

APPENDIX K: Emergency Preparedness and Response and COVID-19 Addendum

Background:

This standalone appendix may be utilized by the state during emergency situations to request amendments to its approved waiver, to multiple approved waivers in the state, and/or to all approved waivers in the state. It includes actions that states can take under the existing Section 1915(c) home and community-based waiver authority in order to respond to an emergency. Other activities may require the use of various other authorities such as the Section 1115 demonstrations or the Section 1135 authorities.¹ This appendix may be applied retroactively as needed by the state. Public notice requirements normally applicable under 1915(c) do not apply to information contained in this Appendix.

Appendix K-1: General Information

General Information:

- A. **State:** Indiana
- B. **Waiver Title(s):** Aged & Disabled Waiver (A&D) and Traumatic Brain Injury Waiver (TBI)
- C. **Control Number(s):**
IN.0210.R06.04 & IN.4197.R04.02

D. Type of Emergency (The state may check more than one box):

<input checked="" type="checkbox"/>	Pandemic or Epidemic
<input type="checkbox"/>	Natural Disaster
<input type="checkbox"/>	National Security Emergency
<input type="checkbox"/>	Environmental
<input type="checkbox"/>	Other (specify):

E. Brief Description of Emergency. *In no more than one paragraph each,* briefly describe the: 1) nature of emergency; 2) number of individuals affected and the state’s mechanism to identify individuals at risk; 3) roles of state, local and other entities involved in approved waiver operations; and 4) expected changes needed to service delivery methods, if applicable. The state should provide this information for each emergency checked if those emergencies affect different geographic areas and require different changes to the waiver.

COVID-19 pandemic. This amendment will apply waiver-wide for each waiver included in this Appendix, to all individuals impacted by the virus or the response to the virus (e.g. closure of day programs, etc.)

F. Proposed Effective Date: Start Date: March 1, 2020 **Anticipated End Date:** February 28, 2021

G. Description of Transition Plan.

All activities will take place in response to the impact of COVID-19 as efficiently and effectively as possible based upon the complexity of the change.

H. Geographic Areas Affected:

These actions will apply across the waivers to all individuals impacted by the COVID-19 virus.

I. Description of State Disaster Plan (if available) *Reference to external documents is acceptable:*

Indiana’s State Emergency Operations Plan can be found at:
<https://www.in.gov/isdh/28470.htm>

Appendix K-2: Temporary or Emergency-Specific Amendment to Approved Waiver

Temporary or Emergency-Specific Amendment to Approved Waiver:

These are changes that, while directly related to the state’s response to an emergency situation, require amendment to the approved waiver document. These changes are time limited and tied specifically to individuals impacted by the emergency. Permanent or long-ranging changes will need to be incorporated into the main appendices of the waiver, via an amendment request in the waiver management system (WMS) upon advice from CMS.

a. ___ Access and Eligibility:

i. ___ Temporarily increase the cost limits for entry into the waiver.

[Provide explanation of changes and specify the temporary cost limit.]

[Empty text box for explanation of changes and temporary cost limit.]

ii. ___ Temporarily modify additional targeting criteria.

[Explanation of changes]

[Empty text box for explanation of changes.]

b. X Services

i. X Temporarily modify service scope or coverage.

[Complete Section A- Services to be Added/Modified During an Emergency.]

ii. ___ Temporarily exceed service limitations (including limits on sets of services as described in Appendix C-4) or requirements for amount, duration, and prior authorization to address health and welfare issues presented by the emergency.

[Explanation of changes]

iii. X Temporarily add services to the waiver to address the emergency situation (for example, emergency counseling; heightened case management to address emergency needs; emergency medical supplies and equipment; individually directed goods and services; ancillary services to establish temporary residences for dislocated waiver enrollees; necessary technology; emergency evacuation transportation outside of the scope of non-emergency transportation or transportation already provided through the waiver).

[Complete Section A-Services to be Added/Modified During an Emergency]

iv. X Temporarily expand setting(s) where services may be provided (e.g. hotels, shelters, schools, churches). Note for respite services only, the state should indicate any facility-based settings and indicate whether room and board is included:

[Explanation of modification, and advisement if room and board is included in the respite rate]:

- Temporarily expand settings to nursing facilities and adult day service provider congregate settings as respite providers for waiver participants who are unable to receive care due to provider agencies and facilities placing services on hold due to COVID-19. Room and board is not included. Respite services provided in these setting will not be extended for more than 30 days.
 - Allow Adult Day Service providers, who have closed, to provide the services in a participant home.

v. ___ Temporarily provide services in out of state settings (if not already permitted in the state's approved waiver). [Explanation of changes]

c. ___ Temporarily permit payment for services rendered by family caregivers or legally responsible individuals if not already permitted under the waiver. Indicate the services to which this will apply and the safeguards to ensure that individuals receive necessary services as authorized in the plan of care, and the procedures that are used to ensure that payments are made for services rendered.

d. X Temporarily modify provider qualifications (for example, expand provider pool, temporarily modify or suspend licensure and certification requirements).

i. X Temporarily modify provider qualifications.

[Provide explanation of changes, list each service affected, list the provider type, and the changes in provider qualifications.]

Temporarily modify provider qualifications to suspend DA & state administrative code requirements 455 IAC 2-6 for Attendant Care, Home and Community Based Assistance (Homemaker), Home Delivered Meal, Respite Services, and Integrated Health Care Coordination. This includes obtaining a limited criminal history, proof of insurance, and proof of TB test, personnel policy, and operations policy.

ii. Temporarily modify provider types.

[Provide explanation of changes, list each service affected, and the changes in the provider type for each service].

iii. X Temporarily modify licensure or other requirements for settings where waiver services are furnished.

[Provide explanation of changes, description of facilities to be utilized and list each service provided in each facility utilized.]

Temporarily modify provider licensure to suspend license requirements 455 IAC 2-6 for Attendant Care and Respite services including collecting the license and checking the nurse registry.

e. Temporarily modify processes for level of care evaluations or re-evaluations (within regulatory requirements). [Describe]

f. Temporarily increase payment rates.

[Provide an explanation for the increase. List the provider types, rates by service, and specify whether this change is based on a rate development method that is different from the current approved waiver (and if different, specify and explain the rate development method). If the rate varies by provider, list the rate by service and by provider.]

g. X Temporarily modify person-centered service plan development process and individual(s) responsible for person-centered service plan development, including qualifications.

[Describe any modifications including qualifications of individuals responsible for service plan development, and address Participant Safeguards. Also, include strategies to ensure that services are received as authorized.]

Person-Centered Service Plans that are due to expire within the next 60 days require case management contact to the participant using allowable remote contact methods to verify with the participant or representative that the current assessment and services, including providers, remain acceptable and approvable for the upcoming year. The state will verify by obtaining electronic signatures/or electronic verification dated the day of the meeting via secure email consent from service providers and the individual or representative, in accordance with the state's HIPAA requirements.

The state will ensure the service plan is modified to allow for additional supports/and or services to respond to the COVID-19 pandemic. The specificity of such services including amount, duration and scope will be appended as soon as possible to ensure that the specific service is delineated accordingly to the date it began to be received. The care coordinator must submit the request for additional supports/services no later than 30 days from the date the service begins.

Given the rapid response that will be necessary to ensure participant health and welfare and to avoid delays while waiting for approval and authorization of individual plan changes, documentation of verbal approval or email approval of changes and additions to individual plans will suffice as authorization. Services may start while waiting for the signature to be returned to the case manager, whether electronically in accordance with HIPAA requirements or by mail. Signatures will include a date reflecting the meeting date.

h. ___ Temporarily modify incident reporting requirements, medication management or other participant safeguards to ensure individual health and welfare, and to account for emergency circumstances. [Explanation of changes]

i. X Temporarily allow for payment for services for the purpose of supporting waiver participants in an acute care hospital or short-term institutional stay when necessary supports (including communication and intensive personal care) are not available in that setting, or when the individual requires those services for communication and behavioral stabilization, and such services are not covered in such settings.

[Specify the services.]

Temporarily allow for the payment of Attendant Care, Home and Community Based Assistance, Structured Family Caregiving, and Health Care Coordination for the purpose of supporting waiver participants when these supports are not available in institutional settings.

To be provided in these settings, these necessary supports:

To be provided in these settings, these necessary supports:

- Must be identified in an individual's person-centered service plan;
- Must be provided to meet the individual's needs and cannot be provided in such settings;
- Should not substitute for services that the setting is obligated to provide through its condition of participation under Federal or State law, or under another applicable requirements; and
- Should be designed to ensure smooth transitions between the setting and the home and community-based setting and preserves the participant's functional abilities.

j. ___ Temporarily include retainer payments to address emergency related issues.

[Describe the circumstances under which such payments are authorized and applicable limits on their duration. Retainer payments are available for habilitation and personal care only.]

k. ___ Temporarily institute or expand opportunities for self-direction.

[Provide an overview and any expansion of self-direction opportunities including a list of services that may be self-directed and an overview of participant safeguards.]

l. ___ Increase Factor C.

[Explain the reason for the increase and list the current approved Factor C as well as the proposed revised Factor C]

m. X Other Changes Necessary [For example, any changes to billing processes, use of contracted entities or any other changes needed by the State to address imminent needs of individuals in the waiver program]. [Explanation of changes]

Appendix K Addendum: COVID-19 Pandemic Response

1. HCBS Regulations

- a. Not comply with the HCBS settings requirement at 42 CFR 441.301(c)(4)(vi)(D) that individuals are able to have visitors of their choosing at any time, for settings added after March 17, 2014, to minimize the spread of infection during the COVID-19 pandemic.

2. Services

- a. Add an electronic method of service delivery (e.g. telephonic) allowing services to continue to be provided remotely in the home setting for:
 - i. Case management
 - ii. Personal care services that only require verbal cueing
 - iii. In-home habilitation
 - iv. Monthly monitoring (i.e., in order to meet the reasonable indication of need for services requirement in 1915(c) waivers).
 - v. Other *[Describe]*:

- For the non-personal care activities performed by the Structured Family Caregiving service.
- Screening of COVID-19 prior to in-home visits by any home-based provider.

- b. Add home-delivered meals
- c. Add medical supplies, equipment and appliances (over and above that which is in the state plan)
- d. Add Assistive Technology

3. Conflict of Interest: The state is responding to the COVID-19 pandemic personnel crisis by authorizing case management entities to provide direct services. Therefore, the case management entity qualifies under 42 CFR 441.301(c)(1)(vi) as the only willing and qualified entity.

- a. Current safeguards authorized in the approved waiver will apply to these entities.
- b. Additional safeguards listed below will apply to these entities.

The DA will make a case-by-case determination if the care management agency is the only willing and qualified entity in the county they want to serve.

4. Provider Qualifications

- a. Allow spouses and parents of minor children to provide personal care services
- b. Allow a family member to be paid to render services to an individual.
- c. Allow other practitioners in lieu of approved providers within the waiver. *[Indicate the providers and their qualifications]*

Adult Day Providers as Attendant Care, Home and Community Based Assistance (Homemaker), and Respite Care

- d. Modify service providers for home-delivered meals to allow for additional providers, including non-traditional providers.

5. Processes

- a. Allow an extension for reassessments and reevaluations for up to one year past the due date.
- b. Allow the option to conduct evaluations, assessments, and person-centered service planning meetings virtually/remotely in lieu of face-to-face meetings.
- c. Adjust prior approval/authorization elements approved in waiver.
- d. Adjust assessment requirements
- e. Add an electronic method of signing off on required documents such as the person-centered service plan.

Contact Person(s)

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

First Name: BreAnn
Last Name: Teague
Title: Senior Manager, Program Administration
Agency: Indiana Family & Social Services Administration, Office of Medicaid Policy & Planning
Address 1: 402 West Washington Street, Room W374 (MS07)
Address 2: Click or tap here to enter text.
City: Indianapolis
State: Indiana
Zip Code: 46204
Telephone: 317-232-7294
E-mail: breann.teague@fssa.in.gov
Fax Number: 317-232-7382

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

First Name: Jesse
Last Name Wyatt
Title: Deputy Director of Division of Aging
Agency: Indiana Family & Social Services Administration, Division of Aging
Address 1: 402 West Washington Street, Room W454
Address 2: Click or tap here to enter text.
City Indianapolis
State Indiana
Zip Code 46204
Telephone: 317-232-0604
E-mail jesse.wyatt@fssa.in.gov
Fax Number 317-232-2182

8. Authorizing Signature

Signature:

Date: 04/20/2020

_____/S/_____
State Medicaid Director or Designee

First Name: Allison
Last Name Taylor
Title: Medicaid Director
Agency: Office of Medicaid Planning and Policy
Address 1: 402 W. Washington St.
Address 2: Click or tap here to enter text.
City Indianapolis
State IN
Zip Code 46204
Telephone: 317-232-4354
E-mail allison.taylor@fssa.in.gov
Fax Number 317-234-5076

Section A---Services to be Added/Modified During an Emergency

Complete for each service added during a time of emergency. For services in the approved waiver that the state is temporarily modifying, enter the entire service definition and highlight the change. State laws, regulations and policies referenced in the specification should be readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification

Service Title: Care Management

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

Service Definition (Scope):

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

ALLOWABLE ACTIVITIES

Person Centered Assessment and Planning.

This activity includes but not limited to discovering the participant's strengths, needs, goals, and preferences. The Care manager will appropriately facilitate the assessment process through utility of person centered discovery tools and practice to engage the individual and their circle of support. The assessment and planning phase can include but 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 individual's functional and social needs. Service planning is a process to determine funded services and eligibility to appropriately meet the individual's needs.

Monitoring and evaluating all action and/or service plans.

Care Managers are responsible to monitor progress for all services displayed on the action and/or service plans.

The care manager will provide and coordinate high quality services to the individual, while promoting seamless, integrated, coordinated care.

Monitoring person centered support plans will be completed by the Care manager 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 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 care manager is responsible to complete annual person centered assessments including eligibility and service planning.

The care manager is responsible to coordinate 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 a terminated or re-start status.

The care manager will be responsible to evaluate the effectiveness of all services. Evaluation is demonstrated through but not limited to:

- Monitoring the progress from identifying need to meeting goals/preferences identified by the individual.
- Direct collaboration and coordination with providers to ensure services are within the individual's preferences
- Adjusting action and service plans appropriately to identify changing needs that meet the participant's needs

Termination of plans

The care manager will follow the Medicaid Nursing Facility level of Care Home and Community-Based Services Waivers Termination Procedures when a participant is no longer to receive services under the waiver program. This includes providing a thirty (30) day notice to any participant the care manager is terminating.

Care managers will perform wellness checks as directed by the DA during the COVID-19 public health emergency period.

SERVICE STANDARDS

- Care management services must be reflected in the service plan of the participant.
- Care managers enhance the individual's functional and social well-being.
- Broker community resources that align with the participant's unique needs.

- Care manager's will engage the participant and their circle of support in all aspects of the care management process and tailor the person centered support plan to the participant's needs, preferences, goals, and strengths.
- Care managers are expected to coordinate and collaborate with other care managers, other organizations, community partners, and DA 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.
- Care manager maximum Medicaid waiver caseload is not to exceed 65 participants at any time.
- Care managers are responsible for identifying when a participant is residing in a provider owned or controlled setting, monitoring HCBS characteristics, monitoring person centered modifications to HCBS characteristics, and documented in the PCMT as such.

DOCUMENTATION STANDARDS

Person Centered Assessment and Planning.

This activity includes but not limited to discovering the participant's strengths, needs, goals, and preferences. The care manager will appropriately facilitate the assessment process to engage the individual and their circle of support. The assessment and planning phase can include but 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 individual's functional and social needs. Service Planning is a process to determine funded services and eligibility to appropriately meet the individual's needs.

Monitoring and evaluating all action and/or service plans.

Care managers are responsible to monitor progress for all services displayed on the action and/or service plans.

The care manager will provide and coordinate high quality services to the individual, while promoting seamless, integrated, coordinated care.

Monitoring person centered support plans will be completed by the care manager 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 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 care manager is responsible to complete Annual person centered assessments including eligibility and service planning.

The care manager is responsible to complete all assessment tools including but not limited to incident reports timely.

The care manager will be responsible to evaluate the effectiveness of all services. Evaluation is demonstrated through but not limited to:

1. Monitoring the progress from identified need to meeting goals/preferences identified by the individual.
2. Direct collaboration and coordination with providers to ensure services are within the individual's preferences
3. Adjusting action and service plans appropriately to identify changing needs that meet the participant's needs

Termination of plans

The care manager will follow the Medicaid Nursing Facility level of Care Home and Community-Based Services Waivers Termination Procedures when a participant is no longer to receive services under the waiver

program.

Transition follow up

It is the responsibility of the care manager to assure the individual fully understands their ability to make choices concerning all services they receive. This includes care management services. In the event the individual chooses, another care management agency the current care management agency is to fully assist the individual in their transition, to the new agency or individual care manager of choice. The goal is to assure a seamless transition for the individual.

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

ACTIVITIES NOT ALLOWED

Care management 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's DA to provide direct services to participants.

Prior to billing, a care manager must have completed the care management curriculum to become a Medicaid certified care manager.

Note: Common ownership exists when a participant, or any legal entity possess ownership or equity of at least five percent in the provider as well as the institution or organization serving the provider. Control exists where 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 by which to be controlled.

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

Reimbursement of case management under Medicaid Waivers may not be made unless and until the participant becomes eligible for Medicaid Waiver services. Case management provided to participants who are not eligible for Medicaid Waiver services will not be reimbursed as a Medicaid Waiver service.

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

Provider Specifications

Provider Category(s) (check one or both):	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
		FSSA/DA approved Case Management Individual		FSSA/DA approved Case Management Agency
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input checked="" type="checkbox"/>	Relative/Legal Guardian
Provider Qualifications (provide the following information for each type of provider):				
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)	

Both	N/A	N/A	<p>DA, 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 Training in the nursing facility level of care process by the DA or designee Education and work experience An individual continuously employed as a Care Manager by an AAA since June 30, 2018; or A qualified mental retardation professional (QMRP) who meets the QMRP requirements at 42 CFR 483.430; or A registered nurse with one year's experience in human services; or A Bachelor's degree in Social Work, Psychology, Sociology, Counseling, Gerontology, Nursing or Health & Human Services; or Associate's Degree in nursing. A Bachelor's degree in any field with a minimum of two years full-time, direct service experience with the elderly or disabled (this experience includes assessment, care plan development, and monitoring); or A Master's degree in a related field may substitute for the required experience.</p>
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Verification of Provider Qualifications				
Provider Type:	Entity Responsible for Verification:		Frequency of Verification	
Both	DA		At least every three years	
Service Delivery Method				
Service Delivery Method (check each that applies):	<input type="checkbox"/>	Participant-directed as specified in Appendix E	x	Provider managed
Service Specification				

Service Title:	Respite
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>	
Service Definition (Scope):	

Respite 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

- Home health aide services (RHHA)
- Skilled nursing services (RSKNU)
- **Temporarily expand settings for Respite to be provided in closed adult day service provider congregate setting during the COVID-19 public health emergency**
- **Temporarily expand settings for Respite to be provided in a nursing facility as respite providers for waiver participants who are unable to receive care due to provider agencies and facilities placing services on hold due to COVID-19**
- Room and board is not included. Respite services provided in these setting will not be extended for more than 30 days.

SERVICE STANDARDS

If respite occurs in a HCBS certified facility targeting children and young adults twenty-two (22) and younger, staff to participant ratio cannot be greater than 1 staff per 2 participants. When respite is provided in this environment, the intent is to provide support to families in an effort to avoid institutionalization of their children. The level of professional care provided under respite services depends on the needs of the participant and caregiver determined in the PCA.

RHHA:

A participant who is eligible for State Plan Home Health Services (HOHE) should be considered for respite home health aide under the supervision of a registered nurse. RHHA authorized hours would 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 care manager must coordinate with the agency to verify unused hours before requesting the additional hours. If there are unused hours, they must first be used before requesting additional hours. Agency providing respite service is responsible for tracking participant's respite hours, notifying participant, and care manager of hours used as well as hours remaining.

RSKNU: A participant who is eligible for State Plan Nursing Services (SKNU) must be considered for respite nursing services. RSKNU 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 care manager must coordinate with the agency to verify unused hours before requesting the additional hours. If there are unused hours they must first be used before requesting additional.

DOCUMENTATION STANDARDS

Care management Documentation Standards:

The care manager must identify the primary caregiver being relieved. The care manager needs to identify the primary caregiver is not being paid by the agency to respite themselves during this time.

The care manager must document needs and activities that require respite.

Provider Documentation Standards

- 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
- 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
- Documentation should include date and time, and at least the last name and first initial of the staff person making the entry. If the person providing the service is required to be a professional, that title must also be included (example: if a nurse is required to perform the service then the RN title would be included with the name)
- Any significant issues involving the participant requiring intervention by a health care professional, or care

manager that involved the participant also needs to be documented <ul style="list-style-type: none"> Specify applicable (if any) limits on the amount, frequency, or duration of this service Documentation must include the following elements: the reason for the respite and the type of respite rendered • Notification to the participant’s care manager and other un-skilled provider, within forty-eight hours, upon and changes to the participant’s person-centered service plan. 				
Specify applicable (if any) limits on the amount, frequency, or duration of this service:				
ACTIVITIES NOT ALLOWED				
<ul style="list-style-type: none"> Respite may not be used to replace services that should be provided under the Medicaid State Plan Respite will not be reimbursed when the owner of the organization is the parent of a minor child, the spouse of a participant, the attorney-in-fact (POA) of a participant, the health care representative (HCR) of a participant, or the legal guardian of a participant Respite must not duplicate any other service being provided under the participant’s service plan. Respite service to participants receiving Adult Family Care waiver service, or Assisted Living waiver service. 				
Provider Specifications				
Provider Category(s) <i>(check one or both):</i>	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
				Licensed Home Health Agency
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input checked="" type="checkbox"/>	Relative/Legal Guardian
Provider Qualifications <i>(provide the following information for each type of provider):</i>				
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>	
Licensed Home Health Agency	Waiving IC 16-27-1	-	DA Approved	
Verification of Provider Qualifications				
Provider Type:	Entity Responsible for Verification:		Frequency of Verification	
Licensed Home Health Agency	DA		Up to 3 years	
Service Delivery Method				
Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input type="checkbox"/>	Provider managed

Service Specification

Service Title: Structured Family Caregiving

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

Service Definition (Scope):

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

Necessary support services are provided by the principal caregiver (family caregiver) as part of Structured Family Caregiving. 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. Caregivers receive training based on their 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 non-institutional 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 caregiver, HCBS Medicaid Waiver care manager and the Structured Family Caregiving provider. Participant needs shall be addressed in a manner that support and enable the individual to maximize abilities to function at the highest level of independence possible while caregivers receive initial and ongoing support in order to 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 caregivers being qualified as able to meet the participant's needs. The provider agency must conduct at a minimum of two quarterly y 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 capture daily notes that are completed by the family 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 and the State, upon request.

ALLOWABLE ACTIVITIES

Structured Family Caregiving includes (Levels 1-3)

Home and Community Assistance care services related needed IADLs.

Attendant care services related to needed ADLs.

Medication oversight (to the extent permitted under State law).

Escorting for necessary appointments, whenever possible, such as transporting individuals to doctor.

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.

Caregivers not living in the home of the participant is allowable if this arrangement began prior to February 1, 2020.

Unskilled Respite for the family caregiver for a maximum of fifteen (15) days per calendar year (funding for this respite is included in the per diem paid to the service provider, the actual service of Respite Care may not be billed in addition to the per diem).

Other appropriate supports as described in the individual's service plan

SERVICE STANDARDS

- Agency providers must demonstrate 3 years of delivering services to elders and adults with disabilities and their caregivers in Indiana or as 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 PCA.
- Agency providers 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 throughout the day based on the participant's daily needs.
- Structured Family Caregiving is provided in a private residence and affords all of 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 quarterly home visits 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.
- Caregivers receive a minimum of 8 hours in person annual training that reflects the participant's and caregiver's assessed needs. Training may be delivered during quarterly home visits, or in another manner that is flexible and meaningful for the caregiver.
- Agency providers must work with participants and caregivers to establish backup plans for emergencies and other times when the principal caregiver is unable to provide care.
- Paid unskilled respite services must be provided by a qualified caregiver familiar with the participant's needs during those times when the primary caregiver is absent from the home or otherwise cannot provide the necessary level of 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.
- Employees of Agency providers who provide medication oversight, as addressed under Allowable Activities, must receive necessary instruction from a doctor, nurse, or pharmacist regarding medications prescribed to the participant.

DOCUMENTATION STANDARDS

Identified need in the service plan,

Services outlined in the service plan,

Care manager must give the completed PCA to the provider,

Documentation to support service rendered include:

- Electronic caregiver notes that record and track the participant's status, and updates or significant changes in their 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 agency provider in order 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 and investigate and refer reportable events to the Waiver Care manager.
- Documentation of home visits conducted by the registered nurse and caregiver coach.
- 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 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).

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

ACTIVITIES NOT ALLOWED

- Structured Family Caregiving service will not be reimbursed when provided by a parent of a minor child participant,
- 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 nurse or other health professional.
- Separate payment will not be made for Home and Community Assistance, Transportation, Attendant Care, Assisted Living, or Adult Family Care. Removing above restriction for Home and Community Assistance, Transportation, and Attendant Care.

Provider Specifications

Provider Category(s) (check one or both):	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
				FSSA/DA approved Structured Family Caregiving Agency

Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input checked="" type="checkbox"/>	Relative/Legal Guardian
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Provider Qualifications (provide the following information for each type of provider):

Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
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FSSA/DA approved Structured Family Caregiving Agency			Provider and home must meet the requirements of the Indiana Adult Foster Care Service Provision and Certification Standards. DA 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
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Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
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Agency	DA Certification	At least every three years
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Service Delivery Method

Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed
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ⁱ Numerous changes that the state may want to make may necessitate authority outside of the scope of section 1915(c) authority. States interested in changes to administrative claiming or changes that require section 1115 or section 1135 authority should engage CMS in a discussion as soon as possible. Some examples may include: (a) changes to administrative activities, such as the establishment of a hotline; or (b) suspension of general Medicaid rules that are not addressed under section 1915(c) such as payment rules or eligibility rules or suspension of provisions of section 1902(a) to which 1915(c) is typically bound.