
	Implement conflict-free case management procedures.	September 2015			Provider communications

Category	Major Objective/Interim Tasks	Due Date from Work Plan Submission	Lead Person	Status of Task	Deliverables
Core Standardized Assessment	Validate that ICMS design and existing assessment tools meet the BIP Core Standardized Assessment (CSA) requirements.				
	Review ICMS design to assess compliance with Level I screening requirements.	December 2012			Compliance crosswalk
	Implement ICMS and Level I screening process.	Spring 2013			Implementation plan and web screen shots
	Identify all assessment tools used to determine LTSS eligibility.	May 2013			Assessment tool list
	Crosswalk Core Data Set (CDS) with each of the existing state assessment tools.	July 2013			Completed crosswalk documentation
	Identify any CSA requirements not met.	December 2014			Crosswalk documentation
	Remediate processes/assessments to meet requirements.	September 2015			Work plan and timeline

## Application Narrative

### A. Understanding of Balancing Incentive Program Objectives

In 2003, the Indiana State Legislature unanimously passed SEA 493, a bill designed to rebalance the State's long-term care delivery system. The bill's intention called for removing barriers to home and community-based care, creating a full array of home and community-based services, and establishing the necessary funding and resources to move Indiana toward a more balanced long-term care system. Work to determine the method by which to implement this significant piece of legislation – while maintaining its intent – began.

In 2005, the Indiana Family and Social Services Administration (FSSA) announced the agency's plan for a new strategic direction. As part of that plan, the FSSA Secretary announced the Aging Reform Initiative (Initiative). The Initiative recognized the State's need to address:

- increasing preference for community-based LTC services among older adults and persons with disabilities;
- increasing pressure to provide community-based alternatives to nursing facility care, as a result of the Olmstead Supreme Court decision ;
- increasing federal support for community-based options ; and
- committing to its desire to “rebalance” long-term care.

Through the Initiative, the agency committed to the following overarching goals:

- improving access to the array of long-term care services,
- expanding capacity of home and community-based services, while systematically closing nursing facility beds
- increasing public awareness for personal responsibility and actively promoting consumer choice of long-term care options, and
- balancing government funded long-term care.

As a result of meeting these goals, FSSA believed it would reduce the number of residents in nursing facilities by 25% over 5 years and 50% over 10 years. Since 2005, FSSA's Division of Aging (DA) has taken the following actions, among others, to meet the goals established under the Initiative:

- Added and expanded community living options (Assisted Living and Adult Foster Care) under the State's HCBS waivers.
- Amended waiver eligibility to support special income level and increase access to community services.
- Pursued and was awarded \$1.1M in federal grants to establish 16 Aging and Disability Resource Centers (ADRC) located throughout the State.
- Successfully implemented Money Follows the Person (MFP), which granted the State \$21M in federal dollars, and has resulted in the transition of 538 Hoosiers from institutions to community living.

The actions have enabled Indiana to hold nursing facility enrollment at a steady rate, and increase participation in home and community-based waivers by over 170% since 2003. The State recognizes there is still progress to be made in continuing these trends, and is currently engaged in the following efforts to ensure success in these endeavors. In 2003, Indiana implemented a nursing facility Quality Assessment Fee (QAF) to incentivize nursing facilities to improve the quality of care. Despite these additional dollars, the system has shown little improvement in terms of quality of care since the QAF was implemented. As a result, effective in 2010, the Division of Aging revised the nursing facility rate methodology to incentivize quality and ensure the appropriate discharge of residents to less restrictive settings. The Division expects the new methodology will reduce expenditures to nursing facilities, and plans to utilize those savings to expand HCBS. Already, two of the State's HCBS waivers and its MFP program have begun expanding services in the community. Over the past 12 months, the Aged and Disabled (A/D) waiver waitlist has declined by more than 32% and enrollment on the waiver has increased by 16%. This fiscal year, approximately 3,850 slots will be released on the (A/D) waiver. Similarly, the Division expects to release 108 slots this calendar year for the Traumatic Brain Injury (TBI) waiver. Efforts thus far have led to a 7% increase in enrollment on the waiver and a 15% reduction of the TBI waitlist. Finally, the MFP program has also experienced great success over the past 12 months enrolling 273 new participants.

While the Initiative focused on rebalancing services for individuals who are aged or physically disabled, FSSA has pursued – and continues to set – similar goals for other populations it serves, an action that demonstrates its ongoing commitment to the tenants of the BIP.

The Division of Mental Health and Addiction (DMHA) is charged with serving Indiana's adults with serious mental illness (SMI) and chronic addictions, as well as children and adolescents with a serious emotional disturbance (SED). DMHA oversees 6 state operated psychiatric facilities (SOF) and ensures the availability of a broad continuum of community-based services through the State's community mental health centers (CMHCs).

In 2007, DMHA made a commitment to transforming Indiana's mental health system with a greater focus on recovery-based community services. A significant part of that work involved redesigning the State's Medicaid Rehabilitation Option (MRO) which is the primary delivery and financing mechanism for community-based services for individuals with SMI and SED. Changes were made to realign the program with its intended rehabilitation focus and ensure that accurate services are provided to individuals at the right time.

As part of its transformation process, DMHA evaluated the status of individuals being served in SOFs and identified a population of long-term SOF consumers who, if provided the right array of community-based services, could successfully transition to community living. In State Fiscal Year (SFY) 2011, with the support of community-based providers and advocates, the State began transitioning individuals out of SOFs and into community living arrangements. Those targeted for transition were individuals with chronic addictions and intellectual disabilities. Consequent to the 110 transitions made, DMHA reduced long-term inpatient capacity by 30%.

In 2007, Indiana sought and was awarded a Community Alternatives to Psychiatric Residential Treatment Facilities (CA-PRTF) grant, under which the State committed to ensuring intensive community-based care would be available as an alternative to children and adolescents who would otherwise require a stay in a PRTF. As of May 2012, the CA-PRTF program has been very successful in Indiana having served 1,504 consumers over the past 5 years. With the grant ending, Indiana is planning to sustain the program by designing a 1915(i) state plan option and expanding the State's existing Money Follows the Person (MFP) Program to include children and adolescents residing in a PRTF or SOF who are able to transition to community care. This continued expansion of community-based services further demonstrates Indiana's commitment to rebalancing behavioral health services. As a result of the state's ongoing evaluation of community-based programming, DMHA and the Office of Medicaid Policy and Planning recognized the behavioral health continuum of care lacked a program that provided habilitation services for adults with SMI. To meet this need, in May 2012, Indiana submitted a 1915(i) state plan amendment designed to offer services aimed at assisting individuals with SMI who have reached their recovery goals, yet are in need of services to continue living in the community.

Indiana's Division of Disability and Rehabilitative Services (DDRS) provides services to approximately 18,000 Hoosiers. DDRS has committed to and begun the process of assessing its current system and making changes to transition qualifying members to community-based settings. This project includes moving all qualified nursing home residents with a developmental disability to an appropriate community setting, and transitioning the State's small Intermediate Care Facilities for the Intellectually Disabled (ICF/ID) to waiver homes. Individuals currently served through small institutional ICF/IDs will receive the same services through the same providers; however, once ICF/IDs are transitioned to waiver homes, these individuals will have the right to the greater freedom and choice associated with being served through an HCBS waiver. Under the DDRS initiative, approximately 3,200 individuals will be transitioned to waiver homes. Additionally, DDRS has made the commitment to expand HCBS by increasing slots under the Family Supports Waiver. The waiver currently serves approximately 4,800 individuals and is projected to serve more than 11,000 by 2015.

## B. Current System's Strengths and Challenges

Currently, when a person is interested in receiving long-term services and supports, he/she can access services through various programs. Specifically, services cover these populations: older adults, people with physical disabilities, individuals with intellectual disabilities and autism, and people with mental illness.

### **Entering LTSS for Older Adults and Individuals with Physical Disabilities**

In Indiana, the majority of older adults and individuals with physical disabilities receive long-term services and supports through the Aged and Disabled Waiver or the smaller waiver for individuals who have experienced a traumatic brain injury (TBI). The State is developing a Program of All-Inclusive Care for the Elderly (PACE), which will offer Hoosiers another option to receive the long-term supports and services they need to reside in the community.

In addition to Medicaid programming, Indiana operates a state-funded program, Community and Home Options to Institutional Care for the Elderly and Disabled (CHOICE). CHOICE provides case management services, assessment, and in-home and community services to individuals who are at least 60 years of age, or persons of any age who have a disability due to a mental or physical impairment and who are found to be at risk of losing their independence. CHOICE funds may only be utilized after an applicant has been determined and documented ineligible for Medicaid, or, if currently eligible for Medicaid, after a determination that the requested service(s) is not available from Medicaid.

#### *Aged and Disabled Waiver*

The Aged and Disabled (A/D) Waiver is a 1915(c) Home and Community-Based Services waiver which provides a wide array of long-term care services and supports to adults age 65 and older and persons of all ages with a disability. The waiver is administered by the Division of Aging under the authority of the Office of Medicaid Policy and Planning.

A/D waiver services (*i.e.*, adult day services, adult foster care, assisted living, attendant care, case management, community transition services, environmental modifications, health care coordination, homemaker, home delivered meals, nutritional supplements, personal emergency response systems, pest control, respite, specialized medical equipment and supplies, transportation and vehicle modifications) are designed to supplement informal supports for individuals who would otherwise require care in a nursing facility. These services can be used to help people remain in their own homes, as well as assist people living in nursing facilities to return to community settings such as their own homes, apartments, assisted living or adult foster care.

Prior to the receipt of services, all A/D waiver participants must meet nursing facility Level of Care (LOC) and receive a medical and functional assessment by case management staff at an Area Agency on Aging (AAA). The AAA is the single entry point for nursing facility level of care waivers. The same LOC determination process is completed for individuals applying for A/D waiver services (even if an individual has a developmental disability or mental illness diagnosis) as for a nursing facility.

The process begins with a waiver application being completed by the applicant and a case manager at a local AAA. If a waiver slot is not available immediately, the applicant will be placed on a waitlist and

referred to other services, if eligible. The A/D waiver is currently operating a waitlist due to limited resources. Once a slot becomes available, the State notifies the AAA and the case manager begins to work with the applicant to complete the LOC evaluation. Case managers performing LOC re-evaluations on persons must meet all qualifications as detailed in the A/D Waiver and have received training in the nursing facility LOC process by qualified State staff. In addition, all LOC re-evaluations for participants managed by the AAA are reviewed by a case management supervisor prior to final level of care re-determination. For those participants who have chosen a non-AAA case manager, the LOC re-evaluation decisions are required to be reviewed and a decision rendered by designated staff members within the Division of Aging. The Division will review case management practices within its work plan and remediate any conflicts after further analysis.

The financial determination for Medicaid eligibility is conducted independent of the LOC evaluation by the Division of Family Resources (DFR). It is the responsibility of the applicant to submit application for Medicaid to DFR, if he/she is not already Medicaid eligible.

Indiana has established the Eligibility Screen (E-Screen), a tool used to determine basic criteria that identifies nursing facility level of care. A case manager is required to complete the Eligibility Screen as part of the LOC packet. An E-screen will not be accepted by the computer system if all of the pages of the E-screen have not been addressed, or if the applicant/participant is not deficient in at least three (3) activities of daily living (ADL). Initially, the individual's physician must complete the Physician Certification for Long-term Care (450B). This medical document lists the diagnosis/(es), medications, abilities, disabilities and prognosis/(es). The 450B also includes the physician recommendation regarding the safety and feasibility of the individual to receive home and community-based services. The final Level of Care determination is documented in the section of the "Transmittal for Medicaid Level of Care Eligibility" form.

Once an applicant is determined to meet nursing facility LOC and Medicaid financial eligibility requirements, a Plan of Care (POC) is developed with the participant. The AAA works with the Division of Aging to receive approval of the POC. Once approved, the case manager notifies the applicant who must then select an ongoing case manager so that services may begin.

#### *Traumatic Brain Injury Waiver*

The Traumatic Brain Injury (TBI) waiver is authorized under 1915(c) authority to provide home and community-based services to individuals of all ages who have suffered a traumatic brain injury and, but for the provision of waiver services, would require nursing facility level of care. Indiana defines a traumatic brain injury as a *trauma that has occurred as a closed or open head injury by an external event that results in damage to brain tissue, with or without injury to other body organs*. The array of services offered by the TBI waiver includes those provided under the A/D waiver, as well as, Behavior Management/Behavior Program and Counseling, Occupational Therapy, Physical Therapy, Residential Based Habilitation, Speech/Language Therapy, Structured Day Program, and Supported Employment.

The TBI waiver is administered by the Division of Aging under the oversight of the Office of Medicaid Policy and Planning. As noted above, all nursing facility LOC determinations are made by AAA case

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managers (and/or the state), which operate as the single entry point to the system for older adults and individuals with physical disabilities. The TBI Waiver also has a second ICF/ID level of care, which is approved by the Division of Disability and Rehabilitative Services' Bureau of Developmental Disabilities Services (BDDS). In this case, the AAA case managers gather the initial information and send to the BDDS Service Coordinator for approval.

The TBI waiver referral and eligibility processes follow the same steps as the A & D waiver and thus, also face similar challenges, such as requiring to operate a waitlist due to limited resources.

### *Money Follows the Person*

Indiana's Money Follows the Person (MFP) demonstration assists Medicaid eligible Hoosiers receiving services in a nursing facility or hospital to transition to a residential setting in the community (*i.e.*, leased/owned home, leased apartment, adult foster care, or assisted living). Eligible individuals (meet the appropriate LOC) will transition to the community and receive waiver services under the A/D, TBI, or Developmental Disabilities waiver. MFP educates consumers about their options for transition and participation in the program and waivers. Once an eligible consumer has consented to the program, a nurse completes an assessment to determine whether the individual can safely move to a community setting and live independently. In addition to the transition nurse, a transition specialist/case manager, works with the individual to create a care plan, which includes the services needed during the transition and in the year to follow.

MFP helps participants locate a place to live and arrange for medical, rehabilitative, home health, and other services in the community, as needed. As long as the individual continues to meet the appropriate LOC, he/she will be covered by the MFP program for 365 days. In addition to the services provided under the Medicaid state plan and appropriate waiver, MFP participants are eligible for personal emergency response system, enhanced transportation, and targeted case management. Following the 365-day eligibility period for MFP, the A/D, TBI, or Developmental Disabilities waiver will provide ongoing services.

As of June 2012, Indiana's MFP program has assisted 538 Hoosiers transition to the community from an institutional setting.

### **Entering LTSS for Individuals with Development/Intellectual Disabilities and Autism**

The Division of Disability and Rehabilitative Services currently administers three home and community-based waivers serving individuals in Indiana with developmental/intellectual disabilities and/or autism who meet Intermediate Care Facilities for the Intellectually Disabled (ICF/ID) level of care: Support Services Waiver (SSW), Developmental Disability (DD) Waiver, and the Autism Waiver (AUW). Currently, DDRS operates a waitlist due to limited resources.

In addition to meeting ICF/ID LOC, waiver participants must also meet the state defined criterion for developmental disability as follows: A mental and/or a physical impairment (other than a sole diagnosis of mental illness) that begins before the age of 22 and is expected to continue indefinitely. An individual must have substantial limitation in at least three (3) of the following areas:

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- Self care
- Learning
- Mobility
- Receptive and expressive communication
- Self-direction
- Capacity for independent living
- Economic Self-Sufficiency

Participants may choose to live in their own home, family home, or community setting appropriate to their needs. To remain in one of these settings, individuals require a broad array of services, including:

- Adult Day Services
- Prevocational Services
- Residential Habilitation and Support
- Respite
- Supported Employment Follow Along
- Adult Foster Care
- Behavioral Support Services
- Community-Based Habilitation
- Community Transition
- Electronic Monitoring
- Environmental Modifications
- Facility Based Habilitation
- Facility Based Support Services
- Family and Caregiver Training
- Intensive Behavioral Intervention
- Music Therapy
- Personal Emergency Response System
- Recreational Therapy
- Specialized Medical Equipment and Supplies
- Transportation
- Workplace Assistance
- Therapy (occupational, physical, physiological, speech/language)

To qualify for waiver services, applicants must contact their local Bureau of Developmental Disabilities Services (BDDS) and complete an application packet. If the applicant is not a Medicaid recipient, he/she will be referred to the local Division of Family Resources to apply for Medicaid at the same time as applying to BDDS for waiver services.

Once a completed application packet is received, an intake specialist from the local BDDS office will work with the applicant to obtain necessary documentation to begin the assessment process, which includes the determination of both DD eligibility and the preliminary LOC.

Currently, as stated above, due to limited resources, individuals who are determined eligible for waiver services will be placed on the waiting list and referred to Vocational Rehabilitation Services. Once a slot is available, DDRS will mail a targeting letter to the individual. The applicant must then confirm that services are still needed. A BDDS intake specialist then completes a current LOC to determine whether the applicant remains eligible for services.

Once it has been determined that the applicant meets all necessary Medicaid eligibility and LOC criteria, the case will be referred to the case management entity to begin the person centered planning process. A transition manager will be assigned and the waiver participant will be given the option of selecting a new permanent case manager. This case manager will work with the participant to complete the objective based allocation (OBA) and a plan of services (cost comparison budget (CCB)) based on his/her budget. The OBA is the method used by the State to determine the level of supports an individual needs

to live in a community setting. The case manager assists the participant in selecting providers and obtaining CCB approval. Once approved, waiver services may begin.

### **Entering LTSS for Individuals with Mental Illness**

#### *Community Alternatives to Psychiatric Residential Treatment Facilities*

The Community Alternatives to Psychiatric Residential Treatment Facilities (CA-PRTF) grant program operates much like a 1915(c) HCBS waiver, in that it requires applicants to meet a LOC. Under the grant, PRTF is the “institutional” level of care that must be met for an applicant to be eligible services. Individuals in need of services will complete an application at an Access site, often a Community Mental Health Center. In addition to taking standard demographic information, qualified staff at the Access site will work with the applicant to complete a Children and Adolescent Needs and Strengths Assessment (CANS). This assessment is entered into the State system and submitted with the completed application to the State by Access site staff. Upon receipt, the State reviews the application and accompanying documentation and makes a LOC determination. Pending Medicaid eligibility, a slot will be approved or the individual will be placed on a waitlist for services. As soon as a slot is approved, the Wraparound facilitator (WF) will work with the child and family to create an initial Plan of Care (POC). This initial POC must be approved by the State before services can begin. The WF will assist the family with the selection of providers and together this team will work to create a comprehensive plan of care for the child.

#### *Medicaid Rehabilitation Option*

As previously noted, the Division of Mental Health and Addiction (DMHA) administers the Medicaid Rehabilitation Option (MRO) program on behalf of the Office of Medicaid Policy and Planning. In this role, DMHA has set standards under the community-based continuum of care and contracts with providers that meet all the standards and provide MRO services. These providers are referred to as Community Mental Health Centers (CMHCs) in Indiana. Individuals with SMI or SED who require intensive community-based services must access the behavioral health system through CMHCs. Of the 92 counties, 90 have at least one satellite office of a CHMC. In the other 2 counties, there is active outreach coupled with the provision of transportation to the nearest CMHC facility for services in the two counties without a satellite.

The CMHCs are responsible for performing an individualized assessment of a person’s behavioral health needs using the CANS or the Adult Needs and Strengths Assessment (ANSA). The CMHCs must document these assessments along with other data in the State’s registry, DARMHA. Data from DARMHA is transferred on a nightly basis to the State’ Medicaid Management Information System (MMIS). Those individuals who have a qualifying diagnosis and a CANS/ANSA score indicating intensive community-based services will be assigned a MRO service package by the MMIS. A case manager from the CMHC will work with the consumer to create an Individualized Integrated Care Plan (IICP) which documents the recovery oriented goals of the consumer and then services needed to meet those goals. Assessments must be updated by the CMHC every 6 months in order to continue to deliver services under MRO.

Under this current system, the CMHCs both employ the case managers that perform functional assessments to determine service needs and also deliver direct behavioral health services to consumers. DMHA recognizes that this process does not conform to the BIP conflict of interest structural requirements, and is committed to reviewing and redesigning the processes to mitigate the conflict by the end of the BIP term in 2015. This will be done in collaboration with the Office of Medicaid Policy and Planning and other stakeholders to ensure that the system redesign not only meets the BIP standards, but also protects the best interests of consumers.

*1915(i) State Plan Option—Habilitation*

The referral and eligibility process for the 1915(i) State plan option for adults is still under review at CMS. The proposed process will require a referring CMHC to perform a face to face assessment of a consumer using the ANSA to determine an individual's functional abilities. This assessment information, along with additional evaluation criteria, will be submitted to the State. Using the information provided, the State will make an independent assessment of the consumer's needs and determine whether they meet the standards required for receipt of habilitation services under the 1915(i) option. Once eligibility is approved, a service package will be authorized and the case manager from the CMHC will work with the consumer to develop an ICP addressing the consumer's individualized service needs. Eligibility for the 1915(i) will be assessed annually.

**Current System-wide Strengths**

The State divisions (OMPP, DA, DDRS, DMHA and DFR) that are responsible for the oversight and delivery of LTSS all reside within a single agency in Indiana, FSSA. The staff within these divisions has long-term relationships and experience working together to provide services to this very vulnerable population. Operating under a single agency umbrella not only provides for greater administrative ease, but, more importantly, provides for a singular mission to rebalance LTSS.

Indiana has implemented a statewide ADRC system which today provides aged and physically disabled Hoosiers with a single entry point for long-term services and supports. The State's experience with this system will be leveraged to implement a SEP for all LTSS, no matter the population. While there remains much work to do to bring independent processes together, current achievements and the unified commitments the divisions have made provide a strong basis for bringing the BIP NWD concept to fruition in Indiana.

Indiana is committed to completing the work necessary to implement the State's new Integrated Case Management System (ICMS). This system will allow for all necessary data to be stored and shared among those stakeholders who require access. Providing access to such data will help deliver a seamless referral and eligibility experience for the consumer, thus ensuring Indiana's efforts to create No Wrong Door will be successful.

**Current System-wide Challenges**

In Indiana, the Office of Medicaid Policy and Planning delegates its authority for Medicaid eligibility determinations to the Division of Family Resources (DFR). DFR conducts the financial eligibility determinations for Medicaid separately from each of the waiver eligibility processes described above.

While the systems and staff performing this work are responsible for coordinating between the two processes and ensuring a streamlined eligibility process for those entering Medicaid waiver services, there continues to be room for improvement.

Over the past 5 years, DFR has engaged in a redesign of the eligibility systems for Medicaid among other programs. This effort has been challenged by many obstacles, yet the State has remained committed to finding a solution that meets its administrative needs while preserving policies and processes that best suit the interest of applicants. Today, an individual with developmental disabilities in need of LTSS must work through two separate processes and entities (*i.e.*, DFR and BDDS) to apply for services. Often, this means traveling to or making contact with two separate offices and staff.

Throughout these changes, ensuring a more streamlined process for waiver applicants has been a priority for FSSA. One commitment to this effort is the co-location of DFR staff at ADRC sites. As part of a co-location pilot, which will be discussed further in later sections of this application, DFR will implant eligibility staff at the ADRC. This will allow individuals in need of LTSS to make application for both Medicaid and waiver services simultaneously. FSSA is currently piloting the co-location project with plans to expand statewide by the end of 2013.

### C. NWD/SEP Agency Partners and Roles

The Office of Medicaid Policy and Planning (OMPP) is the Single State Agency for Indiana's Medicaid program. As such, OMPP will ultimately hold responsibility for oversight over BIP in Indiana and work with CMS to ensure that the commitments made in this application are honored through the term of the program. OMPP has elected to designate the Division of Disability and Rehabilitative Services (DDRS) as the administrative lead for the BIP due to the role the Division plays, today, in administering LTSS. OMPP and DDRS have an existing Memorandum of Understanding (MOU) which will be amended to include the roles and responsibilities enumerated throughout this application.

Indiana is one of 54 states and territories funded by the Administration on Aging (AoA) and CMS to develop an Aging and Disability Resource Center (ADRC) program that streamlines access to long-term care information and community-based services. The goals of Indiana's ADRC system are to streamline access to LTSS information and eligibility for services to help redirect long-term care from institutions to the community. In Indiana, the ADRC system operates statewide with all sixteen Area Agencies on Aging (AAAs) contracted as ADRCs.

Indiana's approach to the SEP system is to assure that individuals seeking assistance from historical and traditional entry points either receive the same information from those traditional entry points or are easily connected with the ADRC. Current Division contracts require formal partnerships between the traditional entry points, such as the Centers for Independent Living, and designated ADRC sites to assure that information is standardized and appropriate referrals are made within the system. As the SEP expands to include populations beyond the aged and physically disabled, relationships with additional traditional entry points, such as CMHCs, will also need to be developed.

The State's current efforts to co-locate other agencies within the ADRCs will have a significant role in creating a true NWD/SEP system for all persons with LTSS needs. The pilot project will bring staff from the Bureau for Developmental Disability Services (BDDS) and the Division of Family Resources (DFR) into the ADRCs to perform their respective eligibility functions. While these staff will continue to be responsible for the functions their Divisions perform, all staff within the ADRC will receive training to ensure that they can assist and/or properly refer individuals with all needs to the appropriate services.

Future steps to integrate the LTSS system include bringing the tradition entry point for behavioral health services into the SEP. Indiana will address this effort as a second phase of the pilot. This will allow the State to assess current entry points into the behavioral health system and determine how to minimize or eliminate any existing conflict of interest. The current entry points for behavioral health, the CMHCs, have experience serving older adults and, consequently, existing relationships with the ADRCs. For many years, DMHA has required CMHCs to provide services for older adults. Specifically, CMHCs are required to have a plan on how they intend to serve older adults, to designate a contact person for older adult services, and to complete the federally mandated PASRR/MI Level II reviews. In addition to building upon current practice, the State will be able to gain valuable experience through the co-location pilot and work to identify best practices that will ease the transition of future populations.

## IN BIP Application

In addition to physical locations, LTSS users will have access to a website which will contain LTSS information and a self-evaluation of needs. The website will be integrated with a 1-800 number and other Medicaid program information. This integration will ensure that anyone seeking LTSS can review an online directory of services, as well as access a 1-800 number that will allow them to begin the eligibility determination and enrollment process. In addition to the website, all SEP/NWD agencies and partners will have access to the State's Integrated Case Management System (ICMS). This system will provide authorized users access to a single source for all LTSS data, which will further integrate the system ultimately creating a Single Entry Point system with No Wrong Door.

#### D. NWD/SEP Person Flow

Individuals with LTSS needs will be able to initially seek information about the available service array through either the website, over the phone, or in person at the SEP. Regardless of what door an individual enters, the Medicaid information provided to them will be the same.

An individual accessing the website will have the opportunity to respond to a series of questions which constitute a Level I screen. The same individual who calls the 1-800 number or presents at a physical SEP location will also have the opportunity to respond to the same series of questions with the assistance of a staff person who will input the information into the website or directly into ICMS. Following completion of these questions, if it appears an individual may be eligible, he/she will be referred to appropriate services. If the individual indicates he/she would like to pursue application for any of these services, a referral will be made by the system to the appropriate agency.

The applicant will next be contacted by a staff person from the appropriate agency to complete the Level II functional assessment. An appointment will be made to complete this additional level of assessment to determine whether the applicant meets the functional criteria for receipt of LTSS. The staff person will be able to use ICMS to access the data previously provided by the applicant through the screening process and build upon it to complete the assessment.

In addition to the functional assessment during this appointment, agency staff will be able to assist applicants with the completion of the Medicaid financial eligibility application at ADRCs that have been integrated with DFR staff through the co-location process. This will be the most significant change impacting the person flow within the NWD/SEP system. As of today, waiver application and Medicaid financial eligibility are not completed together, requiring applicants to present at multiple locations and work with multiple staff to complete the two processes. Under the new system, the process will appear seamless to the applicant despite the fact that the functional eligibility data and financial eligibility data will be input and stored in two separate IT systems and approved through separate administering entities.

Once function eligibility and Medicaid financial eligibility are approved, a case manager will contact the newly eligible waiver enrollee to begin the person-centered process of creating a care plan and choosing a provider(s). Once the care plan is approved, services may begin. If there are no slots available on the waiver of application, the applicant will be placed on a waitlist. Once funding becomes available for that waiver slot, the individual will be contacted and service planning will begin.

See Appendix C for work flows documenting the assessment and eligibility process.

### E. NWD/SEP Data Flow

Indiana is implementing a new waiver and LTSS case management system (ICMS) that is slated to replace existing systems (INsite/DART/IRIS) in the spring of 2013. The requirements for this new system include a web-based database which will allow for multiple user access including the Indiana Family and Social Services Agency (FSSA), its partner agencies, providers, Medicaid members and the general public. Implementation of this system will move the State toward improving accessibility to data required for determining LTSS eligibility and authorizing services. This single system of record will allow for a more streamlined data flow than exists under current processes.

The ICMS system requirements include a Level I screening module which will ask general questions of the applicant to determine their LTSS needs. These data points will be entered through the publically accessible website and stored in the ICMS system. Should the applicant choose to make application for services, the system will prompt an internal referral to the most appropriate FSSA Division(s) based on the data provided by the applicant. As a result of this internal system trigger, the FSSA Division staff will review the information obtained through the Level I screening process and contact the applicant to schedule a follow-up appointment.

During the follow-up appointment, the Division staff will access the applicant's data record, containing the Level I screening responses. Utilizing the appropriate population specific assessment module, the staff person will perform a Level II functional ability assessment. Once all required information has been gathered and input into the system, a determination will be made as to whether the individual is eligible for services. Determination of eligibility is dependent upon the program of application. In some programs, the determination may be auto-generated by ICMS utilizing a built-in assessment algorithm; for others, state staff may be required to review the gathered data and make a manual determination based on standardized criteria. All functional eligibility determinations will be stored in ICMS as the system of record. This information will, therefore, be accessible by all authorized SEP staff.

As the State continues to expand the co-location pilot to additional ADRC offices, applicants residing in those localities will be able to simultaneously make application for Medicaid with completion of the Level II assessment. Functionally, the financial data will be input and stored in a separate system from ICMS. While links do exist between the two systems and some data is shared, they are not fully integrated. The determination for waiver services and Medicaid eligibility will also remain distinct as separate Divisions with FSSA administer and authorize each of the processes.

## F. Potential Automation of Initial Assessment

As discussed above, Indiana is pursuing the implementation of a new case management system, ICMS, in the spring of 2013. ICMS will allow for enhanced data gathering, access, and sharing, including automation of the initial assessment. Whether online, over the phone, or at an SEP location, applicants will be able to complete the Level I screening module through the NWD/SEP website. Individuals will be asked to respond to a series of general questions regarding their functional and financial status. Based on their responses, the website will generate a list of Medicaid and non-Medicaid services for which the individual may be eligible.

Automating the initial assessment process will allow website users to access standardized programmatic LTSS information specific to their needs, in real time. This creates greater transparency for the user, as well as increased efficiencies for the State. Users will be able to educate themselves about information regarding the various community LTSS options that meet their personalized needs. Should they require additional information, they will be able to contact the state using the 1-800 number, through which they will be able to speak directly with agency staff and schedule a meeting regarding the functional assessment process, should they choose.

ICMS will capture the information entered by the individual for purposes of the initial assessment and store it for future use. Should the individual choose to pursue application for a specific program, this information will be accessed by the appropriate FSSA Division and utilized, along with additional information gathered, to perform the Level II functional assessment.

### G. Potential Automation of CSA

The State has designed ICMS as a web-based database to maximize accessibility for a broad user group. As is discussed further in section H of this application, the State will not be pursuing a single standardized assessment tool at this time. Rather, Indiana has chosen to continue to use the population specific, time tested assessment tools current in use.

The web-based tool has been designed to allow users real time access to functional assessment data. However, given operational barriers/challenges, the reality is that, in many cases, data will not be entered into the system in real time. Some of the functional assessments used by the State were intentionally designed to be completed with the applicant by engaging in an informal dialogue rather than a guided question and answer session. Given the personal nature of some of the required data points, Indiana found that certain populations are more inclined to be open to discussing their functional limitations if done in a more conversational format. As such, these conversations do not lend themselves to the case manager/staff person sitting behind a laptop or computer entering data. Often, the data is entered into the system at a later date and/or time with the use of notes taken by the staff person. In addition, supplying all of the field staff with computers or other electronic means of recording assessment data in real time is cost prohibitive given the limited resources of the State.

The State recognizes the value of automation and has designed the new system to be capable of capturing data in real time. However, given current challenges, this function will not be universally mandated.

## H. Incorporation of a CSA in the Eligibility Determination Process

Indiana does not currently utilize a single Core Standardized Assessment (CSA) for LTSS. The assessment tools used today are population specific and have been developed over time to meet the needs of the individual LTSS program criteria.

Indiana has considered the BIP recommendation of creating a single CSA for all LTSS populations. At this time, it has been determined that Indiana will continue to utilize its current assessment tools and work toward ensuring that all necessary data elements are stored, therein, as well as captured and stored within the single case management system, ICMS.

The new case management system will have the capability of housing and operating under a single CSA, should the State choose to move in that direction at a future date. The major challenge to the State would be identifying a single tool that adequately captures the various program functional eligibility criteria, while maintaining the reliability and validity that exists today across the current tools. At this time, the State does not have the resources needed (i.e., clinical, financial, or operational) to engage in this significant effort.

Indiana believes its current assessment tools have been successful in meeting the needs of its programs and best serving each individual population seeking services. Utilizing the existing, time-tested assessments will allow the State to focus on streamlining other aspects of the LTSS system, which have a greater impact on the consumer's overall experience.

### **I. Staff Qualifications and Training**

FSSA is aware that the structural changes to be implemented through BIP will require various levels of training and is prepared to develop and conduct such training.

FSSA staff receives training as-needed to remain current on various policy and system changes. The BIP team will coordinate with each Division to identify, develop, and provide necessary updates to the functional assessment policies and procedures, including training on the use of and electronic access to assessment tools and the data warehouse.

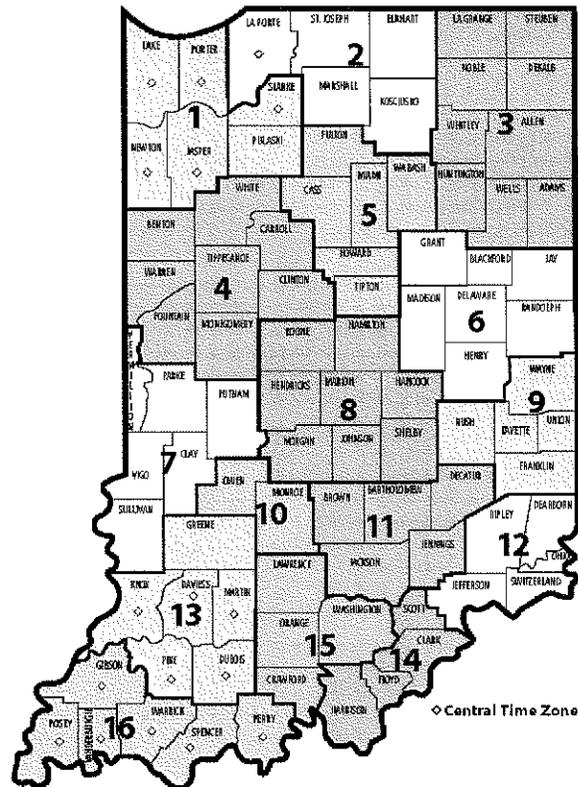
Many of the staff affected by these changes will already be aware of them through participation as internal stakeholders in the review and development of these improvements.

### J. Location of SEP Agencies

Indiana proposes to use the statewide ADRC system as the SEP for BIP. Today, the ADRCs are the access points for aged and physically disabled individuals needing LTSS services. The State is divided into 16 Areas, each of which is overseen by a contracted ADRC. The State has set-up the system to ensure that all Hoosiers live within the service area of an ADRC. Per contracts, the ADRCs must meet State access standards and ADA accessibility standards. One such standard requires that ADRC staff conduct functional assessments with applicants in their homes, thereby eliminating the need for older adults and individuals with physical disabilities to travel.

As the State engages in the co-location pilot, these physical locations will eventually house staff capable of assisting LTSS applicants with all their Medicaid eligibility needs. Current plans for the pilot include adding BDDS and DFR staff to Area 8 which covers central Indiana, specifically, Marion, Boone, Hamilton, Hancock, Shelby, Johnson, Morgan and Hendricks counties. As the State gains experience with the pilot, additional Areas will be converted to co-located ADRCs. The final phase of the co-location process will identify best practices for incorporating into the SEPs staff from agencies charged with assisting individuals with serious mental illness.

## Indiana's Aging & Disability Resource Centers



1	<b>Northwest Indiana Community Action Corporation</b>
2	<b>REAL Services, Inc.</b>
3	<b>Aging and In-Home Services of Northwest Indiana, Inc.</b>
4	<b>Area IV Agency on Aging &amp; Community Action Programs, Inc.</b>
5	<b>Area Five Agency on Aging &amp; Community Services, Inc.</b>
6	<b>LifeStream Services, Inc.</b>
7	<b>Area 7 Agency on Aging and Disabled, West Central Indiana Economic Development District, Inc.</b>
8	<b>CICOA Aging &amp; In-Home Solutions</b>
9	<b>Area 9 In-Home and Community Services Agency</b>
10	<b>Area 10 Agency on Aging</b>
11	<b>Aging &amp; Community Services of South Central Indiana, Inc.</b>
12	<b>LifeTime Resources, Inc.</b>
13	<b>Generations Vincennes University Statewide Services</b>
14	<b>LifeSpan Resources, Inc.</b>
15	<b>Hoosier Uplands/Area 15 Agency on Aging and Disability Services</b>
16	<b>SWIRCA &amp; More</b>

## K. Outreach and Advertising

Indiana will conduct outreach to educate Hoosiers throughout the state about the enhanced resources for community-based LTSS made available through BIP.

FSSA will make use of public relations capabilities, including but not limited to public services announcements, printed materials and social marketing, to make the public aware of these new resource offerings to enable people to remain in the community. FSSA will also engage its partners (ADRCs, CMHCs, and advocacy groups) to utilize their extensive outreach capabilities, including health fairs, presentations to local groups, and newspaper articles.

In addition to consumer and stakeholder outreach, providers will be educated on the new network and systems through trainings and other conferences/meetings. These sessions will create awareness and generate interest among providers who have direct contact with Hoosiers in need of these services. To ensure statewide dissemination is established, these sessions will be held at various geographic locations throughout the state. Reaching out to existing partners and establishing new ones is a key element to the growth of non-institutional long-term care services in Indiana.

Finally, existing communications will be utilized to continually update stakeholders on the implementation and progress of the planned BIP restructuring activities.

### L. Funding Plan

CMS has approved funding for the development and implementation of ICMS through an Advanced Planning Document (APD). The majority of the required structural changes within the BIP will be met under the planning and implementation of ICMS. Specifically, structural changes incorporated into the design and implementation of ICMS include creating a web-based database (which will capture and store Level I screens completed by prospective applicants), as well as Level II functional assessments (completed by agency staff as part of the LTSS application process). ICMS will house assessment data that will represent the Core Data Set necessary to meet the BIP requirement for a CSA. Finally, ICMS will be available to the SEPs and other program partners in real time to support the No Wrong Door structure. Further, it will ensure that regardless of where or how an individual presents to the system, he/she will receive the same Medicaid information and be able to make application for services.

Indiana is committed to working with CMS and other federal agencies to secure their authorization to utilizing other funding sources to support the structural requirements of BIP. There has been commitment from ADRCs to provide for a more robust single entry point through the co-location of state workers that perform necessary eligibility determination functions. The State will seek approval from federal funding authorities to use funds that are originally intended for other programs, but the goals of which are aligned with those of the BIP.

## M. Challenges

Large scale system changes, such as rebalancing the long-term care system, often require culture change at the core. Indiana, like most states, has relied heavily on institutional forms of long-term care for decades. The structural changes required by the BIP will provide opportunities for Indiana to move the system in the right direction, but these cannot occur without buy-in from all stakeholders involved. It is, therefore, critical that the State continues to seek partnerships that will ease the transition and improve the experience for those individuals who require LTSS.

As discussed, the State and its partners will be conducting outreach to create awareness and inform all Hoosiers of their LTSS options. This outreach, along with the expanded capacity to provide supports in a person's desired setting, will increase the demand for community services. The challenges discussed below will need to be considered as the State continues to develop the BIP work plan and throughout implementation of the structural changes.

### **Infrastructure Capacity**

Ensuring that the long-term care infrastructure has the capacity to meet the needs of the LTSS population poses the most significant challenge as the State commits to rebalancing the system in favor of community-based services. As medical technology continues to improve and the population ages, states need to be prepared to support an ever growing group of individuals in need of long-term services and supports. This growth comes at a time when states, like Indiana, are facing considerable pressure to maintain current service levels under shrinking budgets. Limited resources have made it challenging for the State to maintain enough waiver slots to serve all currently on waitlists. Incrementally, the State is working towards minimizing waitlists and getting Hoosiers access to waiver services more quickly.

The budget is not the only limiting factor when considering capacity needs of Indiana's LTSS programs. Transitioning individuals from institutional living to community living requires sufficient accessible and affordable housing. Indiana has pursued the following population-based housing projects in an effort to eliminate barriers to accessible and affordable housing.

The Indiana Housing and Community Development Authority (IHCDA), in partnership with the Division of Aging, launched a program called Home Again, funded under the State's MFP grant. The program provides incentives to developers to build new units for MFP participants. In addition, IHCDA has made funds available for accessibility improvements to units (agreed to by property owners) for participants of the Home Again Program.

FSSA successfully applied for a Real Choice Systems Change Grant, Building Sustainable Partnerships for Housing. The planning grant will assist FSSA and IHCDA in creating and expanding Indiana's housing infrastructure for adults with mental illness. The grant will be used to further current efforts to expand the State's Permanent Supportive Housing program, which has demonstrated that individuals with chronic and serious mental illness can live successfully in apartments of their own when provided with comprehensive community support services.

### **Eligibility**

Indiana currently operates as a 209(b) state under Medicaid statute, which allows the State to use its own criteria to determine eligibility for the populations that are aged, blind, and disabled rather than accepting the Supplemental Security Income (SSI) determination. Under these rules, not every individual in Indiana who receives SSI also receives Medicaid, either because he/she did not qualify under Indiana rules, or because he/she did not apply. Additionally, as a 209(b) state, Indiana operates a Spend Down program through which individuals must first reduce their income to the SSI level through expenditures on qualified medical services to receive Medicaid benefits. State legislation passed in 2011 allows Indiana to make the transition and become a 1634 state and accept the federal disability determination. As Indiana prepares for the changes required under the Affordable Care Act, plans are also being made to move forward with the transition to 1634. These changes would impact the disabled population that is eligible for Medicaid. This change will need to be monitored closely in relation to BIP, to assess and prepare for any unanticipated demands on the long-term care system.

In addition to the design and implementation of ICMS, Indiana is also procuring a new Medicaid Management Information System (MMIS) and Medicaid eligibility system. While challenging, this convergence of change represents a great opportunity to improve the coordination between these systems. The State is working to ensure that where necessary these systems operate seamlessly and will continue to monitor progress to minimize any potential disruption to the BIP structural changes.

### **Coordination across LTSS Populations**

While there are inherent commonalities across populations in need of LTSS, there are also distinct differences that have historically driven the design Indiana's system. Due to these differences, each LTSS population is represented by separate funding sources, oversight entities, provider groups, advocacy groups, and legislative committees. While the BIP provides Indiana with a significant opportunity to implement structures that develop efficiency and consistency to the system, it will take ongoing coordination to sustain achieved progress once the program and funding end. The State will need to develop additional administrative structures to ensure that, over time, all stakeholders are incentivized to continue to work together to highlight the commonalities – and manage the differences – among the populations they serve.

## N. NWD/SEP's Effect on Rebalancing

The NWD/SEP structural changes will provide Indiana's LTSS oversight entities and community partners with opportunity and greater incentives to coordinate across organizational boundaries, and integrate their efforts to provide an effective and high quality continuum of LTSS to those in need.

While each of the Divisions serving a LTSS population in Indiana currently operates under an SEP model (*e.g.*, aged and physically disabled-ADRC, developmentally disabled-BDDS, seriously mentally ill-CMHC), the Division of Aging – through its implementation of a statewide ADRC structure – has most closely embraced the tenants of the BIP NWD/SEP system. This ADRC structure has demonstrated the benefits of NWD/SEP by:

- Creating a person-centered, community-based environment that promotes independence and dignity for individuals;
- Providing easy access to information to assist consumers in exploring a full range of long-term support options; and
- Providing resources and services that support the range of needs for family caregivers.

Leveraging the ADRC best practices and working systematically to affect change across all populations in need of LTSS will have a significant long-term impact on rebalancing and enhancing access to Indiana's community-based services.

Utilizing the NWD/SEP, all individuals in need of LTSS will have a single access point, making it easier for to gather information about the various LTSS programming available. Implementing a single case management system to house all necessary data will streamline:

- eligibility and assessment processes;
- the development of care plans; and
- the provision of services for consumers, providers, and the state.

Instituting conflict-free case management will preserve a person-centered LTSS system and protect the best interests of the consumer. All of these efforts, combined, will contribute to improved quality of care, consumer satisfaction, and organizational and cost efficiencies.

Finally, the additional funding the State will receive as a result of committing to the BIP structural changes will be used to expand the capacity of Indiana's HCBS system. This additional capacity is critical to meet the ever growing demand for LTSS and rebalance the system.

## O. Other Balancing Initiatives

Indiana is pursuing new balancing incentives while continuing to build on the success of ongoing efforts.

Current Indiana Balancing Incentives include:

- MFP funding to enable transitions from nursing facilities to community living
- Outreach and Education provided by ADRCs
- AoA and Social Service Block Grant funding of community care
- Restructuring the nursing facility rate and quality assessment fee methodology
- CA-PRTF grant funding to enable diversions and transition to community-based care
- Real Choice Systems Change Grant-Building Sustainable Partnerships for Housing

Future Balancing Incentives include:

- 1915(i) state plan option for adults with serious mental illness
- 1915(i) state plan option for children and adolescents with serious emotional disturbance
- Expansion of MFP targeting funding for transitions of children and adolescents with serious emotional disturbances
- Health homes for the individuals with developmental disabilities and individuals with serious mental illness

**P. Technical Assistance**

Indiana would appreciate information that CMS can provide about rebalancing efforts in other states, specifically, best practices, to assist in meeting the BIP goal of increasing LTSS expenditures for home and community-based services.

In addition, the State will request assistance in assuring all data reporting on quality and outcomes for BIP are sufficient and acceptable to CMS.

## Proposed Budget

The "Balancing Incentive Payments Program Applicant Funding Estimates" form for Indiana is included in as Appendix B.

These estimates are based upon claims payment and eligibility data, as paid through March 31, 2012.

The projections are consistent with plans by the Family and Social Services Administration (FSSA) to provide more care in home and community-based settings, including:

- Approximately 500 current nursing facility residents are considered to be appropriate for community-based services, provided through the Developmental Disabilities waiver. These transitions are expected to take place during FFY 2013 through FFY 2015.
- Approximately 1,000 individuals currently served in small group ICF/IDs are expected to be served through the Developmental Disabilities waiver beginning October 2012.
- Development of Program of All-Inclusive Care for the Elderly, with at least two organizations opening centers over the next eighteen months to two years.
- Continued success in serving individuals in the Money Follows the Person Demonstration.
- Growth in home health utilization, primarily by populations served in the Aged and Disabled waiver and the Traumatic Brain Injury waiver.
- FSSA expects to enroll individuals from the waitlist to be served through the Family Supports waiver.
- 1915(i) state plan option for adults with serious mental illness requiring habilitation services to remain in the community.

## Appendix A—Letters of Support

Copies of letters of support from the following agencies and organizations are included here:

- Division of Aging
- Division of Mental Health and Addiction
- Division of Disability and Rehabilitative Services
- Division of Family Resources
- Aging and Disability Resource Centers



*"People  
helping people  
help  
themselves"*

Mitchell E. Daniels, Jr., Governor  
State of Indiana

**Indiana Family and Social Services Administration**  
402 W. WASHINGTON STREET, P.O. BOX 7083  
INDIANAPOLIS, IN 46207-7083

Michael A. Gargano, Secretary

June 29, 2012

Shane Spotts  
Director, Division of Disability and Rehabilitation Services  
Family & Social Services Administration  
402 W. Washington St.  
Indianapolis, IN 46204

Dear Mr. Spotts:

The Division of Family Resources (DFR) within the Indiana Family & Social Services Administration is pleased to offer its support to the Division of Disability and Rehabilitative Services (DDRS) in submitting an application to the Centers Medicare and Medicaid Services (CMS) for the Balancing Incentive Program, authorized by Section 10202 of the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148).

The Division of Family Resources provides various tools to strengthen families through services that focus on prevention, early intervention, self-sufficiency, family support and preservation. The division administers cash assistance, child care assistance, food assistance, employment and training services for low-income clients, as well as Medicaid eligibility, throughout the state.

DFR will collaborate with DDRS and other organizational partners in providing systems that include: no wrong door—single entry point system; conflict free case management services; and core standardized assessment instruments. DFR is also committed to shifting the institutional spend to home and community-based care spend, so that 50 percent of Indiana's long-term care dollars are spent on community non-institutionally based long-term services and supports.

DFR strongly encourages CMS to accept DDRS' application to promote new opportunities to provide quality care to individuals in the most appropriate, least restrictive setting. We look forward to working with DDRS and CMS on the activities related to this cooperative agreement.

Sincerely,

Adrienne Shields  
Deputy Director, Division of Family Resources  
Family & Social Services Administration





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help  
themselves"

Mitchell E. Daniels, Jr., Governor  
State of Indiana

*Indiana Family and Social Services Administration*  
402 W. WASHINGTON STREET, P.O. BOX 7083  
INDIANAPOLIS, IN 46207-7083

Michael A. Gargano, Secretary

June 29, 2012

Shane Spotts  
Director, Division of Disability and Rehabilitation Services  
Family & Social Services Administration  
402 W. Washington St.  
Indianapolis, IN 46204

Dear Mr. Spotts:

The Division of Mental Health and Addiction (DMHA) within the Indiana Family & Social Services Administration is pleased to offer its support to the Division of Disability and Rehabilitative Services (DDRS) in submitting an application to the Centers Medicare and Medicaid Services (CMS) for the Balancing Incentive Program, authorized by Section 10202 of the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148).

DMHA provides policy oversight for the publicly funded mental health and addiction services system. DMHA operates six state psychiatric hospitals and contracts with community mental health centers as well as child and addiction treatment providers to offer a full continuum of mental health and addiction treatment services.

DMHA will collaborate with DDRS and other organizational partners in providing systems that include: no wrong door—single entry point system; conflict free case management services; and core standardized assessment instruments. DMHA is also committed to shifting the institutional spend to home and community-based care spend, so that 50 percent of Indiana's long-term care dollars are spent on community non-institutionally based long-term services and supports.

DMHA strongly encourages CMS to accept DDRS' application to promote new opportunities to provide quality care to individuals in the most appropriate, least restrictive setting. We look forward to working with DDRS and CMS on the activities related to this cooperative agreement.

Sincerely,

A handwritten signature in black ink, appearing to read 'Debra K. Herrmann', is written over a light blue horizontal line.

Debra K. Herrmann  
Division of Mental Health and Addiction  
Family & Social Services Administration





"People  
helping people  
help  
themselves"

Mitchell E. Daniels, Jr., Governor  
State of Indiana

*Indiana Family and Social Services Administration*  
402 W. WASHINGTON STREET, P.O. BOX 7083  
INDIANAPOLIS, IN 46207-7083

Michael A. Gargano, Secretary

June 27, 2012

Shane Spotts  
Director, Division of Disability and Rehabilitation Services  
Family & Social Services Administration  
402 W. Washington St.  
Indianapolis, IN 46204

Dear Mr. Spotts:

The Office of Medicaid Policy and Planning (OMPP) within the Indiana Family & Social Services Administration is pleased to offer its support to the Division of Disability and Rehabilitative Services (DDRS) in submitting an application to the Centers Medicare and Medicaid Services (CMS) for the Balancing Incentive Program, authorized by Section 10202 of the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148).

OMPP is committed to helping seniors and people with disabilities become active members of their communities instead of living in an institution through the use of Medicaid waiver programs.

OMPP will collaborate with DDRS and other organizational partners in providing guidance in systems that include: no wrong door—single entry point system; conflict free case management services; and core standardized assessment instruments. OMPP is also committed to provide guidance on shifting the institutional spend to home and community-based care spend, so that 50 percent of Indiana's long-term care dollars are spent on community non-institutionally based long-term services and supports.

OMPP strongly encourages CMS to accept DDRS' application to promote new opportunities to provide quality care to individuals in the most appropriate, least restrictive setting. We look forward to working with DDRS and CMS on the activities related to this cooperative agreement.

Sincerely,

Pat Casanova  
Director, Office of Medicaid Policy and Planning  
Family & Social Services Administration





"People  
helping people  
help  
themselves"

Mitchell E. Daniels, Jr., Governor  
State of Indiana

**Indiana Family and Social Services Administration**  
402 W. WASHINGTON STREET, P.O. BOX 7083  
INDIANAPOLIS, IN 46207-7083

Michael A. Gargano, Secretary

June 27, 2012

Shane Spotts  
Director, Division of Disability and Rehabilitation Services  
Family & Social Services Administration  
402 W. Washington St.  
Indianapolis, IN 46204

Dear Mr. Spotts:

The Division of Aging within the Indiana Family & Social Services Administration is pleased to offer its support to the Division of Disability and Rehabilitative Services (DDRS) in submitting an application to the Centers Medicare and Medicaid Services (CMS) for the Balancing Incentive Program, authorized by Section 10202 of the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148).

The Division of Aging oversees two waivers: The Aged & Disabled Waiver and the Traumatic Brain Injury Waiver. The Division of Aging is committed to redefining the long-term care marketplace for consumers and providers, while striving to provide long term care options to traditional facility placement and improving quality of life by providing community based care.

The Division of Aging will collaborate with DDRS and other organizational partners in providing systems that include: no wrong door—single entry point system; conflict free case management services; and core standardized assessment instruments. The Division of Aging is also committed to shifting the institutional spend to home and community-based care spend, so that 50 percent of Indiana's long-term care dollars are spent on community non-institutionally based long-term services and supports.

The Division of Aging strongly encourages CMS to accept DDRS' application to promote new opportunities to provide quality care to individuals in the most appropriate, least restrictive setting. We look forward to working with DDRS and CMS on the activities related to this cooperative agreement.

Sincerely,

Faith Laird  
Director, Division of Aging  
Family & Social Services Administration





**Indiana Association  
of Area Agencies on Aging**

*leadership. advocacy. access.*

June 29, 2012

Mr. Shane Spotts  
Director, Division of Disability and Rehabilitation Services  
Indiana Family & Social Services Administration  
402 W. Washington Street  
Indianapolis, IN 46204

Re: IAAAA Support for Indiana BIP Application

Dear Mr. Spotts:

The Indiana Association of Area Agencies on Aging (IAAAA) is pleased to offer its support to the Division of Disability and Rehabilitative Services (DDRS) in submitting an application to the Centers Medicare and Medicaid Services (CMS) for the Balancing Incentive Program, authorized by Section 10202 of the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148).

IAAAA represents Indiana's 16 Area Agencies on Aging (AAAs) which assure home and community-based services for older adults and people with disabilities of any age. Further, all 16 of Indiana's AAAs are designated Aging and Disability Resources Centers (ADRCs) by the U.S. Administration on Aging. In addition to information and referral services provided through the ADRC's, Indiana's AAAs offer Options Counseling and case management. They also connect and monitor long-term services and supports for their clients so they can live safely and independently in their own homes and communities. Please see the attached map and flier for a description of Indiana AAAs locations and available services.

IAAAA values empowerment, ease of access, quality, innovation, and lifelong communities. IAAAA will collaborate with DDRS and other organizational partners in providing systems that include: no wrong door-single entry point system; conflict free case management services; and core standardized assessment instruments.

IAAAA is also committed to rebalancing Indiana's long-term care system so that a minimum of 50 percent of the state's long-term care investment is spent on home and community-based services and supports which are consumer-preferred and less costly than institution-based care.

IAAAA strongly encourages CMS to accept DDRS' application to promote new opportunities to provide quality care to individuals in the most appropriate, least restrictive setting. We look forward to working with DDRS and CMS on the activities related to this cooperative agreement.

Most Sincerely,

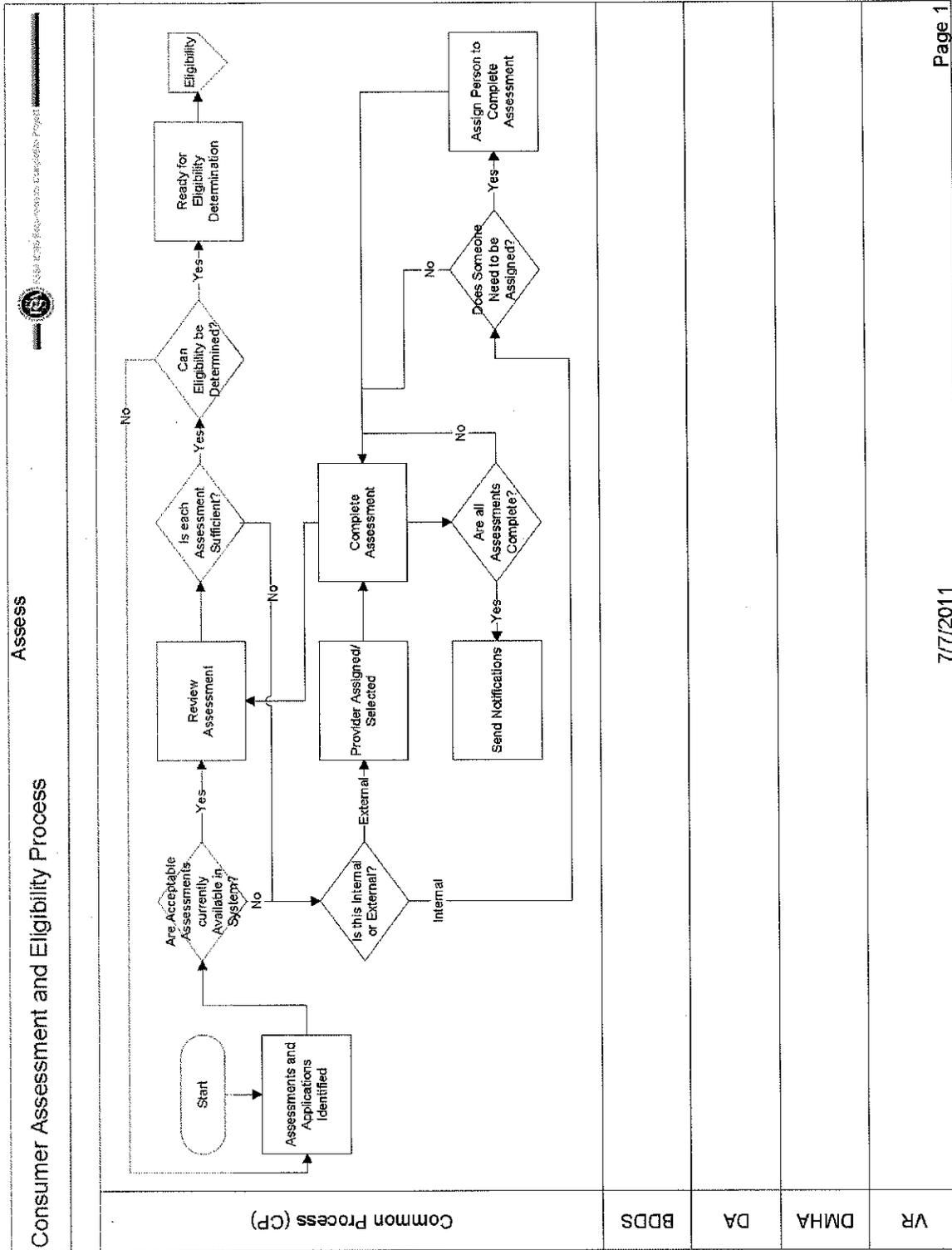
Kristen S. LaEace  
Chief Executive Officer

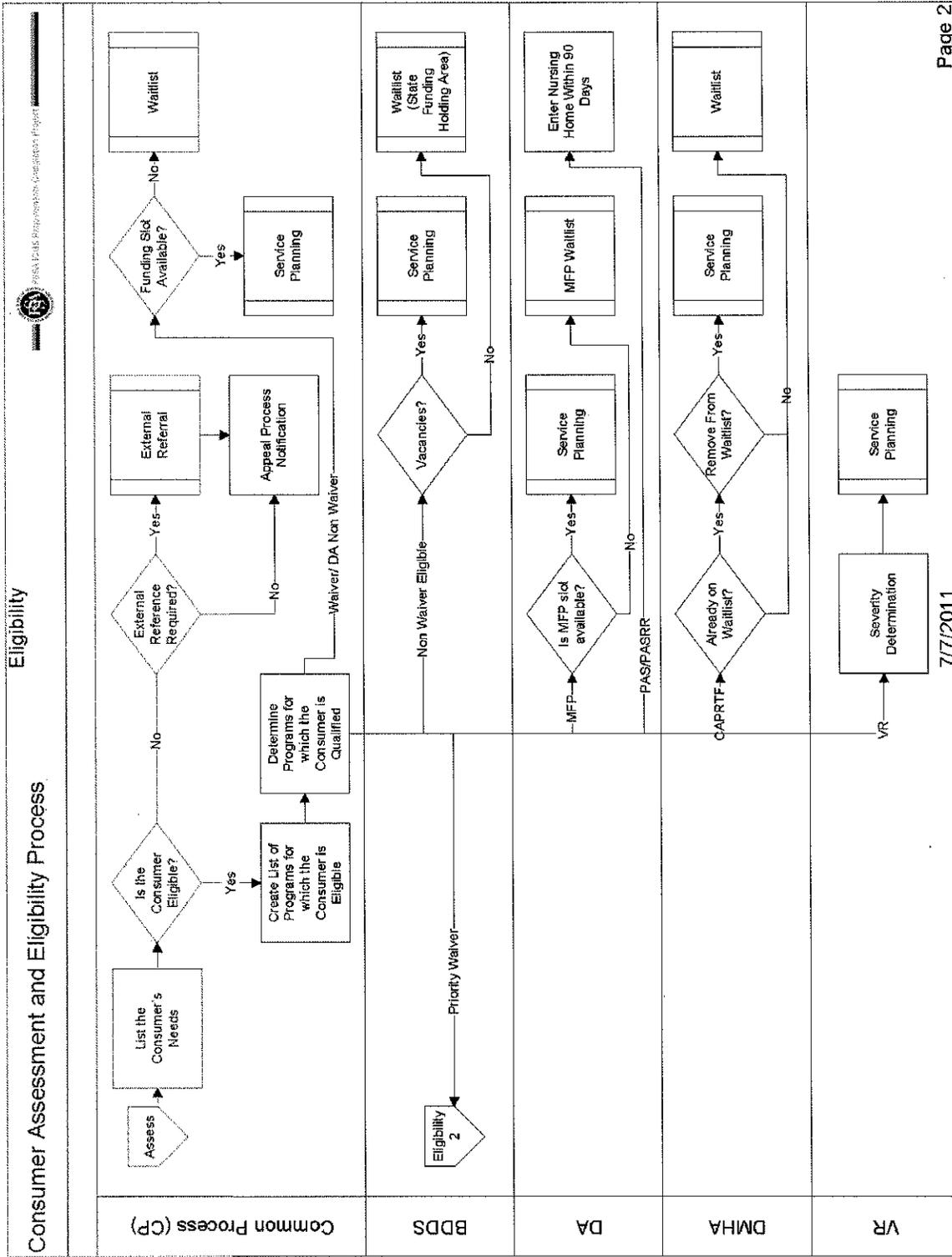
Appendix B—Applicant Funding Estimates

**CENTERS FOR MEDICARE & MEDICAID SERVICES  
BALANCING INCENTIVE PAYMENTS PROGRAM (Balancing Incentive Program) APPLICANT FUNDING ESTIMATES  
LONG-TERM SERVICES AND SUPPORTS**

<b>State</b>	Indiana	<b>State FMAP Rate FFY 2013</b>	67.16%
<b>Agency Name</b>	Family and Social Services Administration	<b>Extra Balancing Incentive Program Portion (2 or 5%)</b>	2%
<b>Quarter Ended</b>			
<b>Year of Service (1-4)</b>	FFY 2012-2015		

LTSS	Total Service Expenditures	Regular FEDERAL Portion	Regular STATE Portion	Amount Funded by BIP (4 year total)	Year 1 July - Sept. 2012	Year 2 Oct. - Sept. 2013	Year 3 Oct. - Sept. 2014	Year 4 Oct. - Sept. 2015	Projected LTSS Spending				
									(A)	(B)	(C)	(D)	(E)
Aged and Disabled Waiver	1,125,525,000	755,902,590	369,622,410	22,510,500	63,725,000	307,000,000	360,900,000	393,900,000					
MFP Demonstration	29,875,000	20,064,050	9,810,950	597,500	1,875,000	9,000,000	9,400,000	9,600,000					
Traumatic Brain Injury Waiver	30,900,000	20,752,440	10,147,560	618,000	1,900,000	9,400,000	9,700,000	9,900,000					
Developmental Disability Waiver	2,025,050,000	1,360,023,580	665,026,420	40,501,000	111,850,000	511,500,000	594,500,000	807,200,000					
Autism Waiver	92,025,000	61,803,990	30,221,010	1,840,500	5,625,000	26,500,000	28,700,000	31,200,000					
Family Supports Waiver	301,950,000	202,789,620	99,160,380	6,039,000	11,250,000	73,400,000	97,300,000	120,000,000					
CA-PRTF Grant	51,800,000	34,788,880	17,011,120	1,036,000	3,800,000	14,800,000	16,600,000	16,600,000					
MRO	671,725,000	451,130,510	220,594,490	13,434,500	50,525,000	203,200,000	206,400,000	211,600,000					
Other Home Health	158,325,000	106,331,070	51,993,930	3,166,500	11,525,000	47,500,000	48,900,000	50,400,000					
PACE	24,000,000	16,118,400	7,881,600	480,000	-	2,000,000	11,000,000	11,000,000					
<b>Totals</b>	<b>\$ 4,511,175,000</b>	<b>\$ 3,029,705,130</b>	<b>\$ 1,481,469,870</b>	<b>\$ 90,223,500</b>	<b>\$ 262,075,000</b>	<b>\$ 1,204,300,000</b>	<b>\$ 1,383,400,000</b>	<b>\$ 1,661,400,000</b>					





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Consumer Assessment and Eligibility Process		Eligibility 2	
Common Process (CP)	<pre> graph TD     Start([User Determines that Internal Referral is Required (at anytime)]) --&gt; Decision{Does Internal Referral Exist?}     Decision -- Yes --&gt; End([End])     Decision -- No --&gt; Action[Make Internal Referral Assignment]             </pre>		
BDS	<pre> graph TD     Start([Eligibility]) --&gt; Decision{Is a Priority Slot Available?}     Decision -- Yes --&gt; Action[Service Planning]     Decision -- No --&gt; Action[Waitlist (Priority)]             </pre>		
DA			
DMHA			
VR			

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