2011

DDRS Waiver Manual

Our Mission: To facilitate effective partnerships which enhance the quality of life for the people we serve in the communities and pursuits of their choice.

[DDRS]
State of Indiana
12/30/2011

Division of Disability and Rehabilitative Services

2011 Waiver Manual

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Section 1.1: The Centers for Medicare and Medicaid Services (CMS)

The Centers for Medicare and Medicaid Services (CMS), under the U.S. Department of Health and Human Services is the Federal agency that administers the Medicare and Medicaid programs that provide health care to the aged and indigent populations. In Indiana, the Medicaid program provides services to indigent families, children, pregnant women, senior citizens, persons with disabilities, and persons who are blind.

To provide home and community based Medicaid services as an alternative to institutional care, 1915(c) of the Social Security Act allows states to submit a request to CMS, to "waive" certain provisions in the Social Security Act which apply to state Medicaid programs:

1. Comparability of services provided to all Medicaid recipients. A waiver of comparability allows states to offer individuals in target groups services that are different from those the general Medicaid population receives.
2. A waiver of statewideness gives states the option of limiting availability of services to specified geographic areas of the state; and
3. A waiver of income and resource requirements for the Medically Needy permits states to apply different eligibility rules for medically needy persons in the community.

CMS must review and approve all Waiver proposals and amendments submitted by each state. CMS reviews all waiver requests/applications, renewals, amendments, and financial reports. Additionally, CMS performs management reviews of all Home and Community-Based Services (HCBS) Waivers to ascertain their effectiveness, safety, and cost-effectiveness. CMS requires states to assure that federal requirements for waiver service programs are met and verifies that the state's assurances in their waiver program are being upheld in their day to day operation.

Additional information about CMS is available at https://www.cms.gov/.

Section 1.2: The Division of Disability and Rehabilitative Services (DDRS)

A part of the Family and Social Services Administration, DDRS assists people with disabilities and their families who need support to attain employment, self-sufficiency or independence. The Bureaus of Developmental Disabilities Services and Quality Improvement Services are under DDRS' responsibilities. The DDRS operates the ICF/MR Level of Care Medicaid Waivers and other services for people with developmental disabilities.

Additional information about DDRS is available at http://www.in.gov/fssa/2328.htm

Section 1.3: The Bureau of Developmental Disabilities Services (BDDS)

A part of Family and Social Services Administration/Division of Disability and Rehabilitative Services (DDRS), BDDS administers a variety of services for persons with developmental disabilities, which include the Autism, the Developmental Disabilities, and the Support Services Waiver. There are eight District Offices serving specific counties. The Service Coordinators determine eligibility for developmental disabilities' services and facilitate the determination of Level of Care for ICF/MR services.

BDDS has statutory authority over state programs for individuals with developmental disabilities. BDDS is also the placement authority for persons with developmental disabilities and assists with the development of policies and procedures for Indiana Medicaid waivers that serve persons with developmental disabilities.

Additional information about BDDS is available at http://www.in.gov/fssa/ddrs/2639.htm
http://www.in.gov/fssa/files/BDDS.pdf

Section 1.4: The Bureau of Quality Improvement Services (BQIS)

A part of the Family and Social Services Administration/Division of Disability and Rehabilitative Services, BQIS is responsible for assuring the quality of services delivered to persons in the Autism, Developmental Disabilities and Support Services Waivers. Oversight activities include managing the state's system for reporting instances of abuse, neglect, and exploitation, assuring compliance with Indiana waiver regulations, researching best practices, and analyzing quality data.

Additional information about BQIS is found at http://www.in.gov/fssa/ddrs/2635.htm

Section 1.5: The Office of Medicaid Policy and Planning (OMPP)

A part of Family and Social Services Administration (FSSA), OMPP is the State Medicaid Agency. It is responsible to the Centers for Medicare and Medicaid Services for administration and oversight of the Medicaid Waiver program, as well as the funding for nursing facilities and group homes. It is also responsible for the State's Medicaid Health Care Program overall.

Additional information about OMPP may be found at http://www.in.gov/fssa/2408.htm and for Medicaid eligibility requirements: http://member.indianamedicaid.com/am-i-eligible.aspx l

Section 1.6: Indiana Professional Management Group (IPMG)

As the contracted case management agency, IPMG provides case management to participants including implementing the Person Centered Planning process, assisting the participant to identify members of the Individualized Support Team, and developing an Individualized Support Plan prior to developing and submitting to the State, the service plan known as the Plan of Care/Cost Comparison Budget (CCB).

Section 1.7: Division of Family Resources (DFR)

The DFR is the part of FSSA that provides Medicaid and Children's Services, including the First Steps program for infants and toddlers with developmental delays. Offices in each county serve as a single point of entry for many of the social services available to Hoosiers. Some of these services include Temporary Assistance to Needy Families (TANF), Medicaid, Medicaid-Disability, Food Stamps and Hoosier Healthwise. Additional information about DFR may be found at http://www.in.gov/fssa/2407.htm

Section 1.8: Waiver Service Providers

Waiver Services Providers are agencies, companies, and individuals that the Division of Disability and Rehabilitative Services (DDRS) has approved as waiver service providers and that are paid by Medicaid to provide direct services to Medicaid waiver program participants. The waiver participant's chosen case manager will provide a list of available service providers at any time that the participant desires to select or change service providers.

Section 1.9: Hearings and Appeals

Hearings and Appeals is an administrative section within FSSA that receives and processes appeals from people receiving services within any FSSA program and many others. Administrative hearings are held throughout the State of Indiana, usually at county Division of Family Resources locations, at which time all parties have the opportunity to present their case to an Administrative Law Judge.

Section 1.10: Participants and Guardians

It is the policy of the Bureau of Developmental Disabilities (BDDS) that individuals, or their legal representative when indicated, participate actively and responsibly in the administration and management of their Medicaid waiver funded services.

BDDS supports and encourages individual choice in the development of an Individualized Support Plan (ISP) and in the selection of service providers. Successful service delivery is dependent upon the collaboration of the Individualized Support Team (IST) and entities with oversight responsibilities, including the Bureau of Quality Improvement Services (BQIS). The individual receiving services is the most prominent member of the IST, making their participation and cooperation in waiver service planning and administration essential.

Information Sharing
The Individual (or the Individual's legal representative when indicated) shall upon request from BDDS, BQIS or a Division of Disability and Rehabilitative Services (DDRS) contracted vendor, provide information for the purpose of administration and/or management waiver services.

Changing Providers
The individual (or the individual's legal representative when indicated) shall complete all actions as requested by BDDS to secure a replacement provider within:

- 60 days from the date the change is requested; or
- 60 days from when the provider gives notice of terminating services to the individual.

If a new provider is not in place after 60 days, the current provider shall continue to provide services to an individual until BDDS determines it is no longer necessary.

Participating in Risk Plan Development and Implementation
The individual (or the individual's legal representative when indicated) shall participate in:

- the development of risk plans for the individual, per current BDDS and/or BQIS procedures; and
- the implementation of risk plans developed for the individual, in lieu of documented risk negotiation with the individual's Individualized Support Team, and a signed risk non-agreement document.

Allowing Representatives of the State into the Individual's Home
The individual (or the individual's legal representative when indicated) shall allow representatives from BDDS, BQIS and/or a DDRS contracted vendor into the individual's home for visits scheduled at least 72 hours prior

Consequences for Non-Participation
Should an individual (or their legal representative when indicated) choose not to participate actively and responsibly in the administration and management of their Medicaid waiver funded services, BDDS may terminate the individual's waiver services. If BDDS decides to terminate the individual's waiver services pursuant to this policy, BDDS must provide written notice of intent to terminate the individual's waiver services to the individual (or the individual's legal representative when indicated).

Should a termination occur, the individual (or their legal representative when indicated) has a right to appeal the State's decision. Refer to Part 8: Appeal Process of this Manual for further information regarding appeals.

Additional information regarding DDRS' policy on this issue can be found here:
http://www.in.gov/fssa/files/Individual_and_Guradian_Responsibilities.pdf

Part 2: Provider Information

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Section 2.1: Approval Process

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Section 2.1: Approval Process

The Division of Disability and Rehabilitative Services (DDRS) will no longer be holding New Provider Orientation Sessions. Instead, a prospective provider shall submit a proposal during one of the quarterly open enrollment periods listed at http://www.in.gov/fssa/ddrs/2644.htm.

All components of the New Provider Proposal Packet (listed below) must be completed in order for an application to be considered. If any portion of the packet is incomplete, the proposal will be denied.

Proposals should be submitted to:
Director of Provider Relations
DDRS- Division of Disability and Rehabilitative Services
402 W. Washington St., RM 453, MS 18
Indianapolis, IN 46207
BDDSprovider@fssa.IN.gov

Bureau of Developmental Disabilities Services (BDDS) New Provider Proposal Packet

The packet consists of the six documents listed below. Open and print each of them to complete the packet. Reference material is also provided below.

- Application for Approval to Become a Provider of BDDS Services for Individuals with Developmental Disabilities
- Residential Services Documentation Requirements, Part 3
- Ancillary Services Documentation Requirements, Part 4
- FSSA Provider Data Form
- State of Indiana Automated Direct Deposit Authorization Agreement
- DDRS Provider Agreement

References

- Tool used for 460 Policy Development
- New Provider Orientation Slide Presentation 2011
- IAC 460 Rule 6
- Waiver Service Definitions/DD Renewal Appendix C
- Nurse Aide Registry
- Taxpayer Identification Request Form, W-9

Section 2.2: Requirements for all Providers

All Waiver Service providers must meet the following general requirements to gain approval and to remain in approved status:

- General administrative requirements for providers (460 IAC 6-10) include, but are not limited to, compliance with Medicaid and Medicaid Waivers, collaboration and quality control and quality assurance.
- Financial status for providers documenting financial stability and other fiscal issues. 460 IAC 6-11
- Insurance requirements for providers. 460 IAC 6-12
- Professional qualifications and requirements, including but not limited to, requirements for qualified personnel and training requirements. 460 IAC 6-14
- Personnel records requirements. 460 IAC 6-15
- Personnel policies and manuals requirements. 460 IAC 6-16
- Maintenance of records of services provided requirements. 460 IAC 6-17

Section 2.3: Provider Re-Approval

It is the policy of the Bureau of Developmental Disabilities Services (BDDS) that approved providers must meet the specified requirements for re-approval in order to continue to offer services to individuals. The Division of Disability and Rehabilitative Services (DDRS) must have a signed Provider Agreement on file for all approved providers.

- DDRS will conduct a review of approved providers prior to the expiration of a provider's one (1) or three (3) year approval.

- DDRS will evaluate the following criteria for re-approval purposes:

    - CERT survey;
    - complaints investigations;
    - incident reports; and
    - any other information DDRS deems necessary.

- When DDRS issues a notice of re-approval, the provider will receive a letter indicating a term of one (1) or three (3) years with explicit instructions indicating that the re-approval is contingent upon the provider returning the signed Provider Agreement within thirty (30) days of receipt.

    - A provider will be required to return signed a Provider Agreement at least once every three years.

        - If a provider fails to return a Provider Agreement within thirty (30) days, the provider has failed to meet the requirements for re-approval.

- If the provider fails to meet the requirements for re-approval, the provider will receive a letter indicating that the provider is under a six (6) month probationary approval and may be referred to the DDRS Sanctioning Committee.

    - During the six (6) month probationary period, the provider must show:

        - All incidents, sentinel events, and/or complaints open past the acceptable timeframes have been closed.

        - All systemic problems have been identified, addressed, and corrective action plans are in place and operational.

        - Compliance with the Sanctioning Committee's order(s).
            - If a provider fails to comply with any of the above requirements, the Sanctioning Committee may recommend that the Director terminate the provider's approval.

- All provider reviews under this policy may go before the DDRS Provider Review Committee for final re-approval decisions.

Administrative Review:

- To qualify for administrative review of a DDRS order, a provider shall file a written petition for review that does the following:

    - States facts demonstrating that the provider is:

        - a provider to whom the action is specifically directed;
        - aggrieved or adversely affected by the action; or
        - entitled to review under any law.

    - Is filed with the director of DDRS within fifteen (15) days after the provider receives notice of the sanctioning order.

- Administrative review shall be conducted in accordance with IC 4-21.5-3-7.

A provider adversely affected or aggrieved by BDDS' determination may request administrative review of the determination, in writing, within fifteen (15) days of receiving the notification. 460 IAC 6-6-5 (g)

If a provider has complied with the renewal timelines and if the BDDS does not act upon a provider's request for renewal of approved status before expiration of the provider's approved status, the provider will continue in approved status until such time as the BDDS acts upon the provider's request for renewal of approved services. 460 IAC 6-6-5 (f).

Section 2.4: Claims and Billing

Waiver Authorization

The waiver case manager is responsible for completing the Plan of Care/Cost Comparison Budget (CCB), which, upon approval by the State, results in an approved Notice of Action (NOA). The NOA details the services and number of units to be provided, the name of the authorized provider, and the approved billing code with the appropriate modifiers. The case manager transmits this information to the waiver database (INsite). INsite communicates this data to Indiana*AIM* where it is stored in the prior authorization database. Claims will deny if no authorization exists in the database or if a code other than the approved code is billed. Providers are not to render or bill services without an approved NOA. It is the provider's responsibility to contact the case manager in the event there is any discrepancy in the services authorized or rendered and the approved NOA.

Claim Tips and Reminders

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

- **The IHCP does not reimburse time spent by office staff billing claims.**
- Providers may only bill for those services authorized on an approved NOA.
- A claim may include dates of service within the same month. Do not submit a claim with dates that span across more than one month on the same claim.
- The units of service as billed to the IHCP must be substantiated by documentation in accordance with the appropriate Indiana Administrative Code (IAC) regulations and the waiver documentation standards issued by the OMPP and the Division of Disability and Rehabilitative Services (DDRS).
- Services billed to the IHCP must meet the service definitions and parameters as published in the aforementioned rules and standards.
- Updated information is disseminated through IHCP provider bulletins posted on indianamedicaid.com and/or the DDRS website at http://www.in.gov/fssa/2328.htm . Each provider is responsible for obtaining the information and implementing new or revised policies and procedures as outlined in these notices.

Part 3: Additional Medicaid Information

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Section 3.1: Hoosier Healthwise

Hoosier Healthwise is Indiana's health care program for low income families, pregnant women, and children. Based on family income, children up to age 19 may be eligible for coverage. The program covers medical care like doctor visits, prescription medicine, mental health care, dental care, hospitalizations, surgeries, and family planning at little or no cost to the member or the member's family.

Parents and children receiving Temporary Assistance for Needy Families (TANF) as well as non-TANF pregnant women and children with incomes at or just above the poverty level may choose to participate in Hoosier Healthwise. The program covers medical care like doctor visits, prescription medicine, mental health care, dental care, hospitalizations, surgeries, and family planning at little or no cost to the member or the member's family.

Medicaid recipients are **not** allowed to enroll in both the HCBS Waiver Program and Hoosier Healthwise. They must choose one program or the other.

Additional information about Hoosier Healthwise may be found at
http://member.indianamedicaid.com/programs--benefits/medicaid-programs/hoosier-healthwise.aspx

Section 3.2: Care Select

Care Select is a health care program that is designed to serve Medicaid recipients who may have special health needs or benefit from specialized attention. In *Care Select*, you pick a primary doctor and a health plan by choosing one of the Care Management Organizations (CMOs) contracted with the state to coordinate your health care needs. The CMO will assist you in coordinating your health care benefits and tailor them to your individual needs, circumstances and preferences.

People served by *Care Select* may be aged, blind, disabled, wards of the court and foster children, or children receiving adoptive services. You must also have one of the following medical conditions:

- Asthma
- Diabetes
- Heart Failure
- Congestive Heart Failure
- Hypertensive Heart Disease
- Hypertensive Kidney Disease
- Rheumatic Heart Illness
- Severe Mental Illness
- Serious Emotional Disturbance (SED) for Wards and Fosters
- Depression

Care Select is an optional program for those who qualify. If you think you should be in this program, discuss it with your doctor. Your doctor can request that you be added to this program if you have a qualifying disease and meet all other criteria. If you qualify for *Care Select*, but do not wish to be on *Care Select*, you may choose to be on Traditional Medicaid.

Home and Community Based Services (HCBS) waiver recipients are **not** eligible for the *Care Select* program, even if you have one of the included chronic conditions. HCBS waiver recipients are eligible for case management under the waiver, which is similar to disease management.

Additional information about *Care Select* may be found at
http://member.indianamedicaid.com/programs--benefits/medicaid-programs/care-select.aspx

Section 3.3: Hospice Services

Individuals who receive Medicaid HCBS waiver services and elect to use the Indiana Health Care Program Hospice benefit do not have to terminate their waiver program. However, the hospice provider will coordinate the direct care for those services held in common by both programs, so there is no duplication of services. In short, the individual receiving waiver services, who elects the hospice benefit may still receive waiver services that are not related to the terminal condition and do not replicate hospice care. The hospice provider and the IPMG case manager must collaborate and communicate regularly to ensure the best possible overall care to the waiver/hospice member.

Section 3.4: Spend-down

In certain cases, a Medicaid member may have income or resources that are too high to qualify for Medicaid services; in these cases the member has what is called a spend-down. A spend-down is the amount of money a person must spend on qualified medical expenses each month before Medicaid will pay for services. After the spend-down is met each month, Medicaid will begin to cover the remaining medical expenses that you have incurred. An example of spend-down is:

Your income is $1000 monthly

The income limit for Medicaid is $700 per month.

The spend-down is the difference between the income limit ($700) and your income ($1000) equaling $300.

Therefore, you must incur $300 in medical expenses each month before Medicaid coverage will begin to pay for services. You can meet your spend-down by paying for any medical service that is covered by your Medicaid program. This could be prescription drugs or a doctor visit.

REMEMBER: This is just an example and is not indicative of what the income limits are or what your spend-down maybe if you are over the income limit. Many members do not have a spend-down at all. You will be notified of any spend-down you will have when you are notified of acceptance into Medicaid.

Section 3.5: M.E.D. Works

Introduction to M.E.D. Works

In July 2002, Indiana created a health care program called M.E.D. Works, which stands for **M**edicaid for **E**mployees with **D**isabilities. M.E.D. Works is Indiana's health care program for working people with disabilities. Now people with disabilities do not have to fear losing their health care benefits under Medicaid or having a Medicaid spend-down (spend-down is an out of pocket cost for members whose income or assets are too high) just because they get a job, get a raise, or work more hours.

M.E.D. Works would allow you to work without losing health care coverage while also being able to save money for goals like retirement, education or starting a new business. As a M.E.D. Works member you may pay a small monthly premium based on your income; however, this is much smaller than the cost of a spend-down payment.

Who Is Eligible?

To be eligible for M.E.D. Works, you must:

- be age 16-64,
- meet certain income and assets guidelines (see below),
- be disabled according to Indiana's definition of disability, and
- be working

Most M.E.D. Works members will be those already on Medicaid and are often on Social Security Disability Income (SSDI). However, new members who are working and disabled may still have M.E.D. Works as an available option. Like all Medicaid programs, qualifying is partially based on your income (money earned from a job and unearned income such as a Social Security check) and you may pay a Medicaid premium to receive coverage. The premiums are generally much lower than the Medicaid disability spend-down amount. Please note that M.E.D. Works is an individual only program. Your spouse or children will not be eligible through you for coverage under M.E.D. Works, even though they may be eligible for other Medicaid services.

Financial Eligibility

To financially qualify for M.E.D. Works, you must not have countable income above 350% of the Federal Poverty Level (FPL). The Federal Poverty Level is determined by the Federal government and changes on an annual basis. Below is a FPL table for 2009 that can be used as a guide. The only way to know for sure is to apply.

The 2009 Poverty Guidelines for the 48 Contiguous States and the District of Columbia

Persons in family	Poverty guideline
1	$10,830
2	14,570
3	18,310
4	22,050
5	25,790
6	29,530
7	33,270
8	37,010

For families with more than 8 persons, add $3,740 for each additional person.

There are certain types of income that are not included when deciding if you are eligible for M.E.D. Works, examples of these include;

- tax refunds,
- grants or scholarships allowed by federal law,
- Impairment Related Work Expenses (IRWE's), and
- income of your spouse or parents

In addition to income, your assets are also part of your eligibility determination.

Certain assets do not count when deciding if you are eligible for M.E.D. Works, these include:

- a car (if you use it to drive to work or medical appointments),
- a home (if it is where you live),
- burial spaces,
- retirement savings held by you or, if you are married, your spouse.

Medical Eligibility

In Indiana, Medicaid has its own eligibility criteria for disability determination. This criteria differs from the Social Security Administration's eligibility determination. In Indiana, the definition of disability is a physical or mental impairment verifiable by a physician that is expected to last 12 or more months or result in death.

M.E.D. Works Services

M.E.D. Works offers the same services to its members with disabilities as those in regular Medicaid. This means if you are already a member of Medicaid because of your disability, but would like to start working your benefits under M.E.D. Works will be the same as they are now.

M.E.D. Works Savings for Independence and Self-Sufficiency

Another benefit that is available to M.E.D Works participants is called the Savings for Independence and Self Sufficiency account. It is a special account for members who have extra money to set aside to save for purchasing goods or services that increase their ability to find or retain a job and make them more independent.

Members can put up to $20,000 in the approved accounts; before the accounts are approved a member must explain what he/she will be using the money for and how it helps them to improve their employability or independence. Each request is based on an individual's unique situation and goods or services to be purchased must meet some of the criteria listed below:

- Your savings will be used to buy something that is necessary for you to keep or increase your employment.
- You must explain what will be purchased and give an expected date that you will purchase the item.
- Your goal must be something that you can achieve in a reasonable amount of time.
- Your account cannot be used for personal recreation.

If you are interested in completing an application for an Independence and Self-Sufficiency Account for M.E.D.Works members, contact your local Division of Family Resources.

Section 3.6: Medicaid Prior Authorization

CMS requires that a HCBS waiver member exhaust all services on the State Plan before utilizing HCBS waiver services. HCBS waiver programs are considered funding of last resort and have a closed funding stream.

The following list provides the hierarchy of funding streams for ease of reference with HCBS waiver programs.

1. Private Insurance/Medicare
2. Medicaid State Plan Services
3. HCBS Waiver Programs

Issue 1: As a funding stream of last resort, teams must ensure that all other revenue streams are exhausted before utilizing waiver services.

Issue 2: Medicaid Home Health Prior Authorization Requests must specify if there are other caregiving services received by the member, including, but not limited to services provided by Medicare, Medicaid waiver programs, CHOICE, vocational rehabilitation, and private insurance programs. The number of hours per day and the days per week for each service must be listed.

For additional information please visit Indiana Medicaid at
http://provider.indianamedicaid.com/general-provider-services/providing-services/prior-authorization.aspx

Part 4: Developmental Disabilities Services Waivers

Sections 4.1 – 4.7

Section 4.1: Medicaid Waiver Overview

Section 4.2: Definition of a Developmental Disability

Section 4.3: Cost Neutrality

Section 4.4: Medicaid Prior Authorization

Section 4.5: Developmental Disabilities Waiver (DDW)

Section 4.6: Autism Waiver (AW)

Section 4.7: Support Services Waiver (SSW)

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Section 4.1: Medicaid Waiver Overview

The Medicaid Waiver program began in 1981, in response to the national trend toward providing Home and Community-Based Services (HCBS). In the past, Medicaid paid only for institutionally based long term care services, such as nursing facilities and group homes.

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population.

Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Indiana applies for permission to offer Medicaid Waivers from the Centers' for Medicare and Medicaid Services (CMS). The Medicaid Waivers make use of federal Medicaid funds (plus state matching funds) for Home and Community-Based Services (HCBS), as an alternative to institutional care, under the condition that the overall cost of supporting people in the home or community is no more than the institutional cost for those people.

The goals of Waiver services are to provide to the person meaningful and necessary services and supports, to respect the person's personal beliefs and customs, and to ensure that services are cost-effective. Specifically:

Waivers for individuals with a developmental disability assist a person to:

- Become integrated in the community where he/she lives and works
- Develop social relationships in the person's home and work communities
- Develop skills to make decisions about how and where the person wants to live
- Be as independent as possible

DDRS oversees three waiver programs: Developmental Disability Waiver, Autism Waiver, and the Support Services Waiver.

Section 4.2: Definition of Developmental Disability

Individuals meeting the state criteria for a developmental disability and meeting the criteria for an ICF/MR level of care determination are eligible to receive waiver services.

“Developmental Disability" means a severe, chronic disability of an individual that meets all of the following conditions:

- Is attributable to:
  - intellectual disability, cerebral palsy, epilepsy, or autism; or
  - any other condition (other than a sole diagnosis of mental illness) found to be closely related to intellectual disability, because this condition results in similar impairment of general intellectual functioning or adaptive behavior or requires treatment or services similar to those required for a person with an intellectual disability.
- Is manifested before the individual is twenty-two (22) years of age.
- Is likely to continue indefinitely.
- Results in substantial functional limitations in at least three (3) of the following areas of major life activities:
  - Self-care.
  - Understanding and use of language.
  - Learning.
  - Mobility.
  - Self-direction.
  - Capacity for independent living.

Section 4.3: Cost Neutrality

Indiana must demonstrate that average per capita expenditure for the Developmental Disabilities, Autism, and Support Services Waiver program participants are equal to or less than the average per capita expenditures of institutionalization for the same population. Indiana must demonstrate this cost neutrality for each waiver separately.

Section 4.4: Medicaid Prior Authorization

CMS **requires** that a HCBS waiver member exhaust all services on the State Plan before utilizing HCBS waiver services. **HCBS waiver programs are considered funding of last resort and have a closed funding stream.** Please reference Section 3.6 of this manual for more specific information.

Section 4.5: Developmental Disabilities Waiver (DDW)

PURPOSE:
The Developmental Disabilities (DD) Waiver provides Medicaid Home and Community-Based Services (HCBS) waiver services to participants of any age residing in a range of community settings as an alternative to care in an intermediate care facility for persons with intellectual disabilities (known as an ICF/MR) or related conditions. The waiver serves persons with a developmental disability, intellectual disability or autism and who have substantial functional limitations, as defined in 42 CFR 435.1009. Participants may choose to live in their own home, family home, or community setting appropriate to their needs. Participants develop an Individual Service Plan (ISP) using a person centered planning process guided by an Individual Support Team (IST). The IST is comprised of the participant, their case manager and anyone else of the participant's choosing but typically family and/or friends. The participant with the IST selects services, identifies service providers of their choice and develops a Plan of Care/Cost Comparison Budget (CCB).

GOALS and OBJECTIVES:
The DD Waiver provides access to meaningful and necessary home and community-based services and supports, seeks to implement services and supports in a manner that respects the participant's personal beliefs and customs, ensures that services are cost-effective, facilitates the participant's involvement in the community where he/she lives and works, facilitates the participant's development of social relationships in his/her home and work communities, and facilitates the participant's independent living.

LIST OF SERVICES AVAILABLE:

- Adult Day Services
- Prevocational Services
- Rent and Food for Unrelated Live-in Caregiver
- Residential Habilitation and Support
- Respite
- Supported Employment Follow Along
- Occupational Therapy
- Physical Therapy
- Psychological Therapy
- Speech /Language Therapy
- Adult Foster Care
- Behavioral Support Services
- Community Based Habilitation - Group
- Community Based Habilitation - Individual
- Community Transition
- Electronic Monitoring
- Environmental Modifications
- Facility Based Habilitation - Group
- Facility Based Habilitation - Individual
- Facility Based Support Services
- Family and Caregiver Training
- Intensive Behavioral Intervention

- Music Therapy
- Personal Emergency Response System
- Recreational Therapy
- Specialized Medical Equipment and Supplies
- Transportation
- Workplace Assistance

Section 4.6: Autism Waiver (AW)

PURPOSE:
The Autism Waiver maximizes available Indiana resources by providing home and community-based services to individuals who, but for the provision of such services, would require Intermediate care facility for mentally retarded or persons with related conditions (ICF/MR) level of care, the cost of which could be reimbursed under the approved Medicaid State plan. A waiver of section 1902(a)(10)(B) of the Social Security Act is requested to target waiver services to the select group of individuals who are developmentally disabled, with the additional targeting restriction of a diagnosis of Autism Spectrum Disorder (includes Autism, Asperger's syndrome, and Other Pervasive Developmental Disorders).

GOALS and OBJECTIVES:
To provide opportunities for meaningful and necessary services and supports, to respect the person's personal beliefs and customs, and to ensure that services are cost effective by assisting the person to become involved in the community where he/she lives and works, to develop social relationships in the person's home and work communities, to develop skills to make decisions about how and where the person wants to live, and to be as independent as possible.

LIST OF SERVICES AVAILABLE:
- Adult Day Services
- Day Services*
- Rent and Food for Unrelated Live-In Caregiver
- Residential Habilitation and Support
- Respite Care
- Adult Foster Care
- Behavioral Support Services/Crisis Assistance
- Community Transition Services
- Environmental Modifications
- Family and Caregiver Training
- Music Therapy
- Occupational Therapy
- Personal Emergency Response System
- Physical Therapy
- Psychological Therapy
- Recreational Therapy
- Specialized Medical Equipment and Supplies

- Speech/Language Therapy

*Day Services under the Autism Waiver include Prevocational Services, Supported Employment Follow Along, Community Based Habilitation (Individual and Group) and Facility Based Habilitation (Individual and Group), and Transportation Services.

Section 4.7: Support Services Waiver (SSW)

PURPOSE:
The Support Services (SS) Waiver provides Medicaid Home and Community-Based Services (HCBS) waiver services to participants of any age residing in a range of community settings as an alternative to care in an intermediate care facility for persons with intellectual disability (known as an ICF/MR) or related conditions. The waiver serves persons with a developmental disability, intellectual disability or autism and who have substantial functional limitations, as defined in 42 CFR 435.1009. Participants may choose to live in their own home, family home, or community setting appropriate to their needs. Participants develop an Individual Service Plan (ISP) using a person centered planning process guided by an Individual Support Team (IST). The IST is comprised of the participant, their case manager and anyone else of the participant's choosing but typically family and/or friends. The participant with the IST selects services, identifies service providers of their choice and develops a Plan of Care/Cost Comparison Budget (CCB). **The CCB is subject to an annual waiver services cost cap of $13,500.**

GOALS and OBJECTIVES:
The SS Waiver provides access to meaningful and necessary home and community-based services and supports, seeks to implement services and supports in a manner that respects the participant's personal beliefs and customs, ensures that services are cost-effective, facilitates the participant's involvement in the community where he/she lives and works, facilitates the participant's development of social relationships in his/her home and work communities, and facilitates the participant's independent living.

LIST OF SERVICES AVAILABLE:
- Adult Day Services
- Prevocational Services
- Respite
- Supported Employment Follow Along
- Occupational Therapy
- Service Physical Therapy
- Psychological Therapy
- Speech/Language Therapy
- Behavioral Support Services
- Community Based Habilitation - Group
- Community Based Habilitation - Individual
- Facility Based Habilitation - Group
- Facility Based Habilitation - Individual
- Facility Based Support Services
- Family and Caregiver Training
- Intensive Behavioral Intervention

- Music Therapy
- Personal Emergency Response System
- Recreational Therapy
- Specialized Medical Equipment and Supplies
- Transportation
- Workplace Assistance

Part 5: Application and Start of Waiver Services

Sections 5.1 – 5.8

Section 5.1: Request for Application

Section 5.2: Medicaid Eligibility: How to apply for Medicaid

Section 5.3: Initial Level of Care Evaluation

Section 5.4: Waiting List

Section 5.5: Targeting Process

Section 5.6: Initial Plan of Care/Cost Comparison Budget (CCB) Development

Section 5.7: State Authorization of the Initial Plan of Care/Cost Comparison Budget (CCB)

Section 5.8: Initial Service Plan Implementation

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Section 5.1: Request for Application

An individual or his/her guardian may apply for the Development Disabilities, Autism, and/or Support Services Medicaid waiver programs through the local Bureau of Developmental Disabilities Services (BDDS) office. Individuals (or their guardians) have the right to apply without questions or delay.

To apply for the Developmental Disabilities, Autism or Support Services Waiver(s), the individual or guardian must complete, sign, and date an Application for Long Term Care Services (State Form 4594) including the time of day that the application is signed. An individual who has not already applied for waiver services may also need to complete, sign, and date a DDRS Referral and Application (State Form 10057) located at http://www.in.gov/fssa/ddrs/3349.htm . Other individual or agency representatives may assist the individual or guardian in completing the application form and forward it to the BDDS office service the county in which the individual currently resides. The application may be submitted in person, by mail or by fax.

Upon receiving the waiver application, the BDDS staff must contact the individual and/or his/her guardian and discuss the process for determining eligibility for the waiver (documentation of a developmental disability, diagnosis within the Autism Spectrum for the Autism Waiver, Medicaid eligibility, and level of care). If the applicant is not a Medicaid recipient, he/she will be referred to the local Division of Family Resources to apply for Medicaid.

Section 5.2: Medicaid Eligibility: How to Apply for Medicaid

To apply for Medicaid, you will need to fill out and submit an application.

The Medicaid eligibility guide (http://member.indianamedicaid.com/am-i-eligible/eligibility-guide.aspx) will help you determine which application form you will need to fill out and submit.

Once you submit your complete application, it will take about 45-90 days to determine if you are eligible.

Applications for Medicaid, Food Stamps, and Cash Assistance are processed by the Family and Social Services Administration (FSSA), Division of Family Resources (DFR). Indiana is changing the way people apply for benefits. The application process depends on where you live. If you live in a county operating under the "Hybrid" or "modernized" system you can begin to apply on the internet, over the phone, or in your local DFR office. If you live in a non-modernized county you can go to your local DFR office.

DFR office Locations

To find a DFR office near you, visit the DFR website at www.in.gov/fssa/dfr/2999.htm. Scroll down the screen until you see the map and the list of counties. From that list, click on your county of residence.

Online application

To apply online, visit the Family and Social Services Administration site at www.in.gov/fssa/ click on "Apply For Benefits."

Information Required to Complete Medicaid Application

For all the people in your household you will need to know:

- Names and dates of birth
- Social Security Number
- Income from jobs or training
- Benefits you get now (or got in the past) such as Social Security, Supplemental Security Income (SSI), veteran's benefits, child support
- Amount of money in your checking account, savings accounts or other resources you own.
- Monthly rent, mortgage payment and utility bills
- Payments for adult or child care Health coverage and/or medical benefits you currently have
- Go to the Family and Social Services Administration web site to get the specific application instructions based on your county of residence.

Applicants *must* submit the Plan of Care/Cost Comparison Budget (CCB) approval letter (described under Section 5.7 of this manual) to the Division of Family and Children (DFR) when submitting an application for Medicaid benefits or when requesting for a change of Medicaid Aid Category in order to qualify for waiver eligibility.

NOTE: Medicaid eligibility is required prior to the start of waiver services.

Section 5.3: Initial Level of Care Evaluation

An individual targeted for the Developmental Disabilities, Support Services or Autism Waivers must meet the level of care required for placement in an Intermediate Care Facility for the Mentally Retarded or Developmentally Disabled (ICF/MR). In addition, if applying for the Autism Waiver, an individual must have a diagnosis within the Autism Spectrum to be eligible for services through the Autism Waiver.

Initial Level of Care evaluations for these waivers are performed by the Bureau of Developmental Disabilities Services (BDDS) Service Coordinator or a designated contractor, with the following exceptions:

- the individual targeted for waiver services is age five (5) or younger, or
- the individual is currently a resident of an ICF/MR facility and has been cited by the Indiana State Department of Health as being inappropriately placed, indicating a violation of a federal standard

Under these exceptions, the level of care determination is made by the DDRS Central Office.

Reevaluations are performed by the contracting entity of case management services.

Qualifications of Individuals Performing Initial Evaluation: Only individuals (contracted staff or state employees) who are Qualified Mental Retardation Professionals (QMRP) as specified by the standard within 42 CFR 483.430(a) may perform initial Level of Care determinations.

Level of Care Criteria: If collateral records are not available or are not a valid reflection of the individual, additional assessments may be obtained from contracted psychologists, physicians, nurses and licensed social workers. Following review of the collateral records, the Developmental Disabilities Profile (DDP) is completed, applicable to individuals with intellectual disability and other related conditions, in order to ascertain if the individual meets ICF/MR LOC.

The DDP assessment tool is used to identify and record:

- vocational programs of applicant/participant
- all developmental disabilities applicable to the applicant/participant as well as any psychiatric diagnosis and results of the individual's intellectual assessment
- status of hearing and vision
- any alleged perpetration of crimes committed by the applicant/participant as well as the need for police involvement for maladaptive behaviors
- barriers which hinder the achievement of personal independence, productivity, integration and community inclusion as well as barriers which hinder achieving the identified lifestyle and related needs
- significant medical conditions requiring specialized medical supports or impacting the participation in services

- utilization and frequency of health-related services including the identification and detailing of issues within the respiratory, cardiovascular, gastro-intestinal and genito-urinary systems, and any evidence of neoplastic or neurological diseases
- seizures by type, frequency and required medications
- medication support needs and medical consequences related to the above conditions
- mobility issues, motor control, cognitive and communication abilities
- the frequency and consequences of behaviors
- self care and activities of daily living support needs
- the need for and frequency of utilization of clinical services

The BDDS Service Coordinator, LOC contractor (initial LOC) or contracting Case Manager (re-evaluations) reviews the DDP and collateral material, applicable to individuals with intellectual disability*, developmental disability and other related conditions, in order to ascertain if the individual meets ICF/MR LOC. An applicant/participant must meet three of six substantial functional limitations and each of four basic conditions (listed below) in order to meet LOC.

The basic conditions are:

- intellectual disability, cerebral palsy, epilepsy, autism, or condition similar to intellectual disability,
- the condition identified in #1 is expected to continue,
- the condition identified in #1 had an age of onset prior to age 22, and
- the applicant needs a combination or sequence of services.

The substantial functional limitation categories, as defined in 42 CFR 435.1009, are:

- self-care,
- learning,
- self direction,
- capacity for independent living,
- receptive and expressive language, and
- mobility.

*Intellectual disability is also known as mental retardation

Section 5.4: Waiting List

It is the policy of the Bureau of Developmental Disabilities Services (BDDS) that individuals may be placed on a waiting list after applying for waiver services and meeting specified criteria. Individuals are responsible for maintaining current collateral and contact information with their local BDDS office.

Initial Placement on Home and Community Based Services Waiver Waiting List(s)

- Individuals or their legal representative must complete an application and submit the application to their local BDDS office to apply for HCBS waiver services.
- Individual is expected to complete the following:
    - Application
    - Collateral Information, including the following:
        - Development Disabilities Profile (DDP)
        - Supporting documents:
            - Diagnostic Evaluation(s)
            - Functional Evaluation(s)
            - Psychological Report(s)
            - Individualized Education Program from schools
            - School records
            - Physician diagnosis and remarks
            - Existing evaluation done by Supplemental Security Income or Vocational Rehabilitation
            - IQ testing done at any time
    - Medicaid application for individuals over eighteen (18) years of age
    - Supplemental Security Income application, if applicable
- A DDP will be used to assess any individual six (6) years of age and older.
- An individual must meet:
    - the State definition of a developmental disability found in IC 12-7-2-61(a); and
    - Intermediate Care Facility for the Mentally Retarded (ICF/MR) Level of Care (LOC) found in 42 CFR §435.1009.
- If an individual completes the application and meets the LOC criteria listed in Section 5.3 above, they will be placed on the waiting list using the individual's application date.

Waiting List Targeting for a Waiver Slot

- Individuals will be targeted for a waiver slot from the statewide waiting list using the individual's application date.
- Individuals will be targeted in the order they applied for services, from the oldest date of application to newest.

Responsibilities of Individuals on the Waiting List

- An individual, or an individual's legal representative, is expected to maintain current contact information with their local BDDS office. This shall include any change in address or telephone number.
- If BDDS attempts to contact an individual or the individual's legal guardian and the identified secondary contact person and is unable to make contact by mail or telephone, the individual may be removed from the waiting list.

Children under the Age of Six (6)

- A parent or guardian may apply for Home and Community Based Services (HCBS) at any time after a child's birth.
- Children under the age of six (6) years old will have their information input into the BDDS database along with date of application.
- Once a child turns six (6) years old, families will have two (2) years to come into their local BDDS office and complete a DDP.
- If upon the child's eighth (8th) birthday a DDP has not been completed, the child will lose his/her original application date.
- It is the family's responsibility to ensure that the local BDDS office receives adequate information to complete the DDP within the timeframe.
- If the child's DDP is completed by the age of eight (8) and BDDS determines that the child meets the criteria for HCBS waiver services, the child will be placed on the waiting list with <u>their original application date</u>.

<u>Section 5.5: Targeting Process</u>

When a slot becomes available, an individual on the waiting list will receive a letter from BDDS Central Office, asking them to accept or decline the waiver slot, apply for Medicaid if he/she hasn't already, and provide or obtain confirmation of their diagnosis from a physician on the DDRS form known as the 450B. A response accepting or declining the waiver slot must be received within 30 days.

If an individual declines placement, his or her name is removed from the waiting list.

If an individual accepts placement:

- An intake meeting at the local BDDS District Office is scheduled to complete the following:
    - Collateral information, provided by the individual, is reviewed and level of care, again, established
    - DDP is completed
    - ICAP is ordered
    - Allocation is recorded into system
- The individual/guardian must obtain confirmation of their diagnosis on a 450B form signed by their physician within 21 days from date of letter

- The individual/guardian has 60 days to apply for/obtain Medicaid when the individual does not yet have Medicaid coverage
- If the individual already has Medicaid coverage, but the Aid Category to which the individual's Medicaid eligibility has been assigned is not compatible with waiver program requirements, he or she has 30 days from the date on the contact letter from BDDS to request that the DFR process the needed change in Medicaid Aid Category
- The individual/guardian must cooperate fully with requests related to the application for Medicaid eligibility and/or any needed change in Medicaid Aid Category

Once all assessments have been made and criteria met, a referral is made to contracting case management entity to interview and choose a permanent case manager, choose a provider, complete the service planning process, and submit a CCB for waiver service.

From the date of contact with the State's contracting of case management:

- Individual/guardian has five (5) days to interview and choose a permanent case manager
- Individual/guardian has 14 days to interview and choose, at minimum, one provider

From the date a provider is chosen:

- Individual/guardian has 14 days to complete the service planning process and submit a CCB
- Once CCB is completed, consumer has three (3) days to review and sign service planning documents

If the individual is unable to start waiver services within the given timeframes, the individual may be removed from the targeting process.

Section 5.6: Initial Plan of Care/Cost Comparison Budget (CCB) Development

The Plan of Care/Cost Comparison Budget (CCB) is developed based upon the outcomes of the initial, annual or subsequent meeting of the Individualized Support Team during which the Person-Centered Plan and the Individualized Support Plan are developed. This entire process is driven by the individual/participant and is designed to recognize the participant's needs and desires. The Case Manager holds a series of structured conversations, beginning with the participant/ guardian and with other individuals, identified by the participant that know them well and can provide pertinent information about them, to gather initial information to support the person-centered planning process. The overall emphasis of the conversations will be to derive what is important to and what is important for the participant, with a goal of presenting a good balance of the two. The case manager facilitates the IST meeting, reviews the participant's desired outcomes, their health and safety needs and their preferences, and reviews covered services, other sources of services and support (paid and unpaid) and the budget development process using the objective based allocation for waiver services. The case manager then finalizes the ISP and completes the CCB.

Coordination of Waiver Services and other services is completed by the Case Manager. Within 30 days of implementation of the plan, the Case Manager is responsible for ensuring that all identified services and supports have been implemented as identified in the Individualized Support Plan and the CCB. The Case Manager is responsible for monitoring and coordinating services on an ongoing basis and is required to record a weekly case note for each participant. A formal 90 day review is also completed by the case manager with the participant and includes the IST.

Each waiver provider is required to submit a monthly or quarterly report summarizing the level of support provided to the participant based upon the identified supports and services in the Individualized Support Plan and the Cost Comparison Budget. The Case Manager reviews these reports for consistency with the ISP and CCB and works with providers as needed to address findings from this review.

Section 5.7: State Authorization of the Initial CCB

The Case Manager will transmit the Plan of Care/Cost Comparison Budget (CCB) electronically to the State's Waiver Specialist who will review the CCB and Service Planner and confirm the following:

- The individual is a current Medicaid recipient within one of the following categories
  - Aged **(MA A)**
  - Blind **(MA B)**
  - Low Income Families **(MA C)**
  - Disabled **(MA D)**
  - Disabled Worker **(MA DW)**
  - Children receiving Adoption Assistance or Children receiving Federal Foster Care Payments under Title IV E - Sec. 1902(a)(10)(A)(i)(I) of the Act **(MA 4 & MA 8)**
  - Children receiving adoption assistance under a state adoption agreement - Sec 1902(a)(10)(A)(ii)(VIII) **(MA 8)**
  - Independent Foster Care Adolescents – Sec 1902(a)(10)(A)(ii)(XVII) **(MA 14)**
  - Children Under Age 1 – Sec 1902(a)(10)(A)(i)(IV) **(MA Y)**
  - Children Age 1-5 - Sec 1902(a)(10)(A)(i)(VI) **(MA Z)**
  - Children Age 1 through 18 - Sec 1902(a)(10)(A)(i)(VII) **(MA 9 & MA 2)**
  - Transitional Medical Assistance – Sec 1925 of the Act **(MA F)**
  - Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121 **(MA U)**
- The individual has a current ICF/MR level of care approval (and, if applying for the Autism Waiver, a formal diagnosis of within the Autism Spectrum is required)
- The individual has been targeted for an available waiver slot;
- The individual's indentified needs will be met and health and safety will be assured;
- That if the total cost of Medicaid waiver and regular Medicaid State plan services for the individual exceeds the total costs of serving an individual with similar needs in an ICF/MR facility, the programmatic cost-effectiveness will be maintained;
- The individual or guardian has signed, indicating acceptance of, the CCB; signed that he/she has been offered choice of certified waiver service providers; and signed that he/she has chosen waiver services over services in an institution.

The Waiver Specialist may request additional information from the Case Manager to assist in reviewing the CCB.

If the Waiver Specialist approves the Initial CCB, the Initial approval letter and Notice of Action are electronically transmitted to the Case Manager, BDDS (for Initials and Annuals only) and Service Providers. Within three (3) calendar days of receiving the Initial CCB approval letter, the Case Manager must print a Notice of Action form (HCBS Form 5) and sign it. The Case Manager must provide copies of the approval letter, the signed Notice of Action form and Addendum (containing information from the CCB and Person Centered Service Planner) to the individual participant/guardian. The participant's chosen waiver service providers are required to register so that they receive the Notices of Action and the Addendums electronically.

The Notice of Action serves as the official authorization for service delivery and reimbursement.

If the Waiver Specialist approves the CCB pending Medicaid eligibility or change of Aid Category, disenrollment of a child from Hoosier Healthwise, facility discharge, or other reasons, the pending approval letter is to be transmitted to the Case Manager, BDDS and Service Providers. The Case Manager must notify the individual or guardian within three (3) calendar days of receipt of the pending approval and provide a copy of the Initial approval letter naming the pending conditions. No Notice of Action is generated until all pending issues are resolved and a final approval letter is released.

If the Waiver Specialist denies the Initial CCB, a denial letter must be transmitted to the Case Manager, BDDS (for Initials and Annuals only) and Service Providers. Within three (3) calendar days of receipt of the denial the Case Manager must complete and provide a copy of a Notice of Action (HCBS Form 5), the Appeal Rights as an HCBS Waiver Services Recipient, and an explanation of the decision to deny to the individual participant/guardian. The case manager will discuss other service options with the individual and guardian and the individual's name should be removed from the waiting list, unless the individual participant or guardian files an appeal.

NOTE: *Once waiver services begin, waiver participants are sometimes referred to as consumers.*

Section 5.8: Initial Service Plan Implementation

An individual cannot begin waiver services prior to the approval of the Initial Plan of Care/Cost Comparison Budget (CCB) by the State's Waiver Specialist. The Initial CCB represents the service plan identified for the individual as the result of the person-centered description and the individualized support plan development process. If the Waiver Specialist issues an Initial approval letter pending certain conditions being met, those conditions must be resolved prior to the start of the individual's waiver services. If the individual's Medicaid eligibility is approved pending waiver approval, the Case Manager will notify the local DFR Caseworker when the waiver has been approved. The DFR Caseworker and contracting Case Manager coordinate the Medicaid eligibility date and waiver start date. If Medicaid eligibility depends on eligibility for the waiver, the Medicaid start date is usually the first day of the month following approval of the CCB.

If an individual is a Hoosier Healthwise or Medicaid managed care program participant other than Care Select, the Case Manager must contact the local DFR Caseworker to coordinate the managed care program stop date and waiver services start date. Individuals receiving the Indiana Health Care Hospice benefit do not have to disenroll from this benefit to receive waiver services that are not related to the terminal condition and are not duplicative of hospice care. If applicable, the Case Manager and managed care benefit advocate must inform the individual and individual's parent or guardian of his/her options to assure he/she makes an informed choice.

When the CCB is approved by the Waiver Specialist pending facility discharge, the waiver start date can be the same day that the individual is discharged from the facility.

Following discharge from the facility and within three (3) calendar days after the individual begins waiver services, the Case Manager must complete the Confirmation of Waiver Start form in the INsite database and electronically transmit it to the State through the DDRS INsite database.

For all waiver starts, when the Case Manager completes the *Confirmation of Waiver Start* form in the Insite database and electronically transmits it to the DDRS database, the Office of Medicaid Policy and Planning (OMPP) will also be electronically notified to enter the individual's waiver start information in the Indiana AIM database.

When the *Confirmation of Waiver Start* form is received electronically by DDRS, the form is reviewed and, if accepted, an approval letter will be automatically transmitted back to the Case Manager. The period covered by the Initial CCB will be from the effective date of the *Confirmation* form through the end date of the Initial CCB that was previously approved by the Waiver Specialist.

Within three (3) calendar days of receiving the Initial CCB approval letter, the Case Manager must print a Notice of Action form (HCBS Form 5) and sign it. The Case Manager must provide copies of the signed Notice of Action form and Addendum (containing information from the CCB and Person Centered Service Planner) to the individual/guardian. The individual's chosen waiver service providers are required to register so that they receive the Notices of Action and the Addendums electronically.

There is no reimbursement for services delivered prior to receipt of the Notice of Action.

Part 6: Objective Based Allocation (OBA)

Sections 6.1 – 6.7

Section 6.1: OBA Overview and Development

Section 6.2: ICAP Assessment and Algo Level Development

Section 6.3: Budget Review Questionnaire (BRQ) and Budget Modification Review (BMR)

Section 6.4: Assessment (Algo) Level Descriptors

Section 6.5: Algorithm Chart

Section 6.6: Implementation of Objective Based Allocations

Section 6.7: PAR Review and the Appeal Process

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Section 6.1: OBA Overview and Development

In 2007, DDRS and an external group of stakeholders consisting of advocates, providers, and industry professionals began the research and development of an objective based allocation method.

Development strategy included baseline research, provider cost reporting, modeling, assessment validation, pilots, and best practices. Modeling was used to determine the parameters for Algorithm development (Algos)

The Objective Based Allocation (OBA) is the method used by the state to determine the level of supports an individual needs in order to live in a community setting. The OBA is determined by combining the Overall Algo (determined by the ICAP and ICAP addendum), Age, Employment, and Living Arrangement. For more information on the OBA please refer to training modules that were offered as guidance on the implementation of this new method.

Section 6.2: ICAP Assessment and Algo Level Development

The nationally recognized Inventory for Client and Agency Planning (ICAP) was selected to be the primary tool for individual assessment.

The ICAP assessment determines an individual's level of functioning for Broad Independence and General Maladaptive Factors. The ICAP Addendum, commonly referred to as the Behavior and Health Factors, determines an individual's level of functioning on behavior and health factors.

These two assessments determine an individual's overall Algo level which can range from 0-6. Algos 0 & 6 are considered to be the outliers representing those who are the highest on both ends of the functioning spectrum.

The Objective Based Allocation (OBA) is determined by combining the Overall Algo (determined by the ICAP and ICAP addendum), Age, Employment, and Living Arrangement

The stakeholder group designed a building block grid to build the allocations. The building block grid was developed with the following tenets playing key roles: Focus on Daytime Programming; Employment; Community Integration; and Housemates.

After the assessments are completed and the information is received by the State, the participants and their support teams are required to review the information and ensure that it accurately reflects them. Upon completion the participant will be notified of the allocation limit through their case manager.

Individual teams may request a formal review of their allocation through their case manager. Teams are asked to review the ICAP and ICAP addendum and provide supporting documentation to substantiate an individual's need for placement in a different Algorithm level. The supporting documentation is reviewed as well as the Person Centered Planning Document, Individualized Service Plans, Behavior Support Plans, High Risk Plans and any other collateral documentation needed to analyze the individual's Algorithm level.

Section 6.3: Budget Review Questionnaire (BRQ) and Budget Modification Review (BMR)

"Budget Review Questionnaire" means a set of qualifying questions to determine why a budget review is necessary. The Budget Review Questionnaire is submitted by the individual's case manager based on information provided by the Individualized Support Team.

Adjustments to the allocation limit may also occur when the participant has a change in their needs. Individual support teams may request a review of the assigned allocation limit through their case manager via a Budget Review Questionnaire (BRQ). The individual support teams must first review the functional assessment findings and provide any other supporting documentation that might lead to an adjustment in the allocation limit. When requested, reviews are conducted by a personal allocation review team within DDRS. If appropriate, adjustments and/or recommendations are provided by the DDRS review team. In addition, a Budget Modification Review (BMR) allows the participant to request short term increases in funding beyond the allocation limit if specific conditions apply. These conditions consist of a change in medical or behavioral needs or a change in living arrangement.
The BMR provides the participant the ability to request additional funding for a short amount of time to meet their needs that are outside the original allocation limit funding amount.

An individual or their legal representative may appeal the ICAP assessment if they feel it is inaccurate. The consumer/legal guardian has the right to appeal any waiver-related decision of the state within 30 days of Notice of Action (NOA). A Notice of Action (NOA) is issued with the release of each State decision pertaining to a Plan of Care/Cost Comparison Budget (CCB). Each NOA contains the appeal rights of the consumer as well as instructions for filing an appeal.

The BMR process is in place for waiver consumers who experience circumstances where additional funds are needed for short-term, unanticipated situations. Each initial event requested, if approved, shall not exceed ninety (90) days.

In order for a BMR to be considered, the following must first be sought:

- Housemates
- Electronic Monitoring Service
- Medicaid Prior Authorization Services
- Natural Supports

The individual's Case Manager (CM) is responsible for submitting initial BMR.

BDDS will respond to a new BMR within seven (7) business days of submission.

- final decision on BMR will not be made until CM responds to all inquiries from BDDS.

BUDGET MODIFICATION REQUEST CATEGORIES (FOR CONSIDERATION)

- Loss of a housemate due to:
    - death;
    - extended hospitalization of fourteen (14) or more days;
    - nursing facility respite stay of fourteen (14) or more days;
    - incarceration of fourteen (14) or more days;
    - State substantiated abuse, neglect, or exploitation;
    - State intervention for behavioral needs;
    - State intervention for health or medical needs; or
    - housemate changes Providers.
- Loss of employment.
- State substantiated abuse, neglect, or exploitation.
- Behavioral needs requiring State intervention.
- Health or medical needs requiring State intervention.

DOCUMENTATION REQUIREMENTS

Documentation requirements for Budget Modification Requests include, but are not limited to the following:

- If increased behaviors result in a BMR, documentation regarding changes to the consumer's behavior plan, staff trainings, etc. will be required within 30 days of the request for the BMR to be considered.
    - If behaviors are anticipated to last longer than ninety (90) days, a Budget Review Questionnaire should be completed rather than a BMR.
- In order for a BMR to be considered in Crisis situations a consumer must first go through the Crisis process.
- Individualized Support Teams (ISTs) must work together to address the individual's need and develop a long term plan within the individual's resources.
    - ISTs will be asked to submit these long term plans and objectives for all additional Budget Modification Requests.

Section 6.4: Assessment (Algo) Level Descriptors

Assessment (Algo) Level Descriptors

Level	Descriptor
0 **Low**	**High level of independence (Few Supports needed). No significant behavioral issues. Requires minimal Residential Habilitation Services.**
1 **Basic**	**Moderately high level of independence (Limited supports needed). Behavioral needs, if any, can be met with medication or informal direction by caregivers (through the use of Medicaid state plan services). Although there is likely a need for day programming and light Residential Habilitation Services to assist with certain tasks, the client can be unsupervised for much of the day and night.**
2 **Regular**	**Moderate level of independence (Frequent supports needed). Behavioral needs, if any, met through medication and/or light therapy (every one to two weeks). Does not require 24-hour supervision – generally able to sleep unsupervised – but needs structure and routine throughout the day.**
3 **Moderate**	**Requires full-time supervision (24/7 staff availability) for medical and/or behavioral needs. Behavioral and medical supports are not generally intense and can be provided in a shared staffing setting**
4 **High**	**Requires full-time supervision (24/7 frequent and regular staff interaction, require line of sight) for medical and/or behavioral needs. Needs are moderately intense, but can still generally be provided in a shared setting.**
5 **Intensive**	**Requires full-time supervision (24/7 absolute line of sight support). Needs are intense and require the full attention of a caregiver (1:1 staff to individual ratio). Typically, this level of services is generally only needed by those with intense behaviors (not medical needs alone).**
6 **High Intensive**	**Requires full-time supervision (24/7 more than 1:1). Needs are exceptional and for at least part of each day require more than one caregiver exclusively devoted to the client. There is imminent risk of individual harming self and/or others without vigilant supervision.**

Section 6.5: OBA Service Hours

Individual RHS Daily Hours	**Algo 1**	**Algo 2**	**Algo 3**	**Algo 4**	**Algo 5**	**Algo 6**
Living with Family	0.2	2	3	4	5	6
Living Alone	0.2	2.6	6	9	11.7	21
Living with One Housemate	0.2	2.6	5.3	7.8	11	12
Living with Two Housemates	0.2	2.6	4.6	7.8	10.1	11
Living with Three Housemates	0.2	2.4	4.3	7.3	9.4	10
BMAN Reserve (Annual hrs)	0	0	36	72	108	144
Day Service Reserve ($/Yr)						
Not Attending School	$10,500	$10,500	$10,500	$10,500	$10,500	$18,000
Attending School or under 19yrs.	$5,500	$5,500	$5,500	$5,500	$5,500	$5,500

Section 6.6: Implementation of Objective Based Allocations

Individuals will receive their new OBA on their annual renewal date. The first group will be the January 1st population. Over the course of 12 months, all waiver participants will be transitioned to an OBA when their waiver is up for annual renewal.

Allocations will receive a pre-release review focusing on individuals whose allocations drop or increase significantly from their previous cost comparison budget.

Training on the OBA can be found on FSSA website at http://www.in.gov/fssa/ddrs/4194.htm

Section 6.7: PAR Review and The Appeal Process

An individual support team may request a PAR (Personal Allocation Review) through the Case Manager via BRQ (Budget Review Questionnaire). The BRQ states the reason for allocation review; i.e. Algo level is incorrect; ICAP assessment has significant error; ICAP Addendum (Behavior and Health Factors) are incorrect; living arrangement is incorrect; etc. The BRQ is submitted to the district BDDS office for review and then submitted to the PARS unit for a PAR review.

If an individual has not received their BRQ results back prior to the new plan start date, the case manager may request a BMR monthly until the BRQ results are completed by the PAR unit.

The PAR reviewer will notify the case manager of any change in Algo or allocation based on their review.

If the individual support team is unhappy with the PAR review, or wishes to appeal without a PAR review, they may appeal one or more of the OBA components after their NOA (Notice of Action) has been generated: The ICAP Assessment; ICAP Addendum (Behavior and Health Factors) are incorrect; or Living Arrangement.

To generate a NOA, a CCB must be submitted at the allocation level or the IST cannot submit a CCB and a default CCB will generate the NOA.

To continue services at the previous year's service level, the team must request a BMR using the "oba xfer" category as the qualifier.

The appeal process, which has not changed with the OBA, is located on the back pages of the NOA and is stated below:

The Right to Appeal and Have a Fair Hearing:

If your application or service is denied, you may file an appeal within 30 days of the decision date shown on this notice. The time limit for filing an appeal is extended by three (3) days if this notice is received by mail. Your Home and Community Based Services (HCBS) benefits will continue if you file an appeal within the required time frame of the decision notice. If you appeal and your benefits are continued and you lose the appeal, you may be required to repay assistance paid in your behalf pending the release of the appeal hearing.

How to Request an Appeal:

- If you wish to appeal this decision, you may request an appeal within 30 days of the date of this notice. The time limit for filing an appeal is extended by three (3) days if this notice is received by mail. To file an appeal, please sign, date and return the Hearings & Appeals copy of this form to:

  Office of Hearings and Appeals
  MS 04
  402 W. Washington St. Room E-034
  Indianapolis, IN 46204

  - If you are unable to sign, date, and return this form to the above mentioned address, you may have someone assist you in requesting the appeal.

- You will be notified in writing by the Indiana Family and Social Services Administration, Hearings and Appeals office of the date, time, and location for the hearing. Prior to, or at the hearing, you have the right to examine the entire contents of your case record maintained by the Case Manager.

- You may represent yourself at the hearing or you may authorize a person to represent you, such as an attorney, relative or other spokesperson. At the hearing you will have full opportunity to bring witnesses, establish all pertinent facts and circumstances advance any arguments with interference and question, or refute any testimony or evidence presented.

Part 7: Monitoring and Continuation of Waiver Services

Sections 7.1 – 7.9

Section 7.1: Level of Care Re-Evaluation

Section 7.2: Medicaid Eligibility Re-Determination

Section 7.3: Annual Plan of Care/Cost Comparison Budget (CCB) Development

Section 7.4: Plan of Care/Cost Comparison Budget (CCB) Updates and Revisions

Section 7.5: State Authorization of the Annual/Update Cost Comparison Budget

Section 7.6: Service Plan implementation and Monitoring

Section 7.7: Interruption/Termination of Waiver Services

Section 7.8: Waiver Slot Retention after Termination and Re-Entry

Section 7.9: Parent/Guardian Providing Paid Services

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Section 7.1: Level of Care Re-Evaluation

The process for re-evaluation of level of care is the same as the initial evaluation, but it is performed by the contracting waiver case management entity as opposed to a contractor or BDDS staff. Developmental Disabilities, Autism, and Support Services Waiver program participants must be re-evaluated each year to meet ICF/MR level of care (Individuals on the Autism Waiver must also have a diagnosis within the Autism Spectrum).

The DDRS Central Office completes the annual level of care re-evaluations for these waivers for children who have not reached their 6th birthday. For children age 6 and older and for all adults, the annual level of care re-evaluations are completed by the contracting case manager who must be a Qualified Mental Retardation Professional (QMRP).

Section 7.2: Medicaid Eligibility Re-Determination

The Division of Family Resources (DFR) is the group that determines eligibility for all Indiana Social Services Programs. The DFR will assist you in determining which programs are right for you and your family. You can learn more about the application process by going to Apply for Medicaid at http://member.indianamedicaid.com/apply-for-medicaid.aspx .

Each year, the local DFR determines the individual's continuing eligibility to receive Medicaid.

Section 7.3: Annual Plan of Care/Cost Comparison Budget (CCB) Development

All individuals/participant (also known as the consumer) receiving Waiver services must have a new Plan of Care/Cost Comparison Budget (CCB) approved on an annual basis and the Person Centered Service Planner must also be updated at least annually. The Annual CCB represents the service plan identified for the individual during the required review of the individualized support plan. **Annual CCBs are to start the date following the expiration of the previous CCB and cover a 12 month period.**

In the event that an Annual CCB is not submitted or cannot be approved in a timely manner, the most recently approved CCB is automatically converted to a new annual CCB. The total cost/amount of services on the "auto-converted", or" default", CCB is determined by the cost of services and supports appearing on the most recently approved but expiring CCB. The auto-converted, or default CCB ensures that there is no loss of services. The case manager is subsequently contacted and required to complete the annual planning process and ISP and CCB revision.

The plan is developed by the Individualized Support Team (IST) identified by the participant. The participant has the right and power to command the entire process. The case manager, participant and others of the participant's choosing form the IST. The CCB is developed a minimum of six weeks prior to the initial start date of services or six weeks prior to the end date of the current annual service plan. The CCB is routinely developed to cover a timeframe of 12 consecutive months.

The Cost Comparison Budget is driven by a person-centered planning process, coordinated in conjunction with the participant, his or her guardian or legal representative, and members of the individual's support team. Case Managers are responsible for the facilitation and development of the participant's Person-Centered Description (PCD), a document divided in to five key components:

1. Personal Priorities, which includes the Personal Priority Statements and Personal Priority Narratives;
2. Relationships;
3. Communication;
4. Initiatives, or Outcomes; and
5. Historical Narrative.

The PCD to be updated at least annually, and is to ascertain the individual's needs, wants, and desires using person-centered planning philosophy processes. It is the Case Manager's responsibility to ensure the person-centered planning process accounts for and documents the participant's preferences, desires, and needs, including his or her likes and dislikes, means of learning, decision-making processes, and desire to be productive. An individual's PCD should be reflective of his or her long-term hopes and desires so as to develop an Individual Support Plan (ISP) that encourages and supports the achievement of these goals. Each participant's PCD will be reviewed and updated every 90 days as part of the individual's Annual Planning Quarterly Update team meetings. All contracting case managers are to be trained in person-centered thinking and be PCD/ISP certified.

The health and safety indicator is an assessment conducted by the case manager that helps identify the health and safety needs of an individual. The assessment is a tool used to help identify risks related to health, behavior, safety and support needs for waiver participants.

The participant is informed of available waiver services at the time of application, during enrollment and development of the PCP/ISP and CCB and on an ongoing basis throughout the year as needed. The participant's Case Manager is knowledgeable in all services available on the waiver and is responsible for providing the participant with information about each covered service, its definition, scope and limitations.

The Plan of Care/Cost Comparison Budget (CCB) is developed based upon the outcomes of the initial, annual or subsequent meeting of the Individualized Support Team during which the Person-Centered Plan and the Individualized Support Plan are developed. This entire process is driven by the participant and is designed to recognize the participant's needs and desires. The Case Manager holds a series of structured conversations, beginning with the participant/ guardian and with other individuals, identified by the participant that know them well and can provide pertinent information about them, to gather initial information to support the person-centered planning process. The overall emphasis of the conversations will be to derive what is important to and what is important for the participant, with a goal of presenting a good balance of the two. The case manager facilitates the IST meeting, reviews the participant's desired outcomes, their health and safety needs and their preferences, and reviews covered services, other sources of services and support (paid and unpaid) and the budget development process using the objective based allocation for waiver services. The case manager then finalizes the ISP and completes the CCB.

Coordination of waiver services and other services is completed by the Case Manager. Within 30 days of implementation of the plan, the Case Manager is responsible for ensuring that all identified services and supports have been implemented as identified in the Individualized Support Plan and the CCB. The Case Manager is responsible for monitoring and coordinating services on an ongoing basis and is required to record a weekly case note for each participant. A formal 90 day review is also completed by the case manager with the participant and includes the IST. Each waiver provider is required to submit a monthly or quarterly report summarizing the level of support provided to the participant based upon the identified supports and services in the Individualized Support Plan and the Cost Comparison Budget. The Case Manager reviews these reports for consistency with the ISP and CCB and works with providers as needed to address findings from this review.

The ISP identifies the services needed by the participant to pursue their desired outcomes and to address their health and safety needs. Each outcome within the ISP has associated initiatives designed to address potential barriers or maintenance needs in relation to the desired outcomes and the support and services needed to facilitate the outcomes. The initiative also identifies all paid and unpaid responsible parties and, includes the name of the provider agency, the service, and the staffing position(s) within the agency that are responsible for the initiative. The participant may be the responsible party for an initiative if they so determine. In addition, each initiative has a specific timeframe identified, including a minimum review timeframe for each initiative.

The Plan of Care/Cost Comparison Budget (CCB) identifies the name of the waiver service, the name of the participant-chosen provider of that service, the cost of the service per unit, the number of units of service and the start and end dates for each waiver service identified on the CCB.

The ISP and CCB are reviewed a minimum of every 90 days and updated a minimum of every 365 days. The participant can request a change to the CCB at any point, be it a new service provider, or a change in the type or amount of service. If a change to the ISP and/or the CCB is determined necessary during that time, the participant and/or family or legal representative and IST will meet to discuss the change. The actual updating of the CCB is completed by the Case Manager based upon the participant and the IST discussion and determination.

Section 7.4: Plan of Care/Cost Comparison Budget (CCB) Updates and Revisions

The ISP and CCB are reviewed a minimum of every 90 days and updated a minimum of every 365 days. The participant can request a change to the CCB at any point, be it a new service provider, or a change in the type or amount of service. If a change to the ISP and/or the CCB is determined necessary during that time, the participant and/or family or legal representative and IST will meet to discuss the change. The actual updating of the CCB is completed by the Case Manager based upon the participant and the IST discussion and determination.

Section 7.5: State Authorization of the Annual/Update Cost Comparison Budget

The Case Manager will transmit the Plan of Care/Cost Comparison Budget (CCB) electronically to the State's Waiver Specialist who will review the CCB and Person Centered Service Planner and confirm the following:

- The individual is a current Medicaid recipient within one of the following categories:
    - Aged **(MA A)**
    - Blind **(MA B)**
    - Low Income Families **(MA C)**
    - Disabled **(MA D)**
    - Disabled Worker **(MA DW)**
    - Children receiving Adoption Assistance or Children receiving Federal Foster Care Payments under Title IV E - Sec. 1902(a)(10)(A)(i)(I) of the Act **(MA 4 & MA 8)**
    - Children receiving adoption assistance under a state adoption agreement - Sec 1902(a)(10)(A)(ii)(VIII) **(MA 8)**
    - Independent Foster Care Adolescents – Sec 1902(a)(10)(A)(ii)(XVII) **(MA 14)**
    - Children Under Age 1 – Sec 1902(a)(10)(A)(i)(IV) **(MA Y)**
    - Children Age 1-5 - Sec 1902(a)(10)(A)(i)(VI) **(MA Z)**
    - Children Age 1 through 18 - Sec 1902(a)(10)(A)(i)(VII) **(MA 9 & MA 2)**
    - Transitional Medical Assistance – Sec 1925 of the Act **(MA F)**
    - Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121 **(MA U)**

- The individual has a current ICF/MR level of care approval and for participants of the Autism Waiver, a formal diagnosis of Autism for the Autism Waiver

- The individual's indentified needs will be met and health and safety will be assured;

- The costs are consistent with identified needs of the individual and the services to be provided;

- That if the total cost of Medicaid waiver and regular Medicaid State plan services for the individual exceeds the total costs of serving an individual with similar needs in an ICF/MR facility, the programmatic cost-effectiveness will be maintained;

- The individual/participant or guardian has signed, indicating acceptance of, the CCB; signed that he/she has been offered choice of certified waiver service providers; and signed that he/she has chosen waiver services over services in an institution.

The Waiver Specialist may request additional information from the Case Manager to assist in reviewing the packet.

If the Waiver Specialist denies the CCB, a denial letter must be transmitted to the Case Manager, BDDS (for Initials and Annuals only) and Service Providers. Within three (3) calendar days of receipt of the denial the Case Manager must complete and provide a copy of a Notice of Action (HCBS Form 5), the Appeal Rights as an HCBS Waiver Services Recipient, and an explanation of the decision to deny to the individual/guardian.

If the Waiver Specialist approves the CCB, the approval letter and Notice of Action are transmitted to the Case Manager, BDDS (for Initials and Annuals only) and Service Providers. The Case Manager notifies the individual or guardian within three (3) calendar days of receipt of the approval and provides a copy of the approval letter.

Section 7.6: Service Plan implementation and Monitoring

Case Managers are responsible for the implementation and monitoring of the service plan (inclusive of the Individualized Support Plan, Cost Comparison Budget and, often, other non-funded services) and participant health and welfare.

A minimum of one face-to-face contact between the case manager and the participant is required every 90 days, and as frequently as needed to support the participant. In each meeting, the participant's support team will review current concerns, progress and implementation of the plan of care.

A 90 Day Checklist is utilized by the Case Manager and Individualized Support Team in order to systematically review the status of the Cost Comparison Budget, the Individualized Support Plan, any behavioral support program, choice and rights, medical needs, medications, including psychotropic medications (if applicable), seizure management (if applicable), nutritional/dining needs, incident review, staffing issues, fiscal issues, and any other issues which may be identified in regard to the satisfaction and health and welfare of the participant. The checklist is also used to verify that emergency contact information is in place in the home, including the telephone numbers for Adult Protective Services or Child Protective Services and the Bureau of Quality Improvement Services. Case Managers educate the participant by offering examples of when the emergency contact numbers should be called.

The case manager is required to enter a weekly case note indicating the progress and implementation of the service plan. The case manager also maintains regular contact with the participant, family/guardian and the provider(s) of services through home and community visits or by phone to coordinate care, monitor progress and address any immediate needs. During each of these contacts the case manager assesses the service plan implementation as well as monitors the participant's needs.

The monitoring and follow up method used by the case manager include conversations with the participant, the parent/guardian, and providers to monitor the frequency and effectiveness of the services through monthly team meetings and regular face-to-face and phone contacts. The case manager asks:

- Are the services being rendered in accordance with the plan of care?
- Are the service needs of the participant being met?
- Do participants exercise freedom of choice of providers?
- What is the effectiveness of the crisis and back up plans?
- Is the participant's health and welfare being ensured?
- Do participants have access to non-waiver services identified in the plan of care including access to health services?

The implementation and effectiveness of the plan of care is reviewed in quarterly IST meetings. A monitoring report has been developed by the contractor of case management services and is sent to the DDRS Case Management Liaison, DDRS management staff and to the Office of Medicaid Policy and Planning (OMPP) on a quarterly basis for review. The report includes confirmation of annual review (PCP/ISP/LOC), noting month and date.

At all times, full, immediate and unrestricted access to the individual data is available to the State, including the DDRS Case Management Liaison position as well as other members of the DDRS Executive Management Team and OMPP.

Service Problems:
Problems regarding services provided to participants are targeted for follow up and remediation by the case management provider in the following manner:

- Case Managers conduct a face-to-face visit with each participant no less frequently than every 90 days, and complete a 90 Day Review Checklist at that time.
- They investigate the quality of participant services, and indicate on the checklist if any problems related to participant services are not in place.
- For each identified problem, they identify the timeframe and person responsible for corrective action, communicate this information to the interdisciplinary team, and monitor to ensure that corrective action takes place by the designated deadline.
- Case Manager Supervisors and District Directors within the case management organization monitor each problem quarterly via the State Hot List system to ensure that case managers are following up on, and closing out, any pending corrective actions for identified problems.

At least every 90 days, in conjunction with the 90 Day Review Checklist, Case Managers update the participant's Individualized Support Plan (ISP) progress notes, to indicate if all providers and other team members are current and accurate in their implementation of plan activities on behalf of the participant. Any lack of compliance on the part of provider entities or other team members is noted within the participant's Participant Outcome Measurement Tool (COMT), and communicated to the noncompliant entity for resolution. Case Manager Supervisors and District Directors monitor this tool on no less than a monthly basis to ensure follow up and completion of all identified outcomes for each participant.

Section 7.7: Interruption/Termination of Waiver Services

An individual's waiver services will be terminated when the individual:

- Voluntarily withdrawals;
- Chooses institutional placement/entering Medicaid-funded long-term care facility;
- Dies;
- Needs services so substantial that the total cost of Medicaid services for the individual would jeopardize the Waiver program's cost effectiveness;

- No longer meets ICF/MR level of care criteria;
- Is no longer eligible for Medicaid services
- No longer requires Home and Community-Based Services; or
- Is no longer developmentally disabled

Other examples of circumstances appropriate for interruption/termination may include a participant being arrested, in jail, awaiting trial, convicted/sentenced.

When an individual terminates Waiver services, the Case Manager must complete an electronic "termination" Data Entry Worksheet (DEW), enter the information in the Insite database, and electronically transmit the information to the DDRS database. The DEW is also automatically transmitted to OMPP to enter the Waiver termination information in the Indiana AIM database.

Completion of the termination DEW also results in an auto-generated Notice of Action. Within three (3) calendar days of the termination, the Case Manager must, provide the individual or guardian with a copy of the Notice of Action form, the *Appeal Rights as an HCBS Waiver Services Recipient* instructions, and an explanation of the termination. As appropriate, other service options are to be discussed with the individual and guardian.

Section 7.8: Waiver Slot Retention After Termination and Re-Entry

The following situations related to waiver slot retention after Termination are contingent upon review and approval by the State.

Upon review and approval of the State, if an individual who has been terminated from the Waiver wishes to return to the program, he or she may do so within the same Waiver year of his or her termination, if otherwise eligible. The individual shall return to the Waiver without going on a waiting list. "Within the same Waiver year" is considered as follows:

- Autism Waiver: January 1 through December 31
- Developmental Disabilities Waiver: October 1 through September 30
- Support Services Waiver: April 1 through March 31

An individual who has been terminated from the Waiver program within 30 calendar days may resume the Waiver with the same level of care approval date and Cost Comparison Budget (CCB) and Service Planner if the individual's condition has not significantly changed and the CCB and Service Planner continue to meet his or her needs.

- The Case Manager must certify that the individual continues to meet level of care criteria
- The Case Manager must complete a "Resumption" Data Entry Worksheet, enter it in the Insite database, and submit it electronically to the DDRS database. The information will be automatically transmitted to the OMPP to enter into the Indiana AIM database.

If an individual who has been terminated from the Waiver program longer than 30 calendar days and wishes to return to the program and is otherwise eligible,

- The Case Manager is responsible for developing the level of care packet and CCB and Person Centered Service Planner following the same processes described in the "Annual Level of Care Determination: and the "Initial CCB" sections.
- The Case Manager is to indicate a "Re-Entry" CCB and Service Planner when electronically transmitting them to the State Waiver Specialist via the INsite database.
- When the individual "Re-Enters" Waiver services, the Case Manager must enter a Confirmation of Waiver Start form in the INsite database and electronically transmits it to the DDRS database. The information will be automatically transmitted to the Office of Medicaid Policy and Planning (OMPP) to enter in the Indiana AIM database.
- When the Confirmation of Waiver Start form is received electronically by DDRS, it is reviewed and once accepted, an approval letter will be automatically transmitted back to the Case Manager.
- Within three (3) days of receiving the Re-Entry CCB approval letter, the Case Manager must print a Notice of Action (HCBS Form 5) and sign it. The Case Manager must provide copies of the Notice of Action form and Addendum (containing information from the CCB and Person Centered Service Planner) to the individual/guardian and to all of the individual's waiver service providers.

When an individual "re-enters" Waiver services:

- If within 30 days of terminating Waiver services, the annual level of care and CCB dates remain the same dates as they were prior to the termination of Waiver services,
- If more than 30 days since terminating Waiver services, the new level of care and CCB dates are used for determining when future annual level of care determinations and CCBs are due.

If an individual participant interrupts or terminates waiver services within 30 days of the end of the waiver year with the intention of returning to waiver services early in the next waiver year, the anticipated return to the waiver must occur within 60 days of the next waiver year or the individual may be permanently removed from services.

Section 7.9: Parent/Guardian Providing Paid Services

Without exception, relatives* are not permitted to provide services to a related* waiver participant under Adult Foster Care.

Without exception, legal guardians of children under 18 may not receive payment for any waiver service.

However, a relative* (excluding a spouse) may sometimes provide other waiver service(s) rendered to **adult** waiver participants when that relative* is employed by or a contractor of a Division of Disability and Rehabilitative Services (DDRS)-approved provider.

All of the following must be met before a relative* may be considered to be a provider:

- The individual receiving services is at least 18 years of age;
- The relative* is employed by or a contractor of an agency that is approved by DDRS to provide care under the waiver;
- The relative* meets the appropriate provider standards (per 460 IAC 6) for the service(s) being provided;
- The decision for the relative* to provide services to an **adult** waiver participant is part of the Person Centered Planning process, which indicates that the relative* is the best choice of persons to provide services from the DDRS-approved provider agency, and this decision is recorded and explained in the Individualized Support Plan (ISP);
- There is detailed justification as to why the relative* is providing service;
- The decision for a relative* to provide service(s) is evaluated periodically (i.e. at least annually) to determine if it continues to be in the best interest of the individual;
- Payment is made only to the DDRS-approved provider agency in return for specific services rendered; and
- The services must be rendered one-on-one with the participant or in shared settings with group sizes allowable per specified waiver service definitions and documented as acceptable by all relevant individualized support teams. Authorization for shared or group services must be reflected on and documented via the approved Notice of Action for each group participant. With the exception of groups of waiver participants as noted above, the relative* may not be responsible for others (including their other children or family members) nor engaged in other activities while providing services.

*** Related/relative implies any of the following natural, adoptive and/or step relationships, whether by blood or by marriage, inclusive of half and/or in-law status:**

1) Aunt (natural, step, adopted)
2) Brother (natural, step, half, adopted, in-law)
3) Child (natural, step, adopted)
4) First cousin (natural, step, adopted)
5) Grandchild (natural, step, adopted)
6) Grandparent (natural, step, adopted)
7) Parent (natural, step, adopted, in-law)
8) Sister (natural, step, half, adopted, in-law)
9) Spouse (husband or wife)
10) Uncle (natural, step, adopted)

NOTE: As explained under Section 10.24 of this manual, Residential Habilitation and Support services (RHS) reimbursable waiver funded services furnished to an adult waiver participant by any combination of relative(s)* and/or legal guardian(s) may <u>not</u> exceed a total of 40 hours per week.

Part 8: Appeal Process

Sections 8.1 – 8.18

Section 8.1: Appeal Request

Section 8.2: Group Appeals

Section 8.3: Time Limits for Requesting Appeals

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Section 8.5: Request for Continuance from the Appellant

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Section 8.1: Appeal Request

An appeal is a request for a hearing before an Administrative Law Judge with the Family and Social Services Administration, Hearings and Appeals Section. The purpose of an appeal is to determine whether a decision made by a Service Coordinator, Case Manager, Waiver Specialist, or the DDRS Central Office affecting the recipient/consumer, is correct. An appeal request must be in writing and forwarded to the hearing authority.

State Form 46015 Form HCBS 5 is used to notify each Medicaid HCBS Waiver applicant/participant of any action that affects the applicant/participant's or prospective participant's Medicaid benefits related to HCBS waivers including determinations regarding level of care, HCBS waiver service actions including reduction, termination or denial of a service and authorized services and service providers.

An explanation regarding a waiver service applicant/participant or prospective participant's appeal rights and the opportunity for a fair hearing is found on the back of the Notice of Action (NOA). Part 2 "Your Right to Appeal and Have a Fair Hearing" advises applicant/participant or prospective participant of his/her right to appeal and the timeliness requirements association with the right to appeal. Part 3 "How to Request an Appeal" provides instructions regarding the procedures that are necessary in the appeal process, including the right of the appellant to authorize representation by an attorney, relative or other spokesperson on behalf of the appellant.

HCBS waiver participants are advised of the Right to Appeal and request a Fair Hearing by the Case Manager (CM) employed by the contracting case management entity. The CM provides each participant and eligible prospective participant (as well as his or her guardian or advocate, as appropriate) with a copy of the NOA.

For HCBS waiver participants, an NOA is generated and sent to a participant when the CM generates the Plan of Care/Cost Comparison Budget (CCB) and the CCB is authorized by the Bureau of Developmental Disabilities Services (BDDS). The NOA specifies any adverse determination (when he/she is denied the service(s) or the provider(s) of his/her choice, or when actions are taken to deny, suspend, reduce or terminate services). The NOA informs the participant (and the participant's guardian or advocate, as appropriate) of his/her right to an appeal the determination and also advises the participant that services will be continued if he/she files the appeal in a timely manner, which is within 30 days of the decision date noted on the NOA.

Additionally, participants have the right to appeal the assessment used to determine the objective based allocation amount. Upon request, the CM assists the participant in preparing the written request for Appeal and Fair Hearing. The CM advises the participant of the required timeframes, the address for submission of the appeal, and provides an opportunity to discuss the issue being appealed. The request for an Appeal and a Fair Hearing is recorded in a Case Note by the CM as well as recorded at the Family and Social Services Administration's Hearing and Appeals office.

Section 8.2: Group Appeals

Family and Social Services Administration, Hearings and Appeals Sections, may respond to a series of requests for hearings by providing group hearings or similar questions or changes in federal or state law or regulation. Similarly, a group of individuals who wish to appeal some aspect of policy may request to be heard as a group. If there is disagreement as to whether the issue is one of federal or state law or regulation or the facts of an appellant's personal situation, Hearings and Appeals will make the decision as to whether the appeal may be included in a group hearing.

The Administrative Law Judge may limit the discussion in a group hearing to the sole issue under appeal. When an appellant's request for a hearing involves additional issues to the one serving as the basis for the group hearing, the appeal will be handled individually. An appellant scheduled for a group hearing may choose to withdraw and be granted an individual hearing even if the grievance is limited to the sole issue involved in the group hearing.

Policies governing the conduct of individual hearings are pertinent to group hearings. Each appellant (or representative) will be given full opportunity to present the case (or have the case presented by a representative).

Section 8.3: Time Limits for Requesting Appeals

Plan of Care/Cost Comparison Budget:

- The consumer/legal guardian has the right to appeal any waiver-related decision of the state within 30 days of Notice of Action (NOA). A Notice of Action (NOA) is issued with the release of each State decision pertaining to a Plan of Care/Cost Comparison Budget (CCB). Each NOA contains the appeal rights of the consumer as well as instructions for filing an appeal.

Objective Based Allocation (OBA):

- The consumer/legal guardian has the right to appeal the OBA within 30 days of the Notice of Action (NOA). Each NOA contains the appeal rights of the consumer as well as instructions for filing an appeal.

DD Eligibility:

- The consumer/legal guardian has the right to appeal DD Eligibility within 15 days of the decision. The decision letter will contain the appeal rights of the consumer as well as instructions for filing an appeal.

Level of Care:

- The consumer/legal guardian has the right to appeal Level of Care within 30 days of the decision. The decision letter will contain the appeal rights of the consumer as well as instructions for filing an appeal.

Section 8.4: The Hearing Notice

The Family and Social Services Administration, Hearings and Appeals Section, sends a notice acknowledging the appeal to the individual by whom the appeal was filed.

The Notice of Scheduled Hearing is then sent to all parties, which includes the individual (the representative), the Service Coordinator and /or the Case Manager. The DDRS Central Office would also be included in receiving a notice if they were involved in making the decision.

The Notice of Scheduled Hearing

- Includes a statement of the date, time, place, and nature of the hearing which is always conducted in the appellant's county of residency;
- Advises the appellant of the name, address, and phone number of the person to notify in the event it is not possible for him to attend;
- Specifies that the hearing request will be dismissed if the appellant fails to appear for the hearing without good cause;
- Specifies that the appellant may request a continuance of the hearing if good cause is shown;
- Includes the appellant's rights, information, and procedures to provide the appellant, or representative with an understanding of the hearing process; and
- Explains that the appellant may examine the case record prior to the hearing

The Notice of Scheduled Hearing is sent out so that it reaches the appellant at least 10 days prior to the hearing.

Section 8.5: Request for Continuance from the Appellant

A written request for a continuance is to be directed to the Hearings and Appeals Section. Good cause must exist for a continuance to be granted. Good cause is defined as a valid reason for the appellant's inability to be present at the scheduled hearing such as inability to attend the hearing because of a serious physical or mental condition, incapacitating injury, death in the family, severe weather conditions making it impossible to travel to the hearing, unavailability of a witness and the evidence cannot be obtained otherwise, or other reasons similar to those listed in this section. If good cause exists and a continuance is granted, the hearing is rescheduled.

Section 8.6: Review of Action

When an appeal request is received, a designated state staff within the appropriate units (Service Coordinator, Case Manager, DDRS Central Office or BDDS Waiver Unit) should review the proposed action to determine whether the proposed action is appropriate.

The designated state staff must offer the individual (or representative) the possibility of an informal conference and an opportunity to review the evidence prior to the hearing. Individuals should be

advised that an informal conference prior to the hearing is optional and in no way delays or replaces the administrative hearing. The conference may lead to an informal resolution of the dispute. An administrative hearing must still be held unless the individual (or representative) in writing withdraws the request for a hearing.

Section 8.7: Disposal of Appeal without a Fair Hearing

An appeal request may be disposed of without holding a fair hearing in the following situations:

- If, after review of the appellant's situation, the Service Coordinator and/or the Case Manager or the DDRS Central Office realizes that the proposed action or action taken is incorrect, then adjusting action may be taken.

- If the appellant wishes to withdraw the appeal, he/she is to be assisted by the Service Coordination and/or the Case Manager or the DDRS Central Office in promptly notifying the Hearings and Appeals Section in writing of the decision. No pressure is to be exerted on the appellant to withdraw the appeal. The withdrawal must be acknowledged in writing and it is only with the receipt of a signed voluntary withdrawal statement from the appellant that the appeal is to be dismissed.

- An appeal is abandoned when the appellant (or representative) without good cause, does not appear at a scheduled hearing. The appeal will be dismissed and the parties so notified.

Section 8.8: The Fair Hearing

An administrative hearing is a review of an action(s) of a Service Coordinator, Case Manager, DDRS Central Office or BDDS Waiver Unit regarding issues relating to the Autism, Developmental Disabilities and Support Services Waivers. An administrative Law Judge, who is an employee of the Family and Social Services Administration, Hearings and Appeals Section, is designated to hold the hearing and to issue findings of fact, conclusions of law, and a decision related to the appeal request.

A hearing allows the dissatisfied appellant an opportunity to present his/her grievance and to describe the circumstance and needs in his/her own words. An attorney or another individual of his choice may represent the individual. A designated state staff within the appropriate unit(s) (Service Coordinator, Case Manager, DDRS Central Office or BDDS Waiver Unit) will attend the hearing and present evidence supporting the action under appeal.

Section 8.9: Preparation for Hearing by Appellant

As the appellant prepares for the hearing, the appellant (or representative) is to be given an opportunity to:

- Discuss the issue being appealed with the Service Coordinator and/or Case Manager, BDDS Waiver Unit (or representative), or the DDRS Central Office representative
- Upon request, examine the entire case file and all documents and records that will be used by the Service Coordinator and/or Case Manager, BDDS Waiver Unit representative or the DDRS Central Office representative at the hearing.
- Obtain free of charge copies of all exhibits that will be used as evidence by the Service Coordinator and/or Case Manager, BDDS Waiver Unit representative or the DDRS Central Office representative at the hearing.
- The appellant is to be advised of any legal services available that can provide representation at the hearing.

Section 8.10: Preparation for Hearing by the Service Coordinator and/or Case Manager, BDDS Waiver Unit, or DDRS Central Office

The correct application of federal or state law or regulation to the appellant's situation should be reviewed by the appropriate state representative for the area in which the decision was made prior to the hearing. Thorough support of the action proposed or taken must be provided at the hearing.

The person testifying should be the person with the most direct contact with the action being proposed or taken. In the absence of the person with the most knowledge of the hearing situation, a person familiar with the action and the case record should substitute.

To prepare for the hearing, the designated state staff is to:

- Review all factors and issues that led to the action being appealed;
- Discuss the issue being appealed with the appellant (or representative) if at all possible, and definitely if a discussion is requested by the appellant. If requested, allow the appellant (or representative) to examine the entire case record;
- Identify and label all documents that are pertinent to the issue under appeal. The exhibits should be labeled in the lower right hand corner with the State's Exhibit being Exhibit A. If more than one page is in an exhibit, the pages are labeled (for the first page) State's Exhibit A, page 1 of 2; and (for page2) State's Exhibit A, page 2 of 2. The next numbers continue for each page in the exhibit being presented. The subsequent exhibit would be labeled Exhibit B and the pages according to the number of pages. Example [If three pages are in an exhibit, the third page would be labeled]:

  State's Exhibit A
  Page 3 of 3

- Make one copy of labeled exhibits for the Administrative Law Judge and one copy for the appellant (unless already given to the appellant). A duplicate copy of the notice sent to the appellant advising of the proposed action should be included as part of the documentation;
- Prepare a written outline that can be used as a tool in presenting the testimony at the hearing. Bear in mind when preparing the outline that the Administrative Law Judge knows nothing about the situation. The outline should focus on:

    - Identification of the staff representative by name and position;
    - The period of time the representative worked directly or indirectly with the appellant;
    - One sentence explanation of the issue under appeal;
    - The important information concerning how it was determined that the action proposed or taken was appropriate; and
    - Federal and state laws and regulations that were the basis for the action

- Include the labeled exhibits at the appropriate point in the presentation outline

Section 8.11: Conduct of the Hearing

The Administrative Law Judge conducts the hearing. Both, the appellant and the appropriate state representative have the opportunity to:

- Present the case or have it presented by legal counsel or another person;
- Present testimony of witnesses;
- Introduce relevant documentary evidence;
- Establish all pertinent facts and circumstances;
- Present any arguments without interference;
- Question or refute any testimony or evidence presented by the other party, including the opportunity to confront and cross-examine any adverse witnesses; and
- Examine the appellant's entire case record and all documents and records used by the Service Coordinator and/or the Case Manager, the DDRS Central Office or BDDS Waiver Unit at the hearing.

These parties are advised at the close of the hearing that they will be informed in writing of the Administrative Law Judge's decision.

Section 8.12: Continuance of Hearing

If the Administrative Law Judge determines that further evidence is needed to reach a decision, the decision is delayed until such further evidence is obtained. The hearing may also be reconvened, if necessary, to obtain additional testimony. The parties will be notified of this and of the time and method for obtaining this evidence. Any evidence submitted must be copied and given to the opposite party, who then has the opportunity for rebuttal.

Section 8.13: The Hearing Record

The hearing record is an official report containing the transcript or recording of the testimony of the hearing, together with all papers and requests filed in the proceeding, and the decision of the Administrative Law Judge.

Section 8.14: The Fair Hearing Decision

A written copy of the Administrative Law Judge's hearing decision is sent to all parties. The decision includes:

- The findings of fact and conclusions of law regarding the issue under appeal; and
- Supporting laws and regulations

In all cases the decision of the Administrative Law Judge is based solely on the evidence introduced at the hearing and the appropriate federal and state laws and regulations. The Administrative Law Judge signs the decision which also contains the findings of fact and the conclusion of law. The decision is to be explained to the appellant upon request.

Section 8.15: Actions of the Administrative Law Judge's Decision

The decision of the Administrative Law Judge shall be binding upon the Division of Disability and Rehabilitative Services or the Office of Medicaid Policy and Plan and is to be enacted even if one of the parties requests an Agency Review. Such decisions do not preclude modifying changed conditions subsequent to the original appeal request as long as the change does not relate to the issue under appeal.

Section 8.16: Agency Review

Any party may request an Agency Review if dissatisfied with the decision made by the Administrative Law Judge. The Agency Review request must be made in writing to the Family and Social Services Administration, Hearings and Appeals Section, within 10 days following receipt of the hearing decision.

Once an Agency Review is requested, the Hearings and Appeals Section will write to all parties to acknowledge receipt of the request and to provide information concerning the review.

No new evidence will be considered during the Agency Review; however, any party may submit a written Memorandum of Law, citing evidence in the record, for consideration.

The Secretary of the Family and Social Services Administration or the Secretary's designee shall complete the agency review. The decision made at Agency Review will be sent to all appropriate parties.

Section 8.17: Judicial Review

The appellant, if not satisfied with the final action, may file a petition for judicial review in accordance with IC 4-21.5-5.

Section 8.18: Lawsuit

If a lawsuit is filed, all inquiries should be directed to the FSSA Office of General Counsel.

Part 9: Bureau of Quality Improvement Services

Sections 9.1 – 9.6

Section 9.1: Overview

Section 9.2: Provider Compliance Reviews

Section 9.3: Incident Reports

Section 9.4: Complaints

Section 9.5: Mortality Reviews

Section 9.6: Statewide Waiver Ombudsman

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Section 9.1: Overview

The Bureau of Quality Improvement Services (BQIS) within the Division of Disability and Rehabilitative Services (DDRS) is responsible for developing and implementing quality improvement and quality assurance systems to assure the health and welfare of individuals receiving services. BQIS is responsible for developing these systems for the Intermediate Care Facility for the Mentally Retarded (ICF/MR) level of care waivers administered by the Bureau of Developmental Disabilities Services (BDDS) which is a bureau of the DDRS. Systems include the development of promulgated rules, survey of providers for compliance with established rules, complaint investigations, mortality reviews, incident reporting, and the transition of individuals from state-operated facilities to community-based services. Information about BQIS can be found at in.gov/fssa/ddrs under Bureaus.

Section 9.2: Provider Compliance Reviews

BQIS is responsible for assuring that the providers of Supportive Living Services are in compliance with Indiana Administrative Code and DDRS Policies, and therefore continue to meet the waivers' qualifications to provide services. BQIS fulfills this oversight function by conducting provider compliance reviews.

The Compliance Evaluation and Review Tool (CERT) was designed to capture provider compliance with Indiana Administrative Code and DDRS Policies in the following focus areas:

- The provider meets qualifications for waiver services being delivered;
- The provider has policies and procedures to ensure the rights of individuals, to direct appropriate services, and to support and manage employees;
- The provider maintains employee information confirming key health, welfare and training issues (this includes validating that the provider conducts criminal background checks) ; and
- Quality assurance and quality improvement.

All providers (except day program providers, because their accreditation exempts them from compliance reviews) are reviewed at least once every three years. BQIS schedules upcoming reviews 4-5 business days in advance to give providers the opportunity to have their policies and procedures ready for review and to provide a list of all employees for surveyors to select a random sample. Following this onsite review, providers receive a report of findings and a request to develop a corrective action plan which BQIS will validate is being implemented. Aggregate d CERT findings are routinely updated in the DDRS Quarterly Communication.

There are two different versions of the CERT – one for non-direct, ancillary service providers, and another for all other types of providers. As DDRS continues to issue new policies the CERT will be updated accordingly.

Copies of the CERT Guides, findings templates, and a process map are available on the BQIS web page under the "Compliance Evaluation and Review Tool" category. http://www.in.gov/fssa/ddrs/2635.htm

Section 9.3: Incident Reports

Incident Reporting

BQIS is responsible for the implementation and monitoring of the BDDS Incident Reporting System. Providers are responsible for reporting incidents on the web-based system, the Incident Review and Follow-up Reporting Tool (IFUR). Reportable incidents are defined as: Any event or occurrence characterized by risk or uncertainty resulting in or having the potential to result in significant harm or injury to an individual or death of an individual. According to Indiana Administrative Code and DDRS policy, the following types of events are reportable:

- Alleged, suspected, or actual abuse, neglect, or exploitation of an individual. An incident in this category shall also be reported to Adult Protective Services or Child Protection Services as applicable. The provider shall suspend staff involved in an incident from duty pending investigation by the provider.
- Death of an individual. A death shall also be reported to Adult Protective Services or Child Protection Services as applicable. If death is a result of alleged criminal activity, the death must be reported to law enforcement. Issues with a service delivery site that compromise the health and safety of an individual while the individual is receiving services, such as:

A significant interruption of a major utility, such as electricity, heat, water, air conditioning, plumbing, or fire alarm.

Environmental or structural problems associated with a habitable site that compromise the health and safety of an individual, including:

- inappropriate sanitation;
- serious lack of cleanliness;
- rodent or insect infestation;
- structural damage; or
- damage caused by flooding, tornado, or other acts of nature.

- Fire that jeopardizes or compromises the health or welfare of an individual Elopement of an individual.
- Suspected or actual criminal activity by: a staff member, employee, or agent of a provider; or an individual receiving services.
- Admission of an individual to a nursing facility, including respite stays.
- Injury to an individual when the origin or cause of the injury is unknown and the injury requires medical evaluation or treatment.
- A significant injury to an individual, including:
    - a fracture,
    - a burn greater than first degree,
    - choking that requires intervention,
    - contusions or lacerations,
    - any injury requiring more than first aid
- An injury that occurs while an individual is restrained.

- A medication error, except for refusal to take medications including the following:
- Medication given that was not prescribed or ordered for the individual.
- Failure to administer medication as prescribed, including: incorrect dosage, missed medication, and failure to give medication at the appropriate time.
- Medication error that jeopardizes an individual's health and welfare and requires medical attention.
- Inadequate staff support for an individual, including inadequate supervision
- Inadequate medical support for an individual, including failure to obtain: necessary medical services, routine dental or physician services, or medication timely resulting in missed medications.
- Use of any PRN (as needed/when necessary) medication related to an individual's behavior.
- Use of any mechanical restraint regardless of whether it was planned, was approved by a Human Rights Committee or if there was informed consent.

The full incident reporting policy can be referred to at:
http://www.in.gov/fssa/files/Incident_Reporting_and_Management.pdf

Additional information about incident reporting is available on the BQIS Incident Reporting web page:
http://www.in.gov/fssa/ddrs/3838.htm

Section 9.4: Complaints

BQIS is responsible for operating the DDRS Complaint System for consumers receiving Supportive Living Services from the DD, Autism, and Support Services waivers.

By definition, complaints are broad in type and scope and can be specific to either one individual, a group of individuals, or a provider. DDRS does not intend for complaints to replace any of the waivers' primary systems established to routinely monitor and assure individuals' health and welfare, specifically the state's case management and incident reporting systems. Instead, the complaint system is meant to provide individuals, their families/guardians, providers, and community members an additional venue for identifying and addressing issues when day-to-day monitoring activities have been, or appear to be, ineffective in assuring an individual's health and safety.

In order to give the system an opportunity to work, BQIS encourages complainants with individual-specific issues, who have not already done so, to approach their case managers to try and resolve the issue first. If this has not produced the desired outcome, the complainant can contact BQIS again to file a complaint. When requested, complainants can choose to be anonymous.

Upon receipt, BQIS reviews and categorizes all initial complaints as urgent, critical, or non-critical and assigns staff to investigate the case within identified time parameters. Certain circumstances may require BQIS to contact Adult Protective Services/Child Protective Services, local law enforcement, and/or the provider to take immediate measures to assure the individual's health and welfare.

It should be noted that BQIS conducts all activities related to complaint investigations on an unannounced basis. Depending on the nature of the complaint investigation activities may include:

- Conducting site visits to the individual's home and/or day program site.
- Conducting one-on-one interviews with individual receiving services and/or their staff, guardians, family members and any other people involved in the issue being investigated.
- Requesting and reviewing of documents/information from involved providers.

When complaint allegations are substantiated, BQIS will request the provider to develop a corrective action plan which BQIS will later validate the provider is implementing. To obtain specific information related to the investigation process you may refer to the BQIS Complaint Policy at http://www.in.gov/fssa/files/BQIS_Complaints.pdf.

Currently, complaints can be filed via email - BQIS.Help@fssa.in.gov or through the BQIS toll free phone number 1-800-545-7763.

Section 9.5: Mortality Reviews

The Bureau of Quality Improvement Services (BQIS) is responsible for conducting mortality reviews for all deaths of individuals receiving Supportive Living Services through the Developmental Disability, Autism, and Support Services waivers.

As indicated in Indiana Administrative Code, all deaths of individuals receiving DDRS-funded services are required to be reported to the state through the BDDS Incident Reporting System. BQIS's Mortality Review Triage Team (MRTT) requests and reviews medical history and other related documentation for all deceased individuals. Reviews involve discussion of events prior to the death, supports/services in place at the time of death, documentation received, whether additional documentation is needed for review, and whether the death should be presented to the Mortality Review Committee (MRC) for further review and discussion. Any death can be brought before the MRC for discussion at the request of the members, the BQIS Director, or other DDRS staff that has a concern.

The MRC is facilitated by the BQIS Director of Incident Management and the BQIS Mortality Review Physician. Committee members include representatives from Adult Protective Services, the Department of Health, the Office of Medicaid Policy and Planning, the Indiana Coroner's Association, the Statewide Waiver Ombudsman, DDRS General Counsel, BDDS field service staff, IPMG case management, and community advocates.

Based on their discussion, the MRC makes recommendations for systemic improvements such as developing new policy, revising policy, training, or sharing key information through the DDRS Quarterly Communication. The MRC also makes provider-specific recommendations for BQIS to review key areas of a provider's system that appear to have not been in place or to have been ineffective at the time of an individual's death. Providers may be required to develop corrective action plans to address identified issues and to prevent other individuals from experiencing negative outcomes

Refer to the DDRS Mortality Review Policy at http://www.in.gov/fssa/files/Mortality_Review(1).pdf for further information regarding mortality reviews and the Mortality Review Committee.

Section 9.6: Statewide Waiver Ombudsman

The role of the statewide waiver ombudsman is to receive, investigate and attempt to resolve complaints and concerns that are made by or on behalf of individuals who have a developmental disability and who receive HCBS waiver services.

Complaints may be received via the toll free number 1-800-622-4484, via e-mail, in hard copy format or by referral.

Types of complaints received include complaints initiated by families and/or participants, complaints involving rights or issues of participant choice, and complaints requiring coordination between legal services, operating agency services and provider services.

The ombudsman is expected to initiate contact with the complainant as soon as possible once the complaint is received. However, precise timelines for the final resolution of each complaint are not established. While it is expected that the ombudsmen diligently and persistently pursue the resolution of each complaint determined to require investigation, it is recognized that circumstances surrounding each investigation vary.

Timeframes for complaint resolution vary in accordance with the required research, in the collection of evidence and in the numbers and availability of persons who must be contacted, interviewed, or brought together to resolve the complaint. The DDRS Director is responsible for oversight of the statewide waiver ombudsman.

With the consent of the waiver participant, the ombudsman must be provided access to the participant records, including records held by the entity providing services to the participant. When it has been determined the participant is not capable of giving consent, the statewide waiver ombudsman must be provided access to the name, address and telephone number of the participant's legal representative. **A provider of waiver services or any employee of a provider of waiver services is immune from civil or criminal liability and from actions taken under a professional disciplinary procedure for the release or disclosure of records to the statewide waiver ombudsman.**

A state or local government agency or entity that has records relevant to a complaint or an investigation conducted by the ombudsman must also provide the ombudsman with access to the records. The statewide waiver ombudsman coordinates his or her activities among the programs that provide legal services for individuals with a developmental disability, the operating agency, providers of waiver services, and providers of other necessary or appropriate services, and ensure that the identity of the participant will not be disclosed without either the participant's written consent or a court order.

At the conclusion of an investigation of a complaint, the ombudsman reports the ombudsman's findings to the complainant. If the ombudsman does not investigate a complaint, the ombudsman notifies the complainant of the decision not to investigate and the reasons for the decision.

The statewide waiver ombudsman prepares a report at least annually (or upon request) describing the operations of the program. A copy of the report is provided to the governor, the legislative council, the operating agency and the members of the Indiana Commission on Developmental Disabilities. Trends

are identified so that recommendations for needed changes in the service delivery system can be implemented.

The operating agency is required to maintain a statewide toll free telephone line continuously open to receive complaints regarding waiver participants with developmental disabilities. All complaints received from the toll free line must be forwarded to the statewide waiver ombudsman, who will advise the participant that the complaint process is not a pre-requisite or a substitute for a Medicaid Fair Hearing when the problem falls under the scope of the Medicaid Fair Hearing process.

A person, who intentionally prevents the work of the ombudsman, knowingly offers compensation to the ombudsman in an effort to affect the outcome of an investigation or a potential investigation; or knowingly or intentionally retaliates against a participant, a client, an employee, or another person who files a complaint or provides information to the ombudsman; commits a Class B misdemeanor.

Part 10: Service Definitions and Requirements

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Section 10.1: Service Definition Overview

This section of the manual lists service definitions for the services currently approved for the Home and Community Based Services (HCBS) waiver programs operated by the Division of Disability and Rehabilitative Services. Each service definition includes the following information:

- A definition of the service.
- A list of reimbursable (allowable) activities for the service.
- Service standards
- Documentation standards
- Limitations
- A list of activities not allowed
- And in some cases, additional information or clarifications that are unique to the service

Note that some services are not available under all waivers. Please refer to Sections 4.5, 4.6 and 4.7 of this manual for the lists of available waiver services unique to each waiver.

A chart containing procedure (billing) codes and modifiers as well as unit rates is found in Section 10.2.

Section 10.2: Service Rates

Division of Disability & Rehabilitative Services • Bureau of Developmental Disabilities Services
Phone: 1-800-545-7763 • E-Mail: BDDSHelp@fssa.IN.gov • Website: www.ddrs.IN.gov

Medicaid Waiver Services, Codes, and Rates

[for Autism (AU), Developmental Disabilities (DD), and Support Services (SSW) Waivers]

Waiver Type			INsite		Natl.	Modifiers					Unit/	Unit/$
AU	DD	SSW	Code	Service Description	Code	1	2	3	4	Rate	Size	Limit
■	■	■	ADS1	Adult Day Services, Level 1	S5101	U7	U5	U1		$21.95	.50/Day	2 Units/ Day
■	■	■	ASD2	Adult Day Services, Level 2	S5101	U7	U5	U2		$28.80	.50/Day	2 Units/ Day
■	■	■	ASD3	Adult Day Services, Level 3	S5101	U7	U5	U3		$34.29	.50/Day	2 Units/ Day
■	■	■	AS14	Adult Day Services, ¼ Hour, Level 1	S5100	U7	U5	U1		$1.38	.25/Day	12 Units/Day
■	■	■	AS24	Adult Day Services, ¼ Hour, Level 2	S5100	U7	U5	U2		$1.80	.25/Day	12 Units/Day
■	■	■	AS34	Adult Day Services, ¼ Hour, Level 3	S5100	U7	U5	U3		$2.14	.25/Day	12 Units/Day
■	■		AF01	Adult Foster Care, Level 1, Day	S5140	U7	U5	U1		$51.87	1.00/Day	1 Unit/Day
■	■		AF02	Adult Foster Care, Level 2, Day	S5140	U7	U5	U2		$75.67	1.00/Day	1 Unit/Day
■	■		AF03	Adult Foster Care, Level 3, Day	S5140	U7	U5	U3		$102.87	1.00/Day	1 Unit/Day
■	■	■	BMGO	Behavior Management, Basic	H0004	U7	U5	U2		$18.20	.25/Hour	
■	■	■	BG1O	Behavior Management, Level 1	H0004	U7	U5	U1		$18.20	.25/Hour	
■	■	■	CHG2	Community Habilitation, Group (2:1)	T2020	U7	U5	U2		$8.48	1.00/Hour	
■	■	■	CHG3	Community Habilitation, Group (3:1)	T2020	U7	U5	U3		$8.48	1.00/Hour	
■	■	■	CHG4	Community Habilitation, Group (4:1)	T2020	U7	U5	U4		$8.48	1.00/Hour	
■	■	■	CHG6	Community Habilitation, Group (6:1)	T2020	U7	U5	U6		$4.72	1.00/Hour	
■	■	■	CHG8	Community Habilitation, Group (8:1)	T2020	U7	U5	U8		$4.72	1.00/Hour	
■	■	■	CHGB	Community Habilitation, Group (10:1)	T2020	U7	U5	UB		$4.72	1.00/Hour	
■	■	■	CHIO	Community Habilitation, Individual	T2020	U7	U5			$22.09	1.00/Hour	AU: 25 Hrs/Month
■	■		CT	Community Transition	T2038	U7	U5			Individual	1.00/Unit	$1,000 Lifetime
	■		EM1	Electronic Monitoring, 1 Participant	A9279	U7	U5	UA		$13.62	1.00/Hour	
	■		EM2	Electronic Monitoring, 2 Participants	A9279	U7	U5	U2		$6.81	1.00/Hour	
	■		EM3	Electronic Monitoring, 3 Participants	A9279	U7	U5	U3		$4.54	1.00/Hour	
	■		EM4	Electronic Monitoring, 4 Participants	A9279	U7	U5	U4		$3.41	1.00/Hour	
■	■		EMOI	Environmental Modification (Install)	S5165	U7	U5	NU		Individual	1.00/Unit	$15,000 Lifetime
■	■		EMOM	Environmental Modification (Maintain)	S5165	U7	U5	U8		Individual	1.00/Unit	$500/Year
■	■	■	INSP	Equipment – Assess/Inspect/Train	T1028	U7	U5			$17.99	.25/Hour	
	■	■	FBS	Facility Based Support	T1020	U7	U5	UA		$1.85	1.00/Hour	
■	■	■	FHG2	Facility Habilitation, Group (2:1)	T1028	U7	U5	UA	U2	$8.48	1.00/Hour	
■	■	■	FHG4	Facility Habilitation, Group (4:1)	T2020	U7	U5	UA	U4	$8.48	1.00/Hour	
■	■	■	FHG6	Facility Habilitation, Group (6:1)	T2020	U7	U5	UA	U6	$4.72	1.00/Hour	
■	■	■	FHG8	Facility Habilitation, Group (8:1)	T2020	U7	U5	UA	U8	$4.72	1.00/Hour	
■	■	■	FHGB	Facility Habilitation, Group (10:1)	T2020	U7	U5	UA	UB	$4.72	1.00/Hour	
■	■	■	FHGC	Facility Habilitation, Group (12:1)	T2020	U7	U5	UA	UC	$3.00	1.00/Hour	
■	■	■	FHGD	Facility Habilitation, Group (14:1)	T2020	U7	U5	UA	UD	$3.00	1.00/Hour	
■	■	■	FHG9	Facility Habilitation, Group (16:1)	T2020	U7	U5	UA	U9	$3.00	1.00/Hour	
■	■	■	FHIO	Facility Habilitation, Individual	T2020	U7	U5	UA		$22.09	1.00/Hour	
■	■	■	FCAR	Family & Caregiver Training, Family	S5111	U7	U5			Individual	1.00/Unit	$2,000/Year
■	■	■	FCNF	Family & Caregiver Training, Non-Family	S5116	U7	U5			Individual	1.00/Unit	$2,000/Year
	■	■	IBI1	Intensive Behavioral Intervention, Level 1	H2020	U7	U5	U1		$104.60	1.00/Hour	
	■	■	IBI2	Intensive Behavioral Intervention, Level 2	H2020	U7	U5	U2		$25.00	1.00/Hour	
■	■	■	MUTH	Music Therapy	H2032	U7	U5	U1		$10.78	.25/Hour	
■	■	■	OCTH	Occupational Therapy	G0152	U7	U5	UA		$17.99	.25/Hour	
■	■	■	PRSI	Personal Response System, Install	S5160	U7	U5			$52.07	1.00/Unit	2 Units/CCB

Revised: March 2011

Waiver Type			INsite		Natl.	Modifiers					Unit/	Unit/$
AU	DD	SSW	Code	Service Description	Code	1	2	3	4	Rate	Size	Limit
■	■	■	PRSM	Personal Response System, Maintain	S5161	U7	U5			$52.07	1.00	1 Unit/mo
■	■	■	PHTH	Physical Therapy	G0151	U7	U5	UA		$18.12	.25/Hour	
■	■	■	PV02	Pre-Vocational (2:1)	T2015	U7	U5	U2		$8.48	1.00/Hour	
■	■	■	PV04	Pre-Vocational (4:1)	T2015	U7	U5	U4		$8.48	1.00/Hour	
■	■	■	PV06	Pre-Vocational(6:1)	T2015	U7	U5	U6		$4.72	1.00/Hour	
■	■	■	PVO8	Pre-Vocational (8:1)	T2015	U7	U5	UA		$4.72	1.00/Hour	
■	■	■	PV10	Pre-Vocational (10:1)	T2015	U7	U5	UB		$4.72	1.00/Hour	
■	■	■	PV12	Pre-Vocational (12:1)	T2015	U7	U5	UC		$3.00	1.00/Hour	
■	■	■	PV14	Pre-Vocational (14:1)	T2015	U7	U5	UD		$3.00	1.00/Hour	
■	■	■	PV16	Pre-Vocational (16:1)	T2015	U7	U5	U9		$3.00	1.00/Hour	
■	■	■	PSTF	Psychological Therapy, Family	90846	U7	U5			$17.27	.25/Hour	
■	■	■	PSTG	Psychological Therapy, Group	90853	U7	U5			$4.81	.25/Hour	
■	■	■	PSTI	Psychological Therapy, Individual	90804	U7	U5			$15.45	.25/Hour	
■	■	■	RETH	Recreational Therapy	H2032	U7	U5	U2		$10.78	.25/Hour	
■	■		R&F	Rent & Food for Unrelated Live-In Caregiver	T2025	U7	U5			$545.00	1.00/ Month	
■	■		RH1O	Residential Habilitation Services (Less than 35 hrs/week)	T2016	U7	U5	UA		$23.24	1.00/Hour	
■	■		RH2O	Residential Habilitation Services (Over 35 hrs/week)	T2016	U7	U5			$19.52	1.00/Hour	
■	■	■	RNUR	Respite Nursing Care, RN	T1005	U7	U5	TD		$7.79	.25/Hour	
■	■	■	RNUR	Respite Nursing Care, LPN	T1005	U7	U5	TE		$5.91	.25/Hour	
■	■	■	RSPO	Respite Care Services	S5151	U7	U5			$23.24	1.00/Hour	
■	■		ATCH	Specialized Medical Equip/Supply, Install	T2029	U7	U5	NU		Individual	1.00/Unit	
		■	ATCH	Specialized Medical Equip/Supply, Install	T2029	U7	U5	NU		Individual	1.00/Unit	$7,500 Lifetime
■	■	■	ATCM	Specialized Medical Equip/Supply, Maintain	T2029	U7	U5	U8		Individual	1.00/Unit	$500/Year
■	■	■	SPTH	Speech Therapy	92507	U7	U5	UA		$18.12	.25/Hour	
■	■	■	SF1O	Supported Employment Tier 1 (Monthly 1-5 hours)	T2018	U7	U5	U1		$175.95	1.00/ Month	
■	■	■	SF2O	Supported Employment Tier 2 (Monthly 6-10 hours)	T2018	U7	U5	U2		$351.90	1.00/ Month	
■	■	■	SF3O	Supported Employment Tier 3 (Monthly 11-15 hours)	T2018	U7	U5	U3		$527.85	1.00/ Month	
■	■	■	SF4O	Supported Employment Tier 4 (Hourly)	T2018	U7	U5			$35.19	1.00/Hour	
■	■	■	TRNO	Transportation	T2002	U7	U5			$4.80	1.00/Trip	2 Trips/Day
■	■		VMOD	Vehicle Modification, Install	T2039	U7	U5			Individual	1.00/Unit	$15,000 Lifetime
		■	VMOD	Vehicle Modification, Install	T2039	U7	U5			Individual	1.00/Unit	$7,500 Lifetime
■	■	■	VMOM	Vehicle Modification, Maintain	T2039	U7	U5	U8		Individual	1.00/Unit	$500/Year
	■	■	WPA	Workplace Assistance	T1020	U7	U5			$26.37	1.00/Hour	

Section 10.3: Adult Day Services

Adult Day Services

Service Definition

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, supervision, support services, and personal care. Meals and/or nutritious snacks are required. The meals need not constitute the full daily nutritional regimen. However, each meal must meet 1/3 of the daily Recommended Dietary Allowance. These services must be provided in a congregate, protective setting in one of three available levels of service; Basic, Enhanced or Intensive.

Reimbursable Activities

- Adult Day Services may be used in conjunction with Transportation Services.

Basic Adult Day (Level 1) includes:

- Monitor and/or supervise all activities of daily living (ADLs) defined as dressing, bathing, grooming, eating, walking, and toileting with hands-on assistance provided as needed.
- Comprehensive, therapeutic activities.
- Health assessment and intermittent monitoring of health status.
- Monitor medication or medication administration.
- Appropriate structure and supervision for those with mild cognitive impairment.
- Minimum staff ratio: One staff for each eight individuals.

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

- Hands-on assistance with two or more ADLs or hands-on assistance with bathing or other personal care.
- Health assessment with regular monitoring or intervention with health status.
- Dispense or supervise the dispensing of medication to individuals.
- Psychosocial needs assessed and addressed, including counseling as needed for individuals and caregivers.
- Therapeutic structure, supervision, and intervention for those with mild to moderate cognitive impairments.

- Minimum staff ratio: One staff for each six individuals.

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

- Hands-on assistance or supervision with all ADLs and personal care.
- One or more direct health intervention(s) required.
- Rehabilitation and restorative services, including physical therapy, speech therapy, and occupational therapy coordinated or available.
- Therapeutic intervention to address dynamic psychosocial needs such as depression or family issues affecting care.
- Therapeutic interventions for those with moderate to severe cognitive impairments.
- Minimum staff ratio: One staff for each four individuals.

Service Standards

Adult Day Services must follow a written plan of care addressing specific needs determined by the individual's assessment.

Documentation Standards

- Services outlined in the Individualized Support Plan (ISP)
- Evidence that level of service provided is required by the individual
- Attendance record documenting the date of service and the number of units of service delivered that day
- Completed Adult Day Service Level of Service Evaluation form

The case manager should give the completed Adult Day Service Level of Service Evaluation form to the provider.

Limitations

- Individuals attend Adult Day Services on a planned basis. A minimum of three (3) hours to a maximum of 12 hours shall be allowable.
- A single half-day (1/2 day) day unit is defined as one unit of three (3) hours to a maximum of five (5) hours/day. Two units are defined as more than five (5) hours to a maximum of 8 hours/day. A maximum of two half-day (1/2 day) units/day is allowed.
- A single quarter-hour (1/4 hour) unit is defined as 15 minutes. Billable only after 8 hours of ADS have been provided on the same day. A maximum of 16 quarter-hour (1/4 hour) units/day is allowed.

Activities Not Allowed

Any activity that is not described in allowable activities is not included in this service.

Provider Qualifications

- DDRS approved
- Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals.
- Must be accredited by at least one (1) of the following organizations:
    1) The Commission on Accreditation of Rehabilitation Facilities (CARF), or its successor.
    2) The Council on Quality and Leadership In Supports for People with Disabilities, or its successor.
    3) The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or its successor.
    4) The National Committee for Quality Assurance, or its successor.
    5) The ISO-9001 human services QA system.
    6) An independent national accreditation organization approved by the secretary

Additional Information:

- Therapies provided through this service will not duplicate therapies provided under any other service.
- Available under the Autism, DD and Support Services Waivers.

Section 10.4: Adult Foster Care

Adult Foster Care

Service Definition

Adult Foster Care Services means a living arrangement in which a participant lives in the private home of a principal caregiver who is unrelated to the participant.

Necessary support services are provided by the principal caregiver (a foster parent) as part of Adult Foster Care Services. Only agencies may be foster care providers, with the foster care settings being approved, supervised, trained, and paid by the approved agency provider. Separate payment will not be made for homemaker or chore services furnished to an individual receiving Adult Foster Care Services, since these services are integral to and inherent in the provision of adult foster care services.

Rate Levels

There are three levels of rates. The Individualized Support Team (IST) determines what level of supports are required for the participant, based on what services an participant would utilize if foster care services were not available. A Service Planner must be completed showing the services and amounts of services required in another setting. If there are changes in the participant's condition that may call for a change in the level of service, the IST will re-determine what level of supports the participant requires, with ultimate approval given according to who can approve a specific level of service.

- Level 1 – Approved by Service Coordinator
- Level 2 – Approved by District Manager
- Level 3 – Approved by Central Office

Issues to consider in determining which tier of services the participant receives include the amount of time the foster family will need to spend in:

1) health and safety management;
2) challenges and experiences aimed at increasing a person's ability to live a lifestyle that is compatible with the person's interest and abilities;
3) modification or improvement of functional skills;
4) guidance and direction for social/emotional support; and
5) facilitation of both the physical and social integration of a person into typical family routines and rhythms.

Reimbursable Activities

- Personal care and services
- Homemaker or chore services
- Attendant care and companion care services
- Medication oversight
- Respite for the foster parent (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 Individualized Support Plan

Service Standards

- Adult Foster Care Services must be reflected in the Individualized Support Plan
- Services must address the needs (for example, developmental needs, vocational needs, and so forth) identified in the person centered planning process and be outlined in the Individualized Support Plan
- 10% of the total per diem amount is intended for use by the provider for respite care as needed. It is the provider's responsibility to approve any providers of respite chosen by the family or the participant
- The provider determines the total amount per month paid to the foster parent
- The agency's administrative/supervision fee comes from the remaining total amount and includes the following duties:

    1) Publish written policies and procedures regarding foster parent support services;
    2) Maintain financial and service records to document services provided to the individual;
    3) Establish a criteria for the acceptance of the foster parent, screen potential foster parents for qualities of stability, maturity, and experiences so as to ensure the safety and well being of the individual, and obtain a criminal background and reference check;
    4) Coordinate/provide adequate initial training and ongoing training, consultation and supervision to the foster parent;
    5) Provide for the safety and well being of the participant by inspection of environment for compliance with DDRS policies and procedures, including, but not limited to, the provider and case management standards found in 460 IAC 6 Supported Living Services and Supports requirements; and
    6) Reimburse foster parent.

Documentation Standards

Adult Foster Care Services documentation must include the services outlined in the Individualized Support Plan

Documentation by Providers:

- Written policies and procedures, including for screening and accepting foster parents.
- Maintain financial and service records to document services provided to the participant.
- Document provision of training to foster parents according to agency policies/procedures.
- Reimbursement of foster parent.
- One entry per participant per week (same as families).

Documentation by Families:

- One dated entry per day detailing an issue concerning the participant
- The entry should detail any outcome-oriented activities, tying those into measurable progress toward the participant's outcome (as identified in the ISP)
- The entry should also include any significant issues concerning the individual, including:
    - Health and safety management
    - Developmental challenges and experiences aimed at increasing an participant's ability to live a lifestyle that is compatible with the participant's interest and abilities
    - Modification or improvement of functional skills
    - Guidance and direction for social/emotional support
    - Facilitation of both the physical and social integration of an participant into typical family routines and rhythms

Limitations

A participant in Level 1 may reside with a family and up to three other participants (no more than four total); a participant in Level 2 may not reside with more than one other participant. A participant in Level 3 may not reside with any other participants in the AFC program.

Activities Not Allowed

- Services provided in the home of a caregiver who is related by blood or marriage, in any degree, to the participant
- The service of Residential Habilitation and Supports is not available to participants receiving the service of Adult Foster Care

- Transportation services through the waiver may not be used in conjunction with Adult Foster Care Services.

Provider Qualifications

- DDRS approved
- Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals

Additional Information:

- Available only under the Autism and DD Waivers. Adult Foster Care is not available under the Support Services Waiver.

Section 10.5: Behavioral Support Services

Behavioral Support Services

Service Definition

Behavioral Support Services means training, supervision, or assistance in appropriate expression of emotions and desires, compliance, assertiveness, acquisition of socially appropriate behaviors, and the reduction of inappropriate behaviors.

Reimbursable Activities

Reimbursable activities of Behavioral Support Services include:

- Observation of the individual and environment for purposes of development of a plan and to determine baseline
- Development of a behavioral support plan and subsequent revisions
- Obtain consensus of the Individualized Support Team that the behavioral support plan is feasible for implementation.
- Training in assertiveness
- Training in stress reduction techniques
- Training in the acquisition of socially accepted behaviors
- Training staff, family members, roommates, and other appropriate individuals on the implementation of the behavioral support plan
- Consultation with team members

Service Standards

- Behavioral Support Services must be reflected in the Individualized Support Plan (ISP)
- Services must address needs identified in the person centered planning process and be outlined in the Individualized Support Plan.
- The behavior supports specialist will observe the individual in his or her own milieu and develop a specific plan to address identified issues.
- The behavior supports specialist must assure that Residential Habilitation and Supports direct service staff are aware of and are active individuals in the development and implementation of the Behavioral Support Plan. The behavior plan will meet the requirements stated in 460 IAC 6-18-2.
- The behavior supports provider will comply with all specific standards in 460 IAC 6-18.

- Any behavior supports techniques that limit the individual's human or civil rights must be approved by the Individualized Support Team (IST) and the provider's human rights committee. No aversive techniques may be used. Chemical restraints and medications prescribed for use as needed (PRN) meant to retrain the individual shall be used with caution. The use of these medications must be approved by the Individualized Support Team (IST) and the appropriate human rights committee.
- The efficacy of the plan must be reviewed not less than quarterly and adjusted as necessary.
- The behavior specialist will provide a written report to pertinent parties at least quarterly. Pertinent parties include the individual, guardian, BDDS service coordinator, waiver case manager, all service providers, and other involved entities.

Documentation Standards

- Services outlined in the Individualized Support Plan (ISP)
- Documentation in compliance with 460 IAC 6 Supported Living Services and Supports requirements.

Limitations

Activities Not Allowed

- Aversive techniques – Any techniques not approved by the individual's person centered planning team and the provider's human rights committee.
- Therapy services furnished to the participant within the educational/school setting or as a component of the participant's school day.
- Services furnished to a minor by a parent(s), step-parent(s), or legal guardian.
- Services furnished to a participant by the participant's spouse.
- In the event that a Level 1 clinician performs Level 2 clinician activities, billing for Level 1 services is not allowed. In this situation, billing for Level 2 services only is allowed.
- Simultaneous receipt of facility-based support services or other Medicaid-billable services and intensive behavior supports.

Provider Qualifications

- DDRS approved
- Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals.

Additional Information:

- Waiver funded Behavioral Support Services may not be utilized when the consumer is residing in an institution
- Behavioral Support Services are available under the Autism, DD and Support Services Waivers.

Section 10.6: Community Based Habilitation – Group

Community Based Habilitation – Group

Service Definition

Community Based Habilitation - Group are services provided outside of the Participant's home that support learning and assistance in the areas of: self-care, sensory/motor development, socialization, daily living skills, communication, community living, and social skills. Community based activities are intended to build relationships and natural supports.

Reimbursable Activities

Monitoring, training, education, demonstration, or support to assist with the acquisition and retention of skills in the following areas:

- Leisure activities and community/public events (i.e. integrated camp settings)
- Educational activities
- Hobbies
- Unpaid work experiences (i.e. volunteer opportunities)
- Maintaining contact with family and friends

Training and education in self direction designed to help participants achieve one or more of the following outcomes:

- Develop self advocacy skills
- Exercise civil rights
- Acquire skills that enable the ability to exercise self control and responsibility over services and supports received or needed
- Acquire skills that enable the participant to become more independent, integrated or productive in the community

Service Standards

- Community Based Habilitation Services must be reflected in the Individualized Support Plan (ISP).
- Services must address needs identified in the person centered planning process and be outlined in the ISP.

Documentation Standards

- Services outlined in the Individualized Support Plan (ISP)

In addition to compliance with documentation requirements outlined in 460 IAC 6, the following data elements are required for each service rendered:

- Name of participant served
- RID Number of the participant
- Name of provider
- Service rendered
- Time frame of service (include a.m. or p.m.)
- Date of service including the year
- Notation of the primary location of service delivery
- A brief activity summary of service rendered
- Description* by direct care staff of an issue or circumstance concerning the participant including, but not limited to, significant medical or behavioral incidents or any other situation that may be uncommon for the participant
- Signature that includes at least the last name and first initial of the direct care staff person making the entry.
- Electronic signatures are permissible when in compliance with the Uniform Electronic Transactions Act (IC 26-2-8).
- Upon request, all data elements must be made available to auditors, quality monitors, case managers, and any other government entity.

*The data may reside in multiple locations but must be clearly and easily linked to the participant or the standard will not be met.

For Group services

Upon request, the provider must be able to verify the following in a concise format:

- the ratio for each claimed time frame of service did not exceed the maximum allowable ratio whether or not all group participants utilize a waiver funding stream

Limitations

Group Sizes:

- Small groups (4:1 or smaller)
- Medium groups (5:1 to 10:1)

Habilitation services reimbursement does not include reimbursement for the cost of the activities in which the individual is participating when they receive skills training, such as the cost to attend a community event.

Activities Not Allowed

- Services that are available under the Rehabilitation Act of 1973 or PL 94-142.
- Skills training for any activity that is not identified as directly related to an individual habilitation outcome. Activities that do not foster the acquisition and retention of skills.
- Services furnished to a minor by parent(s), step parents(s) or legal guardian.
- Services furnished to a participant by the participant's spouse.
- Services rendered in a facility.
- Group size in excess of 10:1.

Provider Qualifications

- DDRS approved
- Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals.
- Must be accredited by at least one (1) of the following organizations:
    1) The Commission on Accreditation of Rehabilitation Facilities (CARF), or its successor.
    2) The Council on Quality and Leadership In Supports for People with Disabilities, or its successor.
    3) The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or its successor.
    4) The National Committee for Quality Assurance, or its successor.
    5) The ISO-9001 human services QA system.
    6) An independent national accreditation organization approved by the secretary

Additional Information:

- Activities must have a habilitation component.
- Community Based Habilitation – Group services are available under the Autism, DD and Support Services Waivers.

Section 10.7: Community Based Habilitation – Individual

Community Based Habilitation - Individual

Service Definition

Community Based Habilitation - Individual are services provided outside of the Participant's home that support learning and assistance in the areas of: self-care, sensory/motor development, socialization, daily living skills, communication, community living, and social skills. Community based activities are intended to build relationships and natural supports.

Reimbursable Activities

Monitoring, training, education, demonstration, or support to assist with the acquisition and retention of skills in the following areas:

- Leisure activities and community/public events (i.e. integrated camp settings)
- Educational activities
- Hobbies
- Unpaid work experiences (i.e. volunteer opportunities)
- Maintaining contact with family and friends

Training and education in self direction designed to help participants achieve one or more of the following outcomes:

- Develop self advocacy skills
- Exercise civil rights
- Acquire skills that enable the ability to exercise self control and responsibility over services and supports received or needed
- Acquire skills that enable the participant to become more independent, integrated or productive in the community

Service Standards

- Community Based Habilitation Services must be reflected in the Individualized Support Plan (ISP).
- Services must address needs identified in the person centered planning process and be outlined in the ISP.

Documentation Standards

- Services outlined in the Individualized Support Plan
- Need for service continuation and justification of goals is to be evaluated annually and reflected in the ISP

In addition to compliance with documentation requirements outlined in 460 IAC 6, the following data elements are required for each service rendered:

- Name of participant served
- RID Number of the participant
- Name of provider
- Service rendered
- Time frame of service (include a.m. or p.m.)
- Date of service including the year
- Notation of the primary location of service delivery
- A brief activity summary of service rendered
- Description* by direct care staff of an issue or circumstance concerning the participant including, but not limited to, significant medical or behavioral incidents or any other situation that may be uncommon for the participant
- Signature that includes at least the last name and first initial of the direct care staff person making the entry.
- Electronic signatures are permissible when in compliance with The Uniform Electronic Transactions Act (IC 26-2-8).
- Upon request, all data elements must be made available to auditors, quality monitors, case managers, and any other government entity.

*The data may reside in multiple locations but must be clearly and easily linked to the participant or the standard will not be met.

Limitations

Allowable Ratio - 1:1

Habilitation services reimbursement does not include reimbursement for the cost of the activities in which the individual is participating when they receive skills training, such as the cost to attend a community event.

Activities Not Allowed

- Services that are available under the Rehabilitation Act of 1973 or PL 94-142.
- Skills training for any activity that is not identified as directly related to an individual habilitation outcome
- Activities that do not foster the acquisition and retention of skills.
- Services furnished to a minor by parent(s), step parents(s) or legal guardian.
- Services furnished to a participant by the participant's spouse.
- Services rendered in a facility.

Provider Qualifications

- DDRS approved
- Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals.
- Must be accredited by at least one (1) of the following organizations:
    1) The Commission on Accreditation of Rehabilitation Facilities (CARF), or its successor.
    2) The Council on Quality and Leadership In Supports for People with Disabilities, or its successor.
    3) The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or its successor.
    4) The National Committee for Quality Assurance, or its successor.
    5) The ISO-9001 human services QA system.
    6) An independent national accreditation organization approved by the secretary

Additional Information:

- Activities must have a habilitation component.
- Community Based Habilitation – Group services are available under the Autism, DD and Support Services Waivers.

Section 10.8: Community Transition

Community Transition

Service Definition

Community Transition Services include reasonable, one-time set-up expenses for individuals who make the transition from an institution to their own home in the community and will not be reimbursable on any subsequent move.

> Note: Own Home is defined as any dwelling, including a house, an apartment, a condominium, a trailer, or other lodging that is owned, leased, or rented by the individual and/ or the individual's guardian or family, or a home that is owned and/ or operated by the agency providing supports.

Items purchased through Community Transition Services are the property of the individual receiving the service, and the individual takes the property with him or her in the event of a move to another residence, even if the residence from which he or she is moving is owned by a provider agency. Nursing Facilities are not reimbursed for Community Transition Services because those services are part of the per diem.

Reimbursable Activities

- Security deposits that are required to obtain a lease on an apartment or home.
- Essential furnishings and moving expenses required to occupy and use a community domicile including a bed, table or chairs, window coverings, eating utensils, food preparation items, bed or bath linens
- Set-up fees or deposits for utility or service access including telephone, electricity, heating, and water
- Health and safety assurances including pest eradication, allergen control, or one time cleaning prior to occupancy
- When the individual is receiving residential habilitation and support services under the DD Waiver, the Community Transition Supports service is included in the Cost Comparison Budget

Service Standards

- Community Transition services must be reflected in the Individualized Support Plan (ISP) and Cost Comparison Budget (CCB) of the individual.
- Services must address needs identified in the ISP and CCB.

Documentation Standards

Documentation requirements include maintaining receipts for all expenditures, showing the amount and what item or deposit was covered.

Limitations

Community Transition Services are limited to one time set-up expenses, up to $1,000.

Activities Not Allowed

- Apartment or housing rental expenses
- Food
- Appliances
- Diversional or recreational items such as hobby supplies
- Television
- Cable TV access
- VCRs or DVD players

Provider Qualifications

- DDRS approved
- Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals.

Additional Information:

- Available only under the Autism and DD Waivers. Community Transition services are not available under the Support Services Waiver.

Section 10.9: Electronic Monitoring

Electronic Monitoring

Service Definition

Electronic Monitoring/Surveillance System & On-Site Response includes the provision of oversight and monitoring within the residential setting of adult waiver participants through off-site electronic surveillance. Also included is the provision of stand-by intervention staff prepared for prompt engagement with the participant(s) and/or immediate deployment to the residential setting.

Reimbursable Activities

- Electronic Monitoring/Surveillance System & On-Site Response may be installed in residential settings in which all residing adult participants, their guardians and their support teams request such surveillance and monitoring in place of on-site staffing.
- Use of the system may be restricted to certain hours through the Individualized Support Plans of the participants involved.

Service Standards

To be reimbursed for operating an electronic monitoring and surveillance system, a provider must adhere to the following:

- The system to be installed must be reviewed and approved by Director of DDRS.
- The Electronic Monitoring/Surveillance System & On-Site Response system must be designed and implemented to ensure the health and welfare of the participant in his/her own home/apartment and achieve this outcome in a cost neutral manner.
- The case manager and/or the BDDS Service Coordinator will review the use of the system at seven (7) days, and again at fourteen (14) days post installation.
- Services provided to waiver participants or otherwise reimbursed by the Medicaid program is subject to oversight/approval from the OMPP.
- Retention of written documentation is required for seven (7) years
- Retention of video/audio records, including computer vision, audio and sensor information, shall be retained for seven (7) years if an Incident Report is filed.

Assessment and informed consent

- Initial assessment: Participants requesting this service must be preliminarily assessed by the Individualized Support Team (IST) for appropriateness in ensuring the health and welfare of the participants and have written approval by the human rights committee (HRC). These actions must be documented in the ISP and the DDRS case management system.

- Informed consent: Each participant, guardian and IST must be made aware of both the benefits and risks of the operating parameters and limitations. Informed consent documents must be acknowledged in writing, signed and dated by the participant, guardian, case manager, and provider agency representative, as appropriate. A copy of the consent shall be maintained by the local BDDS office, the guardian (if applicable) and in the home file.

- Annual assessment updates: At least annually, the IST must assess and determine that continued usage of the electronic monitoring system will ensure the health and welfare of the participant. The results of this assessment must be documented in the ISP and in the DDRS case management system. A review of all incident reports and other relevant documentation must be part of this assessment.

System design

- The provider must have safeguards and/or backup system such as battery and generator for the electronic devices in place at the monitoring base and the participant's residential living site(s) in the event of electrical outages.

- The provider must have backup procedures for system failure (e.g., prolonged power outage), fire or weather emergency, participant medical issue or personal emergency in place and detailed in writing for each site utilizing the system as well as in each participant's ISP. This plan should specify the staff person or persons to be contacted by monitoring base staff who will be responsible for responding to these situations and traveling to the participant's living site(s).

- The electronic monitoring system must receive notification of smoke/heat alarm activation at each participant's residential living site.

- The electronic monitoring system must have two way (at minimum, full duplex) audio communication capabilities to allow monitoring base staff to effectively interact with and address the needs of participants in each living site, including emergency situations when the participant may not be able to use the telephone.

- The electronic monitoring system must allow the monitoring base staff to have visual (video) oversight of areas in participant's residential living sites deemed necessary by the IST.

- A monitoring base may not be located in a participant's residential living site.

- A secure (HIPAA compliant) network system requiring authentication, authorization and encryption of data must be in place to ensure access to computer vision, audio, sensor or written information is limited to authorized staff including the parent/guardian, provider agency, Family and Social Services Administration (FSSA), DDRS, BDDS, Bureau of Quality Improvement Services (BQIS), Qualified Mental Retardation Professional, case manager, and participant.

- The equipment must include a visual indicator to the participant that the system is on and operating.

Situations involving electronic monitoring of participants needing 24 hour support. If a participant indicates that he/she wants the electronic monitoring system to be turned off, the following protocol will be implemented:

1) The electronic caregiver will notify the provider to request an on-site staff.

2) The system would be left operating until the on-site staff arrives.

3) The electronic caregiver would turn off the system at that site once relieved by an on-site staff.

4) A visible light on the control box would signal when the system is on and when it is off.

Monitoring base staff

- At the time of monitoring, the monitoring base staff may not have duties other than the oversight and support of participants at remote living sites.
- The monitoring base staff will assess any urgent situation at a participant's residential living site and call 911 emergency personnel first if that is deemed necessary, and then call the float staff person. The monitoring base staff will stay engaged with the participant(s) at the living site during an urgent situation until the float staff or emergency personnel arrive.
- If computer vision or video is used, oversight of a participant's home must be done in real time by an awake-staff at a remote location (monitoring base) using telecommunications/broadband, the equivalent or better, connection.
- The monitoring base (remote station) shall maintain a file on each participant in each home monitored that includes a current photograph of each participant which must be updated if significant physical changes occur and at least, annually. The file shall also include pertinent information on each participant noting facts that would aid in ensuring the participants' safety.
- The monitoring base staff must have detailed and current written protocols for responding to needs of each participant at each remote living site, including contact information for staff to supply on-site support at the participant's residential living site when necessary.

Stand-by intervention staff (float staff)

- The float staff shall respond and be at the participant's residential living site within 20 minutes or less from the time the incident is identified by the remote staff and float staff acknowledges receipt of the notification by the monitoring base staff. The IST Team has the authority to set a shorter response time based on individual participant need.
- The service must be provided by one (1) float staff for on-site response, the number of participants served by the one (1) float staff is to be determined by the Individualized Support Team (IST) based upon the assessed needs of the participants being served in specifically identified locations.
- Float staff will assist the participant in the home as needed to ensure the urgent need/issue that generated a response has been resolved. Relief of float staff, if necessary, must be provided by the residential habilitation provider.

Documentation Standards

Services outlined in the Individualized Support Plan (ISP)

To be reimbursed, the provider must prepare and be able to produce the following:

- Status as a DDRS/BDDS approved provider
- Approval of the specific electronic monitoring/surveillance system by the Director of DDRS.
- Case notes regarding the assessment and approval by both the IST of each participant and the HRC will be documented within both the DDRS system and the ISP.
- Informed consent documents must be acknowledged in writing, signed and dated by the participant, guardian, case manager, and provider agency representative, as appropriate. Copies of consent documents will be maintained by the local BDDS office, the case manager, the guardian (if applicable) and in the home file.
- Utilization of the electronic monitoring device must be outlined in the ISPs, service planners and budgets of EACH participant in a setting, including typical hours of electronic monitoring

Each remote site will have a written policy and procedure approved by DDRS (and available to OMPP for all providers serving waiver participants) that defines emergency situations and details how remote and float staff will respond to each. Examples include:

- Fire, medical crises, stranger in the home, violence between participants, and any other situation that appears to threaten the health or welfare of the participant.
- Emergency Response drills must be carried out once per quarter per shift in each home equipped with and capable of utilizing the electronic monitoring service. Documentation of the drills must be available for review upon request.
- The remote monitoring base staff shall generate a written report on each participant served in each participant's residential living site on a daily basis. This report will follow documentation standards of the Residential Habilitation Services. This report must be transmitted to the primary RHS provider daily.
- Each time an emergency response is generated, an incident report must be submitted to the State per the BDDS and BQIS procedures.
- At least every 90 days, the appropriateness of continued use of the monitoring system must be reviewed by the IST; the results of these reviews must be documented in the DDRS case management system and/or the ISP. Areas to be reviewed include but are not limited to the number and nature of responses to the home as well as damage to the equipment.

Limitations and Reimbursement Parameters

The budget will be completed for each participant based upon the number of participants residing within the residence.

Table 0.1 – Reimbursement Rates by Tier

Tier	Number of Participants	Reimbursement
Tier 1	1 Participant in a home	$13.62
Tier 2	2 Participants in a home	$ 6.81
Tier 3	3 Participants in a home	$4.54
Tier 4	4 Participants in a home	$3.41

Activities Not Allowed

- Electronic monitoring and surveillance systems which have not received specific approval by the Director of the Division of Disability and Rehabilitative Services (DDRS).
- Electronic Monitoring may not be used concurrently with Adult Foster Care services or in the Adult Foster Care home
- Electronic Monitoring systems intended to monitor direct care staff
- Electronic Monitoring serves as a replacement for Residential Habilitation and Support (RHS) services, therefore, Electronic Monitoring and RHS services are not billable during the same time period
- Electronic Monitoring systems in ICF/MR facilities licensed under IC 16-28 and 410 IAC 16.2
- Electronic Monitoring systems used in place of in-home staff to monitor minors, i.e., participants under the age of 18.
- Installation costs related to video and/or audio equipment
- Services furnished to a minor by a parent(s), step-parent(s), or legal guardian
- Services furnished to a participant by the participant's spouse

Provider Qualifications

- DDRS approved
- Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals.

Additional Information:

- Available only under the DD Waiver. Electronic Monitoring is <u>not</u> yet available under the Autism Waiver and is not/will not be available under the Support Services Waiver.

Section 10.10: *Environmental Modifications*

Environmental Modifications

Service Definition

Those physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which the individual would require institutionalization.

Waiver Services must approve all environmental modifications prior to service being rendered.

Reimbursable Activities

- Installation of ramps and grab bars
- Widening doorways
- Modifying existing bathroom facilities
- Installation of specialized electric and plumbing systems necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual including anti-scald devices
- Maintenance and repair of the items and modifications installed during the initial request
- Assessment and inspection

Service Standards

- Equipment and supplies must be for the direct medical or remedial benefit of the individual
- All items shall meet applicable standards of manufacture, design and installation
- To ensure that environmental modifications meet the needs of the individual and abide by established, federal, state, local and FSSA standards, as well as ADA requirements, approved environmental modifications will reimburse for necessary:
    - Assessment of the individual's specific needs, conducted by an approved, qualified individual who is independent of the entity providing the environmental modifications
    - Independent inspections during the modification process and at completion of the modifications, prior to authorization for reimbursement, based on the complexities of the requested modifications.
- Equipment and supplies shall be reflected in the Individualized Support Plan
- Equipment and supplies must address needs identified in the person centered planning process

Documentation Standards

- Identified direct medical benefit for the individual
- Documented “Prior Authorization Denial” from Medicaid, if applicable
- Receipts for purchases
- Identified need in Individualized Support Plan
- Documentation in compliance with 460 IAC 6 Supported Living Services and Supports requirements.

Limitations

- Reimbursement for Environmental Modification Supports has a lifetime cap of $15,000.
- Service and repair up to $500 per year, outside this cap, is permitted for maintenance and repair of prior modifications that were funded by a waiver service.
- If the lifetime cap is fully utilized, and a need is identified, the case manager will work with other available funding streams and community agencies to fulfill the need.

Activities Not Allowed

- Adaptations to the home which are of general utility
- Adaptations which are not of direct medical or remedial benefit to the individual (such as carpeting, roof repair, central air conditioning)
- Adaptations which add to the total square footage of the home
- Adaptations that are not included in the comprehensive plan of care
- Adaptations that have not been approved on a Request for Approval to Authorize Services
- Adaptations to service provider owned/leased housing. Home accessibility modifications as a service under the waiver may not be furnished to individuals who receive residential habilitation and support services except when such services are furnished in the participant’s own home.
- Compensation for the costs of life safety code modifications and other accessibility modifications may not be made with participant waiver funds to housing owned by providers.

Provider Qualifications

- DDRS approved
- Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals.
- Must hold current professional licensure/certification as appropriate

Additional Information:

- Available only under the Autism and DD Waivers. Environmental Modifications are not available under the Support Services Waiver.
- Photographs of the proposed areas to be modified must be provided
- The Environmental Modification policy appears in **Part 11: RFA Policies, Section 11.1: Environmental Modification Policy** of this manual.

Section 10.11: Facility Based Habilitation – Group

Facility Based Habilitation - Group

Service Definition

Facility Based Habilitation services are services provided outside of the Participant's home in an approved facility that support learning and assistance in the areas of: self-care, sensory/motor development, socialization, daily living skills, communication, community living, and social skills.

Reimbursable Activities

Monitoring, training, education, demonstration, or support to assist with the acquisition and retention of skills in the following areas:

- Leisure activities (i.e. segregated camp settings)
- Educational activities
- Hobbies
- Unpaid work experiences (i.e. volunteer opportunities)
- Maintaining contact with family and friends

Training and education in self direction designed to help participants achieve one or more of the following outcomes:

- Develop self advocacy skills
- Exercise civil rights
- Acquire skills that enable the ability to exercise self control and responsibility over services and supports received or needed
- Acquire skills that enable the participant to become more independent, integrated or productive in the community

Service Standards

- Facility Based Habilitation Services must be reflected in the Individualized Support Plan (ISP).
- Services must address needs identified in the person centered planning process and be outlined in the ISP.

Documentation Standards

Services outlined in the Individualized Support Plan

In addition to compliance with documentation requirements outlined in 460 IAC 6, the following data elements are required for each service rendered:

- Name of participant served
- RID Number of the participant
- Name of provider
- Service rendered
- Time frame of service (include a.m. or p.m.)
- Date of service including the year
- Notation of the primary location of service delivery
- A brief activity summary of service rendered
- Description* by direct care staff of an issue or circumstance concerning the participant including, but not limited to, significant medical or behavioral incidents or any other situation that may be uncommon for the participant
- Signature that includes at least the last name and first initial of the direct care staff person making the entry. Electronic signatures are permissible when in compliance with The Uniform Electronic Transactions Act (IC 26-2-8).
- Upon request, all data elements must be made available to auditors, quality monitors, case managers, and any other government entity.

*The data may reside in multiple locations but must be clearly and easily linked to the participant or the standard will not be met.

For Group services

Upon request, the provider must be able to verify the following in a concise format. The ratio for each claimed time frame of service did not exceed the maximum allowable ratio whether or not all group participants utilize a waiver funding stream.

Limitations

Group sizes:

- Small (4:1 or smaller)
- Medium (5:1 to 10:1)
- Larger (larger than 10:1 but no larger than 16:1)

Habilitation services reimbursement does not include reimbursement for the cost of the activities in which the individual is participating when they receive skills training, such as the cost to attend a community event.

Activities Not Allowed

- Services that are available under the Rehabilitation Act of 1973 or PL 94-142.
- Skills training for any activity that is not identified as directly related to an individual habilitation outcome
- Activities that do not foster the acquisition and retention of skills.
- Activities that would normally be a component of a person's residential life or services, such as: shopping, banking, household errands, medical appointments, etc.
- Services furnished to a minor by parent(s) or step parents(s) or legal guardian.
- Services furnished to a participant by the participant's spouse.

Provider Qualifications

- DDRS approved
- Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals.
- Must be accredited by at least one (1) of the following organizations:
    1) The Commission on Accreditation of Rehabilitation Facilities (CARF), or its successor.
    2) The Council on Quality and Leadership In Supports for People with Disabilities, or its successor.
    3) The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or its successor.
    4) The National Committee for Quality Assurance, or its successor.
    5) The ISO-9001 human services QA system.
    6) An independent national accreditation organization approved by the secretary

Additional Information:

- Activities must have a habilitation component
- Available under the Autism, DD and Support Services Waivers

Section 10.12: Facility Based Habilitation – Individual

Facility Based Habilitation - Individual

Service Definition

Facility Based Habilitation - Individual are services provided outside of the participant's home in an approved facility that support learning and assistance in the areas of: self-care, sensory/motor development, socialization, daily living skills, communication, community living, and social skills.

Reimbursable Activities

Monitoring, training, education, demonstration, or support to assist with the acquisition and retention of skills in the following areas:

- Leisure activities (i.e. segregated camp settings)
- Educational activities
- Hobbies
- Unpaid work experiences (i.e. volunteer opportunities)
- Maintaining contact with family and friends

Training and education in self direction designed to help participants achieve one or more of the following outcomes:

- Develop self advocacy skills
- Exercise civil rights
- Acquire skills that enable the ability to exercise self control and responsibility over services and supports received or needed
- Acquire skills that enable the participant to become more independent, integrated or productive in the community

Service Standards

- Facility Based Habilitation - Individual services must be reflected in the ISP
- Services must address needs identified in the person centered planning process and be outlined in the ISP

Documentation Standards

Services outlined in the Individualized Support Plan

In addition to compliance with documentation requirements outlined in 460 IAC 6, the following data elements are required for each service rendered:

- Name of participant served
- RID Number of the participant
- Name of provider
- Service rendered
- Time frame of service (include a.m. or p.m.)
- Date of service including the year
- Notation of the primary location of service delivery
- A brief activity summary of service rendered
- Description* by direct care staff of an issue or circumstance concerning the participant including, but not limited to, significant medical or behavioral incidents or any other situation that may be uncommon for the participant
- Signature that includes at least the last name and first initial of the direct care staff person making the entry. Electronic signatures are permissible when in compliance with The Uniform Electronic Transactions Act (IC 26-2-8).
- Upon request, all data elements must be made available to auditors, quality monitors, case managers, and any other government entity.

*The data may reside in multiple locations but must be clearly and easily linked to the participant or the standard will not be met.

Limitations

Allowable Ratio - 1:1

Habilitation services reimbursement does not include reimbursement for the cost of the activities in which the individual is participating when they receive skills training, such as the cost to attend a camp

Activities Not Allowed

- Services that are available under the Rehabilitation Act of 1973 or PL 94-142
- Skills training for any activity that is not identified as directly related to an individual habilitation outcome

- Activities that do not foster the acquisition and retention of skills
- Services furnished to a minor by parent(s) or step parents(s), or legal guardian
- Services furnished to a participant by the participant's spouse

Provider Qualifications

- DDRS approved
- Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals.
- Must be accredited by at least one (1) of the following organizations:
    1) The Commission on Accreditation of Rehabilitation Facilities (CARF), or its successor.
    2) The Council on Quality and Leadership In Supports for People with Disabilities, or its successor.
    3) The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or its successor.
    4) The National Committee for Quality Assurance, or its successor.
    5) The ISO-9001 human services QA system.
    6) An independent national accreditation organization approved by the secretary

Additional Information:

- Activities must have a habilitation component
- Available under the Autism, DD and Support Services Waivers

Section 10.13: Facility Based Support Services

Facility Based Support Services

Service Definition

Facility Based Support services are facility-based group programs designed to meet the needs of participants with impairments through individual plans of care. These structured, comprehensive, non-residential programs provide health, social, recreational, therapeutic activities, supervision, support services, personal care and may also include optional or non-work related educational and life skill opportunities. Participants attend on a planned basis.

Reimbursable Activities

- Monitor and/or supervise activities of daily living (ADLs) defined as dressing, grooming, eating, walking, and toileting with hands-on assistance provided as needed
- Appropriate structure, supervision and intervention
- Minimum staff ratio: 1 staff for each 16 participants
- Medication administration
- Optional or non-work related educational and life skill opportunities (such as how to use computers/computer programs/Internet, set an alarm clock, write a check, fill out a bank deposit slip, plant and care for vegetable/flower garden, etc. may be offered and pursued

Service Standards

- Facility Based Support services must be reflected in the Individualized Support Plan
- Facility Based Support services must follow a written Plan of Care addressing specific needs as identified in the Individualized Support Plan

Documentation Standards

Services outlined in the Individualized Support Plan

In addition to compliance with documentation requirements outlined in 460 IAC 6, the following data elements are required for each service rendered:

- Name of participant served
- RID Number of the participant
- Name of provider
- Service rendered

- Time frame of service (include a.m. or p.m.)
- Date of service including the year
- Notation of the primary location of service delivery
- A brief activity summary of service rendered
- Description* by direct care staff of an issue or circumstance concerning the participant including, but not limited to, significant medical or behavioral incidents or any other situation that may be uncommon for the participant
- Signature that includes at least the last name and first initial of the direct care staff person making the entry. Electronic signatures are permissible when in compliance with The Uniform Electronic Transactions Act (IC 26-2-8).
- Upon request, all data elements must be made available to auditors, quality monitors, case managers, and any other government entity.

*The data may reside in multiple locations but must be clearly and easily linked to the participant or the standard will not be met.

For Group Services

Upon request, the provider must be able to verify the following in a concise format the ratio for each claimed time frame of service did not exceed the maximum allowable ratio whether or not all group participants utilize a waiver funding stream

Limitations

- These services must be provided in a congregate, protective setting in groups not to exceed 16:1.
- Habilitation services reimbursement does not include reimbursement for the cost of the activities in which the individual in a group is participating when they receive skills training, such as the cost to attend a community event.

Activities Not Allowed

- Any activity that is not described in allowable activities is not included in this service
- Services furnished to a minor by a parent(s), step-parent(s), or legal guardian
- Services furnished to a participant by the participant's spouse
- Prevocational Services

Provider Qualifications

- DDRS approved
- Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals.

Additional Information:

- Available under the DD and Support Services Waivers. Facility Based Supports is not yet available under the Autism Waiver.

Section 10.14: Family and Caregiver Training

Family and Caregiver Training

Service Definition

Family and Caregiver Training services provide training and education to:

- Instruct a parent, other family member, or primary caregiver about the treatment regimens and use of equipment specified in the Individualized Support Plan; and
- Improve the ability of the parent, family member or primary caregiver to provide the care to or for the individual.

Reimbursable Activities

- Treatment regimens and use of equipment
- Stress management
- Parenting
- Family dynamics
- Community integration
- Behavioral intervention strategies
- Mental health
- Caring for medically fragile individuals

Service Standards

- Family and Caregiver Training Services must be included in the Individualized Support Plan
- The Individualized Support Plan shall be based on the person centered planning process with that individual.

Documentation Standards

- Services outlined in the Individualized Support Plan
- Receipt of payment for activity
- Proof of participation in activity if payment is made directly to individual/family.
- Documentation in compliance with 460 IAC 6 Supported Living Services and Supports requirements.

Limitations

Reimbursement for this service is limited to no more than $2,000/year

Activities Not Allowed

- Training/instruction not pertinent to the caregiver's ability to give care to the individual
- Training provided to caregivers who receive reimbursement for training costs within their Medicaid or state line item reimbursement rates
- Meals, accommodations, etc., while attending the training

Provider Qualifications

- DDRS approved
- Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals.

Additional Information:

- Family and Caregiver Training cannot be used to provide behavioral programs or supports or other direct services covered under other available State Plan or Waiver services.
- Available under the Autism, DD and Support Services Waivers.

Section 10.15: Intensive Behavioral Intervention

Intensive Behavioral Intervention

Service Definition

Intensive Behavioral Intervention (IBI) is a highly specialized, individualized program of instruction and behavioral intervention. IBI is based upon a functional, behavioral and/or skills assessment of an individual's treatment needs. The primary goal of IBI is to reduce behavioral excesses, such as tantrums and acting out behaviors, and to increase or teach replacement behaviors that have social value for the individual and increase access to their community. Program goals are accomplished by the application of research based interventions.

Generally, IBI addresses manifestations that are amenable to change in response to specific, carefully programmed, constructive interactions with the environment.

IBI must include:

- a detailed functional/behavioral assessment;
- reinforcement;
- specific and ongoing objective measurement of progress;
- Family training and involvement so that skills can be generalized and communication promoted;
- Emphasis on the acquisition, generalization and maintenance of new behaviors across other environments and other people;
- Training of caregivers, IBI direct care staff, and providers of other waiver services;
- Breaking down targeted skills into small, manageable and attainable steps for behavior change;
- Utilizing systematic instruction, comprehensible structure and high consistency in all areas of programming;
- Provision for one-on-one structured therapy;
- Treatment approach tailored to address the specific needs of the individual.

Skills training under IBI must include:

- measurable goals and objectives (specific targets may include appropriate social interaction, negative or problem behavior, communication skills, and/or language skills);
- Heavy emphasis on skills that are prerequisites to language (attention, cooperation, imitation).

Reimbursable Activities

- Preparation of an IBI support plan in accordance with 460 IAC 6-5-32
- Application of a combination of the following empirically-based, multi-modal and multidisciplinary comprehensive treatment approaches:
  - Intensive Teaching Trials (ITT), also called Discrete Trial Training, is a highly specific and structured teaching approach that uses empirically validated behavior change procedures. This type of learning is instructor driven, and may use error correction procedures or reinforcement to maintain motivation and attention to task. ITT consists of the following:
    - Antecedent: a directive or request for the individual to perform an action;
    - Behavior: a response from the individual, including anything from successful performance, non-compliance, or no response;
    - Consequence: a reaction from the therapist, including a range of responses from strong positive reinforcement, faint praise, or a negative (not aversive) reaction; and
    - A pause to separate trials from each other (inter-trial interval).
  - Natural Environment Training (NET) is learner directed training in which the learner engages in activities that are naturally motivating and reinforcing to him or her, rather than the more contrived reinforcement employed in ITT.
  - Interventions that are supported by research in behavior analysis and which have been found to be effective in the treatment of individuals with developmental disabilities which may include but are not limited to:
    - Precision teaching: A type of programmed instruction that focuses heavily on frequency as its main datum. It is a precise and systematic method of evaluating instructional tactics. The program emphasizes learner fluency and data analysis is regularly reviewed to determine fluency and learning.
    - Direct instruction: A general term for the explicit teaching of a skill-set. The learner is usually provided with some element of frontal instruction of a concept or skill lesson followed by specific instruction on identified skills. Learner progress is regularly assessed and data analyzed.
    - Pivotal response training: This training identifies certain behaviors that are “pivotal” (i.e., critical for learning other behaviors). The therapist focuses on these behaviors in order to change other behaviors that depend on them.
  - Errorless teaching or other prompting procedures that have been found to support successful intervention. These procedures focus on the prevention of errors or incorrect responses while also monitoring when to fade the prompts to allow the learner to demonstrate ongoing and successful completion of the desired activity.
  - Additional methods that occur and are empirically-based.

- Specific and ongoing objective measurement of progress, with success closely monitored via detailed data collection.

Service Standards

- An appropriate range of hours per week is generally between 20-30 hours of direct service. It is recommended that Intensive Behavioral Intervention Services be delivered a minimum of 20 hours per week. When fewer than 20 hours per week will be delivered, justification must be submitted explaining why the IST feels a number fewer than the recommended minimum is acceptable;
- A detailed IBI support plan is required.
- At least quarterly, the Individualized Support Team (IST) must meet to review the IBI, consider the need for change, develop a new plan, or set new goals;
- IBI Services must be reflected in the Individualized Support Plan;
- Services must address needs identified in the person centered planning process and be outlined in the Individualized Support Plan;
- Services must be detailed in the IBI support plan;
- Services are usually direct and one-to-one, with the exception of time spent in training the caregiver(s) and the family; ongoing data collection and analysis; goal and plan revisions;
- The IBI Case Supervisor will provide a narrative and graphical report to pertinent parties at least monthly. Pertinent parties include the individual, IBI Director, guardian, BDDS service coordinator, waiver case manager, all service providers, and other entities;
- The IBI Director will provide a narrative and graphical report to pertinent parties at least quarterly. Pertinent parties include the individual, IBI Case Supervisor, guardian, BDDS service coordinator, waiver case manager, all service providers, and other entities.

Documentation Standards

- Services outlined in the Individualized Support Plan (ISP).
- Documentation in compliance with 460 IAC 6.
- The IBI Case Supervisor will provide a narrative and graphical report to pertinent parties at least monthly. Pertinent parties include the individual, IBI Director, guardian, BDDS service coordinator, waiver case manager, all service providers, and other entities.
- The IBI Director will provide a narrative and graphical report to pertinent parties at least quarterly. Pertinent parties include the individual, IBI Case Supervisor, guardian, BDDS service coordinator, waiver case manager, all service providers, and other entities.

Limitations

See activities not allowed

Activities Not Allowed

- Aversive techniques as referenced within 460 IAC 6
- Interventions that may reinforce negative behavior, such as "Gentle Teaching"
- Group activities
- Services furnished to a minor by a parent(s), step-parent(s), or legal guardian
- Services furnished to a participant by the participant's spouse
- Therapy services furnished to the participant within the educational/school setting or as a component of the participant's school day

Provider Qualifications

- DDRS approved
- Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals.

Additional Information:

- Available under the DD and Support Services Waivers. Intensive Behavioral Intervention is not yet available under the Autism Waiver.

Section 10.16: Music Therapy

Music Therapy

Service Definition

Music Therapy Services means services provided for the systematic application of music in the treatment of the physiological and psychosocial aspects of an individual's disability and focusing on the acquisition of nonmusical skills and behaviors.

Reimbursable Activities

- Therapy to improve:
  - Self-image and body awareness
  - Fine and gross motor skills
  - Auditory perception
- Therapy to increase:
  - Communication skills
  - Ability to use energy purposefully
  - Interaction with peers and others
  - Attending behavior
  - Independence and self-direction
- Therapy to reduce maladaptive (stereotypic, compulsive, self-abusive, assaultive, disruptive, perseverative impulsive) behaviors.
- Therapy to enhance emotional expression and adjustment.
- Therapy to stimulate creativity and imagination. The music therapist may provide services directly or may demonstrate techniques to other service personnel or family members
- **Planning, reporting and write-up when in association with the actual one-on-one direct care/therapy service delivery with the waiver participant.**

Service Standards

- Music Therapy Services should be reflected in the Individualized Support Plan of the individual
- Services must address needs identified in the person centered planning process and be outlined in the Individualized Support Plan. Services must complement other services the individual receives and enhance increasing health and safety for the individual

Documentation Standards

- Documentation of appropriate assessment by a qualified therapist
- Services outlined in Individualized Support Plan
- Appropriate credentials for service provider
- Attendance record, therapist logs and/or chart detailing service provided, date and times
- Documentation in compliance with 460 IAC 6 Supported Living Services and Supports requirements.

Limitations

One (1) hour of billed therapy service must include a minimum of forty-five (45) minutes of direct patient care/therapy with the balance of the hour spent in related patient services.

Activities Not Allowed

- Any services that are reimbursable through the Medicaid State Plan.
- Therapy services furnished to the participant within the educational/school setting or as a component of the participant's school day
- Specialized equipment needed for the provision of Music Therapy Services should be purchased under "Specialized Medical Equipment and Supplies Supports"
- Activities delivered in a nursing facility

Provider Qualifications

- DDRS approved
- Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals.
- Certified Music Therapist By a Certification Board for Music Therapists, that is Accredited by a

Additional Information:

- The focus of this service must be therapeutic in nature rather than on the acquisition of musical skills obtained as the result of music lessons such as piano lessons, guitar lessons etc.
- Available under the Autism, DD and Support Services Waivers

Section 10.17: Occupational Therapy

Occupational Therapy

Service Definition

Occupational Therapy Services means services provided under 460 IAC 6-5-17 by a licensed/certified occupational therapist.

Reimbursable Activities

- Evaluation and training services in the areas of gross and fine motor function, self-care and sensory and perceptual motor function.
- Screening
- Assessments
- Planning and reporting
- Direct therapeutic intervention
- Design, fabrication, training and assistance with adaptive aids and devices
- Consultation or demonstration of techniques with other service providers and family members

Service Standards

- Individual Occupational Therapy Services must be reflected in the Individualized Support Plan.
- The need for such services must be documented by an appropriate assessment and authorized in the individual's service plan.

Documentation Standards

- Documentation by appropriate assessment by a qualified therapist
- Services outlined in the Individualized Support Plan
- Appropriate credentials for service provider
- Attendance record, therapist logs and/or chart detailing service provided, date and times
- Documentation in compliance with 460 IAC 6 Supported Living Services and Supports requirements.

Limitations

One (1) hour of billed therapy service must include a minimum of forty-five (45) minutes of direct patient care/therapy with the balance of the hour spent in related patient services.

Activities Not Allowed

- Therapy services furnished to the participant within the educational/school setting or as a component of the participant's school day
- Activities delivered in a nursing facility
- Services that are available through the Medicaid State Plan (a Medicaid State Plan prior authorization denial is required before reimbursement is available through the Medicaid waiver for this service).

Provider Qualifications

- DDRS approved
- Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals.
- Must meet licensure and certification requirements of IC 25-23.5

Additional Information

- Therapies provided through this service will not duplicate therapies provided under any other service.
- Available under the Autism, DD and Support Services Waivers.

Section 10.18: Personal Emergency Response System

Personal Emergency Response System

Service Definition

PERS is an electronic device which enables 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 by trained professionals.

Reimbursable Activities

- PERS is limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive supervision.
- Device Installation service
- Ongoing monthly maintenance of device

Service Standards

Must be included in the Individualized Support Plan (ISP)

Documentation Standards

- Identified need in the Individualized Support Plan (ISP)
- Documentation of expense for installation
- Documentation of monthly rental fee

Limitations

See Activities Not Allowed

Activities Not Allowed

- Reimbursement is not available for Personal Emergency Response System Supports when the individual requires constant supervision to maintain health and safety.

Additional Information:

- Available under the Autism, DD and Support Services Waivers.

Section 10.19: Physical Therapy

Physical Therapy

Service Definition

Physical Therapy Services means services provided under 460 IAC by a licensed physical therapist

Reimbursable Activities

- Screening and assessment
- Treatment and training programs designed to preserve and improve abilities for independent functioning, such as gross and fine motor skills, range of motion, strength, muscle tone, activities of daily living
- Planning, reporting and write-up when in association with the actual one-on-one direct care/therapy service delivery with the waiver participant
- Direct therapeutic intervention
- Training and assistance with adaptive aids and devices
- Consultation or demonstration of techniques with other service providers and family members

Service Standards

- Individual Physical Therapy Services must be reflected in the Individualized Support Plan.
- The need for such services must be documented by an appropriate assessment and authorized in the individual's service plan.

Documentation Standards

Physical Therapy Services documentation must include:

- Documentation by appropriate assessment
- Services outlined in the Individualized Support Plan
- Appropriate credentials for service provider
- Attendance record, therapist logs, and chart detailing service provided, date, and times.
- Documentation in compliance with 460 IAC 6 Supported Living Services and Supports requirements

Limitations

One (1) hour of billed therapy service must include a minimum of forty-five (45) minutes of direct patient care with the balance of the hour spent in related patient services.

Activities Not Allowed

- Therapy services furnished to the participant within the educational/school setting or as a component of the participant's school day
- Activities delivered in a nursing facility
- Services available through the Medicaid State Plan (a Medicaid State Plan prior authorization denial is required before reimbursement is available through the waiver for this service)

Provider Qualifications

- DDRS approved
- Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals.
- Must meet licensure/certification criteria of IC 25-27-1

Additional Information:

- Therapies provided through this service will not duplicate therapies provided under any other service.
- Available under the Autism, DD and Support Services Waivers.

Section 10.20: Prevocational Services

Prevocational Services

Service Definition

Prevocational Services are services that prepare a participant for paid or unpaid employment.

Prevocational Services include teaching concepts such as compliance, attendance, task completion, problem solving and safety. Services are not job-task oriented, but instead, aimed at generalized result. Services are habilitative in nature and not explicit employment objectives.

Reimbursable Activities

Monitoring, training, education, demonstration, or support provided to assist with the acquisition and retention of skills in the following areas:

- Paid and unpaid training compensated less than 50% federal minimum wage
- Generalized and transferrable employment skills acquisition

These activities may be provided using off-site enclave or mobile community work crew models.

Participants may also utilize Supported Employment Follow Along (SEFA) in conjunction with Pre-Vocational Services

Service Standards

- Pre-Vocational Services must be reflected in the Individualized Support Plan (ISP)
- All Pre-Vocational Services will be reflected in the participant's plan of care as directed to habilitative, rather than explicit employment objectives
- Participant is not expected to be able to join the general workforce or participate in sheltered employment within one year (excluding Supported Employment)

Documentation Standards

- Services outlined in the Individualized Support Plan
- In addition to compliance with documentation requirements outlined in 460 IAC 6, the following data elements are required for each service rendered:
    - Name of participant served
    - RID Number of the participant
    - Name of provider

- Service rendered
- Time frame of service (include a.m. or p.m.)
- Date of service including the year
- Notation of the primary location of service delivery
- A brief activity summary of service rendered
- Description* by direct care staff of an issue or circumstance concerning the participant including, but not limited to, significant medical or behavioral incidents or any other situation that may be uncommon for the participant
- Signature that includes at least the last name and first initial of the direct care staff person making the entry. Electronic signatures are permissible when in compliance with The Uniform Electronic Transactions Act (IC 26-2-8)

- Upon request, all data elements must be made available to auditors, quality monitors, case managers, and any other government entity.

*The data may reside in multiple locations but must be clearly and easily linked to the participant or the standard will not be met.

For Group services

Upon request, the provider must be able to verify the following in a concise format the ratio for each claimed time frame of service did not exceed the maximum allowable ratio whether or not all group participants utilize a waiver funding stream.

Limitations

Group sizes:

- Small (4:1 or smaller)
- Medium (5:1 to 10:1)
- Large (larger than 10:1 but no larger than 16:1)

Monitoring of prevocational services provision will be performed at a minimum every 6 months using the pre-vocational services monitoring tool administered by the state or their designee. The objectives of monitoring include assessment of the participant's progress toward achieving the outcomes identified on the participant's ISP related to employment and to verify the continued need for prevocational services.

Activities Not Allowed

- Services that are available under the Rehabilitation Act of 1973 or section 602(16) & (17) of Individual with Disabilities Education Act
- Activities that do not foster the acquisition and retention of skills
- Services in which compensation is greater than 50% federal minimum wage
- Activities directed at teaching specific job skills
- Sheltered employment, facility or community based
- Services furnished to a minor by parent(s) or stepparents(s) or legal guardian

Provider Qualifications

- DDRS approved
- Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals.
- Must be accredited by at least one (1) of the following organizations:
    1) The Commission on Accreditation of Rehabilitation Facilities (CARF), or its successor.
    2) The Council on Quality and Leadership In Supports for People with Disabilities, or its successor.
    3) The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or its successor.
    4) The National Committee for Quality Assurance, or its successor.
    5) The ISO-9001 human services QA system.
    6) An independent national accreditation organization approved by the secretary

Additional Information:

- Available under the Autism, DD and Support Services Waivers

Section 10.21: Psychological Therapy

Psychological Therapy

Service Definition

Psychological Therapy services means services provided under 460 IAC 6-3-56 by a licensed psychologist with an endorsement as a health service provider in psychology, a licensed marriage and family therapist, a licensed clinical social worker, or a licensed mental health counselor.

Reimbursable Activities

- Individual counseling
- Biofeedback
- Individual-centered therapy
- Cognitive behavioral therapy
- Psychiatric services
- Crisis counseling
- Family counseling
- Group counseling
- Substance abuse counseling and intervention
- Planning, reporting and write-up when in association with the actual one-on-one direct care/therapy service delivery with the waiver participant

Service Standards

- Therapy Services should be reflected in the Individualized Support Plan of the individual.
- Services must address needs identified in the person centered planning process and be outlined in the Individualized Support Plan
- Services must complement other services the individual receives and enhance increasing independence for the individual

Documentation Standards

- Documentation by appropriate assessment
- Services outlined in the Individualized Support Plan

- Appropriate credentials for service provider
- Attendance record, therapist logs and/or chart detailing service provided, date and times
- Documentation in compliance with 460 IAC 6 Supported Living Services and Supports requirements

Limitations

One (1) hour of billed therapy service must include a minimum of forty-five (45) minutes of direct patient care with the balance of the hour spent in related patient services.

Activities Not Allowed

- Activities delivered in a nursing facility
- Services that are available through the Medicaid State Plan (a Medicaid State Plan prior authorization denial is required before reimbursement is available through the Medicaid waiver for this service).
- Therapy services furnished to the participant within the educational/school setting or as a component of the participant's school day
-

Additional Information:

- Therapies provided through this service will not duplicate therapies provided under any other service.
- Available under the Autism, DD and Support Services Waivers.

Section 10.21: Recreational Therapy

Recreational Therapy

Service Definition

Recreational Therapy Services means services provided under this article and consisting of a medically approved recreational program to restore, remediate, or rehabilitate an individual in order to:

- Improve the individual's functioning and independence; and
- Reduce or eliminate the effects of an individual's disability.

Reimbursable Activities

- Organizing and directing Adapted sports, Dramatics, Arts and crafts, Social activities, and other recreation services designed to restore, remediate or rehabilitate
- Planning, reporting and write-up when in association with the actual one-on-one direct care/therapy service delivery with the waiver participant

Service Standards

- Recreational Therapy Services should be reflected in the Individualized Support Plan (ISP)
- Services must address needs identified in the person centered planning process and be outlined in the Individualized Support Plan.
- Services must complement other services the individual receives and enhance increasing independence for the individual

Documentation Standards

- Documentation by appropriate assessment
- Services outlined in Individualized Support Plan
- Appropriate credentials for service provider
- Attendance record, therapist logs, and/or chart detailing service provided, date, and times
- Documentation in compliance with 460 IAC 6 Supported Living Services and Supports requirements

Limitations

Activities Not Allowed

- Payment for the cost of the recreational activities, registrations, memberships or admission fees associated with the activities being planned, organized or directed
- Any services that are reimbursable through the Medicaid State Plan
- Therapy services furnished to the participant within the educational/school setting or as a component of the participant's school day

Additional Information:

- Available under the Autism, DD and Support Services Waivers.

Section 10.23: Rent and Food for Unrelated Caregiver

Rent and Food for Unrelated Caregiver

Service Definition

Rent and Food for an Unrelated, Live-in Caregiver Supports means the additional cost a participant incurs for the room and board of an unrelated, live-in caregiver (who has no legal responsibility to support the participant) as provided for in the participant's Residential Budget.

Reimbursable Activities

- The individual participant receiving these services lives in his or her own home
- For payment to not be considered income for the participant receiving services, payment for the portion of the costs of rent and food attributable to an unrelated, live-in caregiver (who has no legal responsibility to support the participant) must be made directly to the live-in caregiver
- Room and board for the unrelated live-in caregiver (who is not receiving any other financial reimbursement for the provision of this service)
- Room: shelter type expenses including all property related costs such as rental or purchase of real estate and furnishings, maintenance, utilities and related administrative services
- Board: three meals a day or other full nutritional regimen
- Unrelated: unrelated by blood or marriage to any degree
- Caregiver: an individual providing a covered service as defined by BDDS service definitions or in a Medicaid HCBS waiver, to meet the physical, social or emotional needs of the participant receiving services

Service Standards

- Rent and Food for an Unrelated Live-in Caregiver should be reflected in the Individualized Support Plan (ISP)
- Services must address needs identified in the person centered planning process and be outlined in the Individualized Support Plan
- Services must complement other services the participant receives and enhance increasing independence for the participant
- The person centered planning team will decide and assure that the individual who will serve as a live-in caregiver has the experience, skills, training and knowledge appropriate to the participant and the type of support needed

Documentation Standards

Rent and Food for Unrelated Live-in Caregiver documentation must include:

- Identified in the Individualized Support Plan
- Documentation of how amount of Rent and Food was determined
- Receipt that funds were paid to the live-in caregiver
- Documentation in compliance with 460 IAC 6 Supported Living Services and Supports requirements

Limitations

See Activities Not Allowed

Activities Not Allowed

- When the participant lives in the home of the caregiver or in a residence owned or leased by the provider of other services, including Medicaid waiver services
- When the live-in caregiver is related by blood or marriage (to any degree) to the participant and/or has any legal responsibility to support the participant

Additional Information:

- Paid Caregivers are not eligible for this service
- Available only under the Autism and DD Waivers. Rent and Food for Unrelated Caregivers is not available under the Support Services Waiver.

Section 10.24: Residential Habilitation and Support

Residential Habilitation and Support

Service Definition

Residential Habilitation and Support Services provide up to a full day (24-hour basis) of services and/or supports which are designed to ensure the health, safety and welfare of the participant, and assist in the acquisition, improvement, and retention of skills necessary to support participants to live successfully in their own homes.

Billable either as:

- RH1O for 35 hours or less per week of RHS , OR
- RH2O for greater than 35 hours per week of RHS

Reimbursable Activities

RHS includes the following activities:

- Direct supervision, monitoring and training to implement the Individualized Support Plan (ISP) outcomes for the participant through the following:
  - Assistance with personal care, meals, shopping, errands, chore and leisure activities and transportation (excluding transportation that is covered under the Medicaid State Plan)
  - Coordination and facilitation of medical and non-medical services to meet healthcare needs, including physician consults, medications, development and oversight of a health plan, utilization of available supports in a cost effective manner and maintenance of each participant's health record
  - Assurance that direct service staff are aware and active individuals in the development and implementation of ISP and Behavior Support Plans

Service Standards

- Services must address needs identified in the person centered planning process and be outlined in the Individualized Support Plan (ISP)
- Residential Habilitation and Support services should complement but not duplicate habilitation services being provided in other settings
- Services provided must be consistent with the participant's service planner

Documentation Standards

- RHS documentation must include:
  - Services outlined in Individualized Support Plan
  - Data record of staff-to-consumer service documenting the complete date and time entry (including a.m. or p.m.) All staff members who provide uninterrupted, continuous service in direct supervision or care of the participant must make one entry. If a staff member provides interrupted service (one hour in the morning and one hour in the evening), an entry for each unique encounter must be made. All entries should describe an issue or circumstance concerning the participant. The entry should include complete time and date of entry and at least the last name, first initial of the staff person making the entry

- If the person providing the service is required to be professionally licensed, the title of that individual must also be included. For example, if a nurse is required, the nurse's title should be documented.

- Any significant issues involving the participant requiring intervention by a Health Care Professional, Case Manager or BDDS staff member that involved the participant are also to be documented

- Monthly reporting summaries are required

- Documentation in compliance with 460 IAC 6

Limitations

May be used in conjunction with Transportation Services only when 35 or fewer hours per week of RHS are utilized

Reimbursable waiver funded services furnished to an adult waiver participant by any combination of relative(s)* and/or legal guardian(s) may not exceed a total of 40 hours per week. (See Activities Not Allowed for definition of relative)

Additionally:

- Providers may not bill for RHS reimbursement for time when staff/paid caregiver is asleep. Only awake, engaged staff can be counted in reimbursement. (A team may decide that a staff or contractor may sleep while with a participant, but this activity is not billable.)

- Providers may not bill for RHS reimbursement during the time when a participant is admitted to a hospital. (The care and support of a participant who is admitted to a hospital is a non-billable RHS activity.)

- RHS and Electronic Monitoring services are not billable during the same time period.

- Intermittent use of RHS may not exceed thirty-five (35) hours of service per week

- RHS may not be used in conjunction with Transportation Services when more than 35 hours of RHS are utilized per week.

Activities Not Allowed

Reimbursement is not available through RHS in the following circumstances:

- Services furnished to a **minor** by the parent(s), step-parent(s), or legal guardian
- Services furnished to a participant by the participant's spouse
- Services to individuals in Adult Foster Care or Children's Foster Care
- Services that are available under the Medicaid State Plan
- Reimbursable waiver funded services furnished to an **adult** waiver participant by any combination of relative(s)* and/or legal guardian(s) may not exceed a total of 40 hours per week.

* Related/relative implies any of the following natural, adoptive and/or step relationships, whether by blood or by marriage, inclusive of half and/or in-law status:

1) Aunt (natural, step, adopted)
2) Brother (natural, step, half, adopted, in-law)
3) Child (natural, step, adopted)
4) First cousin (natural, step, adopted)
5) Grandchild (natural, step, adopted)
6) Grandparent (natural, step, adopted)
7) Parent (natural, step, adopted, in-law)
8) Sister (natural, step, half, adopted, in-law)
9) Spouse (husband or wife)
10) Uncle (natural, step, adopted)

Provider Qualifications

- DDRS approved
- Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals.

Additional Information:

- Available only under the Autism and DD Waivers. Residential Habilitation and Support is not available under the Support Services Waiver.

Section 10.25: Respite

Respite

Service Definition

Respite Care services means services provided to participants unable to care for themselves that are furnished on a short-term basis in order to provide temporary relief to those unpaid persons normally providing care. Respite Care can be provided in the participant's home or place of residence, in the respite caregiver's home, in a camp setting, in a DDRS approved day habilitation facility, or in a non-private residential setting (such as a respite home).

Reimbursable Activities

- Assistance with toileting and feeding
- Assistance with daily living skills, including assistance with accessing the community and community activities
- Assistance with grooming and personal hygiene
- Meal preparation, serving and cleanup
- Administration of medications
- Supervision
- Individual services
- Group services (Unit rate divided by number of participants served)

Service Standards

- Respite care must be reflected in the Individualized Support Plan
- Respite Nursing Care (RN) or Respite Nursing Care (LPN) services may only be delivered when skilled care is required

Documentation Standards

Service Notes: A service note can include multiple discrete services as long as discrete services are clearly identified A service note must include:

- Participant name
- RID #
- Date of Service

- Provider rendering service
- Primary location of services rendered
- An activity summary for each block of time this service is rendered must exist and must include: duration, service, a brief description of activities, significant medical or behavioral incidents requiring intervention, or any other situation that is uncommon for the participant. A staff signature must be present for each block of time claimed on a service note. A new entry is not required unless a different discrete service is provided (i.e. one continuous note may exist even if the ratio changes)
- For Group Services upon request, the provider must be able to verify the following in a concise format the ratio for each claimed time frame of service did not exceed the maximum allowable ratio whether or not all group participants utilize a waiver funding stream
- Electronic signatures are acceptable if the provider has a log on file showing the staff member's electronic signature, actual signature and printed name

Limitations

Waiver funded Respite services may not be rendered in a nursing facility

Activities Not Allowed

- Reimbursement for room and board
- Services provided to an participant living in a licensed facility-based setting
- The cost of registration fees or the cost of recreational activities (for example, camp)
- When the service of Adult Foster Care or Children's Foster Care is being furnished to the participant
- Other family members (such as siblings of the participant) may not receive care or supervision from the provider while Respite care is being provided/billed for the waiver participant(s)
- Respite care shall not be used as day/child care
- Respite is not intended to be provided on a continuous, long-term basis as part of daily services that would enable the unpaid caregiver to go to work or to attend school
- Respite care shall not be used to provide service to a participant while the participant is attending school
- Respite care may not be used to replace skilled nursing services that should be provided under the Medicaid State Plan
- Respite care must not duplicate any other service being provided under the participant's Plan of Care/Cost Comparison Budget (CCB)

- Services furnished to a minor by a parent(s), step-parent(s), or legal guardian
- Services furnished to a participant by the participant's spouse

Additional Information:

- Available under the Autism, DD and Support Services Waivers.

Section 10.26: Specialized Medical Equipment and Supplies

Specialized Medical Equipment and Supplies

Service Definition

Specialized medical equipment and supplies to include devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live and without which the individual would require institutionalization.

Waiver Services must approve all specialized medical equipment and supplies prior to service being rendered.

Reimbursable Activities

- Items necessary for life support
- Adaptive equipment and supplies
- Ancillary supplies and equipment needed for the proper functioning of specialized medical equipment and supplies
- Durable medical equipment not available under Medicaid State Plan
- Non-durable medical equipment not available under Medicaid State Plan
- Vehicle Modifications
- Communications devices
- Interpreter services

Service Standards

- Equipment and supplies must be of direct medical or remedial benefit to the individual
- All items shall meet applicable standards of manufacture, design and installation
- Any individual item costing over $500 requires an evaluation by a qualified professional such as a physician, nurse, Occupational Therapist, Physical Therapist, Speech and Language Therapist or Rehabilitation Engineer
- Annual maintenance service is available and is limited to $500 per year. If the need for maintenance exceeds $500, the case manager will work with other available funding streams and community agencies to fulfill the need.

Documentation Standards

- Identified need in Individualized Support Plan (ISP) and Plan of Care/Cost Comparison Budget (CCB).
- Identified direct medical benefit for the individual.
- Documentation of the request for IHCP prior approval (denied PA).
- Documentation of the reason of denial of IHCP prior authorization.
- Receipts for purchases.
- Signed and approved Request for Approval to Authorize Services (State Form 45750)

Limitations

Service and repair up to $500 per year is permitted for maintenance and repair of previously obtained specialized medical equipment that was funded by a waiver service. If the need for maintenance exceeds $500, the case manager will work with other available funding streams and community agencies to fulfill the need.

A lifetime cap of $15,000 is available for vehicle modifications. In addition to the $15,000 lifetime cap, $500 will be allowable annually for repair, replacement, or an adjustment to an existing modification that has been provided through the HCBS waiver. If the lifetime cap is fully utilized, and a need is identified, the case manager will work with other available funding streams and community agencies to fulfill the need.

Vehicle Modifications have a cap of $7,500 under the Support Services Waiver, but a cumulative lifetime cap of $15,000 across all HCBS Waiver Programs operated by the State.

Activities Not Allowed

- Equipment and services that are available under the Medicaid State Plan
- Equipment and services that are not of direct medical or remedial benefit to the individual
- Equipment and services that are not included in the comprehensive plan of care
- Equipment and services that have not been approved on a Request for Approval to Authorize services (RFA)
- Equipment and services that are not reflected in the Individualized Support Plan
- Equipment and services that do not address needs identified in the person centered planning process

Provider Qualifications

- DDRS approved
- Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals.

Additional Information:

- Available under the Autism, DD and Support Services Waivers.

Section 10.27: Speech/Language Therapy

Speech/Language Therapy

Service Definition

Speech-Language Therapy Services means services provided by a licensed speech pathologist under 460 IAC 6 Supported Living Services and Supports requirements.

Reimbursable Activities

- Screening
- Assessment
- Direct therapeutic intervention and treatment for speech and hearing disabilities such as delayed speech, stuttering, spastic speech, aphasic disorders, injuries, lip reading or signing, or the use of hearing aids.
- Evaluation and training services to improve the ability to use verbal or non-verbal communication.
- Language stimulation and correction of defects in voice, articulation, rate and rhythm.
- Design, fabrication, training and assistance with adaptive aids and devices.
- Consultation demonstration of techniques with other service providers and family members.
- Planning, reporting and write-up when in association with the actual one-on-one direct care/therapy service delivery with the waiver participant

Service Standards

- Individual Speech-Language Therapy Services must be reflected in the Individualized Support Plan.
- To be eligible for this service, the individual must have been examined by a certified audiologist and/or a certified speech therapist who has recommended a formal speech/audiological program.
- The need for such services must be documented by an appropriate assessment and authorized in the individual's service plan.

Documentation Standards

- Documentation of an appropriate assessment
- Services outlined in the Individualized Support Plan

- BDDS approved provider
- Appropriate credentials for service provider
- Attendance record, therapist logs and/or chart detailing service provided, date and times.
- Documentation in compliance with 460 IAC 6 Supported Living Services and Supports requirements.

Limitations

One (1) hour of billed therapy service must include a minimum of forty-five (45) minutes of direct patient care/therapy with the balance of the hour spent in related patient services.

Activities Not Allowed

- Services available through the Medicaid State Plan (a Medicaid State Plan prior authorization denial is required before reimbursement is available through the Medicaid waiver for this service).
- Therapy services furnished to the participant within the educational/school setting or as a component of the participant's school day
- Activities delivered in a nursing facility

Provider Qualifications

- DDRS approved
- Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals.

Additional Information:

- Therapies provided through this service will not duplicate therapies provided under any other service.
- Available under the Autism, DD and Support Services Waivers.

Section 10.28: Supported Employment Follow Along (SEFA)

Supported Employment Follow Along

Service Definition

Supported Employment Follow Along services are services and supports (time-limited to 18 months per employment setting), that enable a participant who is paid at or above the federal minimum wage to maintain employment in a competitive community employment setting. The 18-month clock begins with the start date of the SEFA service as it appears on the approved Plan of Care/Cost Comparison Budget (CCB) and Notice of Action (NOA). Note that the 18- month clock does not begin with the date the service is first rendered or with the date the service is first billed for this time-limited service, unless those dates correspond to the start date of the service as it appears on the CCB and NOA.

In each of the following situations (job in jeopardy, career advancement or job loss, as described below) requests for exceptions for SEFA beyond the approved 18 months will be reviewed in accordance with the DDRS special circumstances and exceptions policy. Depending on each participant's circumstances, the time limit may need to be extended or the participant may need to be referred to, or back to, Vocational Rehabilitation for services and reimbursement, in which case, concurrent reimbursement for Supported Employment Follow-Along and Vocational Rehabilitation Services will not be allowed.

Definitions for job in jeopardy, career advancement or job loss:

- Job in jeopardy – the participant will lose his/her job without additional intervention, or
- Career advancement – it is determined that the new job requires more complex, comprehensive, intensive supports than can be offered under the waiver, or
- Job loss, the participant may need to be referred to, or back to, Vocational Rehabilitation for services and reimbursement, in which case, concurrent reimbursement for Supported Employment Follow-Along and Vocational Rehabilitation Services will not be allowed

Reimbursable Activities

Reimbursement is available through Supported Employment Follow-Along Services for the following activities:

- Time spent at the participant’s work site: observation and supervision of the participant, teaching job tasks and monitoring at the work site a minimum of twice a month, to ascertain the success of the job placement
- At the request of the participant, off site monitoring may occur as long as the monitoring directly relates to maintaining a job
- Employment services occur in an integrated work setting
- The provision of skilled job trainers who accompany the participant for short-term job skill training at the work site to help maintain employment

- Regular contact and/or follow-up with the employers, participants, parents, family members, guardians, advocates or authorized representatives of the participants, and other appropriate professional and informed advisors, in order to reinforce and stabilize the job placement
- Facilitation of natural supports at the work site
- Individual program development, writing tasks analyses, monthly reviews, termination reviews and behavioral intervention programs
- Advocating for the participant , but
    - only with persons at the employment site (i.e., employers, co-workers, customers) and only for purposes directly related to employment; **OR**
    - with persons not directly affiliated with the employment site (i.e., parents, bus drivers, case managers, school personnel, landlords, etc.) if the person is hired and currently working
- Staff time used in traveling to and from a work site.
- Supports for up to 18 months per employment setting

Participants may utilize Workplace Assistance in conjunction with SEFA

Participants may also utilize Pre-Vocational Services in conjunction with SEFA

Service Standards

When Supported Employment services are provided at a worksite where persons without disabilities are employed, payment will only be made for the adaptation, supervision and training required by participants receiving waiver services as a result of their disabilities and will not include payment for the supervisory activities rendered as a normal part of the business setting Services are tailored to the needs and interests identified in the person centered planning process and must be outlined in the Individualized Support Plan (ISP)

Documentation Standards

Supported Employment Follow Along services must be outlined in the Individualized Support Plan (ISP)

In addition to compliance with documentation requirements outlined in 460 IAC 6, the following data elements are required for each service rendered:

- Name of participant served
- RID Number of the participant
- Name of provider
- Service rendered
- Time frame of service (include a.m. or p.m.)

- Date of service including the year
- Notation of the primary location of service delivery
- A brief activity summary of service rendered
- Description* by direct care staff of an issue or circumstance concerning the participant including, but not limited to, significant medical or behavioral incidents or any other situation that may be uncommon for the participant
- Signature that includes at least the last name and first initial of the direct care staff person making the entry. Electronic signatures are permissible when in compliance with The Uniform Electronic Transactions Act (IC 26-2-8).
- Upon request, all data elements must be made available to auditors, quality monitors, case managers, and any other government entity.

*The data may reside in multiple locations but must be clearly and easily linked to the participant or the standard will not be met.

Limitations

- Allowable ratio: Individual, 1:1
- Unless an exception is granted by DDRS as described previously, reimbursement is not available under Supported Employment Follow Along services for more than 18 months per employment setting, with the 18-month clock starting with the service start date as it appears on the CCB and NOA.
- A waiver participant who is unable to sustain competitive employment after 18 months of service/support is considered inappropriately placed and continuing funding is not available without movement to a better-fit employment setting or authorization of a DDRS-approved exception for special circumstances.

Activities Not Allowed

Reimbursement is not available under Supported Employment Follow Along services for the following activities:

- Transportation of an individual participant
- Any service that is otherwise available under the Rehabilitation Act of 1973 or Public Law 94-142
- Activities taking place in a group, i.e., work crews or enclaves
- Public relations
- Community education
- In-service meetings, department meetings, individual staff development

- Incentive payments made to an employer to subsidize the employer's participation in a supported employment program
- Payments that are passed through to users of supported employment programs
- Sheltered work observation
- Payments for vocational training that is not directly related to a participant's supported employment program
- Any other activities that are non-participant specific, i.e., the job coach is working the job instead of the participant
- Any activities which are not directly related to the participant's vocational plan
- Services furnished to a minor by a parent(s), step-parent(s) or legal guardian
- Services furnished to a participant by the participant's spouse

Provider Qualifications

- DDRS approved
- Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals.
- Must be accredited by at least one (1) of the following organizations:
    1) The Commission on Accreditation of Rehabilitation Facilities (CARF), or its successor.
    2) The Council on Quality and Leadership In Supports for People with Disabilities, or its successor.
    3) The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or its successor.
    4) The National Committee for Quality Assurance, or its successor.
    5) The ISO-9001 human services QA system.
    6) An independent national accreditation organization approved by the secretary

Additional Information:

- Available under Autism, DD and Support Services Waivers.
- Participants may utilize Workplace Assistance in conjunction with SEFA
- Participants may also utilize Pre-Vocational Services in conjunction with SEFA

Section 10.29: Transportation

Transportation

Service Definition

Transportation Services enable waiver participants to gain access to non-medical community services and resources, maintain or improve their mobility within the community, increase independence and community participation and prevent institutionalization as specified by the Individualized Support Plan and plan of care.

Reimbursable Activities

- Two one-way trips per day to or from a non-medical community service or resource as specified on the ISP and provided by an approved provider of Residential Habilitation and Support, Community Based Habilitation, Facility Based Habilitation, Adult Day Services or Transportation Services.
- Bus passes or alternate methods of transportation may be utilized
- May be used in conjunction with other services, including Community Based Habilitation, Facility Based Habilitation and Adult Day Services

Service Standards

- Transportation service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them.
- Transportation services under the waiver shall be offered in accordance with the Individualized Support Plan (ISP), and when unpaid transportation is not available.
- Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized.

Documentation Standards

Service Notes: A service note can include multiple discrete services as long as discrete services are clearly identified. A service note entry for this service can be part of a comprehensive daily note with other services recorded, as long it is clearly separated from other services in the note.

A service note must include:

- Consumer name
- RID #
- Date of Service

- Provider rendering service
- Pick up point and destination
- If contract transportation is utilized, contractor must provide log and invoice support that includes date(s) of transportation provided.
- If bus passes or alternative methods of transportation are utilized, invoices and attendance logs must support days for which round trips are billed to the waiver.

Limitations

- May not be used in conjunction with Adult Foster Care Services or for consumers receiving more than 35 hours per week of Residential Habilitation Services.
- May not be used when the participant receives more than 35 hours per week in Residential Habilitation and Support Services

Activities Not Allowed

- May not be used to meet medical transportation needs already available under the Indiana Medicaid State Plan

Provider Qualifications

- DDRS approved
- Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals.

Additional Information:

- Available under Autism, DD and Support Services Waivers.
- Transportation Services may be used in conjunction with Residential Habilitation and Support (RHS) services only for waiver participants receiving 35 hours or fewer per week of RHS services (including participants who receive no RHS services at all).

Section 10.30: Workplace Assistance

Workplace Assistance

Service Definition

Workplace Assistance Services provide a range of personal care services and/or supports during paid competitive community employment hours and in a competitive community employment setting to enable waiver participants to accomplish tasks that they would normally do for themselves if they did not have a disability. Assistance may take the form of hands-on assistance (actually performing a personal care task for the participant) or cuing to prompt the participant to perform a personal care task. Workplace Assistance services may be provided on an episodic or on a continuous basis.

Workplace Assistance Services are services that are designed to ensure the health, safety and welfare of the participant, thereby assisting in the retention of paid employment for the participant who is paid at or above the federal minimum wage.

Reimbursable Activities

- Direct supervision, monitoring, training, education, demonstration or support to assist with personal care while on the job or at the job cite (may included assistance with meals, hygiene, toileting, transferring, maintaining continence, administration of medication, etc.)
- May be used in conjunction with Supported Employment Follow-Along services
- May be utilized with each hour the participant is engaged in paid competitive community employment

Service Standards

- Workplace Assistance Services must be reflected in the Individualized Support Plan (ISP)
- Workplace Assistance Services should complement but not duplicate community habilitation services being provided in other settings
- Workplace Assistance Services may only be delivered in the employment setting. There is no requirement for a physician's prescription or authorization. The need for Workplace Assistance Services is determined entirely by the Individualized Support Team.

Documentation Standards

Services outlined in the Individualized Support Plan

In addition to compliance with documentation requirements outlined in 460 IAC 6, the following data elements are required for each service rendered:

- Name of participant served
- RID Number of the participant
- Name of provider
- Service rendered
- Time frame of service (include a.m. or p.m.)
- Date of service including the year
- Notation of the primary location of service delivery
- A brief activity summary of service rendered
- Description* by direct care staff of an issue or circumstance concerning the participant including, but not limited to, significant medical or behavioral incidents or any other situation that may be uncommon for the participant
- Signature that includes at least the last name and first initial of the direct care staff person making the entry. Electronic signatures are permissible when in compliance with The Uniform Electronic Transactions Act (IC 26-2-8).
- Upon request, all data elements must be made available to auditors, quality monitors, case managers, and any other government entity.

*The data may reside in multiple locations but must be clearly and easily linked to the participant or the standard will not be met.

Limitations

- Allowed Ratio - Individual, 1:1
- Reimbursement for Workplace Assistance Services is available only during the participant's hours of paid, competitive community employment
- Workplace Assistance is NOT to be used for observation or supervision of the participant for the purpose of teaching job tasks or to ascertain the success of the job placement
- Workplace Assistance is NOT to be used for offsite monitoring when the monitoring directly relates to maintaining a job

- Workplace Assistance is NOT to be used for the provision of skilled job trainers who accompany the participant for short-term job skill training at the work site to help maintain employment
- Workplace Assistance is NOT to be used for regular contact and/or follow-up with the employers, participants, parents, family members, guardians, advocates or authorized representatives of the participants, or other appropriate professional or informed advisors, in order to reinforce and stabilize the job placement
- Workplace Assistance is NOT to be used for the facilitation of natural supports at the work site
- Workplace Assistance is NOT to be used for Individual program development, writing tasks analyses, monthly reviews, termination reviews or behavioral intervention programs
- Workplace Assistance is NOT to be used for advocating for the participant
- Workplace Assistance is NOT to be used for staff time in traveling to and from a work site.

Activities Not Allowed

Reimbursement is not available through Workplace Assistance Services under the following circumstances:

- When services are furnished to a minor child by the parent(s) or step-parent(s) or legal guardian
- When services are furnished to a participant by that participant's spouse
- Any service that is otherwise available under the Rehabilitation Act of 1973 or Public Law 94-142
- During volunteer activities
- In a facility setting
- In conjunction with sheltered employment
- During activities other than paid competitive community employment
- Workplace Assistance should complement but not duplicate services being provided under Supported Employment Follow Along services

Additional Information:

- Available under Autism, DD and Support Services Waivers.
- May be used in conjunction with Supported Employment Follow-Along services
- May be utilized with each hour the participant is engaged in paid competitive community employment

Part 11: RFA Policies

Sections 11.1 – 11.3

Section 11.1: Environmental Modification Policy

Section 11.2: Specialized Medical Equipment and Supplies

Section 11.3: Vehicle Modification

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Section 11.1: Environmental Modification Policy

Waiver Policy Notification

Authority: 42 CFR §441.302

Policy Topic: Environmental Modification Policy Clarification

Impacts the following Home and Community-Based Services (HCBS) Waivers:

Aged and Disabled (AD) – Division of Aging

Traumatic Brain Injury (TBI) – Division of Aging

Autism (AU) – Division of Disability and Rehabilitative Services

Developmentally Disabled (DD) – Division of Disability and Rehabilitative Services

Note: Not a covered service for the Support Services (SSW) – Division of Disability and Rehabilitative Services

Effective Date: December 1, 2007 and replaces all previous policies related to the authorization of Environmental Modifications.

Description

Environmental modifications are minor physical adaptations to the home, as required by the individual's Plan of Care/Cost Comparison Budget (POC/CCB), which are necessary to ensure 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.

A lifetime cap of $15,000 is available for environmental modifications. The cap represents a cost for basic modification of an individual's home for accessibility and safety and accommodates the individual's needs for housing modifications. The cost of an environmental modification includes all materials, equipment, labor, and permits to complete the project. No parts of an environmental modification may be billed separately as part of any other service category (e.g. Specialized Medical Equipment). In addition to the $15,000 lifetime cap, $500 is allowable annually for the repair, replacement, or an adjustment to an existing environmental modification that was funded by a Home and Community Based Services (HCBS) waiver.

Home Ownership

Environmental modifications shall be approved for the individual's own home or family owned home. Rented homes or apartments are allowed to be modified only when a signed agreement from the landlord is obtained. The signed agreement must be submitted along with all other required waiver documentation.

Choice of Provider

The individual chooses which approved/certified providers will submit bids or estimates for this service. The provider with the lowest bid will be chosen, unless there is a strong written justification from the case manager detailing why a provider with a higher bid should be selected.

Requirements

All environmental modifications must be approved by the waiver program prior to services being rendered.

Environmental modification requests must be provided in accordance with applicable State and/or local building codes and should be guided by Americans with Disability Act (ADA) or ADA Accessibility Guidelines (ADAAG) requirements when in the best interest of the individual and his/her specific situation.

Environmental modifications shall be authorized only when it is determined to be medically necessary and shall have direct medical or remedial benefit for the waiver individual. This determination includes the following considerations:

- The modification is the most cost effective or conservative means to meet the individual's need(s) for accessibility within the home;
- The environmental modification is individualized, specific, and consistent with, but not in excess of, the individual's need(s);
- Three (3) home modification bids must be obtained for all modifications over $1,000;
- If three (3) bids cannot be obtained, it must be documented to show what efforts were made to secure the three (3) bids and explain why fewer than three (3) bids were obtained (e.g. provider name, dates of contact, response received);
- For modifications under $1,000, one (1) bid is required and pricing must be consistent with the fair market price for such modification(s);
- Bids must be itemized to include the following:

Example:

Scope of work	Material	Related Labor
Ramp 15' long	$$	$$
Widen front door to 36"	$$	$$
Widen bathroom door to 36"	$$	$$
Install ADA toilet	$$	$$
Building permits (specify)	$$	$$
Total Cost	$$$$	$$$$

Requests for modifications at two or more locations may only be approved at the discretion of the State division director or State agency designee.

Requests for modifications may be denied if the State division director or State agency designee determines the documentation does not support residential stability and/or the service requested.

Service Standards

Environmental Modification must be of direct medical or remedial benefit to the individual;

To ensure that environmental modifications meet the needs of the individual and abide by established federal, state, local and FSSA standards, as well as ADA requirements, when applicable, approved environmental modifications will include:

- Assessment of the individual's specific needs, conducted by an approved, qualified individual who is independent of the entity providing the environmental modifications;
- Independent inspections during, as well as at the completion of, the modification process, prior to authorization for reimbursement;
- Modifications must meet applicable standards of manufacture, design and installation;
- Modifications must be compliant with applicable building codes.

Documentation Standards:

The identified direct benefit or need must be documented within:

- POC/CCB; and
- 2. Physician prescription and/or clinical evaluation as deemed appropriate; and
- Individual Support Plan (ISP) if under the DD and AU waivers.

Documentation/explanation of the service within the Request for Approval to Authorize Services (RFA) including the following:

- Property owner of the residence where the requested modification is proposed;
- Property owner's relationship to the individual;
- What, if any, relationship the property owner has to the waiver program;
- Length of time the individual has lived at this residence;
- If a rental property - length of lease;
- Written agreement of landlord for modification;
- Verification of individual's intent to remain in the setting; and
- Land survey may be required when exterior modification(s) approach property line.
- Signed and approved RFA;
- Signed and approved POC/CCB;
- Provider of services must maintain receipts for all incurred expenses related to the modification;
- Must be in compliance with FSSA and Division specific guidelines and/or policies.

Reimbursement

Reimbursement is available for modifications which satisfy each of the following:

- Service and documentation standards outlined within this policy;
- Allowable under current Medicaid waiver guidelines;
- Not available under the Rehabilitation Act of 1973, as amended;
- Included in the individual's approved POC/CCB;
- Authorized on the RFA and linked to the POC/CCB;
- Included on a State approved and signed Notice of Action (NOA);
- Completed by an approved Medicaid Waiver Service Provider (who is approved to perform this service);
- Completed in accordance with the applicable Building permits.

Modifications/Items – Covered

Justification and documentation is required to demonstrate that the modification is necessary in order to meet the individual's identified need (s).

Adaptive door openers and locks - limited to one (1) per individual primary residence for an individual living alone or who is alone without a caregiver for substantial periods of time but has a need to open, close or lock the doors and cannot do so without special adaptation.

- Bathroom Modification **-** limited to one (1) existing bathroom per individual primary residence when no other accessible bathroom is available. The bathroom modification may include:
  - removal of existing bathtub, toilet and/or sink;
  - installation of roll in shower, grab bars, ADA toilet and wall mounted sink;
  - installation of replacement flooring, if necessary due to bath modification.

- Environmental Control Units - Adaptive switches and buttons to operate medical equipment, communication devices, heat and air conditioning, and lights for an individual living alone or who is alone without a caregiver for a substantial portion of the day.

- Environmental safety devices limited to:
  - door alarms;
  - anti-scald devices;
  - hand held shower head;
  - grab bars for the bathroom.

- Fence - limited to 200 linear feet (individual must have a documented history of elopement);

- Ramp - limited to one per individual primary residence, and only when no other accessible ramp exists:
  - In accordance with the Americans with Disabilities Act (ADA) or ADA Accessibility Guidelines (ADAAG), unless this is not in the best interest of the client;
  - Portable - considered for rental property only;
  - Permanent – must be a wooden structure;
    Vertical lift - may be considered in lieu of a ramp if there is photographic and written documentation that shows it is not possible for a ramp to be used.

- Stair lift – if required for access to areas of the home necessary to meet the direct medical or remedial benefit of the individual per POC/CCB (and ISP under AU and DD waiver);

- Single room air conditioner (s) / single room air purifier (s) – if required for access to areas of the home necessary to meet the direct medical or remedial benefit of the individual per POC/CCB (and ISP under AU and DD waiver):
    - There is a documented medical reason for the individual's need to maintain a constant external temperature. The documentation necessary for this equipment includes a prescription from the primary care physician.
    - The room air conditioner size is consistent with the room size (square feet) capacity to be cooled.

- Widen doorway **-** to allow safe egress:
    - Exterior - modification limited to one per individual primary residence when no other accessible door exists;
    - Interior - modification of bedroom, bathroom, and/or kitchen door/doorway as needed to allow for access. (A pocket door may be appropriate when there is insufficient room to allow for the door swing).

- Windows - replacement of glass with Plexi-glass or other shatterproof material when there is a documented medical/behavioral reason (s);

- Upon the completion of the modification, painting, wall coverings, doors, trim, flooring etc. will be matched (to the degree possible) to the previous color/style/design;

- Maintenance - limited to $500.00 annually for the repair and service of environmental modifications that have been provided through a HCBS waiver:
    - Requests for service must detail parts cost and labor cost;
    - If the need for maintenance exceeds $500.00, the case manager will work with other available funding streams and community agencies to fulfill the need. If service costs exceed the annual limit, those parts and labor costs funded through the waiver must be itemized clearly to differentiate the waiver service provision from those parts and labor funded through a non-waiver funding source.

- Items requested which are not listed above, must be reviewed and decision rendered by the State division director or State agency designee.

Modifications/Items – Non-Covered

Examples/descriptions of modifications/items Not Covered include, but are not limited to the following, such as:

- Adaptations or improvements which are not of direct medical or remedial benefit to the individual:
    - central heating and air conditioning;
    - routine home maintenance;
    - installation of standard (non-ADA or ADAAG) home fixtures (e.g., sinks, commodes, tub, wall, window and door coverings, etc.) which replace existing standard (non-ADA or ADAAG) home fixtures;
    - roof repair;
    - structural repair;
    - garage doors;
    - elevators;
    - 8. ceiling track lift systems;
    - 9. driveways, decks, patios, sidewalks, household furnishings;
    - replacement of carpeting and other floor coverings;
    - storage (e.g., cabinets, shelving, closets), sheds;
    - swimming pools, spas or hot tubs;
    - video monitoring system;
    - adaptive switches or buttons to control devices intended for entertainment, employment, or education;
    - home security systems.

- Modifications that create living space or facilities where they did not previously exist (e.g. installation of a bathroom in a garage/basement, etc.);
- Modifications that duplicate existing accessibility (e.g., second accessible bathroom, a second means of egress from home, etc.);
- Modifications that will add square footage to the home;
- Individuals living in foster homes, group homes, assisted living facilities, or homes for special services (any licensed residential facility) are not eligible to receive this service. (Note: The responsibility for environmental modifications rests with the facility owner or operator);
- Individuals living in a provider owned residence are not eligible to receive this service. (Note: The responsibility for environmental modifications rests with the facility owner or operator);
- Completion of, or modifications to, new construction or significant remodeling/reconstruction are excluded unless there is documented evidence of a significant change in the individual's medical or remedial needs that now require the requested modification.

Decision Making Authority:

Each Division, with approval from the Office of Medicaid Policy and Planning (OMPP), shall identify a designee(s) to render decisions based upon the articles within this policy.

- The designee(s) is responsible for preparing and presenting testimony for all Fair Hearings.

- The case management entity, working as an agent of the State, shall not attend Fair Hearings in opposition of the State, unless requested by the individual when there is no other advocate to represent the individual at the Hearing. If the case manager does attend the Hearing, working as an agent of the State, he/she must also uphold the established federal, state, local and FSSA

standards and Division specific guidelines and/or policies. Additionally, the case manager must submit a letter, in writing to the Administrative Law Judge at the Fair Hearing, as to what his/her role is at the hearing.

- Each Division shall implement a Quality Assurance Plan. In the event of inappropriate authorizations being granted, any or all of the following actions may be required:
    - a corrective action plan;
    - reimbursement to Medicaid;
    - loss of decision making authority.

Section 11.2: Specialized Medical Equipment and Supplies

Waiver Policy Notification

Authority: 42 CFR §441.302

Policy Topic: Specialized Medical Equipment and Supplies Policy Clarification

Impacts the following Home and Community-Based Services (HCBS) Waivers:

Aged and Disabled (AD) – Division of Aging

Traumatic Brain Injury (TBI) – Division of Aging

Autism (AU) – Division of Disability and Rehabilitative Services

Developmentally Disabled (DD) – Division of Disability and Rehabilitative Services

Support Services (SSW) – Division of Disability and Rehabilitative Services

Effective Date: December 1, 2007 and replaces all previous policies related to the authorization of Specialized Medical Equipment and Supplies (SMES).

Description

Specialized Medical Equipment and Supplies are medically prescribed items required by the individual's Plan of Care/Cost Comparison Budget (POC/CCB) 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.

Under the SSW waiver, a lifetime cap of $7,500 is available for Specialized Medical Equipment and Supplies.

Choice of Provider

The individual chooses which approved/certified providers will submit bids or estimates for this service. The provider with the lowest bid will be chosen, unless there is strong written justification from the case manager detailing why a provider with a higher bid should be selected.

Requirements

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

Individuals requesting authorization for this service through utilization of Home and Community Based Services (HCBS) waivers must first exhaust eligibility of the desired equipment or supplies through Indiana Medicaid State Plan, which may require Prior Authorization (PA).

- There should be no duplication of services between HCBS waiver and Medicaid State Plan;

- The refusal of a Medicaid vendor to accept the Medicaid reimbursement through the Medicaid State Plan is not a justification for waiver purchase;
- Preference for a specific brand name is not a medically necessary justification for waiver purchase. Medicaid State Plan often covers like equipment but may not cover the specific brand requested. When this occurs, the individual is limited to the Medicaid State Plan covered service/brand;
- Reimbursement is limited to the Medicaid State Plan fee schedule, if the requested item is covered under Medicaid State Plan;

- Refer to 405 IAC 5-19 (attached) for additional information regarding Medicaid State Plan coverage. All requests for items to be purchased through a Medicaid waiver must be accompanied by documentation of Medicaid State Plan PA request and decision, if requested item is covered under State Plan.

Specialized Medical Equipment and Supplies shall be authorized only when it is determined to be medically necessary and shall have direct medical or remedial benefit for the waiver individual. This determination includes the following considerations:

- The request is the most cost effective or conservative means to meet the individual's specific need(s);
- The request is individualized, specific, and consistent with, but not in excess of, the individual's need(s);
- Three (3) bids must be obtained for items over $1,000;
- If three (3) bids cannot be obtained, it must be documented to show what efforts were made to secure the three (3) bids and explain why fewer than three (3) bids were obtained (e.g. provider name, dates of contact, response received);
- For requested items under $1,000, one (1) bid is required and pricing must be consistent with the fair market price;
- Bids must be itemized to include the following: picture of the product and detailed product information, including make/model number of the item.

Example:

Scope	**Make/Model #**	**Material**
Adapted plates/bowls		$$
Interpreter service		$$
Wheelchair		$$
Portable generator		$$
Total Cost		$$$$$

Requests will be denied if the State division director, or State agency designee determines the documentation does not support the service requested.

Service Standards

- Specialized Medical Equipment and Supplies must be of direct medical or remedial benefit to the individual;
- All items shall meet applicable standards of manufacture, design and service specifications;
- Under the DD, AU, and SSW, requests for items over $500 require that the individual first be evaluated by a qualified professional such as a physician, nurse, occupational therapist, physical therapist, speech and language therapist or rehabilitation engineer as required per the approved waiver.

Documentation Standards

Documentation standards include the following:

- The identified direct benefit or need must be documented within:
  - POC/CCB; and
  - Physician prescription and/or clinical evaluation as deemed appropriate; and
  - Individual Support Plan (ISP) under the DD, AU, and SSW.
- Medicaid State Plan Prior Authorization request and the decision rendered, if applicable;
- Signed and approved Request for Approval to Authorize Services (RFA);
- Signed and approved POC/CCB;
- Provider of services must maintain receipts for all incurred expenses related to this service;
- Must be in compliance with FSSA and Division specific guidelines and/or policies.

Reimbursement

Reimbursement is available for Specialized Medical Equipment and Supplies which satisfy each of the following:

- Service and documentation standards outlined within this policy;
- Allowable under current Medicaid waiver guidelines;
- Not available under the Rehabilitation Act of 1973, as amended;
- Included in the individual's approved POC/CCB;
- Authorized on the RFA and linked to the POC/CCB;
- Included on a State approved and signed Notice of Action (NOA);
- Completed by an approved Medicaid Waiver Service Provider (who is approved to perform this service).

Items - Covered

Justification and documentation is required to demonstrate that the request is necessary in order to meet the individual's identified need(s).

- Communication Devices - computer adaptations for keyboard, picture boards, etc.

- RFA must be accompanied by documentation of Medicaid State Plan PA request and decision rendered under Medicaid State Plan;

- Generators (portable) - when either ventilator, daily use of oxygen via a concentrator, continuous infusion of nutrition (tube feeding), or medication through an electric pump are medical requirements of the individual. The generator is limited to the kilo-wattage necessary to provide power to the essential life-sustaining equipment, and is limited to one (1) generator per individual per ten (10) year period;

- Interpreter service - provided in circumstances where the interpreter assists the individual in communication during specified scheduled meetings for service planning(e.g. waiver case conferences, team meetings) and is not available to facilitate communication for other service provision;

- Self help devices - including over the bed tables, reachers, adaptive plates, bowls, cups, drinking glasses and eating utensils that are prescribed by a physical therapist or occupational therapist;

- Strollers - when needed because individual's primary mobility device does not fit into the individual's vehicle/mode of transportation, or when the individual does not require the full time use of a mobility device, but a stroller is needed to meet the mobility needs of the individual outside of the home setting. RFA must be accompanied by documentation of Medicaid State Plan PA request and decision rendered under Medicaid State Plan;
- Manual wheelchairs - when required to facilitate safe mobility. RFA must be accompanied by documentation of Medicaid State Plan PA request and decision rendered under Medicaid State Plan;
- Maintenance - limited to $500 annually for the repair and service of items that have been provided through a HCBS waiver:

    - Requests for service must detail parts cost and labor cost;

    - If the need for maintenance exceeds $500, the case manager will work with other available funding streams and community agencies to fulfill the need. If service costs exceed the annual limit, those parts and labor costs funded through the waiver must be itemized clearly to differentiate the waiver service provision from those parts and labor provided through a non-waiver funding source.

- Posture chairs and feeding chairs - as prescribed by physician, occupational therapist, or physical therapist. RFA must be accompanied by documentation of Medicaid State Plan PA request and decision rendered under Medicaid State Plan;

- Vehicle Modifications **(**VMOD) - are administered under separate and independent waiver policy (Vehicle Modification Policy).

Items – Non-Covered
The following items and equipment:

- hospital beds, air fluidized suspension mattresses/beds;
- therapy mats;
- parallel bars;
- scales;
- activity streamers;
- paraffin machines or baths;
- therapy balls;
- books, games, toys;
- electronics – such as CD players, radios, cassette players, tape recorders, television, VCR/DVDs, cameras or film, videotapes and other similar items;
- computers and software;
- adaptive switches and buttons;
- exercise equipment such as treadmills or exercise bikes;
- furniture;
- appliances - such as refrigerator, stove, hot water heater;
- indoor and outdoor play equipment such as swing sets, swings, slides, bicycles adaptive tricycles, trampolines, play houses, merry-go-rounds;
- swimming pools, spas, hot tubs, portable whirlpool pumps;
- temperpedic mattresses, positioning devices, pillows;
- bathtub lifts;
- motorized scooters;
- barrier creams, lotions, personal cleaning cloths;
- totally enclosed cribs and barred enclosures used for restraint purposes;
- medication dispensers.
- Any equipment or items that can be authorized through Medicaid State Plan;
- Any equipment or items purchased or obtained by the individual, his/her family members, or other non-waiver providers.

Note: In rare circumstances, a new or unanticipated item may be presented for consideration as a covered item under this service. **Prior to submission** of an RFA for this item, a written proposal justifying the need for this item must be sent to the OMPP for submission to the FSSA Policy Governance Board for consideration and determination of appropriateness as a Covered Item. The written proposal should be directed to:

Director of Agency Coordination and Integration
Office of Medicaid Policy and Planning
402 W. Washington Street, Room W382
Indianapolis, IN 46204-2739.

These requests should be extremely rare and should not include items on the Non-Covered list, which have been previously vetted at the State, and determined to be Non-Covered items.

Decision Making Authority:

- Each Division, with approval from the Office of Medicaid Policy and Planning (OMPP), shall identify a designee(s) to render decisions based upon the articles within this policy.

- The designee(s) is responsible for preparing and presenting testimony for all Fair Hearings.

- The case management entity, working as an agent of the State, shall not attend Fair Hearings in opposition of the State, unless requested by the individual when there is no other advocate to represent the individual at the Hearing. If the case manager does attend the Hearing; working as an agent of the State, he/she must also uphold the established federal, state, local and FSSA standards and the Division specific guidelines and/or policies. Additionally, the case manager must submit a letter, in writing to the Administrative Law Judge at the Fair Hearing, as to what his/her role is at the hearing.

- Each Division shall implement a Quality Assurance Plan. In the event of inappropriate authorizations being granted, any or all of the following actions may be required:
    - a corrective action plan;
    - reimbursement to Medicaid;
    - loss of decision making authority.

Section 11.3: Vehicle Modification

Waiver Policy Notification

Authority: 42 CFR §441.302

Policy Topic: Vehicle Modification Policy Clarification

Impacts the following Home and Community-Based Services (HCBS) Waivers:

Aged and Disabled (AD) – Division of Aging

Traumatic Brain Injury (TBI) – Division of Aging

Autism (AU) – Division of Disability and Rehabilitative Services

Developmentally Disabled (DD) – Division of Disability and Rehabilitative Services

Support Services (SSW) – Division of Disability and Rehabilitative Services

Effective Date: December 1, 2007 and replaces all previous policies related to the authorization of Vehicle Modifications.

Description

Vehicle Modifications (VMOD) are the addition of adaptive equipment or structural changes to a motor vehicle that permit an individual with a disability to safely transport in a motor vehicle. Vehicle modifications, as specified in the Plan of Care/Cost Comparison Budget (POC/CCB), 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.

A lifetime cap of $15,000 is available for vehicle modifications under the AD, AU, DD, and TBI waivers. Under the SSW waiver, a lifetime cap of $7,500 is available for Specialized Medical Equipment, which includes vehicle modifications. In addition to the applicable lifetime cap, $500 will be allowable annually for repair, replacement, or an adjustment to an existing modification that was funded by a Home and Community Based Services (HCBS) waiver.

Vehicle Ownership

The vehicle to be modified must meet all of the following:

- The individual or primary caregiver is the titled owner;
- The vehicle is registered and/or licensed under state law;
- The vehicle has appropriate insurance as required by state law;
- The vehicle is the individual's sole or primary means of transportation;
- The vehicle is not registered to or titled by a Family and Social Services Administration (FSSA) approved provider agency.

Choice of Provider

The individual chooses which approved/certified providers will submit bids or estimates for this service. The provider with the lowest bid will be chosen, unless there is strong written justification from the case manager detailing why a provider with a higher bid should be selected.

Requirements

All vehicle modifications must be approved by the waiver program prior to services being rendered.

Vehicle modification requests must meet and abide by the following:

- The vehicle modification is based on, and designed to meet, the individual's specific need(s);
- Only one vehicle per an individual's household may be modified;
- The vehicle is less than ten (10) years old and has less than 100,000 miles on the odometer;
- If the vehicle is more than five years old, the individual must provide a signed statement from a qualified mechanic verifying that the vehicle is in sound condition.

All vehicle modification shall be authorized only when it is determined to be medically necessary and/or shall have direct medical or remedial benefit for the waiver individual. This determination includes the following considerations:

- The modification is the most cost effective or conservative means to meet the individual's specific need(s);
- The modification is individualized, specific, and consistent with, but not in excess of, the individual's need(s);
- Three (3) modification bids must be obtained for all modifications over $1,000;
- If three (3) bids cannot be obtained, it must be documented to show what efforts were made to secure the three (3) bids and explain why fewer than three (3) bids were obtained (e.g. provider name, dates of contact, response received);
- For modifications under $1,000, one (1) bid is required and pricing must be consistent with the fair market price for such modification (s);
- All bids must be itemized to include the following:

Example:

Make: Model: Mileage: Year:		
Scope of work	**Materials Cost**	**Related Labor**
Lift	$$	$$
Tie down	$$	$$
Total Cost:	$$$$$	

Many automobile manufacturers offer a rebate of up to $1,000 for individuals purchasing a new vehicle requiring modifications for accessibility. To obtain the rebate the individual is required to submit to the

manufacturer documented expenditures of modifications. If the rebate is available it must be applied to the cost of the modifications.

Requests for modifications may be denied if the State division director or State agency designee determines the documentation does not support the service requested.

Service Standards

- Vehicle Modification must be of direct medical or remedial benefit to the individual;
- All items must meet applicable manufacturer, design and service standards.
- Under the DD, AU, and SSW, requests for items over $500 require that the individual first be evaluated by a qualified professional such as a physician, nurse, occupational therapist, physical therapist, speech and language therapist or rehabilitation engineer as required per the approved waiver.

Documentation Standards

The identified direct benefit or need must be documented within:

- POC/CCB; and
- Physician prescription and/or clinical evaluation as deemed appropriate; and
- Individual Support Plan (ISP) if under the DD, AU, and SSW.

Documentation/explanation of service within the Request for Approval to Authorize Services (RFA) must include:

- ownership of vehicle to be modified; or
- vehicle owner's relationship to the individual; and
- make, model, mileage, and year of vehicle to be modified.
- Signed and approved RFA;
- Signed and approved POC/CCB;
- Provider of services must maintain receipts for all incurred expenses related to the modification;
- Must be in compliance with FSSA and Division specific guidelines and/or policies.

Reimbursement

Reimbursement is available for modifications which satisfy each of the following:

- Service and documentation standards outlined within this policy;
- Allowable under current Medicaid Waiver Guidelines;
- Not available under the Rehabilitation Act of 1973, as amended;
- Included in the individual's approved POC/CCB;
- Authorized on the RFA and linked to the POC/CCB;
- Included on a State approved and signed Notice of Action (NOA);
- Completed by an approved Medicaid Waiver Service Provider (who is approved to perform this service).

Modifications/Items - Covered

Justification and documentation is required to demonstrate that the modification is necessary in order to meet the individual's identified need (s).

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

Maintenance is limited to $500 annually for repair and service of items that have been funded through a HCBS waiver:

- Requests for service must differentiate between parts and labor costs;
- If the need for maintenance exceeds $500, the case manager will work with other available funding streams and community agencies to fulfill the need. If service costs exceed the annual limit, those parts and labor costs funded through the waiver must be itemized clearly to differentiate the waiver service provision from those parts and labor provided through a non-waiver funding source.

Items requested which are not listed above, must be reviewed and decision rendered by the State division director or State agency designee.

Modifications/Items – Non-Covered

Examples/descriptions of modifications/items Not Covered include, but are not limited to the following:

- Lowered floor van conversions;
- Purchase, installation, or maintenance of CB radios, cellular phones, global positioning/tracking devices, or other mobile communication devices;
- Repair or replacement of modified equipment damaged or destroyed in an accident;
- Alarm systems;
- Auto loan payments;
- Insurance coverage;
- Drivers license, title registration, or license plates;
- Emergency road service;
- Routine maintenance and repairs related to the vehicle itself.

Decision Making Authority:

- Each Division, with approval from the Office of Medicaid Policy and Planning (OMPP), shall identify a designee(s) to render decisions based upon the articles within this policy.

- The designee(s) is responsible for preparing and presenting testimony for all Fair Hearings.

- The case management entity, working as an agent of the State, shall not attend Fair Hearings in opposition of the State, unless requested by the individual when there is no other advocate to represent the individual at the Hearing. If the case manager does attend the Hearing; working as an agent of the State, he/she must also uphold the established federal, state, local and FSSA standards and the Division specific guidelines and/or policies. Additionally, the case manager must submit a letter, in writing to the Administrative Law Judge at the Fair Hearing, as to what his/her role is at the hearing.

- Each Division shall implement a Quality Assurance Plan. In the event of inappropriate authorizations being granted, any or all of the following actions may be required:
    - a corrective action plan;
    - reimbursement to Medicaid;
    - loss of decision making authority.