MEDICAID
HOME AND COMMUNITY BASED WAIVERS FOR THE AGED AND DISABLED
The Indiana Plan for Aging in Place

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Elder Law Institute
October 13, 2017

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KEITH P. HUFFMAN

Keith P. Huffman received his undergraduate education from Adrian College and his legal education from Indiana University. Mr. Huffman is a frequent speaker on elder law issues and has served as the President of the Indiana Chapter of the National Academy of Elder Law Attorneys and is past Chair of the Elder Law Section of the Indiana Bar Association. Mr. Huffman is a member of the Ethics Committee at Bluffton Regional Medical Center, Chairman of Aging & In-Home Services Board of Directors, and a member of the Fort Wayne Lutheran Hospital Institutional Review Committee. Keith Huffman was named the Citizen of the Year by the Wells County Chamber in 2003 and was named as the outstanding member of the Indiana National Academy of Elder Law Attorneys in 2009.

In 2016, The National Academy of Elder Law Attorneys (NAELA) recognized Mr. Huffman as the 2016 Powley Award winner. This Award is presented annually to a NAELA member who is recognized in his or her community as a leader in promoting a greater understanding of the rights and needs of the elderly and people with special needs, and of how Elder Law attorneys advocate for those rights.

Mr. Huffman lives in Bluffton with his wife, Suzanne, and is the father of three sons and five grandsons. The law firm of Dale, Huffman & Babcock has offices in Bluffton and Ossian, Indiana.

It is the best of times. It is the worst of times. I paraphrase the immortal words from Charles Dickens, A Tale of Two Cities, to describe the current waiver programs in Indiana.

Indiana currently ranks 45th among all states in the proportionate funding of institutional care, instead of residential care. The Indiana Division of Aging has invited groups across the state to improve care for the aged and disabled in their homes. We have a responsibility to our clients and our families to help implement the needed changes to our system.

There are three main programs I expect to be used to improve residential care for aged and disabled Hoosiers needing nursing home level of care. We need to advocate for a relaxation of the nursing home level of care standard before waiver services are approved to prevent clients from reaching this level of care. The first two programs are under the umbrella of Consumer Directed Care. These programs are Self-Directed Care and Structured Family Care.

Self-Directed Care

We currently have about 375 consumers who hire family members or neighbors to care for them in their home or apartment. There is a Consumer-Directed Attendant Care Guide manual that details how a person can be hired, the duties the person can perform, and how the caregiver will be paid. The State of Indiana has committed to expand this program in the next 9 – 18 months.

Structured Family Care

This program was started in 2013 in Indiana. There are currently 674 families participating in this program. The State of Indiana plans to expand this program in the next 9 – 18 months.

The caregiver, usually a family member, lives with the waiver recipient. The caregiver is paid a nominal stipend to provide care and support: assisting with personal care, aiding in compliance with medical appointments, and providing appropriate social

supports in the community. The caregiver checks in daily with a multi-disciplinary support team. The cost savings are dramatic. The overall aged and disabled waiver recipient in the State plan costs $1,609 per month per enrollee compared to $391 per month for enrollees in the Structured Family Care program. The more important point is mom would rather have a daughter help her than a stranger.

Silver Birch

There are new assisted living providers building in Indiana.

They are taking advantage of multi-family housing revenue bonds and the Low-Income Housing Tax Credit. The facilities include co-located support services, including meals, housekeeping and medication assistance. These programs offer "affordable assisted living."

Silver Birch is one of the companies participating in this new marketplace. They currently have facilities in Hammond, Kokomo, Michigan City, and plan to enter other areas of Indiana.

PACE

This is the Program of All-inclusive Care for the Elderly. Please see Exhibit E for information about PACE.

INDIANA MONEY FOLLOWS THE PERSON

The Money Follows the Person ("MFP") program is funded through a grant from CMS. Indiana was approved for MFP in 2007. Indiana's program is designed to move participants out of a hospital or nursing home into a "qualified residential setting." This term includes:

1. A home owned or leased by the person or family member.

2. A leased apartment that has living, sleeping, bathing, and cooking areas. The apartment must have lockable access and be under the control of the individual or the individual's family.
3. Adult Foster Care (now Adult Family Care) which has four or fewer unrelated individuals living together.
4. Assisted Living.

Eligibility

- You must have a hospital/nursing home stay of at least 90 consecutive days.
- You must need long term nursing home level of care (PASRR).
- You must be eligible for Medicaid at least one day prior to discharge.
- You must have health needs and a support structure to allow you to live safely in the community in a qualified residential setting.
- You must be eligible to participate in the A&D Waiver or the TBI Waiver.
- You must sign a consent form to participate.

The Indiana grant program is administered by the Indiana Division of Aging. The Division has contracted with Area Agencies on Aging to provide services to eligible Hoosiers. There is a tremendous amount of funding for this program at present. This should be the first waiver program you refer clients to if they are eligible.

Application

The application process is very easy. You call your local Area Agency on Aging and say you are interested in applying for MFP services.

The Area Agency on Aging assigns a Case Manager. The Case Manager assigned to the individual will meet with the individual within 24 hours of nursing facility discharge and then weekly for six weeks. The Case Manager is responsible for coordinating services to meet the needs of the participant for the remainder of the MFP

period. At a minimum, the Case Manager will check in quarterly during the first year. The MFP participant moves to the A&D Waiver, or TBI Waiver, as long as they continue to meet level of care at the end of the year without being placed on a wait list.

The requirements for eligibility as a Medicaid recipient are verified by the Indiana AIM.

Community Transition Funds

An individual may receive up to $1500 for help in moving out of an institution. The funds can be used to purchase furniture and other essential household items.

The Case Manager will prepare a written Service Plan describing the medical and other services to be furnished, their frequency, and the type of provider that will furnish each service.

Personal Emergency Response System (PERS) and Hotline

This can be a medical device connected to a person's phone and programmed to notify a response center once the help button is pushed. The response center is staffed around the clock. There are other devices used to notify the response center, depending on the needs of the particular person. MFP participants will receive access to a 24-hour hotline for after-hours emergency services for increased health and safety.

Funding

The Indiana grant has been funded through 2020. There were approximately 380 Hoosiers enrolled in this program and receiving services at the end of August 2015. This means 380 Hoosiers who ordinarily would be in a nursing home are able to stay in the community. You can get more information about MFP from the Indiana Division of Aging at 1-317-234-5715. The contact person is Ellen Burton.

Services

The available services for the MFP participant are the same services as the Aged and Disabled and Traumatic Brain Injury Waivers. We have attached a list of these services. Please note this includes self-directed attendant care for the appropriate situation. These services may also incorporate additional services/equipment under the Medicaid prior authorization program.

Transition

Services are provided for up to 365 days. The participant is then enrolled in an Indiana Home and Community-Based Services waiver program.

AGED AND DISABLED WAIVER

Recipients of the Aged and Disabled Waiver live in a community setting. They are initially approved for level of care services through a notice of action from the Division of Aging. The notice of action contains a list of approved service hours, which are generally for non-medical services such as housekeeping, public feeding assistance, respite care, etc.

The waiver recipient often needs additional services. The care provider can submit a request for Prior Authorization to obtain additional medical care. The Prior Authorization request procedure is spelled out in Chapter 6 of the Indiana Health Coverage Programs Provider Manual.

TIP: You should read Chapter 6 and be aware of the Prior Authorization rules. These services include, but are not limited to:

(1) Durable medical equipment and home medical equipment
- Hospital bed
- Non-motorized wheelchair
- Home oxygen therapy

(2) Out-of-State health care
(3) Request for additional transportation services

(4) Home health nursing services
(5) Food supplements

The call comes in to the Area Agency on Aging. The family is desperately in need of a Medicaid Waiver for an aged (65 or over) or disabled family member. The call is routed to the Aged and Disabled Resource Center (ADRC) options counselor.

The options counselor does a telephone triage to see if the family member appears to meet the necessary level of care for waiver services. The counselor uses the eligibility screen to make an immediate determination of eligibility for services. A favorable immediate determination results in a face-to-face meeting to determine eligibility.

The counselor then starts the assessment process in the Indiana Database (The Insite System will be phased out in 2018). Frequently, the Medicaid category needs to be changed if the client is already receiving some services under the enhanced Medicare Savings Program. The change is to MA A (Aged) or MA D (Disabled) from:

MA L (Qualified Medicare Beneficiary up to 150% FPL);

MA J (Special Low Income Medicare Beneficiary benefit 151%-170% FPL); or

MA I (Qualified Medicare Beneficiary 171%-185% FPL).

The counselor then mails the family information about eligibility for waiver services. For those who do not immediately appear to meet the necessary level of care, they receive a denial notice with their appeal rights. The folks that appear to meet the appropriate level of care are assigned a Case Manager to work up the case.

The patient has met the initial level of care via the telephone assessment, the forms have been mailed to the patient for the doctor to complete, and the patient is now considered “targeted” in the Indiana Database.

The Pre-Admission Screening and Resident Review (“PASRR”) process is the same for waiver services and nursing home admission. The Indiana PASRR screening is then completed under the system administered by Ascend Management Innovations. This new system is designed for level of care approval within hours of submission of the clinical data.

The Area Agency on Aging now assigns a Case Manager to the applicant. Area 3 makes these assignments on a daily basis. The Case Manager then has 20 business days to complete the paperwork and send the completed paperwork to the supervisor for review before it goes to the State for final approval. The Case Manager schedules the face-to-face meeting. These meetings usually take 1½ to 2 hours. The Case Manager documents level of care in the face-to-face meeting. The patient is given a list of the waiver services provided in the Area called a provider pick list. The 450B form is mailed to the applicant's doctor for completion.

If the face-to-face meeting goes well, the patient meets level of care. The Case Manager (there are 28 in Area 3) then completes the Service Plan (formerly the Plan of Care and the Cost Comparison Budget).

The State then approves the Service Plan. You are now able to file an application for Medicaid for your client. You will want to do this as soon as possible, as your client will not start receiving services until the RID (Recipient ID) number is obtained.

TIP: Case Managers check the Indiana Database every month to see if their clients have Medicaid eligibility. You should immediately notify the Case Manager at the Area Agency on Aging when Medicaid is obtained so services will start as soon as possible.

TIP: When you represent single folks, consider an early application for the enhanced Medicare Savings Program so they will already be eligible for services when the CCB is approved by the State.

TIP: Do not let the Case Manager tell you the client must be approved for Medicaid before applying for waiver services.

The State then issues the Notice of Action form showing the number of hours of approved services for the at-home waiver recipient. These can be for respite care for the

caregiver or for other services shown on Exhibit B. The average hours approved are 40-60 hours per month for at-home waiver recipients. The actual hours approved are based on need.

The service provider can then request additional hours of care under the Prior Authorization system. Case Managers are not directly involved in approving Prior Authorization of services.

Case Processing Time – What to Tell Your Clients

When we meet with clients to discuss waiver application for an applicant at home, we generally tell them it takes 3 to 4 months before services are actually started. Please see Exhibit D for a timetable for several recent Medicaid waiver applications.

These folks already meet nursing home level of care and are in dire need for services. The sooner they get services, the more likely they are to stay at home.

The Indiana Division of Aging released a new Home and Community Based Service Report on October 2, 2017. This report contains two important proposals to help obtain services sooner for applicants. These are:

(1) The DFR is now working with a vendor to electronically obtain asset verification to speed up the Medicaid application process. Implementation is expected in the second quarter of 2018. (Page 52)

(2) The State is considering a "Presumptive Eligibility" determination allowing applicants who meet level of care to immediately receive services while they pursue Medicaid approval for continued coverage. The report notes Ohio residents may receive services for up to 90 days while the Medicaid application is pending. Ohio does not recover the cost if Medicaid is not approved (Page 52 of the Report).

WHAT TO TELL YOUR CASE MANAGER WHEN YOU ARE TOLD YOU MUST FILE FOR MEDICAID BEFORE APPLYING FOR WAIVER SERVICES IN INDIANA

Indiana adopted strict income and asset rules for aged and disabled Hoosiers on July 1, 2017. The levels for 2017 are:

	Income	Countable Resources
Single	$1,005	$2,000
Married	$1,354	$3,000

There is no reason to apply for Medicaid if your income/assets are above these levels. You will not be approved.

The income and asset rules change dramatically once a person enters a nursing home or has a service approved for the Aged and Disabled Waiver.

The asset test remains at $2,000 of countable resources for single folks. The spousal impoverishment rules apply for married couples.

Special Rules for Waiver Recipients in Assisted Living Facilities

The waiver recipient in assisted living usually pays a monthly room and board expense of $735 (this changes as the SSI maximum award for a household of 1 changes). The amount will be less if the applicant does not have sufficient funds to pay his or her personal needs allowance, supplemental health insurance costs, and spousal allocation, if any.

The participating facility must have basic rooms available at the minimum rate. The waiver recipient is permitted to occupy a larger room or a single room and pay the additional charge for this room.

The facility is paid one of three different rates by the State, depending on level of care. The 2017 daily rates are:

Level 1	$71.27
Level 2	$78.54
Level 3	$86.68

Waiver Changes for Assisted Living Residents

Several major changes in the Indiana Medicaid program occurred in 2017 that help disabled Hoosiers pay for the cost of assisted living care. There are about 2,500 Hoosiers who pay for their assisted living costs with assistance from Medicaid. These folks need nursing home level of care and have countable resources of $2,000 or less. They pay about $735 each month for room and board, and Medicaid pays the facility one of three rates, depending upon how much care the resident receives.

Most assisted living providers in Indiana are located in a senior living facility that has independent living, assisted living, and nursing home care. These facilities will no longer be able to participate in the assisted living waiver program for new residents as of May 8, 2017. Current residents will be allowed to stay in place until March of 2019.

This change will reduce the number of assisted living residents on the waiver program by about 75%. The State is working on replacement waiver programs. This change is required by the Home and Community Based Services rules adopted by CMS. The goal is to move the waiver program to more independent living areas and out of institutional care where residents do not have as many freedoms as most of us enjoy.

This change will require new facilities to give residents more rights, such as:

- The freedom to have visitors at any hour
- The right to have food as they want to instead of rigid meal times
- The right to lock their door
- The right to have privacy in their sleeping area
- The right to choose a roommate, if a roommate is needed

These changes will be difficult for many Hoosiers that will be denied assisted living care as the State transitions to move residents to less restrictive settings. We are hopeful these changes will improve the way services are provided to Hoosiers who need nursing home care but can live in a less restrictive environment.

ALERT: Serma Verma, CMS Administrator, and Dr. Thomas E. Price, (then) Secretary of Health and Human Services, mailed a letter on March 14, 2017, to all of the Governors. This letter included the following:

> CMS has worked with our state partners and other stakeholders to implement provisions of the final regulation defining a home and community-based setting. In recognition of the significance of the reform efforts underway, CMS will work toward providing additional time for states to comply with the January 16, 2014, Home and Community Based Services (HCBS) rule. Additionally, we will be examining ways in which we can improve our engagement with states on the implementation of the HCBS rules, including greater state involvement in the process of assessing compliance of specific settings."

Most presumed noncompliant assisted living facilities have submitted a remediation plan to the Division of Aging. We are not aware of any approvals of these remediation plans as of the date of this paper.

Snapshot Date

Clients sometimes have prior snapshot dates from a previous fall, illness, or surgery. The resource assessment (RA) is easy to determine in these situations. However, in many situations, clients will not have a prior snapshot date. The resource assessment becomes tricky at this point. IHCPPM Section 3320.05.00 states:

When a married person first enters a nursing home or hospital (or a combination thereof) for more than 30 consecutive days after September 30, 1989, a snapshot (resource assessment) is taken of their assets to determine Medicaid eligibility. When the Medicaid applicant for waiver services has a prior snapshot date, you then know what resource level the married couple has to be below so the applicant can be approved.

The snapshot date for waiver applicants without a prior institutional stay is either the date of application for Medicaid or the date the Cost Comparison Budget (CCB) is approved, whichever is later (Section 3320.05.00 IHCPPM).

Example: CCB completed August 1, 2017. Medicaid application filed August 5, 2017. August 5th is now the snapshot date, so a financial plan can now be implemented to establish eligibility as of September 1st.

TIP: Know the waiver supervisor at your local Area Agency on Aging. Periodically, let the supervisor know the clients you are applying for waivers via email. This allows the waiver supervisor to email the CCB approval to you. This helps your client get the needed services sooner.

Special Income Level

As of June 1, 2014, you need to consider the Special Income Level (SIL) for the waiver applicant (Section 3315.00.00 IHCPPM). When the applicant's income exceeds $2,205 (2017 level) per month, you will want to set up and appropriately fund a Qualified Income Trust in the month before the CCB is completed.

Hospice and Waiver Services

Hospice is a Medicare benefit. An eligible Medicare beneficiary who elects the hospice benefit may also utilize the waiver program for additional services. The hospice provider must work with the waiver Case Manager so there is no duplication of services provided.

VA and Waiver Services

The Veterans Administration provides home health care to disabled veterans and their disabled spouse in some situations. The person may also be eligible for waiver services under Medicaid. The Medicaid Case Manager must work with the VA Case Manager to insure there is not duplication of services.

The Medicaid Waiver Request for Approval (RFA) Process

Aged & Disability waiver recipients may need help with vehicle modifications, environmental modifications, specialized medical equipment, etc. These services are generally requested by the Case Manager and approved by Indiana Professional Management Group, Inc. (IMPG).

Permitted Environmental Modifications include:

- Anti-Scald Device
- Grab Bars
- Stand Lift
- Single Room Air Conditioners
- Ramps
- Bathroom Modifications
- Maintenance of these items ($500 yearly cap).

Vehicle modifications include:

- Wheelchair lifts
- Wheelchair tie downs
- Power transfer seat
- Maintenance for these items ($500 yearly cap).

Specialized Medical Equipment:

- Lift Chairs
- Generators
- Other Specialized Equipment

Aging & In-Home Services of Northeast Indiana, Inc. _____ Due Date
Case Management Services Department
Initial Checklist for Targeted A & D Waiver

EXHIBIT A

Date Targeted _____ Date submitted _____
Client _____ County _____
Case Manager _____ Supervisor_____
MA Status: Needs to apply___ Wkg with atty_____ Has Medicaid_____
_____LOC CODE: _____

Case Manager completes the following using dates:

_____ Target Notice & CSR (complete a CSR documenting the day received, the target date & the date the assessment is to be completed)
_____ Contact client **w/in 3 business days to discuss targeting and redetermine eligibility**
_____ **if client does not have Medicaid ask if they will be ready to apply within 6 weeks**
_____ ***If not proceeding with service at this point, complete CSR and update Status and WL tabs, print CSR and status, change pend notes to Wvradmin AD and turn in file to Supervisor.*** **Cmgr should not complete the DEW.**
Check 'in-home services client' box on client tab in INsite and set up Appt to be completed within the next 5 business days.
_____ confirm physician and mail 450B to be completed and signed
_____ Application – print from INsite and have client sign
_____ Person Centered Planning Tool- discussion with client
_____ ACCM – update Nutrition risk score and special needs tab
_____ Income tab – complete in INsite
_____ Complete long form InterRAI and create new escreen
_____ complete Form 11 (with required signature of client or guardian)
_____ have Form 11 sec 2 signed by BDDS (if triggered by "yes" on Form 11–questions 6–8 this is for MR-DD indicators)
_____ Agency folder given to client – review information with client
_____ HIPAA Release to Authorize PHI – client signs- leave WHITE copy with client
_____ HIPAA Acknowledgement of Receipt of Privacy Practices, signed by client
_____ FSSA Release for MA Agency Portal, signed by client
_____ Give client Consumer Guide for Choosing Providers
_____ PICK LIST for CMGT with client signature (choice of Case Manager offered)
_____ PICK LIST for Choice of Vendors offered - for each service – with client signature
_____ Home Visit form- signed by client (leave white copy with client)
_____ Voter registration offered and documented (completed ones to clerical within 4 days)
_____ Medicare Extra Help, Falls Clinic, and or ACP Handout offered and documented
_____ Complete IA CSR and 90-Day checklist **(bill to:WVRADM-AD, Initial face to face visit)**
_____ review Medicaid Info on IndianaAIM (click on Red Indiana icon on CCB tab)
_____ Complete Safety Screening tool
_____ Complete and sign IA Cover Letter
_____ enter Cost Comparison Budget (CCB) using LOC code at top of page
_____ Acquire applicant / guardian signatures
_____ Finalize CCB--- Turn in only completed signature page and service needs memo
_____ Complete CMGR portion of LOC Review Form in INsite – enter DD Eligibility comments if client has a DD diagnosis
_____ Status History - Review for accuracy – do not print
_____ Self-Directed ATTC – if requesting self-directed ATTC, complete checklist on Waiver tab
_____ IA packet containing the above forms submitted to supervisor.

SUPERVISOR : for terminated targets
On the waiver waiting list tab:
____ complete DEW to remove only if ccb sent to state and "needs confirmed"
____ if not meeting loc, complete dew "code J"-not meet initial loc
____ print status and dew/appeal pages
____ check to make sure pend notes corrected
____ if app, enter F/F paypoint
____ Cover letter for change
___ turn packet into TinaB

CMGT HRS Billing: Bill **CMGT** time to **PEND-** Bill **Travel** to **Non-Billable/Non-client-** Activity code-Travel 1

INITIAL A&D_____ **CLIENT**_____

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LEVEL OF CARE

Supervisor(sign)_____

_____ Review packet
_____ Verifies CCB has been moved
_____ Reviews, signs and dates 450B
_____ Completes LOC Form and prints
_____ LOC Review Form is OK to Export
_____ Marks CCB reviewed before export
_____ Marks export test "ok" for CCB
_____ Check ACP info in special needs
_____ **Enter pay points for Wvr Face to Face and Wvr Initial Service Plan**
_____ Packet to **Dixie**

****

DIXIE:

_____ Transmit LOC Review Form (note export date)
_____ Transmit CCB to State (note export date); if doesn't transmit in 2-3 days, notify Supervisor
_____ Hold Packet for CCB Approval Letter from State
_____ Gives packet with CCB approval letter and LOC approval (state only) to Supervisor
SUPERVISOR _____ reviews and gives Packet to case manager

CASE MANAGER - Initial Packet Approved by State – Confirm Waiver Start Date

Do Not Start Services Until Final CCB Approval and NOA is Received and Spend Down removed

_____ CM receives packet back from Supervisor with written notice from State verifying Slot #, & CCB & LOC approval.
_____ See attached confirmation letter for any special instructions re: eligibility, spend-down, Mgd Care

******DO NOT PROCEED FURTHER UNTIL ALL ITEMS ON CONFIRMATION LETTER ARE RESOLVED****

_____ CM will enter the confirmation date (Waiver Start Date from attached letter)
Start Date cannot be before NF discharge date
_____ **Schedule quarterly visit asap if 90 day visit has not been completed in last 3 months**
_____ Packet to Supervisor
SUPERVISOR _____ Review Packet and give to Dixie
DIXIE _____verifies confirmation exports to State and hold packet for approval
_____ attach NOA to packet
_____ Packet to Supervisor
SUPERVISOR _____ reviews and gives Packet to case manager.
CASE MANAGER - the following is completed once State has approved confirmation of the INITIAL CCB
_____ Contacts and confirms services with vendor and client
_____ Update status codes on Client Tab in INsite
_____ Remove any non-wavier waiting list entries on Wtg List Tab in INsite
_____ CM changes payor source on case notes
_____ All "PEND" notes prior to confirmation date change to WVRADM_AD
_____ All "PEND" notes after confirmation date change to AD
_____ For Clients on active CHOICE or SSBG please terminate those services the month waiver starts
_____ **Write in dates you assisted client with Medicaid application if appropriate**_____
_____ if client is transferring programs (e.g.: MFP to AD, DD to TBI, etc.) coordinate start date with AIHS supervisor and state program reps
_____ **Mark your calendar for 30 day follow up contact, document under 30 day f/u activity**
_____ CM Returns packet to **Supervisor**
SUPERVISOR _____ **enter pay point for Wvr Medicaid assistance if appropriate**, review packet and turn into Dixie

Dixie

_____ Mail to Client:

- Print "Approved" copy of CCB
- NOA with State signature
- LOC Form and Cover letter
- Fax copy of NOA for Nut Supp if appropriate

_____ Processes and files packet

EXHIBIT
B

Home and Community Based Waiver service provider.

Aged and Disabled Waiver (A&D)

The A&D Waiver provides an alternative to nursing facility admission for adults and persons of all ages with a disability. The waiver is designed to provide services to supplement informal supports for people who would require care in a nursing facility if waiver or other supports were not available. Waiver 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 Family Care.

Services

Adult Day Services (ADS), Adult Family Care (AFC), Assisted Living (AL), Attendant Care, Case Management, Community Transition Services, Environmental Modifications, Environmental Modification Assessment, Health Care Coordination, Homemaker, Home Delivered Meals, Nutritional Supplements, Personal Emergency Response Systems (PERS), Pest Control, Respite, Specialized Medical Equipment & Supplies, Structured Family Care-giving, Transportation, Vehicle Modifications

Adult Day Services (ADS) - Adult Day Services are community-based group programs designed to meet the needs of adults with impairments through individual plans of care. These structured, comprehensive, non-residential programs provide health, social, recreational, and therapeutic activities, as well as supervision, support services, and personal care. These services must be provided in a congregate, protective setting and meals and/or nutritious snacks are required.

Adult Family Care (AFC) Adult Family Care is a comprehensive service in which the participant of services resides with an unrelated caregiver in order for the participant to receive personal assistance designed to provide options for alternative long term care to individuals who meet nursing facility level of care and whose needs can be met in a home-like environment. The participant and up to three(3) other participants who are elderly or have physical and/or cognitive disabilities who are not members of the provider's or primary caregiver's family, reside in a home that is owned, rented, or managed by the Adult Family Care provider. Participants selecting the AFC service may also receive Case Management Services, Adult Day Services, Specialized Medical Equipment and Supplies and Health Care Coordination through the waiver. TBI participants may also receive: Behavior Management, Structured Day Program, Individual and Group and Supported Employment.

Assisted Living (AL) – Assisted Living Service is defined as personal care, homemaker, chore, attendant care and companion services, medication oversight (to the extent permitted under State law), therapeutic social and recreational programming, provided in a home-like environment in a residential facility which is licensed by the Indiana State Department of Health, in conjunction with residing in the facility. This service includes 24 hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence,

and to provide supervision, safety and security. Participants may also receive Case Management Services, Specialized Medical Equipment and Supplies and Health Care Coordination through the waiver.

Attendant Care (ATTC) - Attendant Care services primarily involve hands-on assistance for aging adults and persons with disabilities. These services are provided in order to allow older adults or persons with disabilities to remain in their own homes and to carry out functions of daily living, self-care, and mobility.

Case Management - Case Management is a comprehensive service comprised of a variety of specific tasks and activities designed to coordinate and integrate all other services required in the individual's care plan. Case Management is required in conjunction with the provision of any home and community-based service.

Community Transition Services - Community Transition Services include reasonable, set-up expenses for individuals who make the transition from an institution to their own home where the person is directly responsible for his or her own living expenses in the community and will not be reimbursable on any subsequent move. Reimbursement is limited to a lifetime cap for set up expenses up to $1,500.

Environmental Modifications - Environmental Modifications are minor physical adaptations to the home, as required by the individual's Plan of Care/Cost Comparison Budget. The modifications must be necessary to ensure the health, welfare and safety of the individual and enable the individual to function with greater independence in the home, and without which the individual would require institutionalization. Maintenance is limited to $500 annually for the repair and service of environmental modifications that have been provided through the waiver. There is also a lifetime cap of $15,000.

****Environmental Modification Assessment** is a service which determines the scope and specifications for environmental modifications necessary to enable an individual to function with greater independence within their home, and without which they would require institutionalization. The Assessor reviews the feasibility and writes the specifications which serve as the criteria for obtaining and evaluating bids. Upon completion of the work the Assessor conducts a post-project inspection to assure project completion.

Health Care Coordination - Health Care Coordination includes medical coordination provided by a Registered Nurse to manage the health care of the individual including physician consults, medication ordering, and development and nursing oversight of a healthcare support plan. Skilled nursing services are provided within the scope of the Indiana State Nurse Practice Act. The purpose of Health Care Coordination is stabilization; prevention of deteriorating health; management of chronic conditions; and/or improved health status.

Homemaker - Homemaker services offer direct and practical assistance consisting of household tasks and related activities. The services assist the individual to remain in a clean, safe, healthy home environment and are provided when the individual is unable to meet these needs or when an informal caregiver is unable to meet these needs for the individual.

Home Delivered Meals – Home Delivered Meals are nutritionally balanced meals that help prevent institutionalization because the absence of nutrition in individuals with frail and disabling conditions presents a severe risk to health. No more than two meals per day will be reimbursed under the waiver.

Nutritional Supplements – Nutritional Supplements include liquid supplements, such as "Boost" or "Ensure" to maintain an individual's health in order to remain in the community. Supplements should be ordered by a physician based on specific life stage, gender, and/ or lifestyle. There is an annual cap of $1,200.

Personal Emergency Response Systems (PERS) - Personal Emergency Response Systems (PERS) are electronic devices which enable certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable help button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed 24 hours daily/ 7 days per week by trained professionals.

Pest Control - Pest Control services are designed to prevent, suppress, or eradicate anything that competes with humans for food and water, injures humans, spreads disease and/or annoys humans and is causing or is expected to cause more harm than is reasonable to accept. Pests include insects such as roaches, mosquitoes, and fleas; insect-like organisms, such as mites and ticks; and vertebrates, such as rats and mice. There is an annual cap of $600.

Respite - Respite services are those services that are provided temporarily or periodically in the absence of the usual caregiver. Service may be provided in an individual's home; the private home of the caregiver, or in a Medicaid certified nursing facility. For those individuals receiving the service of Adult Family Care, funding for respite is already included in the per diem amount and the actual service of respite may not be billed. The level of professional care provided under respite services depends on the needs of the individual. An individual requiring assistance with bathing, meal preparation and planning, specialized feeding, such as an individual who has difficulty swallowing, refuses to eat, or does not eat enough; dressing or undressing; hair and oral care; and weight bearing transfer assistance should be considered for respite home health aide under the supervision of a registered nurse. An individual requiring infusion therapy; venipuncture; injection; wound care for surgical, decubitus, incision, ostomy care; and tube feedings should be considered for respite nursing services (RNUR).

Specialized Medical Equipment & Supplies - Specialized Medical Equipment and Supplies are medically prescribed items required by the individual's Plan of Care/Cost Comparison Budget, which are necessary to assure the health, welfare and safety of the individual, which enable the individual to function with greater independence in the home, and without which the individual would require institutionalization. Individuals requesting authorization for this service through the waiver must first exhaust eligibility of the equipment or supplies through the Indiana Medicaid State Plan. There should be no duplication of services. Maintenance is limited to $500 annually for the repair and service of items that have been provided though the waiver.

****Structured Family Caregiving** is a service through which a participant receives care in their own home or the home of a principal caregiver. The principal caregiver cannot be the participant's spouse, the parent of a participant who is a minor, or the legal guardian of the participant. Only agencies may offer Structured Family Caregiving. All Structured Family Caregiving settings must be approved and supervised by the provider agency and all paid caregivers are trained and paid by the provider.

Transportation –Transportation Services enable individuals served under the waiver to gain access to waiver and other community services, activities and resources, specified by the plan of care. Transportation services under the waiver shall be offered in accordance with an individual's plan of care and whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, if applicable, and shall not replace them.

Vehicle Modifications - Vehicle Modifications are the addition of adaptive equipment or structural changes to a motor vehicle that permit an individual with a disability to be safely transported in a motor vehicle. Vehicle modifications, as specified in the Plan of Care/Cost Comparison Budget, may be authorized when necessary to increase an individual's ability to function in a home and community based setting to ensure accessibility of the individual with mobility impairments. These services must be necessary to prevent or delay institutionalization. The necessity of such items must be documented in the plan of care by a physician's order. Vehicles necessary for an individual to attend post secondary education or job related services should be referred to Vocational Rehabilitation Services. Maintenance is limited to $500 annually for repair and services of items that have been funded though the waiver and there is a $15,000 lifetime cap

*** Indicates Aged and Disabled services only*

EXHIBIT C

Specialized Medical Equipment and Supplies	Unit	916	2.00	404.08	740274.56	
Structured Family Caregiving Total:						11355301.98
Structured Family Caregiving	Day	809	198.00	70.89	11355301.98	
Transportation Total:						2001654.00
Transportation	Trip	549	200.00	18.23	2001654.00	
Vehicle Modifications Total:						231247.98
Vehicle Modifications	Unit	43	1.00	5377.86	231247.98	
				GRAND TOTAL:		240776750.36
				Total Estimated Unduplicated Participants:		21153
				Factor D (Divide total by number of participants):		11382.63
				Average Length of Stay on the Waiver:		271

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Service Total:						7087194.36
Adult Day Service	1/4 Hour	762	2934.00	3.17	7087194.36	
Attendant Care Total:						98709778.75
Attendant Care	1/4 Hour	11435	1825.00	4.73	98709778.75	
Case Management Total:						22069330.40
Case Management	Monthly	22087	10.00	99.92	22069330.40	
Homemaker Total:						14694033.90
Homemaker	1/4 Hour	5971	631.00	3.90	14694033.90	
Respite Total:						28377994.32
Respite	1/4 Hour	3588	1158.00	6.83	28377994.32	
Adult Family Care Total:						1455695.60
Adult Family Care	Day	67	290.00	74.92	1455695.60	
Assisted Living Total:						64104988.20
Assisted Living					64104988.20	

	Day	3470	253.00	73.02		
Community Transition Total:						**33648.24**
Community Transition	Unit	38	1.00	885.48	**33648.24**	
Environmental Modification Assessment Total:						**84893.67**
Environmental Modification Assessment	Unit	311	1.00	272.97	**84893.67**	
Environmental Modifications Total:						**5118489.60**
Environmental Modifications	Unit	840	2.00	3046.72	**5118489.60**	
Health Care Coordination Total:						**25351.20**
Health Care Coordination RN Service	1/4 Hour	24	105.00	10.06	**25351.20**	
Home Delivered Meals Total:						**15859724.40**
Home Delivered Meals	Meal	9585	296.00	5.59	**15859724.40**	
Nutritional Supplements Total:						**92880.00**
Nutritional Supplements	Unit	180	100.00	5.16	**92880.00**	
Personal Emergency Response System Total:						**4285987.20**
Personal Emergency Response System	Unit	10758	10.00	39.84	**4285987.20**	
Pest Control Total:						**218927.52**
Pest Control	Unit	518	3.00	140.88	**218927.52**	
Specialized Medical Equipment and Supplies Total:						**803712.00**
Specialized Medical Equipment and Supplies	Unit	975	2.00	412.16	**803712.00**	
Structured Family Caregiving Total:						**13074371.10**
Structured Family Caregiving	Day	861	210.00	72.31	**13074371.10**	
Transportation Total:						**2290734.16**
Transportation	Trip	584	211.00	18.59	**2290734.16**	
Vehicle Modifications Total:						**246843.90**
Vehicle Modifications	Unit	45	1.00	5485.42	**246843.90**	
				GRAND TOTAL:		**278634578.52**
				Total Estimated Unduplicated Participants:		**22519**
				Factor D (Divide total by number of participants):		**12373.31**
				Average Length of Stay on the Waiver:		287

Time Line for Age & Disabled Waivers	Married Man at home - age 62	Married Man at home - age 74	Married Man at home - age 67	Married Man at home - age 86	Single Woman at home - age 74	Single Man at home - age 82	Single Woman living with daughter - age 101
When were we hired?	5/1/2017	5/15/2017	5/26/2017	3/16/2016	3/18/2017	6/5/2017	7/7/2016
When was the assessment completed?	5/23/2017	6/6/2017	6/5/2017	7/13/2016	4/19/2017	6/9/2017	11/1/2016
When was CCD approved?	6/22/2017	6/21/2017	6/20/2017	7/29/2016	5/25/2017	6/28/2017	12/12/2016
When was the Medicaid application filed?	7/18/2017	7/17/2017	8/14/2017	9/16/2016	8/1/2017	8/18/2017	1/26/2017
When was Medicaid approved?	8/31/2017	8/22/2017		10/4/2016	8/9/2017	8/31/2017	2/17/2017
When were services stated?	9/13/2017	8/28/2017		9/1/2016	8/1/2017	8/1/2017	1/1/2017
CASE MANAGEMENT							
What services are being provided?	AIS case management - monthly; respite home health aide - 45 hours/week	AIS case management - monthly; emergency response system - monthly; adult day services 2/week with transportation; home delivered meals 2/day	AIS case management - monthly; respie home health aide 60 hours/month hdm 3/week	AIS case management - monthly; home delivered meals - 7x/week; Lifeline; respite home health aide - 60 hours/mo	AIS case management - monthly; home delivered meals 7x/week; attendant care 20 hours/week	AIS case management - monthly; attendant care - 10 hours/week; homemaker - 6 hours/week	AIS case management - monthly; adult day services and transportation - 3x/week; home delivered meals - 7x/week; respite home health aide - 45 hours/month; nutrition supplements - monthly
Is the family satisfied?	Yes, overall	Wife is appreciative for all services	no services yet	yes, overall	yes, overall	no services yet	yes
Any suggestions for improvement?	no	no	no	self-directed attendant care? Better communication about whit is covered and how to sign up	no	no services yet	no
Were home modifications made?	no	no	no	no	no	working on this for bathroom modifications	no
Receiving travel help?	no	no	no	no	no	no	yes - to and from adult day services

Time Line for Age & Disabled Waivers	Single Woman at home - age 70	Married Woman at home - age 69	Married Woman at home - age 74
When were we hired?	6/12/2017	1/17/2017	3/11/2017
When was the assessment completed?	6/22/2017	2/1/2017	4/10/2017
When was CCD approved?	7/7/2017	2/24/2017	5/10/2017
When was the Medicaid application filed?	8/10/2017	3/16/2017	6/20/2017
When was Medicaid approved?	8/16/2017	4/21/2017	7/31/2017
When were services stated?	8/17/2017	4/1/2017	8/1/2017
CASE MANAGEMENT			
What services are being provided?	AIS case management - monthly; attendant care - 22 hours/week; home delivered meals - 7x/week; personal emergency response system - monthly	AIS case management - monthly; adult day services 2x/week; respite home health aide - 45 hrs/month	AIS case management - monthly; adult day services 5x/week; respite home health aide - 45 hrs/month
Is the family satisfied?	yes	yes	yes
Any suggestions for improvement?	no	no	no
Were home modifications made?	no	no	no
Receiving travel help?	no	no	could but husband enjoys driving her

EXHIBIT
E

CENTERS FOR MEDICARE & MEDICAID SERVICES

Quick Facts about Programs of All-Inclusive Care for the Elderly (PACE)

What are Programs of All-inclusive Care for the Elderly (PACE)?

PACE is a Medicare program and Medicaid state option that provides community-based care and services to people age 55 or older who otherwise would need a nursing home level of care. PACE was created as a way to provide you, your family, caregivers, and professional health care providers flexibility to meet your health care needs and to help you continue living in the community.

A team of health care professionals will give you the coordinated care you need. These professionals are also experts in working with older people. They will work together with you and your family (if appropriate) to develop your most effective plan of care.

PACE provides all the care and services covered by Medicare and Medicaid, as authorized by the health care team. They also cover additional medically-necessary care and services not covered by Medicare and Medicaid that the team may decide you need. PACE provides coverage for prescription drugs, doctor care, transportation, home care, checkups, hospital visits, and nursing home stays when necessary.

Who can join PACE?

You can join PACE if you meet the following conditions:

- You're 55 years old or older.
- You live in the service area of a PACE organization.
- You're certified by the state in which you live as needing a nursing home level of care.
- You would be able to live safely in the community if you get PACE services.

Note: You can leave a PACE program at any time.

PACE services include (but aren't limited to) the following:

- Adult Day Care
- Recreational Therapy
- Meals
- Dentistry
- Nutritional Counseling
- Social Services
- Laboratory/X-ray Services
- Social Work Counseling
- Transportation
- Primary Care (including doctor and nursing services)
- Hospital Care
- Medical Specialty Services
- Prescription Drugs
- Nursing Home Care
- Emergency Services
- Home Care
- Physical Therapy
- Occupational Therapy

PACE also includes all other services that are available in your area and determined necessary by your team of health care professionals to improve and maintain your overall health.

What do I need to know about PACE?

PACE Provides Comprehensive Care

PACE uses Medicare and Medicaid funds to cover all of your medically-necessary care and services. You can have either Medicare or Medicaid, or both, to join PACE. You can also pay for PACE privately, if you do not have Medicare or Medicaid.

The Focus is on You

You have a team of health care professionals to help you make health care decisions. Your team is experienced in caring for people like you. Usually they care for a small number of people. That way, they get to know you, what your living situation is, and your preferences. You and your family participate as the team develops and updates your plan of care and your goals in the program. When you enroll in PACE, you may be required to use a PACE preferred physician. These physicians are best suited to help you make health care decisions.

PACE Covers Prescription Drugs

PACE organizations offer Medicare prescription drug coverage (Part D). If you join a PACE program, you'll get your Part D-covered drugs and all other necessary medication from the PACE program.

Note: If you're in a PACE program, you don't need to join a separate Medicare drug plan. If you do, you will be disenrolled from your PACE health and prescription drug benefits.

What do I need to know about PACE? (continued)

PACE Supports Family Caregivers

PACE organizations support your family members and other caregivers with caregiving training, support groups, and respite care to help families keep their loved ones in the community.

PACE Provides Services in the Community

PACE organizations provide care and services in the home, the community, and the PACE center. They have contracts with many specialists and other providers in the community to make sure that you get the care you need. Many PACE participants get most of their care from staff employed by the PACE organization in the PACE center. PACE centers meet state and federal safety requirements and include adult day programs, primary care from physicians and nurses, activities, and occupational and physical therapy facilities.

Preventive Care is Covered and Encouraged

Every PACE organization is focused on helping you live in the community for as long as possible. To meet this goal, PACE organizations focus on preventive care.

PACE Provides Medical Transportation

PACE organizations provide all medically-necessary transportation to the PACE center for activities or medical appointments. You may also be able to get transportation to some medical appointments in the community.

What You Pay for PACE Depends on Your Financial Situation

If you have Medicaid, you will not have to pay a monthly premium for the long-term care portion of the PACE benefit. If you don't qualify for Medicaid but you have Medicare, you will be charged a monthly premium to cover the long-term care portion of the PACE benefit and a premium for Medicare Part D drugs. However, in PACE there is never a deductible or copayment for any drug, service, or care approved by the PACE team.

For more information about PACE:

- Visit www.npaonline.org. This Web site is sponsored by the National PACE Association and provides information about the PACE program and what's covered.
- Visit www.medicare.gov/Nursing/Alternatives/PACE.asp.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

CMS Product No. 11341
Revised January 2011