

- 1) *Description of how the state's oversight systems (licensure and certification standards, provider manuals, person-centered plan monitoring by case managers, etc.) have been modified to embed the regulatory criteria into ongoing operations (info should already be in the state's statewide transition plan)*

### **Division of Aging**

Pages 43-51 of the STP outline this. Overall, oversight is accomplished through site visit, staff interview, Medicaid participant interview, and desk review of paperwork (leases and person-centered service plans, as well as any policies or other documents that support the lease). Assessors visit each site and review the paperwork needed for that site, then create a remediation plan with the site to fix any deficiencies found. Sites work on the remediation plan and are re-assessed by assessors to determine compliance. This procedure has been created to bring all sites into full compliance with the Settings Rule and was used during the transition period to bring sites into compliance with the Rule so they could continue providing HCBS services.

Moving forward after the transition period, this procedure will continue to be in place for all sites that are new applicants to providing Medicaid HCBS services so that we know that they are in compliance with the Rule before they begin operations.

Additionally, the HCBS provider manual will be amended to reflect the policies and procedures that sites must have in place to be compliant with the Settings Rule. The state is continuing to work on the process of person-centered service planning and will be engaging CMS, New Editions, and our own care management team as we work to bring that process into full compliance. These processes are new to Indiana and reflect a change in mindset for the care managers as well as the sites in which individuals are living and receiving HCBS services.

### **Division of Disability and Rehabilitative Services**

HCBS questions are currently addressed and recorded in the Monitoring Checklist as well as the PCISP. The PCISP is based on the LifeCourse Framework and developed annually, with reviews at least semi-annually by the IST. For provider owned or controlled residential settings a systemic verification process has been embedded within the PCISP to ensure ongoing monitoring of HCBS compliance.

The Quality Onsite Provider Review process includes an assessment tool that is organized around the Charting the LifeCourse domains and includes indicators which support in determining if individual outcomes are being achieved as well as provider compliance with the HCBS Settings Rule.

In addition, IAC, policies, and procedures are being updated to include all components of the final rule.

### **Division of Mental Health and Addiction – Adult Team**

CMHC's go through a re-certification every 3 years. The SET will annually send notifications of settings and receive attestation of status of settings. The SET has conducted in-person validation site visits of each setting to ensure for compliance with HCBS Final Rule.

Annually, each CMHC will undergo a Quality Assurance Review which focuses on the application for programming and service delivery. Specifically, the review looks at the following areas:

- Reviews assess for the applicant living in an HCBS eligible setting
- The individual has chosen their services, provider(s), and has been a part of their plan development
- The individual was assessed based on the state's allocated assessment tool (ANSA) and that outcome demonstrates a level of need indicated for HCBS programming
- That the person who supported the application and plan development meets the professional criteria in the SPA
- That the service benefits the consumer, how the service was used to support the consumer, that strengths were used in service delivery, that progress on the plan was assessed during the service, the person providing the service meets the credentialing requirements in the SPA, and that there is a minimum of 3 services during the package period.

Based on outcomes, CMHC's may receive Corrective Action Plans to remediate findings. CMHC's may also undergo technical assistance to support remediation. This can be at the request of the CMHC or by the decision of SET.

Access to program is another QA check. Applications for programming must meet HCBS standards, including person-centeredness, based on need, and attest to choice of services/providers. Applications are not approved that do not meet HCBS eligibility. Individuals must re-apply for additional packages, so this becomes an ongoing tool for monitoring.

Providers must follow critical incident reporting requirements outlined in the SPA. The DMHA SET provides an annual webinar with updates and reinforcement of historical information. The DMHA web pages are maintained with historical trainings, as well as ongoing trainings/information as needed.

## **Division of Mental Health and Addiction – Youth Team**

The provider manual lists the requirement for compliant settings for both eligibility as well as service delivery. Plans of Care require settings to be included and are individually reviewed by state staff. For the purpose of eligibility, a description of the residential setting of the youth is a required field and is reviewed by state staff.

- 2) *Description of how the state assesses providers for initial compliance and conducts ongoing monitoring for continued compliance (info should already be in the state's statewide transition plan)*

## **Division of Aging**

Initial compliance was determined for sites through a two-part process that included both a site visit and document review. At the site visit, contracted assessors view the site to ensure all physical attributes are in compliance with the settings rule (no assigned seats in the dining room, locks on bedroom/bathroom doors, etc.). A member of staff is also interviewed to ensure that staff understand the settings rule process and requirements. The document review primarily consists of reviewing the leases and supporting documentation of residential sites to ensure compliance. Upon completion of both the site visit and the document review, the assessor creates a remediation plan outlining what needs to be done to bring the site into full compliance. Once the site works through the remediation plan, they are issued a certificate of compliance. Ongoing compliance is monitored through the 90-day Person-Centered Monitoring Tool that care managers complete with all waiver participants. Additionally, sites will undergo a three-year recertification that will consist of a physical site assessment, interviews with executive and direct care staff, interviews with waiver participants, and an updated document review.

This is outlined on page 61 of the STP. The primary compliance monitoring tool will be the 90 Day Person Centered Monitoring Tool completed by the care manager. This tool has been updated to include an assessment of the service and setting as experienced by the individual. Any beneficiary response where there is an unresolved discrepancy will be investigated by the Division of Aging on an ongoing basis to ensure compliance with the Settings Rule. Additional review will take the form of the National Core Indicators survey for the aged and disabled population and the PCR conducted every three years. Corrective Action Plans will be created for any provider who may have an issue of noncompliance arise.

### **Division of Disability and Rehabilitative Services**

The provider application process assesses for initial compliance ensuring providers fully embrace person-centered values, practices, and planning through the Charting the LifeCourse Framework and requiring new providers to demonstrate an understanding of the purpose of Home and Community-Based Services (HCBS) by articulating how they will support individuals in a way that complies with the Home and Community-Based Services Final Rule.

BDDS utilizes a variety of ways to monitor HCBS compliance. In addition to the monitoring checklist and PCISP; the Quality Onsite Provider Review (QOPR), the provider reverification process, and case record reviews have all been modified to measure ongoing compliance with the HCBS Final Rule.

### **Division of Mental Health and Addiction – Adult Team**

For settings analysis, providers submit a self-assessment of the setting they wish to add. The self-assessment tool inquires on the characteristics of HCBS Final Rule and was developed by the SET. For a Residential setting, providers must also submit Resident Surveys that inquire on the characteristics of HCBS Final Rule that was developed by the SET

Once the desk audit of these tools has been completed, an in-person validation site visit is completed. For residential settings, this will include in-person interviews to verify HCBS Final Rule characteristics are being met. Once a setting has been deemed compliant, the DMHA SET shifts to ongoing monitoring

If the setting is found non-compliant, we use a Setting Action Plan to work to remediate the setting. If settings are found to become non-compliant, we can use a Member Transition Plan to support individuals in either moving to an eligible setting or choosing to discontinue HCBS services, depending on what their personal decisions need to be.

Ongoing monitoring – 25% of an agency's settings will be visited annually, visits will be randomized. Settings not visited in 2 years or more will be prioritized. Individuals cannot receive HCBS programming until the setting is approved for HCBS eligibility.

### **Division of Mental health and Addiction – Youth Team**

All youth in this program reside in the family home which is presumed to meet all aspects of the Settings Rule. All services are provided in the family home, or in the community. As part of the initial application for eligibility, access personnel will include an assessment of the residential

setting. The CMHW program does not provide residential services, nor does it have provider owned and controlled residences. Providers receive training about compliant settings. Plans of Care require settings to be included and are individually reviewed by state staff.

- 3) *Description of a beneficiary's resource to notify the state provider non-compliance (grievance process, notification of case manager, etc.) and how the state will address beneficiary feedback*

### **Division of Aging**

Beneficiaries can notify their care managers in their 90-day meetings of any areas of noncompliance or may call the Ombudsman at any time if there is an issue they wish to report. When the Division of Aging is made aware of a complaint issued by an individual, it will begin an investigation into the site and what caused the individual to complain. This investigation could include a site visit, personal interview with Medicaid HCBS recipient(s), and/or document review of relevant policies and procedures that may be impacting the daily life of individuals receiving HCBS services. The Division of Aging would compare the complaint to the investigative findings and issue a determination as to whether or not the site violates the Settings Rule based on its findings. If the site violates the Rule, site administration will work with the Division of Aging on a remediation plan and have 60 days to bring their site into compliance, including implementing staff and HCBS participant training to help everyone understand the rights of individuals receiving HCBS services.

DA participants have access to training through their respective sites. All sites are told that when they bring a new participant in, they need to educate on the participant's rights under the settings rule. Additionally, during the three-year recertification cycle, sites are encouraged to re-train all staff and participants on the rule. Participants also have access to the ombudsman hotline if they are in an assisted living facility or to lodge a complaint with the department of health if they are in another type of facility.

### **Division of Disability and Rehabilitative Services**

Individuals are notified of their rights upon admission to programs and annually thereafter. Individuals can report any instances of non-compliance directly to their case manager or BDDS field staff.

BDDS Quality Assurance also provides an online complaint form as well as a complaint hotline to submit reports of non-compliance.

Any individual, guardian, family member, and/or community member has the right to file a complaint on the behalf of an individual receiving waiver services through BDDS. A complaint can be filed if it is felt the provider has not followed state and/or federal rules or program requirements. BDDS will then investigate the complaint and determine the best course of action to assess the situation.

### **Division of Mental Health and Addiction – Adult Team**

If an individual's application is denied, their provider is notified via email immediately, the individual is notified via certified mail. The notification includes the appeal process information

If a setting is found non-compliant and HCBS recipients live at that setting, the Member Transition Plan process proceeds, which allows individuals to choose to remain at that setting and forgo HCBS programming or move to an HCBS eligible location. They have 180 days to complete the plan and are eligible for a 1x extension based on extenuating circumstances.

We are currently undergoing an HCBS CAHPS survey to obtain recipient feedback regarding their programming. The survey will be complete, and reporting expected by August of 2023. DMHA employs other consumer satisfaction surveys annually outside of HCBS surveys

All consumers have access to the DMHA Consumer Service Line 1-800-901-1133 where they can report grievances and concerns. Additionally, all webpages for adult 1915(i) programming (AMHH program page, BPHC program page, and the settings rule information page) all have email addresses and a phone number to contact Division of Mental Health and Addiction. The email addresses are monitored and responded to daily. Messages are relayed to the team via administrative staff and responded to usually same day or next day if a message was received late in the day.

### **Division of Mental Health and Addiction – Youth Team**

Members are notified of their rights at application and again at renewal. Members have access to the complaint portal, the wraparound facilitator and/or contacting the state directly. The state has 72 hours from receipt of the complaint to initiate an investigation into the allegation.