Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

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.

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The **State** of **Indiana** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.
B. **Program Title:**
Family Supports Waiver
C. **Waiver Number: IN.0387**
Original Base Waiver Number: IN.0387.
D. **Amendment Number: IN.0387.R02.02**
E. **Proposed Effective Date:** *(mm/dd/yy)*
07/01/12
Approved Effective Date of Waiver being Amended: 04/01/10

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
HIGHLIGHTS OF PURPOSE OF AMENDMENT REFLECT:
• Reflecting a name change from the Support Services Waiver to the Family Supports Waiver
• Reflecting legislated changes
• Removal of references specific to contracted Case Managers/Management and the contracted Case Management entity but clarified the continuing role and responsibilities of case managers under the waiver service of Case Management.
• Revised the continuing role and responsibilities of the Case Management Liaison due to the return of Case Management as a waiver funded service
• Addition of the Participant Assistance and Care (PAC) service
• Increasing the waiver funding cap from $13,500 to $16,250
• Bringing portions of the Family Supports Waiver in line with recent changes directed by CMS under the recently approved Autism Waiver Amendment

LEGISLATION in 2011 resulted in modifications* under the following appendices of this amendment:
• Appendix B - modification of additional criteria under the waiver target groups (P.L.229-2011, Sec.107)
• Appendix C - modification of provider qualifications (Senate Enrolled Act 331)
*Modifications due to legislation are further explained under the appropriate appendices

Throughout the application, references to the "Support Services Waiver" have been changed to the "Family Supports Waiver", followed by the statement "formerly known as the Support Services Waiver" where applicable. Except as noted

below, these are the only changes made under Appendices B-3; B-6-a-ii; B-7-a; D-1-e; D-1-f; D-1-g; F-1; G-3-b; I-2-a; I-2-d

MAIN, 6. Additional Requirements, I. PUBLIC INPUT was modified to reflect public input specific to the amendment as well as changes within the contract between DDRS and Arc of Indiana (Arc) as funding within the contract increased to enable Arc of Indiana to add staff positions that emphasize employment and focus on advocacy for participants and families as well as to allow billing for training activities

MAIN, Program Description, 2. Brief Waiver Description - Modified by replacing the term "Mental Retardation" with the more appropriate term "Intellectual Disability" wherever possible. The term "Mental Retardation" remains part of the proper name of some terms or titles, such as for a "Qualified Mental Retardation Professional"

MAIN, B. Optional - Reflects the State's understanding that the Amendment Approval in no way rescinds the CMS requirement for QIS Performance Measure revisions

APPENDIX A: Administrative Authority
•Appendix A: 3. Use of Contracted Entities - End-dated description of contracting case management entity responsibilities due to return of Case Management as a waiver funded service; modified description of eligibility contractor noting finalization of contract with implementation during third quarter of waiver year two
• Appendix A: 7. Distribution of Waiver Operational and Administrative Functions - Updated chart to reflect ending role of Case Management as a contracted and administrative service

APPENDIX B: Participant Access and Eligibility
• Appendix B-1: Specification of the Waiver Target Group(s), b. Additional Criteria - Clarified that use of the Developmental Disabilities Profile (DDP) is to be discontinued as of August 1, 2012. Instead, the LOC Screening Tool (first used for waiver Level of Care determinations in September 2011), continues to be used, while other criteria used in the determination of Level of Care remain unchanged
• Appendix B-3: Number of Individuals Served (1 of 4), a. Unduplicated Number of Participants, Table B-3-a - Revised Unduplicated Number of Participants for Waiver Years 3, 4 and 5
•Appendix B-3: Number of Individuals Served (2 of 4): Reflects that access to priority slots is limited to the number indicated in the waiver. Once priority slots are filled, the participant meeting priority access criteria will be placed on the waiting list
• Appendix B-6: Evaluation/Reevaluation of Level of Care, b. Responsibility for Performing Evaluations and Reevaluations - Updated to accurately reflect responsibilities related to Initial Level of Care determination.
• Appendix B-6: Evaluation/Reevaluation of Level of Care, d. Level of Care Criteria - Modified by replacing the term "Mental Retardation" with the more appropriate term "Intellectual Disability"; Explained that use of the Developmental Disabilities Profile (DDP) is to be discontinued as of August 1, 2012. Instead, the LOC Screening Tool (first used for waiver Level of Care determinations in September 2011), continues to be used, while other criteria used in the determination of Level of Care remain unchanged
• Appendix B-7: Freedom of Choice, a. Procedures - Modified references to STATEMENT FOR FREEDOM OF CHOICE FORM, now replaced by the FREEDOM OF CHOICE FORM
• Appendix B-7: Freedom of Choice, b. Maintenance of Forms - Modified references to STATEMENT FOR FREEDOM OF CHOICE FORM, now replaced by the FREEDOM OF CHOICE FORM
• Appendix B-8: Access to Services by Limited English Proficiency Persons - Removed reference to the contractor of case management
• Appendix B:QIS b. Methods for Remediation/Fixing Individual Problems - Removed reference to contractor of case management.

APPENDIX C: Participant Services
• Appendix C-1: Summary of Services Covered (1 of 2), a. Waiver Services Summary - Added two new waiver funded services, 1) Case Management and 2) Participant Assistance and Care
• Appendix C-1/C-3: - Provider qualifications for Family and Caregiver Training Supports are modified, thereby expanding the pool of DDRS-approved providers available to provide this service
• Appendix C: QIS b. Methods for Remediation/Fixing Individual Problems, i. (description of State's method) - Included further clarification of the state's oversight responsibilities for accredited providers, mirroring clarifications requested by CMS within the recently approved Autism Waiver Amendment
• Appendix C-4: Additional Limits on Amount of Waiver Services - Revised expenditure cap from $13,500 to $16,250 and removed reference to contracted case management

• As directed by CMS, boxes were checked boxes indicating which services may be provided by relatives, legal guardians and/or legally responsible persons (permissible only when said persons render services on behalf of the DDRS-approved provider entity to which payment is made)

APPENDIX D: Participant-Centered Planning and Service Delivery
• Appendix D-1: Service Plan Development (4 of 8), d. Service Plan Development Process - Removed references to contracted case management but clarified the ongoing responsibilities of the case manager under the service of Case Management
• Appendix D-1: Service Plan Development (5 of 8), e. Risk Assessment and Mitigation - Removed references to contracted case management but clarified the ongoing responsibilities of the case manager under the service of Case Management
• Appendix D-2-a: Service Plan Implementation and Monitoring - Removed references to contracted case management but clarified the ongoing responsibilities of the case manager under the service of Case Management.

APPENDIX F: Participant Rights
• Appendix F-1: Opportunity to Request a Fair Hearing - Removed references to contracted case management but clarified the ongoing responsibilities of the case manager under the service of Case Management
• Appendix F-3: State Grievance/Complaint System, c. Description of System - Updated to reflect current DDRS policy, mirror recently approved DD and Autism Waiver Amendments, removed an outdated reference to the no longer existent Outreach Services left in prior amendment due to an oversight of the State, as well as modifying a reference to a Commission now known as the "Developmental Disabilities Commission", but formerly known as the "Indiana Commission on Mental Retardation and Developmental Disabilities"

APPENDIX G: Participant Safeguards
• Appendix G-1: Response to Critical Events or Incidents, c. Participant Training and Education - Removed references to contracted case management but clarified the ongoing responsibilities of the case manager under the service of Case Management
• Appendix G-1: Response to Critical Events or Incidents, d. Responsibility for Review of and Response to Critical Events or Incidents - Modified references from "consumer" to "participant", removed references to the contracting case management entity and included the additional clarifications requested by CMS under the recently approved Autism Waiver Amendment
• Appendix G-1: Response to Critical Events or Incidents, e. Responsibility for Oversight of Critical Incidents and Events - Added clarification that "consumer" refers to "participant"
• Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 2), a. Use of Restraints or Seclusion, ii. State Oversight Responsibility - Removed references to contracted case management but clarified the ongoing responsibilities of the case manager under the service of Case Management
• Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 2), b. Use of Restrictive Interventions, ii. State Oversight Responsibility - Removed references to contracted case management but clarified the ongoing responsibilities of the case manager under the service of Case Management
• Appendix G-3: Medication Management and Administration (1 of 2), b. Medication Management and Follow-Up, i. Responsibility - Removed requirement that providers of Case Management employ a nurse
• Appendix G-3: Medication Management and Administration (1 of 2), b. Medication Management and Follow-Up, ii. Methods of State Oversight and Follow-Up - Removed references to contracted case management but clarified the ongoing responsibilities of the case manager under the service of Case Management
• Appendix G - QIS: b. Methods for Remediation/Fixing Individual Problems - Removed references to contracted case management but clarified the ongoing responsibilities of the case manager under the service of Case Management

APPENDIX H: Quality Improvement Strategy
• Appendix H: Quality Improvement Strategy (2 of 2), H-1: Systems Improvement, b. System Design Changes, i. - Removed references to contracted case management but clarified the ongoing responsibilities of the case manager under the service of Case Management

APPENDIX I: Financial Integrity
• Appendix I-1: Financial Integrity and Accountability - Updated SUR language and provided a current link to the Indiana Health Coverage Programs Provider Manual
• Appendix I-2: Financial Accountability: a. Rates, Billing and Claims (1 of 3)- Included language addressing rate development methodology for the two new waiver services, Case Management and Participant Assistance and Care

APPENDIX J: Cost Neutrality Demonstration
Appendix J-1: Composite Overview and Demonstration of Cost-Neutrality Formula – Revised for Waiver Years 3-5 due to the addition of two new services and increase in slots
Appendix J-2: Derivation of Estimates (1 of 9), a. Number of Unduplicated Participants Served – Revised Table J-2-a: Unduplicated Participants to reflect increases for Waiver Years 3-5.
Appendix J-2: Derivation of Estimates (2 of 9), b. Average Length of Stay – Revised for Waiver Years 3-5
Appendix J-2: Derivation of Estimates (3 of 9), c. Derivation of Estimates for Each Factor (i. – iv.) – Clarified general assumptions, new service assumptions and general expenditure cap applicable to Waiver Years 3-5
Appendix J-2: Derivation of Estimates (4 of 9) – Added Case Management and Participant Assistance and Care to table of waiver services
Appendix J-2: Derivation of Estimates sections (5 of 9) through (9 of 9), d. Estimate of Factor D. - Revised to reflect the addition of two new waiver funded services, 1) Case Management and 2) Participant Assistance and Care applicable to Waiver Years 3-5

3. Nature of the Amendment

A. **Component(s) of the Approved Waiver Affected by the Amendment.** This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

Component of the Approved Waiver	Subsection(s)
☑ Waiver Application	2. Brief Waiver Desc
☑ Appendix A – Waiver Administration and Operation	A-3: Use of Contracte
☑ Appendix B – Participant Access and Eligibility	B-1: Specifications of
☑ Appendix C – Participant Services	C-1: Summary of Ser
☑ Appendix D – Participant Centered Service Planning and Delivery	D-1: Service Plan De
☐ Appendix E – Participant Direction of Services	
☑ Appendix F – Participant Rights	F-1: Opportunity to R
☑ Appendix G – Participant Safeguards	G-1: Response to Crit
☐ Appendix H	
☑ Appendix I – Financial Accountability	I-1: Financial Integrit
☑ Appendix J – Cost-Neutrality Demonstration	J-1: Composite Over

B. **Nature of the Amendment.** Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*

- ☐ **Modify target group(s)**
- ☐ **Modify Medicaid eligibility**
- ☑ **Add/delete services**
- ☑ **Revise service specifications**
- ☑ **Revise provider qualifications**
- ☑ **Increase/decrease number of participants**
- ☑ **Revise cost neutrality demonstration**
- ☐ **Add participant-direction of services**
- ☐ **Other**

Specify:

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The **State** of **Indiana** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):
Family Supports Waiver

C. Type of Request: amendment

Requested Approval Period: *(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ◉ **5 years**

Original Base Waiver Number: IN.0387
Waiver Number: IN.0387.R02.02
Draft ID: IN.07.02.02

D. Type of Waiver *(select only one):*
Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 04/01/10
Approved Effective Date of Waiver being Amended: 04/01/10

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (*check each that applies*):

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**
If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☐ **Nursing Facility**

Select applicable level of care

○ **Nursing Facility As defined in 42 CFR §440.40 and 42 CFR §440.155**
If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☑ **Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150)**

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR level of care:

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities
Select one:

- (●) **Not applicable**
- ( ) **Applicable**

Check the applicable authority or authorities:

- [ ] **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**
- [ ] **Waiver(s) authorized under §1915(b) of the Act.**

  Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

  Specify the §1915(b) authorities under which this program operates *(check each that applies):*

  - [ ] **§1915(b)(1) (mandated enrollment to managed care)**
  - [ ] **§1915(b)(2) (central broker)**
  - [ ] **§1915(b)(3) (employ cost savings to furnish additional services)**
  - [ ] **§1915(b)(4) (selective contracting/limit number of providers)**
- [ ] **A program operated under §1932(a) of the Act.**

  Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:
- [ ] **A program authorized under §1915(i) of the Act.**
- [ ] **A program authorized under §1915(j) of the Act.**
- [ ] **A program authorized under §1115 of the Act.**

  Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

- [x] **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.
PURPOSE: The Family Supports 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 mental retardation (ICF/MR) or related conditions.

The waiver serves persons with a developmental disability, intellectual disability (also known as mental retardation) or autism and who have substantial functional limitations, as defined in 42 CFR 435.1010. 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 (POC/CCB). The POC/CCB is subject to an annual waiver services cost cap of $16,250.

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.

ORGANIZATIONAL STRUCTURE: Indiana's Family and Social Services Administration's, Office of Medicaid Policy and Planning (OMPP), is the single State Medicaid agency having administrative discretion in the administration and supervision of the waiver. The Division of Disability and Rehabilitative Services (DDRS), Bureau of Developmental Disabilities Services (BDDS) and the Bureau of Quality Improvement Services (BQIS) are responsible for the day-to-day

operations of the waiver. BDDS Field offices implement waiver policies and procedures under the supervision of the BDDS Central office.

The BDDS Office or the eligibility contractor conducts intake and eligibility screening. The waiting list is maintained by the BDDS Central office. In order to ensure we systematically move people off of the waiting list and enroll them into the waiver, we have allocated a specific number of slots each year for this purpose.

DDRS-approved case management agencies provide case management services to participants that include 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).

HCBS waiver providers are enrolled on the basis of an ongoing open application process.

SERVICE DELIVERY METHODS: Traditional service delivery methods are utilized while incorporating as much flexibility as possible within the delivery of services.

QUALITY MANAGEMENT: Indiana's quality management system for the SS Waiver includes monitoring, discovery and remediation processes to ensure the waiver is operated in accordance with federal and state requirements, to ensure participant health and welfare, to ensure participant goals and preferences are part of the person centered planning process and reflected in the ISP and POC/CCB and as the basis to identify opportunities for ongoing quality improvement.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. **Waiver Administration and Operation. Appendix A** specifies the administrative and operational structure of this waiver.

B. **Participant Access and Eligibility. Appendix B** specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. **Participant Services. Appendix C** specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. **Participant-Centered Service Planning and Delivery. Appendix D** specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. **Participant-Direction of Services.** When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- ○ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ◉ **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. **Participant Rights. Appendix F** specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. **Participant Safeguards. Appendix G** describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

H. **Quality Improvement Strategy. Appendix H** contains the Quality Improvement Strategy for this waiver.

I. **Financial Accountability. Appendix I** describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. **Cost-Neutrality Demonstration. Appendix J** contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. **Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. **Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- (●) **Not Applicable**
- ( ) **No**
- ( ) **Yes**

C. **Statewideness.** Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- (●) **No**
- ( ) **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.
Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.
Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

A. **Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

B. **Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. **Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

   1. Informed of any feasible alternatives under the waiver; and,

   2. Given the choice of either institutional or home and community based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. **Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. **Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. **Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. **Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. **Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. **Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. **Service Plan**. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. **Inpatients**. In accordance with 42 CFR §441.301(b)(1) (ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community- based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the State secures public input into the development of the waiver:
Public input for the 2012 waiver amendment was obtained via the following means:
• The Operating Agency (DDRS) continues to hold twice monthly meetings with the Advocates during which issues, concerns, ideas and suggestions are discussed
• DDRS hosts a monthly DDRS Advisory Council meeting

The 2012 Amendment is partially driven by legislation. Public input indicated concerns with the ongoing use of the term "mental retardation", which has been appropriately replaced with the term "intellectual disability" within this amendment. Public input also played a key role in the addition of accreditation requirements for providers of habilitative day services.

Public input regarding Indiana's waiver program, including the Family Supports Waiver, formerly known as the Support Services Waiver, is obtained through the following activities:

Ongoing, the Division of Disability, Rehabilitative Services (DDRS) Executive Management Team holds twice-monthly meetings with an organized group of stakeholders that includes nationally recognized organizations, professional trade associations, and leaders among the service providers, addressing concerns and suggestions on behalf of the group and the participants each represents in regard to DDRS program policy and operations. DDRS hosts Quarterly Provider Meetings, posts and sends DDRS Quarterly Updates to all interested parties registered to receive them. DDRS also meets with small groups of parents and providers and attends Powerful Parent meetings on a regular basis.

The DDRS issues a quarterly update announcing any waiver-related policy releases or updates authorized by the Office of Medicaid Policy and Planning (OMPP). As noted above, public input is considered as policies are developed. With the approval of OMPP, these policies and updates are posted on the DDRS Website.

The Bureau of Developmental Disabilities Services (BDDS) hosts quarterly provider meetings within each of its eight statewide districts and meets with participant providers. The BDDS also maintains an electronic helpline available 24 hours daily, serving as a source of answering general questions and as a receptor of suggestions and ideas from any interested party.

The DDRS holds public forums and Webinars as needed toward the dissemination of program or operational changes and maintains an electronic helpline to address questions surrounding programs, policies and procedures.

Since July 1, 2007, the DDRS has contracted with the Arc of Indiana (Arc) to serve as an extension of the Division. The Arc employs “self-advocates” as well as ten “family advocates” (family members) from among the total population of participants with developmental disabilities served within Indiana. Focus is on the provision of statewide support to both participants and family members as they conduct a variety of training, development, outreach, assistance, promotion and follow up tasks. Tasks and reporting requirements are specified within the contract.

The DDRS hosts a monthly DDRS Advisory Council meeting (established within IC 12-9-4) consisting of the Director of DDRS and ten other participants with knowledge of or interest in the programs administered by the Division. All ten are appointed by the Secretary of the Indiana Family and Social Services Administration and represent a wide and diverse membership including providers, parents, self-advocates, the Department of Education, and OMPP, as well as other Bureaus within the Division; including First Steps, Vocational Rehabilitation, and the BQIS. The mission of the Council is to recommend strategies and actions that will ensure DDRS empowers people with disabilities to be independent and self-sufficient.

Prior to the renewal, the DDRS and OMPP sought public input on how to improve the ways participants and their families are served as well as ways to heighten person-centered principles in the architecture of Indiana’s waiver service delivery system. In addition to partnering with a group known as the Meaningful Day, the Indiana Institute on Disability and Community (IIDC) was enlisted to assist in this goal, soliciting feedback from stakeholders across the State about how the existing waiver system is or is not meeting their needs.

The IIDC hosted Community Conversations in three cities: Indianapolis (Central Indiana), New Albany (Southern Indiana), and Fort Wayne (Northern Indiana). Each Community Conversation consisted of a two-hour evening meeting for people with disabilities, families, and advocates, followed by another two-hour meeting the next day for area providers and other professionals. The Conversations were open to “all comers,” and extensive publicity was disseminated about the invitation via newspapers, radio stations, e-mail notices, and announcements releases from organizations serving constituents with disabilities. In all, 197 participants participated in the Conversations. The IIDC invited knowledgeable and leadership participants to participate in focus groups. A total of 27 professions participated from professional organizations such as INARF and ICEARC, among whom there were 14 Executive Directors from service providers; The Arc’s Family Network Leaders and Self-Advocates, and the contractor of Indiana’s case management services at that time.

A statewide online survey was used to complement the Conversations and Invited Focus Groups to give all interested parties in Indiana an opportunity to share their concerns and suggestions for the waiver re-write process. In a one month time frame, a total of 432 individuals responded to the survey.

In total, 656 individuals participated in the various public input opportunities to address: What’s Working; What’s Not Working; Concerns and Suggestions about Current and New Waiver Services; and Concerns and Suggestions about Processes and Procedures.

J. Notice to Tribal Governments. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

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

Last Name: Amos

First Name: Angela

Title: Waiver Services Manager

Agency: Indiana Family & Social Services Administration, Office of Medicaid Policy and Planning

Address: 402 W. Washington St., Room W374 (MS07)

Address 2:

City: Indianapolis

State: **Indiana**

Zip: 46204-2739

Phone: (317) 234-6340 **Ext:** ☐ ☐ **TTY**

Fax: (317) 232-7382

E-mail: Angela.amos@fssa.in.gov

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

Last Name: Myszak

First Name: Tracy

Title: DDRS Deputy Director

Agency: Indiana Family and Social Services Administration, Division of Disability and Rehabilitati

Address: 402 W. Washington St., Room W451 (MS26), PO Box 7083

Address 2:

City:

State: Indianapolis

Zip: **Indiana**

Phone: 46207-7083

8. Authorizing Signature

Fax: (317) 232-1147 **Ext:** ☐ **TTY**

E-mail: (317) 232-1240

Tracy.Myszak@fssa.in.gov

This document, together with the attached revisions to the affected components of the waiver, constitutes the State's request to amend its approved waiver under §1915(c) of the Social Security Act. The State affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The State further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The State certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature: Pat Casanova

State Medicaid Director or Designee

Submission Date: Apr 16, 2012

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name: Amos

First Name: Angela

Title: Waiver Services Manager

Agency: Indiana Family & Social Services Administration, Office of Medicaid Policy & Planning

Address: 402 W. Washington Street, Room W374 (MS 07)

Address 2:

City: Indianapolis

State: **Indiana**

Zip: 46204-2739

Phone: (317) 234-6340 **Ext:** ☐ **TTY**

Fax:

E-mail: (317) 232-7382

Attachment #1: Transition Plan

angela.amos@fssa.in.gov

Specify the transition plan for the waiver:

It is the goal of DDRS to create a system that is both fair and equitable.

Beginning January 2009, DDRS began transitioning participants served under the existing Support Services Waiver (to be known as the Family Supports Waiver effective with the 2012 Amendment) from their previous per diem amounts for bundled Days Services to services utilizing hourly, uniform rates. The previously bundled Day Services have been replaced with an array of discrete services, now billed based upon the participant's service utilization.

This renewal includes those discrete services:

1.Day Services – once bundled into a flat per diem, is now comprised of the following discrete services, with each discrete service having a unique hourly uniform rate:
a. Community Based Habilitation – Individual
b. Community Based Habilitation – Group
c. Facility Based Habilitation – Individual
d. Facility Based Habilitation – Group
e. Pre-Vocational Services
f. Supported Employment Follow Along
g. Transportation

These discrete services are contained within this renewal and additional services are being requested for approval.

In order to transition participants to the uniform rate structure during the expiring Support Services (SS) Waiver, participants of the expiring SS Waiver were allowed to purchase these discrete services and any other combination of services available under the SS Waiver at the time of their annual renewal (anniversary) date using a total budget amount up to the SS Waiver cap of $13,500 for all services combined.

In all cases, the SS Waiver participant continued to complete the Person Centered Planning process and, in conjunction with the participant-selected Individualized Service Team (IST), developed an Individualized Support Plan (ISP). The participant could choose any combination of the above listed discrete services in addition to any other SS Waiver services desired by the participant consistent with his or her needs and his or her ISP. This transition process (moving to uniform rates and the use of unbundled services) was completed as of Sept 30, 2009 for all participants of the expiring SS Waiver.

Specific changes implemented during the transition period and continued in this waiver renewal are:
• Unbundling of previously bundled services,
• Addition of time-limitations to Prevocational Services and Supported Employment Follow Along Services
• Expanded opportunities for community access through the new (revised) Transportation service.
• Addition of Workplace Assistance, Intensive Behavioral Intervention, and Facility Based Support services.

The limitations are included with each service description in Appendix C for Transportation Services, Prevocational Services, Supported Employment Follow Along, Workplace Assistance, Intensive Behavioral Intervention, and Facility Based Support services and summarized below;

• While previously bundled with Day Services, the newly added Transportation Service is limited to two, one-way trips per day for all participants of the SS Waiver.

• As a component of the bundled Day Services under the expiring waiver, no limit previously existed for the amount or duration of Prevocational Services. Under the SS Waiver Renewal, a participant may only utilize Prevocational Services for a time period of up to 24 months from the start date of the service as it appears on an approved Plan of Care/Cost Comparison Budget (CCB) and subsequent Notice of Action.

• As a component of the bundled Day Services under the expiring waiver, no limit previously existed for the amount or duration of the Supported Employment Follow Along (SEFA) services. Under the SS Waiver Renewal, a participant may only utilize SEFA for a time period of up to 18 months in the same employment setting without the requirement to find a more appropriate employment setting.

• There are no established dollar amount limits associated with the individually listed replacement services for the formerly bundled Day Services. The participant may choose to utilize all, none, or any desired combination or dollar amount of the replacement services listed above, provided the total cost remains within the revised SS Waiver Renewal cap of $13,500.

• For the new service of Workplace Assistance, utilization is limited to those times when the participant is engaged in paid competitive community employment.

• For the new service of Intensive Behavioral Intervention, participants may utilize this highly specialized, individualized program of instruction and behavioral intervention to reduce behavioral excesses and increase/teach replacement behaviors as needed.

• For the new service of Facility Based Supports, participants may chose to utilize these structured group programs in congregate, protective settings to meet social, recreational, therapeutic activity and personal care needs while under supervision.

• The Crisis Assistance component was removed from the previous Behavioral Support Services/Crisis Assistance definition and from the expiring SS Waiver Renewal, leaving Behavioral Support Services as a stand-alone service. The Crisis Assistance service was never utilized or billed under the expiring SS Waiver.

Prior to the renewal, and outside of the medical transportation services available under the Indiana Medicaid State Plan, transportation services were previously available only as a component of Day Services or Adult Day Services. Rather than a loss of services, the renewal offers expanded opportunities for community access through the use of the revised Transportation service.

Eligibility criteria for the SS waiver remains unchanged.

As noted above, transition to the new uniform rate methodology occurred for all individuals served under the SS Waiver prior to the effective date of the renewal.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Performance measures submitted within this amendment are currently under review for possible revision as required by CMS. CMS has requested that these revisions be submitted collectively by July 2012. The State understands approval of this amended Family Supports Waiver, formerly known as the Support Services Waiver, does not imply approval of the performance measures contained herein.

Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

   ○ **The waiver is operated by the State Medicaid agency.**

   Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

   ○ **The Medical Assistance Unit.**

   Specify the unit name:

   (Do not complete item A-2)

○ **Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.**

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

(Complete item A-2-a).

◉ **The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:
Indiana Family and Social Services Administration, Division of Disability and Rehabilitative Services

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

   a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
   As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

   b. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
   The Office of Medicaid Policy and Planning (OMPP) located in the Indiana Family and Social Services Administration (FSSA) is the single state Medicaid agency authorized to administer Indiana's Medicaid program.

   The waiver is operated by the Indiana Division of Disability and Rehabilitative Services (DDRS), a separate division of the state from the single state Medicaid agency.

   The OMPP is responsible for monitoring DDRS operation of the waiver through:

   1. The Memorandum of Understanding: A copy of the Memorandum of Understanding setting forth the authority and arrangements for this policy is on file at the State Medicaid agency. Memorandums of Understanding are written for a two year period with the option to renew.

   2. A Quality Management Plan that outlines in detail the quality assurance responsibilities and activities is being derived from the performance measures included in this waiver renewal. As part of OMPP's oversight authority for assuring that participants' service plans (which include risk plans for identified health issues) are appropriate and effective, OMPP has selected several administrative authority and key health issues to monitor for individuals with developmental disabilities. Monitoring is conducted to ensure issues are identified timely and addressed appropriately. OMPP refers specific issues to DDRS for remediation as appropriate.

3. Ongoing and periodic reporting and analysis of data including service utilization data, claims data, and reportable events. OMPP receives management reports from DDRS, BQIS and the fiscal contractor. These reports include:
•From DDRS, the case management contractor's quarterly management report (while case management is/was a contracted administrative service),
•From BQIS, the quality contractor's quarterly management report which contains aggregate data from the CST reviews, transition reviews, financial reviews, incident reports, mortality reviews and trend analysis; and
•From the fiscal agent, monthly and quarterly management reports.

4. Periodic inter-division meetings to discuss activities, issues, outcomes and needs and to jointly plan ongoing system improvements and remediation, when indicated. Management teams from OMPP and DDRS meet every other week to review programs, recommend changes and address programming concerns. The performance of contracting entities is reviewed, discussed and addressed as needed during these meetings. The OMPP is notified by the operating agency of performance issues. Termination of a vendor contract is possible should the contractor be unable or unwilling to meet the expectations of the State. The executive office of the Family and Social Services Administration is also represented at these meetings where programs are reviewed, changes are recommended, programming concerns are addressed and the performance of contracting entities is reviewed, discussed and addressed as needed.

OMPP exercises oversight of DDRS operation of the waiver through the following activities:

•Annually, OMPP supervises the development of the CMS annual waiver expenditure reports, reviews the final report with DDRS and identifies problem areas that may need to be discussed and resolved with DDRS prior to submission by OMPP.

•Monthly, OMPP reviews Medicaid waiver expenditure reports, after which, any identified problems will be discussed and resolved with DDRS.

•Daily, OMPP, or OMPP's Fiscal Intermediary, reviews, approves and assures payment of Medicaid claims for waiver services consistent with OMPP established policy.

•On an ongoing basis, OMPP is responsible for oversight of all waiver activities (including the contract for case management throughout the life of the contract, level of care (LOC) determinations, plan of care reviews, identification of trends and outcomes, and initiating action to achieve desired outcomes) retaining final authority for approval of level of care and plans of care.

•OMPP develops Medicaid policy for the State of Indiana and on an ongoing and as needed basis, works collaboratively with DDRS to formulate policies specific to the waiver or that have a substantial impact on waiver participants. OMPP seeks and reviews comment from DDRS before the adoption of rules or standards that may affect the services, programs, or providers of medical assistance services for persons with developmental disabilities who receive Medicaid services.

•OMPP, or OMPP's fiscal agent, approves and enrolls all providers of waiver services.

•OMPP reviews and approves Medicaid waiver applications, requests for renewals and amendments, and submits applications, renewals and amendments to the Centers for Medicare and Medicaid Services (CMS).

•OMPP reviews and approves all waiver manuals, bulletins, communications regarding waiver policy, and quality assurance/improvement plans prior to implementation or release to providers, participants, families or any other entity.

•OMPP retains final authority for rate setting and coverage criteria for all Medicaid services, including provider rates, the basis for any activities reimbursed through administrative funds, and state plan services provided to waiver participants.

Appendix A: Waiver Administration and Operation

3. **Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

A contract exists between the State Medicaid agency (OMPP) or the operating agency (DDRS) and each contracted entity listed below that sets forth the responsibilities and performance requirements of the contracted entity. The contract(s) under which contracted entities conduct waiver operational functions are available to CMS upon request through the State Medicaid agency or the operating agency (as applicable). Specific to the operational and administrative functions of this waiver, the following activities are conducted by contracted entities.

Until the August 31, 2012 end of the contract and the effective date of CMS approval of Case Management as a waiver-funded service, CASE MANAGEMENT CONTRACTOR is responsible for:
•Ensuring the health and welfare of participants
•Completing annual evaluations and redeterminations of level of care
•Providing participants determined to meet requirements for waiver enrollment with the choice between ICF/MR and waiver services
•Providing participants with case management pick lists that provide participants with a choice of at least 2 case managers
•Providing participants with the choice of waiver services based on individual needs
•Ensuring completion of face-to-face contacts between the case manager and participant in accordance with 460 IAC
•Providing additional contacts and reporting for participants identified by DDRS as high-risk
•Coordinating and facilitating the Person Centered Planning (PCP) Process
•Developing, updating, and reviewing the ISP using the PCP Process
•Ensuring that participants have the assistance needed to locate and choose waiver services providers
•Ensuring that participants understand how to exercise their right to a fair hearing
•Facilitating completion of the annual waiver requirements including:
• Annual review and update of the PCP and ISP
• Annual submission of the waiver budget
• Developing the annual Cost Comparison Budgets using State approved processes in conjunction with the BDDS Eligibility process.
•Monitoring service utilization
•Dissemination of information and forms as needed
•Incident report completion, submission, and follow-up using State approved processes
•Ensuring participant's immediate protection from harm when participants have had sentinel events
•Monitoring service delivery, including quality of services received, and utilization via telephone calls, home visits, and team meetings
•Monitoring participant satisfaction and service outcomes
•Acting as an agent for the participant to ensure the interests and preferences of the participant are represented across all environments
•Overseeing the Residential Living Allowance process to ensure participants have adequate resources to reside in the community
•Performing pre-transition and post-transition assessment, planning, monitoring and follow-up
•Addressing the findings of the participant's Health Assurance Screening with the participant and his/her team in order to determine appropriate action related to the findings
•Providing case manager training and ongoing oversight and monitoring of case manager performance
•Gathering and submitting data as required under the terms of their contract.1. Ensuring the health and welfare of participants

ELIGIBILITY CONTRACTOR is responsible for:
•the functions of eligibility determination recommendation and waiver enrollment as related to the initial level of care evaluation, which was implemented during the third quarter of waiver year two.

FISCAL AGENT is responsible for:
•Reimbursement of claims for authorized waiver services submitted by authorized waiver providers;
•Qualified providers are enrolled as providers of waiver services;
•Provider training is performed periodically and technical assistance is provided concerning waiver requirements; and
•Monthly and quarterly reporting for all contracted activities is compiled and submitted timely.

UTILIZATION MANAGEMENT FUNCTIONS:
The waiver auditing function is incorporated into the Surveillance Utilization Review (SUR) functions of the contract between the Medicaid agency and SUR Contractor, as detailed in Appendix I-1. OMPP has expanded its program integrity activities by using a multi-pronged approach to SUR activity that includes provider self-audit, contractor desk audit and full on-site audit functions. The SUR Contractor sifts and analyzes claims data and identifies providers/claims that indicate aberrant billing patterns and other risk factors such as the correcting of claims. The Contractor submits recommendations for review based on their data.
The Contractor's audit process utilizes data mining, research, identification of outliers, problem billing patterns, aberrant providers, and issues referred by the State. On-site visits are conducted to review supporting documentation for paid claims to recoup overpayments as applicable, and educate the provider. If warranted, the provider is placed on prepayment review monitoring for future claim submissions.
Additionally, it is expected that OMPP staff will periodically accompany the contractor during on-site audits.

QUALITY ASSURANCE/QUALITY IMPROVEMENT CONTRACTOR withhin the operating agency is responsible for:
•The discovery and remediation activities conducted for the waiver including:
o Quality Monitoring
o Incident Review
o Mortality Review
o Risk Management
•Development of recommended mechanisms for overall systems improvement including Information Technology Development to support ongoing QA/QI
•Submission of quarterly management reporting

FINANCIAL ANALYSIS CONTRACTOR is responsible for:
•Collecting and analyzing waiver paid claims data
•Compiling this data for the annual waiver reporting to CMS
•Completing cost neutrality calculations for the waiver
•Providing ad hoc analyses to support quality of care investigations, program integrity investigations, budget planning and forecasting, and waiver development

○ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. **Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

◉ **Not applicable**

○ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

☐ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
• The Division of Disability and Rehabilitative Services (DDRS) Case Management Liaison position is responsible for monitoring and assessing the performance of the contracted case management entity (until the contract's end in August 2012) reports directly to the Deputy Director of the Division. The liaison develops an audit report annually that is provided to OMPP. Family and Social Services Administration (FSSA) auditors also conduct an annual financial survey of the case management contractor.

   •The Office of Medicaid Policy and Planning (OMPP), is responsible for assessing performance of the Medicaid Fiscal Agent Contractor's provision of training and technical assistance concerning waiver requirements and, in collaboration with DDRS, the execution of the Medicaid Provider Agreements for enrollment of Autism Waiver providers approved by DDRS.

   •Oversight of the contractor of Quality Improvement Services is monitored by the Quality Vendor Manager employed by the operating agency's (DDRS) Bureau of Quality Improvement Services (BQIS). The Quality Vendor Manager position reports directly to the Director of BQIS.

   •The State Medicaid Agency has oversight responsibility of the Financial Analysis contractor.

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
Through the August 2012 end of the contract, the contracting case management entity is required to comply with all reporting requirements of the State. Reporting and communication between the contractor and the Indiana Family and Social Services Administration's Division of Disability and Rehabilitative Services (DDRS) is managed through the DDRS Case Management Liaison position, dedicated to oversight of this contractor. Assessment methods include weekly teleconferences and monthly meetings between the Liaison and the contractor's management team; daily, weekly, monthly and quarterly review of multiple reports and data points by the Liaison. When corrective action plans are necessary, oversight to ensure implementation is the responsibility of the Liaison.

   Through the review of the various reports, data points and participant satisfaction surveys, the DDRS Case Management Liaison in conjunction with the DDRS Executive Management Committee is able to determine whether or not the contractor is fulfilling the requirements and deliverables of the existing contract.

   NOTE: Due to its critical nature, the Case Management Liaison position will continue to closely monitor Case Management as a waiver service.

   The OMPP oversees the contracting Medicaid Fiscal Agent's monthly reports of reviews. Oversight of the Fiscal Agent also involves the DDRS/BDDS Provider Relations Specialist position, which oversees and assures that providers are appropriately enrolled through the Medicaid fiscal agent. The required Waiver Enrollments and Updates Weekly Report is sent by the fiscal agent to the Provider Relations Specialist. Providers are to be enrolled by the dedicated fiscal agent Provider Enrollment Specialist within an average 30 days from receipt of the completed provider agreement paperwork. Complaints about the timeliness or performance of the Medicaid fiscal agent are relayed to the OMPP Director of Operations and Systems by the Provider Relations Specialist.

   The majority of primary functions of the Bureau of Quality Improvement Services (BQIS) are completed by a contractor. Specifically the privatization vendor is responsible for Quality Monitoring, Incident Review, Mortality Review, Risk Management and Information Technology Development.

The BQIS has a full-time, Quality Liaison position dedicated to monitoring this contract. This position uses the following methods to assure that the contractor performs its assigned functions in accordance with contract and waiver requirements:

• The Quality Liaison meets with the contractor's Project Director and Assistance Project Director on a weekly basis to review and follow-up on outstanding issues.

• On a quarterly basis BQIS receives reports indicating the number of comprehensive surveys completed, analysis of findings, and trends identified. The Quality Liaison reviews these reports and follows-up with the contractor when concerns are identified. In addition to analytical reports based on survey findings, the contractor submits quarterly reports on their performance.

• On a monthly basis the Quality Liaison uses the automated survey tool to randomly validate any of the performance measures identified in this report. Discrepancies are brought to the contractor's attention for discussion.

• On a quarterly basis, the Quality Liaison reviews a random sample of the survey results for at least 2% of the participants surveyed during the previous quarter. This activity is utilized to confirm for BQIS that the contractor is conducting the reviews that have been reported. The Quality Liaison also validates the sample size.

• Other indicators that the contractor reports on quarterly include Incident Review and Mortality Review. The Quality Liaison works with the contractor to develop additional performance measures.

Ultimately, the goal of the BQIS is to assure that the state is aware of and has taken appropriate actions to ensure the participant's health, safety and welfare. The Quality Liaison participates in all risk management meetings and oversees the contractor's interactions with others as well as monitors that it implements assigned tasks.

Monitoring of the eligibility contractor occurs through Case Review, monthly progress reports and quarterly face-to-face meetings between the DDRS Deputy Director and the contractor. Meetings will occur more frequent if necessary.

Regarding the financial analysis contractor, the State Medicaid Agency contracts with an actuarial contractor, who provides financial analysis and actuarial consultant services for Indiana Medicaid. The contractor performs Medicaid enrollment and expenditure forecasts, by program, which aid in monitoring expenses and support state budgeting. Forecasting is done on both a paid basis and service incurred basis. Trends are determined and vary by population as appropriate. Trends are developed taking into account historical Indiana Medicaid trends, State and National trends, trends used by the CMS Office of the actuary, and future program changes. Final documentation from the contractor includes an executive summary, detailed results, sources of data, methodologies, and assumptions.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency.
Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Participant waiver enrollment	☑	☑	☐
Waiver enrollment managed against approved limits	☑	☑	☐
Waiver expenditures managed against approved levels	☑	☑	☐
Level of care evaluation	☑	☑	☑

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Review of Participant service plans	☑	☑	☐
Prior authorization of waiver services	☑	☑	☑
Utilization management	☑	☑	☑
Qualified provider enrollment	☑	☑	☑
Execution of Medicaid provider agreements	☑	☑	☑
Establishment of a statewide rate methodology	☑	☑	☐
Rules, policies, procedures and information development governing the waiver program	☑	☑	☐
Quality assurance and quality improvement activities	☑	☑	☑

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Administrative Authority**
The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. **Performance Measures**

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of waiver participants enrolled into the waiver in accordance with state established criteria. Numerator: Total number of participants enrolled in accordance with state criteria. Denominator: Total number of waiver participants enrolled.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Operating Agency Report/ Executive Committee Tracking Report

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	

		☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of approved waiver slots filled. Numerator: Total number of current waiver participants. Denominator: Total number of approved waiver slots.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Operating Agency Report/Executive Committee Tracking Report

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*

☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of LOC compliance issues identified by OMPP remediated by DDRS within specified timeframes. Numerator: Total number of LOC compliance

issues identified by OMPP remediated by DDRS within specified timeframes.
Denominator: Total number of LOC issues identified by OMPP.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Operating Agency Report/Executive Committee Tracking Report

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of service plans/CCBs with issues identified by OMPP that were remediated by DDRS within specified timeframes. Numerator: Total number of service plan/CCBs with issues identified that were remediated by DDRS within specified timeframes. Denominator: Total number of service plan/CCBs with issues identified by OMPP.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Operating Agency Report/Executive Committee Tracking Report

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of service provider non-compliance issues identified by OMPP that were remediated by DDRS within specified timeframes. Numerator: Total number of identified service provider non-compliance issues remediated within specified timeframes. Denominator: Total number of service provider compliance issues identified by OMPP.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Operating Agency Report/Executive Committee Tracking Report

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of QA/QI contractor issues that are remediated within specified timeframes. Numerator: Total number of QA/QI contractor issues identified by OMPP corrected by DRRS within specified timeframes. Denominator: Total number of QA/QI contractor issues identified by OMPP.

Data Source (Select one):
Other
If 'Other' is selected, specify:
BQIS Report

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of SS Waiver policies and procedures that were approved by OMPP prior to implementation. Numerator: Total number of SS Waiver policies and procedures approved by OMPP. Denominator: Total number of SS Waiver policies and procedures implemented.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Operating Agency Report/Executive Committee Tracking Report

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	

		☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Rate of UTIs. Numerator: The total number of waiver participants seen in inpatient or outpatient setting with UTI diagnosis. Denominator: The total number of waiver participants.

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)

If 'Other' is selected, specify:

Claims data

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*

Performance Measure:
Review of Service Plans - Appropriate Care Plans for incontinence. Numerator: The total number of waiver participants with appropriate care plan documentation. Denominator: The total number of sampled waiver participants identified as being incontinent.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
Individualized Support Plans

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 5%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Prevention Quality Indicator (PQI) Urinary tract infection (UTI) rate. Number of admissions for UTI per 10,000 waiver participant months. Numerator: The total number of waiver participants admitted for UTI during prior 12 month period. Denominator: The total number of months enrolled on waiver.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Claims data

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Anti-Psychotic Medication Management. Numerator: The total number of waiver participants who had a visit to a mental health prescriber in the past year. Denominator: The total number of waiver participants identified as being on anti-psychotic medications.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Claims data

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:

	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Hemoglobin A1c for all waiver participants on anti-psychotic medications. Numerator: The total number of waiver participants on anti-psychotic medications who received HbA1c test. Denominator: The total number of waiver participants who have been identified as being on anti-psychotic medications.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Claims data

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	

		☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Annual Preventive Care Visit. Numerator: The total number of waiver participants with a PMP or OB/GYN visit in the past 12 months. Denominator: The total number of waiver participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Claims data

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:

Number and percent of claims paid to authorized waiver providers by the fiscal contractor. Numerator: The number of claims paid to authorized providers corresponding to the executed contract. Denominator: The total number of waiver claims paid during the review period.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS claims data

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of waiver service providers who met all provider enrollment requirements corresponding to the executed contract. Numerator: The total number of prospective waiver service providers who met all provider enrollment requirements who were enrolled by the fiscal contractor. Denominator: The total number of prospective waiver service providers who were enrolled.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Fiscal contractor data and reporting

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of newly qualified providers assigned a Medicaid provider number (executed provider agreement)timely (on average within 30 days of receipt of the application from a certified provider). The number of newly qualified providers who are assigned a Medicaid provider number timely. The total number of newly qualified providers who are assigned a Medicaid provider number.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Fiscal contractor data and reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other**

		Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of SSW claims paid timely by the fiscal contractor. Numerator: Total number of claims paid, denied or suspended within 30 calendar days of receipt or as indicated in the executed contract. Denominator: Total number of SSW claims submitted during the review period.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Fiscal contractor data and reporting

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 5%

☑ **Other** Specify: Fiscal Contractor	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Medicaid staff (OMPP) meets at least weekly with the operating agency (DDRS)to answer questions, identify areas of concern and resolve issues to ensure the successful implementation of the waiver program. OMPP works with DDRS to ensure that problems are addressed and corrected. These items are documented through meeting minutes between the OMPP and DDRS as well as through the analysis of the data aggregation as outlined in this appendix.

OMPP staff are also active, permanent members on numerous DDRS oversight committees: The Mortality Review Committee, Provider Sanctions Committee and The Quality Improvement Executive Council.

ii. Remediation Data Aggregation
Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

- ◉ **No**
- ○ **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to a group or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each of the subgroups in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
○ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
○ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☐	Technology Dependent			☐
◉ Mental Retardation or Developmental Disability, or Both					
	☑	Autism	0		☑
	☑	Developmental Disability	0		☑
	☑	Mental Retardation	0		☑
○ Mental Illness					
	☐	Mental Illness			
	☐	Serious Emotional Disturbance			

b. **Additional Criteria.** The State further specifies its target group(s) as follows:

In regard to specific State policies concerning the reasonable indication of the need for waiver services, as described in Appendix B-1-a of this application, the target groups for this waiver include persons with intellectual disability (ID)* and/or other developmental disabilities (DD) as defined in Indiana Code [IC 12-7-2-61], such as cerebral palsy, epilepsy, autism, or other conditions closely related to intellectual disability.

The "other condition" (other than a sole diagnosis of mental illness) may be considered closely related to intellectual disability because that 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. The ID, DD or other related condition must have an onset prior to age 22 and be expected to continue. The ID, DD or related condition must also result in substantial functional limitations in at least three (3) of the following areas of major life activities:

a. Self-care.
b. Understanding and use of language.
c. Learning.
d. Mobility.
e. Self-direction.
f. Capacity for independent living.
g. Economic self-sufficiency

These criteria are considered along with the LOC Screening Tool and an array of collateral materials when considering eligibility for waiver services. Throughout this Renewal, use and consideration of the Developmental Disabilities Profile (DDP) has also been required with LOC determinations. However, use of the DDP will be discontinued as of August 1, 2012. Use and consideration of the LOC Screening Tool will continue, as will other requirements and criteria described in this section as well as in Appendix B-6.

Waiver participants must meet ICF/MR level of care, which is assessed using the LOC screening tool. Eligibility requirements are found within the Bureau of Developmental Disabilities Services' policies for intake and assessment as well as the policy governing eligibility determination.

*Intellectual disability is also known as mental retardation.

c. **Transition of Individuals Affected by Maximum Age Limitation.** When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

◉ **Not applicable. There is no maximum age limit**

○ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. **Individual Cost Limit.** The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)* Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

  The limit specified by the State is *(select one)*

  - **A level higher than 100% of the institutional average.**

    Specify the percentage:

  - **Other**

    Specify:

- **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- **Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

  Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

  Participants will be allowed a total cost limit of $16,250 per year for any combination of services selected under the Family Supports Waiver, formerly known as the Support Services (SS) Waiver. The State reasonably expects that targeted individuals have available services and supports from sources other than the waiver (for example, family caregivers, educational settings, or other public programs and supports) which, in combination with the waiver services, will be sufficient to ensure their health, safety and welfare.

  At the time of this amendment, the State does not project additional increases or adjustments in the $16,250 individual cost limit will be needed. Any future decision to adjust the individual cost limit will be addressed via an amendment to the SS Waiver. The individual cost limit will be applied uniformly and fairly to all applicants and participants of the SS Waiver.

  The State will actively pursue other resources, including Medicaid State Plan services, informal supports, other community resources and the potential eligibility and movement to other waivers the participant may be eligible for.

  The cost limit specified by the State is *(select one)*:

  - **The following dollar amount:**

Specify dollar amount: 16250

The dollar amount *(select one)*

- **Is adjusted each year that the waiver is in effect by applying the following formula:**

  Specify the formula:

- **May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.**

- **The following percentage that is less than 100% of the institutional average:**

  Specify percent:

- **Other:**

  Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

b. **Method of Implementation of the Individual Cost Limit.** When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

All potentially eligible waiver participants who:

- meet ICF/MR LOC; and
- have been targeted from the Family Supports Waiver (formerly known as the Support Services Waiver) waiting list or are found to meet reserved capacity (priority) criteria with an available budgeted slot granting entry into the Family Supports Waiver, are afforded the opportunity to develop a plan of care based upon results of the Person Centered Planning Process and development of the Individualized Support Plan by the applicant/participant selected Individualized Support Team (as described in Appendix D), which is submitted to the State for review and determination.

Upon review of the plan of care, the State determines whether or not the waiver services, in combination with other sources of coverage including the Medicaid state plan, natural supports and other available community supports and resources, can adequately meet the needs of the individual and ensure his or her health, safety and welfare.

c. **Participant Safeguards.** When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

- [ ] **The participant is referred to another waiver that can accommodate the individual's needs.**
- [ ] **Additional services in excess of the individual cost limit may be authorized.**

  Specify the procedures for authorizing additional services, including the amount that may be authorized:

- [x] **Other safeguard(s)**

  Specify:

When there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount which exceeds the cost limit, in order to ensure the participant's health and welfare, the State will take the following actions:

• Evaluate the participant for enrollment into another waiver operated by the Division of Disability and Rehabilitative Services when the participant meets the specific reserved capacity criteria for entrance to the waiver
• Evaluate the participant to determine if they appear to meet the eligibility criteria for participation under another waiver program operated by another Division, such as a waiver requiring Nursing Facility Level of Care and operated by the State's Division of Aging and complete a referral to the Division of Aging when the participant appears to meet criteria or upon participant request

In any situation, providers of case management services, with support from the participant selected Individualized Support Team, are required to identify, inform, assist, and ensure that the participant accesses and receives all Medicaid State Plan services to which he or she is entitled, as well as to ensure other available supports and community resources, including natural supports, are accessed as needed.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. **Unduplicated Number of Participants.** The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	5267
Year 2	5669
Year 3	6686
Year 4	8326
Year 5	9884

b. **Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

- (●) **The State does not limit the number of participants that it serves at any point in time during a waiver year.**
- ( ) **The State limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 4	
Year 5	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. **Reserved Waiver Capacity.** The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

- ○ **Not applicable. The state does not reserve capacity.**
- ◉ **The State reserves capacity for the following purpose(s).**

Purpose(s) the State reserves capacity for:

Purposes
Eligible individuals age 18-24 with permanent separation from their educational setting
Eligible individuals transitioning from 100% state funded services

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Eligible individuals age 18-24 with permanent separation from their educational setting

Purpose *(describe):*

Qualified/eligible individuals age 18 through age 24 who have aged out of, graduated from or have permanently separated from their school setting may be able to enter waiver services upon that separation if funded slots are available.

Priority access by reserve capacity category is made available as long as priority waiver slots in the reserve capacity category remain open. Once the priority waiver slots in the reserve capacity category are filled, individuals meeting the priority access criteria will be placed on the waiting list. They will subsequently be tracked based on their need for a priority waiver slot and offered a waiver slot when:

•A newly available priority waiver slot for which they qualify becomes available; or
•A non-priority waiver slot using the first come, first served criteria for waiver enrollment (date placed on the waiting list) becomes available and the applicant is the first person on the waiting list.

Describe how the amount of reserved capacity was determined:

This reserved capacity was determined based on prior year experience for the past three years.

The State anticipates the number of participants for this group will grow slightly from Year 1 to Year 2 and then remain constant in Years 2 through 4.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	326
Year 2	240
Year 3	240
Year 4 (renewal only)	240
Year 5 (renewal only)	240

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Eligible individuals transitioning from 100% state funded services

Purpose *(describe):*

In 2009, the BDDS announced that qualified/eligible individuals from the former 100% state-funded day services programs must transition to the Support Services Waiver (to be known as the Family Supports Waiver effective with the 2012 Amendment), as 100% state funding will no longer be provided for waiver eligible participants. These slots provide priority access to waiver slots for this group transitioning to the SS Waiver.

Priority access by reserve capacity category is made available as long as priority waiver slots in the reserve capacity category remain open. Once the priority waiver slots in the reserve capacity category are filled, individuals meeting the priority access criteria will be placed on the waiting list. They will subsequently be tracked based on their need for a priority waiver slot and offered a waiver slot when:

•A newly available priority waiver slot for which they qualify becomes available; or
•A non-priority waiver slot using the first come, first served criteria for waiver enrollment (date placed on the waiting list) becomes available and the applicant is the first person on the waiting list.

Describe how the amount of reserved capacity was determined:

Original projections for these transitions to waiver services during the Support Services Waiver amendment #0387.03 estimated use of 1,800 priority slots for this transition. During the last renewal (April 2005 through March 2010) it was estimated that 450 of the original 1,800 had not yet transitioned, but would do so during the expiring renewal.

As of the April 1, 2010 effective date of this renewal, there are still approximately 367 potentially eligible/qualifying individuals who have yet to complete the transition from the 100% state-funded services onto the Support Services Waiver, which is to be known as the Family Supports Waiver effective with the 2012 Amendment.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	367
Year 2	5
Year 3	5
Year 4 (renewal only)	5
Year 5 (renewal only)	5

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. **Scheduled Phase-In or Phase-Out.** Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

- (●) **The waiver is not subject to a phase-in or a phase-out schedule.**
- ( ) **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. **Allocation of Waiver Capacity.**

Select one:

- (●) **Waiver capacity is allocated/managed on a statewide basis.**
- ( ) **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. **Selection of Entrants to the Waiver.** Specify the policies that apply to the selection of individuals for entrance to the waiver:

Entrance to the Family Supports Waiver, formerly known as the Support Services Waiver, is governed on a first come, first served basis by the applicant's signed and dated application for waiver services. Entrance to the Family Supports Waiver may also occur via the reserved capacity (priority) criteria noted in Appendix B-3-c.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a *(select one)*:
   - ( ) **§1634 State**
   - ( ) **SSI Criteria State**
   - (●) **209(b) State**
2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:
   - ( ) **No**
   - (●) **Yes**

b. **Medicaid Eligibility Groups Served in the Waiver.** Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- [x] **Low income families with children as provided in §1931 of the Act**
- [ ] **SSI recipients**
- [x] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [ ] **Optional State supplement recipients**
- [ ] **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

- ( ) **100% of the Federal poverty level (FPL)**
- ( ) **% of FPL, which is lower than 100% of FPL.**

Specify percentage: [ ]

- [ ] **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- [x] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- [x] **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- [ ] **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- [ ] **Medically needy in 209(b) States (42 CFR §435.330)**
- [ ] **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- [x] **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

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

Children receiving adoption assistance under a state adoption agreement - Sec 1902(a)(10)(A)(ii)(VIII)

Independent Foster Care Adolescents – Sec 1902(a)(10)(A)(ii)(XVII)

Children Under Age 1 – Sec 1902(a)(10)(A)(i)(IV)

Children Age 1-5 - Sec 1902(a)(10)(A)(i)(VI)

Children Age 1 through 18 - Sec 1902(a)(10)(A)(i)(VII)

Transitional Medical Assistance – Sec 1925 of the Act

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

- ( ) **No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*
- (•) **Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

- ( ) **All individuals in the special home and community-based waiver group under 42 CFR §435.217**
- (•) **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

Check each that applies:

☑ **A special income level equal to:**

Select one:

◉ **300% of the SSI Federal Benefit Rate (FBR)**
○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

○ **A dollar amount which is lower than 300%.**

Specify dollar amount:

☑ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
☐ **Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
☐ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**
☐ **Aged and disabled individuals who have income at:**

Select one:

○ **100% of FPL**
○ **% of FPL, which is lower than 100%.**

Specify percentage amount:

☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 4)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

a. **Use of Spousal Impoverishment Rules.** Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217 *(select one):*

○ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the State elects to (*select one*):

○ **Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-c (209b State) and Item B-5-d)
○ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-c (209b State) . Do not complete Item B-5-d)

- **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**
  (Complete Item B-5-c (209b State) . Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 4)

b. Regular Post-Eligibility Treatment of Income: SSI State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 4)

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- **The following standard included under the State plan**

  (*select one*):

  - **The following standard under 42 CFR §435.121**

    Specify:

  - **Optional State supplement standard**
  - **Medically needy income standard**
  - **The special income level for institutionalized persons**

    (*select one*):

    - **300% of the SSI Federal Benefit Rate (FBR)**
    - **A percentage of the FBR, which is less than 300%**

      Specify percentage:
    - **A dollar amount which is less than 300%.**

      Specify dollar amount:
  - **A percentage of the Federal poverty level**

    Specify percentage:
  - **Other standard included under the State Plan**

    Specify:

- **The following dollar amount**

  Specify dollar amount: If this amount changes, this item will be revised.

- **The following formula is used to determine the needs allowance:**

  Specify:

- **Other**

  Specify:

ii. Allowance for the spouse only (*select one*):

- **Not Applicable (see instructions)**
- **The following standard under 42 CFR §435.121**

  Specify:

- **Optional State supplement standard**
- **Medically needy income standard**
- **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised.

- **The amount is determined using the following formula:**

  Specify:

  Subtract the SSI maximum Federal Benefit Rate (FBR) for an individual from the SSI maximum FBR for a couple.

iii. Allowance for the family (*select one*):

- **Not Applicable (see instructions)**
- **AFDC need standard**
- **Medically needy income standard**
- **The following dollar amount:**

  Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

- **The amount is determined using the following formula:**

  Specify:

- **Other**

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- **Not Applicable (see instructions)** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- **The State does not establish reasonable limits.**
- **The State establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 4)

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan.. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

ii. Frequency of services. The State requires (select one):

- ○ **The provision of waiver services at least monthly**
- ◉ **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

Identified needs of the participant served under the Family Supports Waiaver, formerly known as the Support Services Waiver, must be such that the participant requires the provision of at least one Family Supports Waiver service on a quarterly basis (as evidenced by the service plan) in order to avoid institutionalization. All participants, including those for whom less than monthly service provision is required, shall require regular monthly monitoring which shall be documented in the service plan. Requirements for monitoring the participant at least monthly are specified in Appendix D-2-a of this application.

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

- ○ **Directly by the Medicaid agency**
- ○ **By the operating agency specified in Appendix A**
- ○ **By an entity under contract with the Medicaid agency.**

Specify the entity:

- ◉ **Other**

Specify:

Initial Level of Care evaluations are performed by the BDDS Service Coordinator or eligibility contractor as specified in Appendix A, with the following exceptions: 1) the individual targeted for waiver services is age 5 or younger; or 2) the individual is currently a resident of an ICF/MR facility and has been identified by the Indiana State Department of Health as being the subject of a W-197 or W-198 tag, indicating a violation of a federal standard related to the need for active treatment.

•The W197 tag = active treatment does not include services to maintain generally independent participants who are able to function with little supervision or in the absence of a continuous active treatment program.
•The W198 tag = participants who are admitted by the facility must be in need of and receiving active treatment services

Under these exceptions, the level of care determination is made by the BDDS Level of Care Unit which is part of the operating agency specified in Appendix A.

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

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

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.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

To complete a waiver level of care determination, operating agency staff or the operating agency's contractor must obtain and review the following:

1) Psychological records including I.Q. score;
2) Social assessment records;
3) Medical records;
4) Additional records necessary to have a current and valid reflection of the individual; and

5) A completed 450B Confirmation of Diagnosis form, signed and dated by a physician within the past year.

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.

The BDDS Central Office or LOC contractor (initial LOC) or Case Manager (re-evaluations) reviews the LOC Screening Tool 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. Throughout this Renewal, use and consideration of the Developmental Disabilities Profile (DDP) has also been required with LOC determinations. However, use of the DDP will be discontinued as of August 1, 2012. Use and consideration of the LOC Screening Tool will continue, as will other requirements and criteria described in this section.

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 substantial functional limitation categories, as defined in 42 CFR 435.1010, are: 1) self-care, 2) learning, 3) self-direction, 4) capacity for independent living, 5) receptive and expressive language, and 6) mobility.

• The basic conditions are: 1) intellectual disability*, cerebral palsy, epilepsy, autism, or condition similar to intellectual disability*, 2) the condition identified in #1 is expected to continue, 3) the condition identified in #1 had an age of onset prior to age 22, and 4) the applicant needs a combination or sequence of services.

*Intellectual disability is also known as mental retardation.

e. **Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

- (●) **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
- ( ) **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. **Process for Level of Care Evaluation/Reevaluation:** Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

The process for reevaluation of level of care is the same as the initial evaluation, but it is performed by the waiver case manager as opposed to a contractor or BDDS staff. The level of care initial evaluation process as described in Appendix B-6-d is utilized for reevaluations of level of care.

g. **Reevaluation Schedule.** Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

- ( ) **Every three months**
- ( ) **Every six months**
- ( ) **Every twelve months**
- (●) **Other schedule**

Specify the other schedule:

Level of care reevaluations are required for each participant at least every twelve months. Level of care reevaluations will also be completed when there is significant change in the participant's health or circumstances.

h. **Qualifications of Individuals Who Perform Reevaluations.** Specify the qualifications of individuals who perform reevaluations *(select one)*:

- (●) **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ( ) **The qualifications are different.**

Specify the qualifications:

i. **Procedures to Ensure Timely Reevaluations.** Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care *(specify):*

The state's electronic case management data system allows case managers to generate reports indicating the due dates for Level of Care (LOC) redeterminations for each participant. Case management agencies may also utilize their own internal data systems to monitor and track the timeliness of LOC determinations by the case managers they employ. In addition, the state's data system prevents completion of the POC/CCB when a LOC redetermination has not been completed within required time frames.

Note that the state's electronic case management data system is also programmed so that it does not permit the state's approval of a service plan (described in Appendix D) for which the level of care determination or redetermination has not been made within the past 12 months.

j. **Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Records are maintained by the operating agency's Bureau of Developmental Disabilities Services office within the electronic case management data system and are retrievable indefinietly upon request.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Level of Care Assurance/Sub-assurances**
   i. **Sub-Assurances:**

      a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

      Performance Measures

      For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

      For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

      Performance Measure:
      The number and percent of new enrollees who had a level of care evaluation completed prior to waiver enrollment. Numerator: The number of new enrollees who had a level of care evaluation completed prior to waiver enrollment. Denominator: The total number of new enrollees.

      Data Source (Select one):
      Other
      If 'Other' is selected, specify:
      DART and INsite database

Responsible Party for data	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

collection/generation *(check each that applies):*		
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
The number and percent of active waiver participants whose level of care was redetermined within 365 days of their previous level of care. Numerator: The total number of active Waiver participants who received a reevaluation of level of care within 365 days of the previous level of care. Denominator: The total number of active Waiver participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
INsite database reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Performance Measure: Number and percent of participants whose level of care was conducted based on requirements for determining LOC in the waiver. Numerator: The total number of participants sampled whose level of care was conducted based on requirements for determining LOC in the waiver. Denominator: The total number of participants in the sample.

Data Source (Select one):
Other
If 'Other' is selected, specify:
INsite databse reports and DART

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Performance Measure: Number and percent of initial levels of care completed accurately. Numerator: The total number of participants sampled whose level of

care was completed accurately. Denominator: The total number of participants sampled.

Data Source (Select one):
Other
If 'Other' is selected, specify:
INsite database reports and DART

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Eligibility contractor	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: 100% of all denials based on redeterminations and a valid sample (5% confidence interval) of all other redeterminations
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of annual levels of care completed accurately. Numerator: The total number of participants sampled whose anual level of care were completed accurately. Denominator: The total number of participants sampled.

Data Source (Select one):
Other
If 'Other' is selected, specify:
INsite database reports and DART

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Case management contractor	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: 100% of all denials based on redeterminations

		and a valid sample (5% confidence interval) of all other redeterminations
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: Case management contractor	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Data is compiled regarding LOC determinations and a written quarterly report developed with recommendations for quality improvement. A full description of the LOC instrument appears under Appendix B-6-e.

On a monthly basis, the operating agency, the Division of Disability and Rehabilitative Services (DDRS) Central Office, will run a series of reports to monitor the total number of participants for whom an annual renewal Plan of Care/Cost Comparison Budget (CCB) was due in that month, the number of annual CCBs actually received for that month and the number of annual CCBs for which no renewal was submitted. When the annual CCB is not submitted on time, a default CCB is created to ensure the continuation of services for the participant until the annual CCB is submitted.

The BDDS Waiver Unit within DDRS is responsible for the review and approval of all CCBs and notifies the DDRS Case Management Liaison of the findings resulting from the monthly LOC reviews. The Liaison is

responsible for relaying these findings to the appropriate provider or providers of case management.

The case management provider is responsible for reporting back to the Liaison on the status of all late POC/CCBs and to confirm completion once accomplished, The Liaison verifies reported completion against the case management database to ensure completion has occurred. Any undue delays or failures to complete POC/CCBs or LOCs are reported to the DDRS Central Office for remediation. Remediation may include focused reviews of case management performance, required completion of Corrective Action Plans by the case management provider, and sanctions if required including restitution of funds paid for specific case management activities.

Problems with POC/CCB timeliness and any resulting CAPs are reported to OMPP and reviewed in the periodic management meetings.

ii. **Remediation Data Aggregation**
Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. **Timelines**
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

◉ **No**
○ **Yes**
Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. **Procedures.** Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Following a determination that the applicant meets the eligibility requirements for enrollment into the Family Supports Waiver, formerly known as the Support Services Waiver, Bureau of Developmental Disabilities Services (BDDS)Service Coordinator is responsible for informing the applicant and/or his or her legal representative, if applicable, of the feasible alternatives available under the waiver and given the choice of waiver services or ICF/MR services.

The applicant or legal representative is asked to sign the FREEDOM OF CHOICE form.

The FREEDOM OF CHOICE form is initially completed by potential "targeted" HCBS waiver participants and at least annually by active waiver participants. This form is signed and dated by the individual, the individual's family/guardian, representative or advocate when applicable, and the case manager or service coordinator working with
the individual. The case manager or service coordinator is responsible for explaining the services available in an institutional setting as well as the feasible alternatives available under the Family Supports Waiver.

The signed form reflects the individual/participant/guardian's choice between waiver services and non-waiver/institutionally based services.

If a "targeted" HCBS Waiver participant is currently enrolled in a Risk-Based Managed Care program or if an HCBS Waiver participant wants to transfer to a Risk-Based Managed Care program (if eligible), the Service Coordinator or Case Manager is responsible for explaining eligibility under 42 CFR 435.217 (Medicaid eligible if receiving home and community-based waiver services) and the impact the selection of Risk-Based Managed Care could have on the individual's eligibility. They also explain the array of services available under the HCBS Waiver program and under Risk-Based Managed Care. In Indiana, the Risk-Based Managed Care programs and HCBS Waiver programs are mutually exclusive.

A Plan of Care/Cost Comparison Budget (POC/CCB) is used for individuals who choose waiver services. Once an individual is "targeted" for a waiver slot, is Medicaid eligible, and has met Level of Care approval, a Plan of Care/Cost Comparison Budget (POC/CCB) is developed. The Plan of Care/Cost Comparison Budget (POC/CCB) is used for waiver participants at the time of initial determinations, updates, and annual re-determinations. Although a FREEDOM OF CHOICE form is obtained with each service plan update, a statement regarding freedom of choice is also contained in Section I of the POC/CCB form. The waiver participant/guardian signs and dates this section indicating his/her choice of waiver services or institutional services. The Case Manager is responsible for explaining the array of services available in an institutional setting as well as the feasible alternatives available through the Family Supports Waiver program.

b. **Maintenance of Forms.** Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

   The initial signed and dated FREEDOM OF CHOICE form is maintained within the Bureau of Developmental Disabilities Services Field Office having jurisdiction over the participant's county of residence.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
As an integral part of the operating agency, the Division of Disability and Rehabilitative Services' (DDRS) Bureau of Deaf and Hard of Hearing Services serves as a resource for interpreter services to the deaf and hard of hearing. As needed, the operating agency is able to assist with referrals for sign language interpreters toward the effective communication with applicants or participants, when interpreter services are not already included on the service plan of the participant.

Staff members of the operating agency sometimes utilize locally available interpreters associated with community or neighborhood organizations and church groups for interpretation of non-English languages. Some metropolitan communities within Indiana offer access to interpreters of varying languages through local colleges, universities or libraries.

The http://www.imcpl.org/cgi-bin/irnget.pl?Interpreters is a website offering connections to Asian, Latino, and American

Sign Language interpreters within the Marion County/Indianapolis area as well as the translation of personal documents.

As outlined within the Individualized Support Plan (ISP) and incorporated into the Plan of Care/Cost Comparison Budget (CCB), providers of services are expected to meet the needs of the participants they serve, inclusive of effectively and efficiently communicating with each participant by whatever means is preferred by the participant. If the participant is a Limited English Proficient (LEP) person, the provider is expected to accommodate those needs during the delivery of any and all services they were chosen to provide.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. **Waiver Services Summary.** *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service		
Statutory Service	Adult Day Services		
Statutory Service	Case Management		
Statutory Service	Prevocational Services		
Statutory Service	Respite		
Statutory Service	Supported Employment Follow Along		
Extended State Plan Service	Occupational Therapy		
Extended State Plan Service	Physical Therapy		
Extended State Plan Service	Psychological Therapy		
Extended State Plan Service	Speech/Language Therapy		
Other Service	Behavioral Support Services		
Other Service	Community Based Habilitation - Group		
Other Service	Community Based Habilitation - Individual		
Other Service	Facility Based Habilitation - Group		
Other Service	Facility Based Habilitation - Individual		
Other Service	Facility Based Support Services		
Other Service	Family and Caregiver Training		
Other Service	Intensive Behavioral Intervention		
Other Service	Music Therapy		
Other Service	Participant Assistance and Care		
Other Service	Personal Emergency Response System		
Other Service	Recreational Therapy		
Other Service	Specialized Medical Equipment and Supplies		
Other Service	Transportation		
Other Service	Workplace Assistance		

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):
Adult Day Services
Service Definition *(Scope):*
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.

Individuals attend Adult Day Services on a planned basis. A minimum of 3 hours to a maximum of 12 hours shall be allowable. The three levels of Adult Day Services are Basic, Enhanced and Intensive.

A 1/2 day unit is defined as one unit of 3 hours to a maximum of 5 hours/day. Two units is more than 5 hours to a maximum of 8 hours/day. A maximum of two units/day is allowed.

A 1/4 day unit is defined as 15 minutes. Billable only after 8 hours of ADS have been provided on the same day. A maximum of 16 units/day is allowed.

REIMBURSABLE ACTIVITIES:

BASIC ADULT DAY SERVICES (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.

Adult Day Services may be used in conjunction with Transportation Services.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Adult Day Services are allowed for a minimum of 3 hours to a maximum of 12 hours per day.

ACTIVITIES NOT ALLOWED
• Any activity that is not described in allowable activities is not included in this service.

NOTE: Therapies provided through this service will not duplicate therapies provided under any other service.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [x] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DDRS Approved Adult Day Service Facilities

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Adult Day Services

Provider Category:
Agency
Provider Type:
DDRS Approved Adult Day Service Facilities
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
DDRS-approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Financial Status of Providers,
460 IAC 6-5-2 Qualification for ADS,
460 IAC 6-14-5 Direct Care Staff Qualifications,
460 IAC 6-14-4 Staff Training, and Transportation Requirements.

Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals.
Verification of Provider Qualifications
Entity Responsible for Verification:
Initially, BDDS. For reapproval, BDDS or BQIS.
Frequency of Verification:
Up to 3 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

Service Definition *(Scope):*

Case Management Services means services that enable a participant to receive a full range of appropriate services in a planned, coordinated, efficient and effective manner. Case management assists participants in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services, regardless of the funding source for the services to which access is gained. Case Management Services must be reflected in the Individual Support Plan (ISP) and must address needs identified in the person centered planning process.

REIMBURSABLE ACTIVITIES:

• Developing, updating, and reviewing the Individualized Support Plan (ISP) using the Person Centered Planning Process.
• Convening team meetings quarterly and as needed to discuss the ISP and any other issues needing consideration in relation to the participant.
• Completion of a DDRS-approved health and safety indicator assessment tool during service plan development, initially, annually and when there is a change in the participant's status.
• Monitoring of service delivery and utilization (via telephone calls, home visits and team meetings) to ensure that services are being delivered in accordance with the ISP.
• Completing and processing the annual Level of Care determination.
• Compiling weekly case notes for each participant.
• Conducting face-to-face contacts with the individual (and family members, as appropriate) at least once each quarter and as needed to ensure health and welfare and to address any reported problems or concerns.
• Completing and processing the 90-Day Checklist.
• Developing initial, annual and update Cost Comparison Budgets using the State approved process.
• Disseminating information including all Notices of Action and forms to the participant and the Individualized Support Team (IST).
• Completing, submitting and following up on incident reports in a timely fashion using the State-approved process, including notifying the family/guardian of the incident outcome, all of which must be verifiable by documented supervisory oversight and monitoring of the Case Management agency.
• Monitoring participants' health and welfare.
• Monitoring participants' satisfaction and service outcomes.
• Monitoring claims reimbursed through the approved Medicaid Management Information System (MMIS) and pertaining to waiver-funded services.
• Maintaining files in accordance with State standards.
• Cultivating and strengthening informal and natural supports for each participant.
• Identifying resources and negotiating the best solutions to meet identified needs.

NOTE: Timeframes related to required activities, service standards and/or responsibilities of the Case Manager are specified in the DDRS Waiver Manual which is located at http://www.in.gov/fssa/ddrs/4312.htm.

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

ACTIVITIES NOT ALLOWED:

The case management entity may not own or operate another waiver service agency, nor may the case management entity be an approved provider of any other waiver service.

Reimbursement is not available through Case Management Services for the following activities or any other activities that do not fall under the definition listed above:
• Services delivered to persons who do not meet eligibility requirements established by BDDS.
• Counseling services related to legal issues. Such issues shall be directed to the Indiana Advocacy Services, the designated Protection and Advocacy agency under the Developmental Disabilities Act and Bill of Rights Act, P.L. 100-146.

• Case Management conducted by a person related through blood or marriage to any degree to the waiver participant.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DDRS Approved Case Management Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Case Management

Provider Category:
Agency
Provider Type:
DDRS Approved Case Management Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Enrolled as an active Medicaid provider
DDRS Approved
460 IAC 6-10-5 Criminal Histories
460 IAC 6-11 Financial Status of Providers
460 IAC 6-12 Insurance
460 IAC 6-19 Case Management

Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals.
Verification of Provider Qualifications
Entity Responsible for Verification:
Initially, BDDS. For Reapproval, BDDS or BQIS.
Frequency of Verification:
Up to 3 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Prevocational Services

Alternate Service Title (if any):

Service Definition *(Scope):*

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 results. Services are habilitative in nature and not explicit employment objectives.

Monitoring of prevocational services provision will be performed at a minimum every 6 months using the prevocational
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.

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

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.

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

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-based
• Services furnished to a minor by parent(s) or stepparents(s) or legal guardian

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [x] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	DDRS Approved Prevocational Services Individual
Agency	DDRS Approved Prevocational Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Prevocational Services

Provider Category:
Individual
Provider Type:
DDRS Approved Prevocational Services Individual
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
DDRS Approved
460 IAC 6-10-5-Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-14-5 Direct Care Staff qualifications,
460 IAC 6-5-20 Prevocational Services provider qualifications,
460 IAC 6-14-4 Staff Training

Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals.
Verification of Provider Qualifications
Entity Responsible for Verification:
Initially, BDDS. For re-approval, BDDS or BQIS.
Frequency of Verification:
Up to 3 years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Prevocational Services

Provider Category:
Agency
Provider Type:
DDRS Approved Prevocational Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
DDRS Approved
460 IAC 6-10-5-Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-14-5 Direct Care Staff qualifications,
460 IAC 6-5-20 Prevocational Services provider qualifications,
460 IAC 6-14-4 Staff Training

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

Verification of Provider Qualifications

Entity Responsible for Verification:
Initially, BDDS. For re-approval, BDDS or BQIS.

Frequency of Verification:
Up to 3 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Statutory Service

Service:
Respite

Alternate Service Title (if any):

Service Definition *(Scope):*
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)

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Activities Not Allowed:
• Reimbursement for room and board

• Services provided to a 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/Individual Service Plan (POC/ISP)
• 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

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [x] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	DDRS Approved Respite Providers - Individual
Agency	DDRS Approved Licensed Home Health Agencies
Individual	DDRS Approved Respite Providers - Individual - Skilled Nursing
Agency	DDRS Approved Respite Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Individual
Provider Type:
DDRS Approved Respite Providers - Individual
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Financial Status of Providers,

460 IAC 6-5-26 Respite Care Qualifications,
460 IAC 6-5-14 Health Care Coordination Qualifications,
460 IAC 6-14-5 Direct Care Staff Qualifications,
460 IAC 6-14-4 Staff Training

Must comply with BDDS service standards, guidelines, policies and/or manuals.

Verification of Provider Qualifications

Entity Responsible for Verification:
Initially, BDDS. For re-approval, BDDS or BQIS.

Frequency of Verification:
Up to 3 years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency

Provider Type:
DDRS Approved Licensed Home Health Agencies

Provider Qualifications

License *(specify):*
Home Health Agency IC 16-27-1, RN and LPN IC 25-23-1

Certificate *(specify):*
Home Health Aide Registered IC 16-27-1.5

Other Standard *(specify):*
DDRS approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Financial Status of Providers,
460 IAC 6-5-26 Respite Care Qualifications,
460 IAC 6-5-14 Health Care Coordination Qualifications,
460 IAC 6-14-5 Direct Care Staff Qualifications,
460 IAC 6-14-4 Staff Training

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

Verification of Provider Qualifications

Entity Responsible for Verification:
Initially, BDDS. For re-approval, BDDS or BQIS.

Frequency of Verification:
Up to 3 years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Individual

Provider Type:
DDRS Approved Respite Providers - Individual - Skilled Nursing

Provider Qualifications

License *(specify):*
IC 25-23 Licensed Practical Nurses and Registered Nurses
Certificate *(specify):*

Other Standard *(specify):*
DDRS approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Financial Status of Providers,
460 IAC 6-5-26 Respite Care Qualifications,
460 IAC 6-5-14 Health Care Coordination Qualifications,
460 IAC 6-14-5 Direct Care Staff Qualifications,
460 IAC 6-14-4 Staff Training

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

Verification of Provider Qualifications

Entity Responsible for Verification:
Initially, BDDS. For re-approval BDDS and BQIS.
Frequency of Verification:
Up to 3 years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
DDRS Approved Respite Agencies
Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
DDRS approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Financial Status of Providers,
460 IAC 6-5-26 Respite Care Qualifications,
460 IAC 6-5-14 Health Care Coordination Qualifications,
460 IAC 6-14-5 Direct Care Staff Qualifications,
460 IAC 6-14-4 Staff Training

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

Verification of Provider Qualifications

Entity Responsible for Verification:
Initially, BDDS. For re-approval, BDDS or BQIS.
Frequency of Verification:
Up to 3 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

Supported Employment Follow Along

Service Definition *(Scope):*

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. While there is a suggested 18 month time limit, time can be extended when a CCB (plan of service) is submitted. 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. Extensions are currently granted to anyone who is still making efforts toward employment.Definitions for job in jeopardy, career advancement or job loss:

• Job in jeopardy – the participant will lose his/her job without additional intervention
• Career advancement – it is determined that the new job requires more complex, comprehensive, intensive supports than can be offered under the waiver
• 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.

Allowable ratio: Individual, 1:1

REIMBURSABLE ACTIVITIES:

• 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.
• 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
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Activities Not Allowed:
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. As previously noted, while there is a suggested 18 month time limit, time can be extended when a CCB (plan of service) is submitted and extensions are currently granted to anyone who is still making efforts toward employment. A formal appeal is not necessary to request this extension.

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

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [x] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DDRS Approved Supported Employment Follow Along Agencies
Individual	DDRS Approved Supported Employment Follow Along - Individuals

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Supported Employment Follow Along

Provider Category:
Agency
Provider Type:
DDRS Approved Supported Employment Follow Along Agencies
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-30(b) and 6-34 Transportation,
460 IAC 6-14-5 Direct Care Staff qualifications,
460 IAC 6-5-29 Supported Employment provider qualifications,
460 IAC 6-14-4 Staff Training

Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals.
Verification of Provider Qualifications
Entity Responsible for Verification:
Initially, BDDS. For re-approval, BDDS or BQIS.
Frequency of Verification:
Up to 3 years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Supported Employment Follow Along

Provider Category:
Individual
Provider Type:
DDRS Approved Supported Employment Follow Along - Individuals
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,

460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-30(b) and 6-34 Transportation,
460 IAC 6-14-5 Direct Care Staff qualifications,
460 IAC 6-5-29 Supported Employment provider qualifications,
460 IAC 6-14-4 Staff Training

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

Verification of Provider Qualifications

Entity Responsible for Verification:
Initially, BDDS. For re-approval, BDDS or BQIS.
Frequency of Verification:
Up to 3 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Extended State Plan Service

Service Title:
Occupational Therapy

Service Definition *(Scope):*
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, 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
• Design, fabrication, training and assistance with adaptive aids and devices
• Consultation or demonstration of techniques with other service providers and family members

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.

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

NOTE: Therapies provided through this service will not duplicate therapies provided under any other service.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [x] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DDRS Approved Agency Providing Occupational Therapy
Individual	Licensed Occupational Therapist
Agency	Home Health Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Occupational Therapy

Provider Category:
Agency
Provider Type:
DDRS Approved Agency Providing Occupational Therapy
Provider Qualifications
License *(specify):*
Occupational Therapist IC 25-23.5
Certificate *(specify):*

Other Standard *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-17 Occupational Therapy qualifications

Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals.
Verification of Provider Qualifications
Entity Responsible for Verification:
Initially, BDDS. For re-approval, BDDS or BQIS.
Frequency of Verification:
Up to 3 years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Occupational Therapy

Provider Category:
Individual
Provider Type:

Licensed Occupational Therapist
Provider Qualifications
License *(specify):*
IC 25-23.5 (Licensure and certification requirments)
Certificate *(specify):*

Other Standard *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-17 Occupational Therapy qualifications

Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals.
Verification of Provider Qualifications
Entity Responsible for Verification:
Initially, BDDS. For re-approval, BDDS or BQIS.
Frequency of Verification:
Up to 3 years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Occupational Therapy

Provider Category:
Agency
Provider Type:
Home Health Agencies
Provider Qualifications
License *(specify):*
IC 16-27-1
Certificate *(specify):*

Other Standard *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-17 Occupational Therapy provider qualifications

Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals.
Verification of Provider Qualifications
Entity Responsible for Verification:
Initially, BDDS. For re-approval, BDDS or BQIS.
Frequency of Verification:
Up to 3 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service

Service Title:

Physical Therapy

Service Definition *(Scope):*

Physical Therapy Services means services provided under this article 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

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.

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

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 Medicaid waiver for this service).

NOTE: Therapies provided through this service will not duplicate therapies provided under any other service.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [x] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DDRS Approved Agency Providing Physical Therapy
Individual	Licensed Physical Therapist
Agency	Home Health Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Physical Therapy

Provider Category:
Agency
Provider Type:
DDRS Approved Agency Providing Physical Therapy
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-19 Physical Therapy Provider qualifications

Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals.
Verification of Provider Qualifications
Entity Responsible for Verification:
Initially, BDDS. For re-approval, BDDS or BQIS.
Frequency of Verification:
Up to 3 years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Physical Therapy

Provider Category:
Individual
Provider Type:
Licensed Physical Therapist
Provider Qualifications
License *(specify):*
IC 25-27-1
Certificate *(specify):*

Other Standard *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-19 Physical Therapy Qualifications

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Initially, BDDS. For re-approval BDDS or BQIS.

Frequency of Verification:

Up to 3 years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Physical Therapy

Provider Category:

Agency

Provider Type:

Home Health Agencies

Provider Qualifications

License *(specify):*

IC 16-27-1

Certificate *(specify):*

Other Standard *(specify):*

DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-19 Physical Therapy Provider qualifications

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Initially, BDDS. For re-approval, BDDS or BQIS.

Frequency of Verification:

Up to 3 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service

Service Title:

Psychological Therapy

Service Definition *(Scope):*

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

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

NOTE: Therapies provided through this service will not duplicate therapies provided under any other service.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [x] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Clinical Social Worker
Agency	DDRS Approved Qualified Agencies
Individual	Mental Health Counselor
Individual	Marriage/Family Therapist
Individual	Licensed Psychologists

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Psychological Therapy

Provider Category:
Individual
Provider Type:
Clinical Social Worker
Provider Qualifications

License *(specify):*
IC 25-23.6
Certificate *(specify):*

Other Standard *(specify):*
DDRS approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-21 (Psychological) Therapy Provider qualifications

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

Verification of Provider Qualifications

Entity Responsible for Verification:
Initially, BDDS. For re-approval, BDDS or BQIS.
Frequency of Verification:
Up to 3 years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Psychological Therapy

Provider Category:
Agency
Provider Type:
DDRS Approved Qualified Agencies
Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
DDRS approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-21 (Psychological) Therapy Provider qualifications

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

Verification of Provider Qualifications

Entity Responsible for Verification:
Initially, BDDS. For re-approvals, BDDS and BQIS.
Frequency of Verification:
Up to 3 years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service

Service Name: Psychological Therapy

Provider Category:
Individual
Provider Type:
Mental Health Counselor
Provider Qualifications
License *(specify):*
IC 25-23.6
Certificate *(specify):*

Other Standard *(specify):*
DDRS approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-21 (Psychological) Therapy Provider qualifications

Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals.
Verification of Provider Qualifications
Entity Responsible for Verification:
Initially, BDDS. For re-approval, BDDS or BQIS.
Frequency of Verification:
Up to 3 years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Psychological Therapy

Provider Category:
Individual
Provider Type:
Marriage/Family Therapist
Provider Qualifications
License *(specify):*
IC 25-23.6
Certificate *(specify):*

Other Standard *(specify):*
DDRS approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-21 (Psychological) Therapy Provider qualifications

Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals.
Verification of Provider Qualifications
Entity Responsible for Verification:
Initially, BDDS. For re-approval, BDDS or BQIS.
Frequency of Verification:
Up to 3 years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Psychological Therapy

Provider Category:
Individual
Provider Type:
Licensed Psychologists
Provider Qualifications
License *(specify):*
IC 25-33-1-5.1
Certificate *(specify):*

Other Standard *(specify):*
DDRS approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-21 (Psychological) Therapy Provider qualifications

Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals.
Verification of Provider Qualifications
Entity Responsible for Verification:
Initially, BDDS. For re-approval, BDDS or BQIS.
Frequency of Verification:
Up to 3 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Extended State Plan Service
Service Title:
Speech/Language Therapy
Service Definition *(Scope):*
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

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

NOTE: Therapies provided through this service will not duplicate therapies provided under any other service.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☑ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Licensed Speech/Language Therapist
Agency	Home Health Agencies
Agency	DDRS Approved Agency providing Speech/Language Therapy

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Speech/Language Therapy

Provider Category:
Individual
Provider Type:
Licensed Speech/Language Therapist
Provider Qualifications
License *(specify):*
IC 25-35.6
Certificate *(specify):*

Other Standard *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-28 Speech/Language Therapy Qualifications

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Initially, BDDS. For re-approval, BDDS or BQIS.

Frequency of Verification:

Up to 3 years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Speech/Language Therapy

Provider Category:

Agency

Provider Type:

Home Health Agencies

Provider Qualifications

License *(specify):*

IC 16-27-1

Certificate *(specify):*

Other Standard *(specify):*

DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-28 Speech-Language Therapy Provider Qualifications

Must comply with applicable BDDS service standards, guidelines, policies and/or manuals.

Verification of Provider Qualifications

Entity Responsible for Verification:

Initially, BDDS. For re-approval, BDDS and BQIS.

Frequency of Verification:

Up to 3 years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Speech/Language Therapy

Provider Category:

Agency

Provider Type:

DDRS Approved Agency providing Speech/Language Therapy

Provider Qualifications

License *(specify):*

IC 25-35.6 licensed Speech/Language Therapist

Certificate *(specify):*

Other Standard *(specify):*

DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-28 Speech-Language Therapy provider qualifications

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

Verification of Provider Qualifications

Entity Responsible for Verification:
Initially, BDDS. For re-approval, BDDS or BQIS.
Frequency of Verification:
Up to 3 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Behavioral Support Services

Service Definition *(Scope):*
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

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

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☑ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	DDRS Approved BSS Individuals
Agency	DDRS Approved BSS Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Behavioral Support Services

Provider Category:
Individual

Provider Type:
DDRS Approved BSS Individuals

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-4 Behavioral Support Services Provider Qualifications
460 IAC 6-18 Behavioral Support Services Standards

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

Verification of Provider Qualifications

Entity Responsible for Verification:
Initially, BDDS. For re-approval, BDDS or BQIS.

Frequency of Verification:
Up to 3 years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Behavioral Support Services

Provider Category:
Agency
Provider Type:
DDRS Approved BSS Agencies
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-4 Behavioral Support Services Provider qualifications
460 IAC 6-18 Behavior Support Services Standards

Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals.
Verification of Provider Qualifications
Entity Responsible for Verification:
Initially, BDDS. For re-approval, BDDS or BQIS.
Frequency of Verification:
Up to 3 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Community Based Habilitation - Group
Service Definition *(Scope):*
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.

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

REIMBURSABLE ACTIVITIES:

Monitoring, training, education, demonstration, or support to assist the individual 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

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

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.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [x] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DDRS Approved Community Based Habilitation Agencies
Individual	DDRS Approved Community Based Habilitation - Individuals

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Based Habilitation - Group

Provider Category:
Agency
Provider Type:
DDRS Approved Community Based Habilitation Agencies
Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
DDRS-approved,
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Financial Status of Providers,
460 IAC 6-14-5 Direct Care Staff Qualifications,
460 IAC 6-14-4 Staff Training,
460 IAC 6-5-14 Health Care Coordination Services provider qualifications, and
Transportation Requirements

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

Verification of Provider Qualifications

Entity Responsible for Verification:
Initially, BDDS. For re-approval, BDDS or BQIS.

Frequency of Verification:
Up to 3 years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Based Habilitation - Group

Provider Category:
Individual

Provider Type:
DDRS Approved Community Based Habilitation - Individuals

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
DDRS-approved,
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Financial Status of Providers,
460 IAC 6-14-5 Direct Care Staff Qualifications,
460 IAC 6-14-4 Staff Training,
460 IAC 6-5-14 Health Care Coordination Services provider qualifications, and
Transportation Requirements

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

Verification of Provider Qualifications

Entity Responsible for Verification:
Initially, BDDS. For re-approval, BDDS or BQIS.

Frequency of Verification:
Up to 3 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Community Based Habilitation - Individual

Service Definition *(Scope):*

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.

Allowable Ratio - 1:1

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

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

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.

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.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [x] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DDRS Approved Agencies
Individual	DDRS Approved Individual

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Based Habilitation - Individual

Provider Category:
Agency

Provider Type:
DDRS Approved Agencies

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
DDRS-approved,
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Financial Status of Providers,
460 IAC 6-14-5 Direct Care Staff Qualifications,
460 IAC 6-14-4 Staff Training,
460 IAC 6-5-14 Health Care Coordination Services provider qualifications, and
Transportation Requirements

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

Verification of Provider Qualifications

Entity Responsible for Verification:
Initially, BDDS. For re-approval, BDDS or BQIS.

Frequency of Verification:
Up to 3 years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Based Habilitation - Individual

Provider Category:
Individual
Provider Type:
DDRS Approved Individual
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
DDRS-approved,
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Financial Status of Providers,
460 IAC 6-14-5 Direct Care Staff Qualifications,
460 IAC 6-14-4 Staff Training,
460 IAC 6-5-14 Health Care Coordination Services provider qualifications, and
Transportation Requirements

Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals.
Verification of Provider Qualifications
Entity Responsible for Verification:
Initially, BDDS. For re-approval, BDDS or BQIS.
Frequency of Verification:
Up to 3 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Facility Based Habilitation - Group
Service Definition *(Scope):*
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.

Group Sizes:

Small Groups (4:1 or smaller);
Medium Groups (from 5:1 to no larger than 10:1); or
Large Groups (larger than 10:1 but no larger than 16:1).

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

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

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.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☑ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DDRS Approved Facility Based Habilitation Agencies
Individual	DDRS Approved Facility Based Habilitation - Individuals

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Facility Based Habilitation - Group

Provider Category:
Agency
Provider Type:
DDRS Approved Facility Based Habilitation Agencies
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
DDRS approved,
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Financial Status of Providers,
460 IAC 6-14-5 Direct Care Staff Qualifications,
460 IAC 6-14-4 Staff Training,
460 IAC 6-5-14 Health Care Coordination Services provider qualifications, and
Transportation Requirements

Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals.
Verification of Provider Qualifications
Entity Responsible for Verification:
Initially, BDDS. For re-approval, BDDS or BQIS.
Frequency of Verification:
Up to 3 years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Facility Based Habilitation - Group

Provider Category:
Individual
Provider Type:
DDRS Approved Facility Based Habilitation - Individuals
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
DDRS approved,
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Financial Status of Providers,
460 IAC 6-14-5 Direct Care Staff Qualifications,
460 IAC 6-14-4 Staff Training,
460 IAC 6-5-14 Health Care Coordination Services provider qualifications, and
Transportation Requirements

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

Verification of Provider Qualifications
Entity Responsible for Verification:
Initially, BDDS. For re-approval, BDDS or BQIS.
Frequency of Verification:
Up to 3 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Facility Based Habilitation - Individual
Service Definition *(Scope):*
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.

Allowable Ratio - 1:1

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

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.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [x] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DDRS Approved Facility Based Habilitation Agencies
Individual	DDRS Approved Facility Based Habilitation - Individuals

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Facility Based Habilitation - Individual

Provider Category:
Agency
Provider Type:
DDRS Approved Facility Based Habilitation Agencies
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
DDRS approved,
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Financial Status of Providers,
460 IAC 6-14-5 Direct Care Staff Qualifications,
460 IAC 6-14-4 Staff Training,
460 IAC 6-5-14 Health Care Coordination Services provider qualifications, and
Transportation Requirements

Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals.
Verification of Provider Qualifications
Entity Responsible for Verification:
Initially, BDDS. For re-approval, BDDS or BQIS.
Frequency of Verification:
Up to 3 years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Facility Based Habilitation - Individual

Provider Category:
Individual
Provider Type:
DDRS Approved Facility Based Habilitation - Individuals
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
DDRS approved,
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Financial Status of Providers,
460 IAC 6-14-5 Direct Care Staff Qualifications,
460 IAC 6-14-4 Staff Training
460 IAC 6-5-14 Health Care Coordination Services provider qualifications and Transportation Requirements

Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals.
Verification of Provider Qualifications
Entity Responsible for Verification:
Initially, BDDS. For re-approval, BDDS or BQIS.
Frequency of Verification:
Up to 3 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Facility Based Support Services
Service Definition *(Scope):*
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.

These services must be provided in a congregate, protective setting in groups not to exceed 16:1.

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

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.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [x] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DDRS Approved Facility Based Support Services Agencies
Individual	DDRS Approved Facility Based Support Services - Individuals

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Facility Based Support Services

Provider Category:
Agency
Provider Type:
DDRS Approved Facility Based Support Services Agencies
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
DDRS approved,
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Financial Status of Providers,
460 IAC 6-5-14 Health Care Coordination Services provider,
460 IAC 6-14-5 Direct Care Staff Qualifications,
460 IAC 6-14-4 Staff Training, and
Transportation Requirements

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Initially, BDDS. For re-approval, BDDS and BQIS.

Frequency of Verification:

Up to 3 years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Facility Based Support Services

Provider Category:

Individual

Provider Type:

DDRS Approved Facility Based Support Services - Individuals

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

DDRS approved,
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Financial Status of Providers,
460 IAC 6-14-5 Direct Care Staff Qualifications,
460 IAC 6-14-4 Staff Training,
460 IAC 6-5-14 Health Care Coordination Services provider qualifications and Transportation Requirements

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Initially, BDDS. For re-approval, BDDS or BQIS.

Frequency of Verification:

Up to 3 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Family and Caregiver Training
Service Definition *(Scope):*
Family and Caregiver Training Services provides training and education to:
(1) instruct a parent, other family member, or primary caregiver about the treatment regimens and use of equipment specified in the Individualized Support Plan; and
(2) 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
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
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

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [x] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DDRS Approved Family and Caregiver Training Agencies
Individual	DDRS Approved Family and Caregiver Training Individuals

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family and Caregiver Training

Provider Category:
Agency
Provider Type:
DDRS Approved Family and Caregiver Training Agencies
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-23-1 Family and Caregiver Training Qualifications,
460 IAC 6-14-4 Staff Training

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

Verification of Provider Qualifications

Entity Responsible for Verification:
Initially, BDDS. For re-approval, BDDS or BQIS.

Frequency of Verification:
Up to 3 years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family and Caregiver Training

Provider Category:
Individual

Provider Type:
DDRS Approved Family and Caregiver Training Individuals

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-23-1 Family and Caregiver Training Qualifications,
460 IAC 6-14-4 Staff Training

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

Verification of Provider Qualifications

Entity Responsible for Verification:
Initially, BDDS. For re-approvals, BDDS or BQIS.

Frequency of Verification:
Up to 3 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Intensive Behavioral Intervention

Service Definition *(Scope):*

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:
(a) Antecedent: a directive or request for the individual to perform an action;
(b) Behavior: a response from the individual, including anything from successful performance, non-compliance, or no response;
(c) Consequence: a reaction from the therapist, including a range of responses from strong positive reinforcement, faint praise, or a negative (not aversive) reaction; and
(d) 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.

Note: 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. • 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.

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

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

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [x] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	DDRS Approved Intensive Behavior Intervention - Individual
Agency	DDRS Approved Intensive Behavior Intervention Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Intensive Behavioral Intervention

Provider Category:
Individual

Provider Type:
DDRS Approved Intensive Behavior Intervention - Individual

Provider Qualifications

License *(specify):*
For IBI Director:

Psychologist licensed under IC 25-33, or
Psychiatrist Licensed under IC 25-22.5
Certificate *(specify):*
For IBI Case Supervisor:

IBI Case Supervisor must be BCBA or BCABA certified.
Other Standard *(specify):*
DDRS Approved
460 IAC 6-10-5-Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-14-5 Direct Care Staff qualifications,
460 IAC 6-14-4 Staff Training

Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals.
Verification of Provider Qualifications
Entity Responsible for Verification:
Initially, BDDS. For re-approval, BDDS or BQIS.
Frequency of Verification:
Up to 3 years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Intensive Behavioral Intervention

Provider Category:
Agency
Provider Type:
DDRS Approved Intensive Behavior Intervention Agency
Provider Qualifications
License *(specify):*
For IBI Director:

Psychologist licensed under IC 25-33, or
Psychiatrist Licensed under IC 25-22.5
Certificate *(specify):*
For IBI Case Supervisor:

IBI Case Supervisor must be BCBA or BCABA certified
Other Standard *(specify):*
DDRS Approved
460 IAC 6-10-5-Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-14-5 Direct Care Staff qualifications,
460 IAC 6-14-4 Staff Training

Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals.
Verification of Provider Qualifications
Entity Responsible for Verification:
Initially, BDDS. For re-approval, BDDS or BQIS.
Frequency of Verification:
Up to 3 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Music Therapy

Service Definition *(Scope):*

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.

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.

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

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.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [x] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency that Employs DDRS Approved Music Therapist
Individual	DDRS Approved Music Therapist

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Music Therapy

Provider Category:
Agency
Provider Type:
Agency that Employs DDRS Approved Music Therapist
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Certified Music Therapist by a Certification Board for Music Therapists, that is Accredited by a National Commission for Certifying Agencies.
Other Standard *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-15 Music Therapy Provider qualifications

Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals.
Verification of Provider Qualifications
Entity Responsible for Verification:
Initially, BDDS. For re-approval, BDDS or BQIS.
Frequency of Verification:
Up to 3 years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Music Therapy

Provider Category:
Individual
Provider Type:
DDRS Approved Music Therapist
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Certified Music Therapist By a Certification Board for Music Therapists, that is Accredited by a National Commission for Certifying Agencies
Other Standard *(specify):*

DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-15 Music Therapy Provider Qualifications

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

Verification of Provider Qualifications

Entity Responsible for Verification:
Initially, BDDS. For re-approval, BDDS or BQIS.

Frequency of Verification:
Up to 3 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Participant Assistance and Care

Service Definition *(Scope):*
Participant Assistance and Care (PAC) Services are provided in order to allow participants (consumers) with developmental disabilities to remain and live successfully in their own homes, function and participate in their communities and avoid institutionalization. PAC services support and enable the participant in activities of daily living, self-care, and mobility with the hands-on assistance, prompting, reminders, supervision and monitoring needed to ensure the health, safety and welfare of the participant.

Reimbursable Activities

Activities may include any task or tasks of direct benefit to the participant that would generally be performed independently by persons without developmental disabilities or by family members for or on behalf of persons with developmental disabilities.

Examples of activities include but are not limited to the following:
• Assistance with personal care, meals, shopping, errands, scheduling appointments, chores and leisure activities (excluding the provision of transportation)
• Assistance with mobility – including but not limited to transfers, ambulation, use of assistive devices
• Assistance with correspondence and bill paying
• Escorting the participant to community activities and appointments
• Supervision and monitoring of the participant
• Reinforcement of behavioral support
• Adherence to risk plans
• Reinforcement of principle of health and safety
• Completion of task list

Participating on the Individualized Support Team (IST) for the development or revision of the service plan (staff must attend the IST meeting in order to claim reimbursement)

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Parents, step-parents and legal guardians may not be paid to provide care to minor children while other relatives* or groups of relatives may provide a combined total of up to 40 hours per week in PAC services to a minor child.

Spouses may not provide paid services at all, while reimbursable waiver funded Participant Assistance and Care (PAC) services furnished to an adult waiver participant by any combination of relative(s)* and/or legal guardian (s) may not exceed a combined 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) Nephew (natural, step, adopted)
8) Niece (natural, step, adopted)
9) Parent (natural, step, adopted, in-law)
10) Sister (natural, step, half, adopted, in-law)
11) Spouse (husband or wife)
12) Uncle (natural, step, adopted)

The State has implemented a process by which the 40 hour per week limit of services to be provided by any combination of relatives may be waived. An Exception Request form (electronically located on the "Forms" webpage of the DDRS Website) may be submitted to BDDS Central Office for approval.

ACTIVITIES NOT ALLOWED

Participant Assistance and Care (PAC) services will not be provided to household members other than to the waiver participant(s)

Reimbursement is not available through Participant Assistance and Care (PAC) in the following circumstances:

• When services are furnished to a minor by the parent(s), step-parent(s), or legal guardian
• When services are furnished to a participant by the participant's spouse
• When services furnished to a minor by relatives* other than parent(s), step-parent(s) or legal guardians exceed a combined total of 40 hours per week
• When services furnished to an adult by any combination of relatives* exceed a combined total of 40 hours per week
• When Indiana Medicaid State Plan services are available for the same task(s)
• When services provided are available under the Rehabilitation Act of 1973 or section 602(16) & (17) of Individual with Disabilities Education Act
• For homeschooling, special education and related activities
• When the participant is admitted to an institutional facility (e.g., Acute Hospital, Nursing Facility, ICF/MR)
• For homemaker or maid service
• As a substitute for care provided by a registered nurse, licensed practical nurse, licensed physician, behaviorist, licensed therapist or other health professional.
• Excludes transportation

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☑ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	DDRS-Approved Participant Assistance and Care Individuals
Agency	DDRS-Approved Participant Assistance and Care agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Participant Assistance and Care

Provider Category:
Individual
Provider Type:
DDRS-Approved Participant Assistance and Care Individuals
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories
460 IAC 6-11 Financial Status
460 IAC 6-12 Insurance
460 IAC 6-14-4 Staff Training
460 IAC 6-14-5 Direct Care Staff Qualifications
Training in completion of Task List

Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals.
Verification of Provider Qualifications
Entity Responsible for Verification:
Initially, BDDS. For reapproval, BDDS or BQIS.
Frequency of Verification:
Up to 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Participant Assistance and Care

Provider Category:
Agency
Provider Type:
DDRS-Approved Participant Assistance and Care agencies
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories
460 IAC 6-11 Financial Status
460 IAC 6-12 Insurance
460 IAC 6-14-4 Staff Training
460 IAC 6-14-5 Direct Care Staff Qualifications
Training in completion of Task List

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

Verification of Provider Qualifications

Entity Responsible for Verification:
Initially, BDDS. For reapproval, BDDS or BQIS.
Frequency of Verification:
Up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Personal Emergency Response System

Service Definition *(Scope):*
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 participant'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

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
ACTIVITIES NOT ALLOWED

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

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [x] **Legally Responsible Person**

☑ **Relative**

☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DDRS Approved Personal Emergency Response System Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Emergency Response System

Provider Category:
Agency
Provider Type:
DDRS Approved Personal Emergency Response System Agencies
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
DDRS approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Financial Status of Provider,
460 IAC 6-5-18 Personal Emergency Response System Qualifications

Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals.
Verification of Provider Qualifications
Entity Responsible for Verification:
Initially, BDDS. For re-approval, BDDS or BQIS.
Frequency of Verification:
Up to 3 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Recreational Therapy
Service Definition *(Scope):*

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:
(1) improve the individual's functioning and independence; and
(2) reduce or eliminate the effects of an individual's disability.

REIMBURSABLE ACTIVITIES:
• Organizing and directing Adapted sports, Dramatics, Arts and crafts, Social activities, 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

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.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
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
• Activities delivered in a nursing facility

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [x] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	DDRS Approved Recreational Therapist
Agency	DDRS Approved Agency That Employs Approved Recreational Therapists

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Recreational Therapy

Provider Category:
Individual
Provider Type:
DDRS Approved Recreational Therapist
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:

DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-22 Recreational Therapy Provider Qualifications

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

Verification of Provider Qualifications

Entity Responsible for Verification:
Initially, BDDS. For re-approval, BDDS or BQIS.

Frequency of Verification:
Up to 3 years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Recreational Therapy

Provider Category:
Agency

Provider Type:
DDRS Approved Agency That Employs Approved Recreational Therapists

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-22 Recreational Therapy provider qualifications

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

Verification of Provider Qualifications

Entity Responsible for Verification:
Initially, BDDS. For re-approval, BDDS or BQIS

Frequency of Verification:
Up to 3 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Specialized Medical Equipment and Supplies
Service Definition *(Scope):*
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.

The Waiver Services Unit 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
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
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 $7,500.00 is available for vehicle modifications. In addition to the $7,500.00 lifetime cap, $500.00 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.

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

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [x] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DDRS Approved Medical Supply Companies, Pharmacies, Electronics/Computer Companies, Vehicle Modification Provider, Electronics Vendors
Individual	Licensed Speech/Language Therapist
Individual	Licensed/Certified Occupational Therapist

Provider Category	Provider Type Title
Individual	Licensed Physical Therapist
Agency	Home Health Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:
Agency
Provider Type:
DDRS Approved Medical Supply Companies, Pharmacies, Electronics/Computer Companies, Vehicle Modification Provider, Electronics Vendors
Provider Qualifications
License *(specify):*
IC 25-26-13-18 Pharmacy
Certificate *(specify):*

Other Standard *(specify):*
DDRS approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Financial Status of Provider,
460 IAC 6-5-27 Specialized Medical Equipment & Supplies Provider Qualifications

Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals.
Verification of Provider Qualifications
Entity Responsible for Verification:
Initially, BDDS. For re-approval, BDDS or BQIS.
Frequency of Verification:
Up to 3 years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:
Individual
Provider Type:
Licensed Speech/Language Therapist
Provider Qualifications
License *(specify):*
IC 25-35.6
Certificate *(specify):*

Other Standard *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,

460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-27 Specialized Medical Equipment and Supplies Provider Qualifications

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

Verification of Provider Qualifications

Entity Responsible for Verification:
Initially, BDDS. For re-approval, BDDS or BQIS.

Frequency of Verification:
Up to 3 years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:
Individual

Provider Type:
Licensed/Certified Occupational Therapist

Provider Qualifications

License *(specify):*
IC 25-23.5 Licensure and Certification requirements

Certificate *(specify):*

Other Standard *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-27 Specialized Medical Equipment and Supplies Provider Qualifications

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

Verification of Provider Qualifications

Entity Responsible for Verification:
Initially, BDDS. For re-approvals, BDDS or BQIS.

Frequency of Verification:
Up to 3 years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:
Individual

Provider Type:
Licensed Physical Therapist

Provider Qualifications

License *(specify):*
IC 25-27-1

Certificate *(specify):*

Other Standard *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-27 Specialized Medical Equipment and Supplies Provider Qualifications

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

Verification of Provider Qualifications

Entity Responsible for Verification:
Initially, BDDS. For re-approval, BDDS or BQIS.

Frequency of Verification:
Up to 3 years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:
Agency

Provider Type:
Home Health Agencies

Provider Qualifications

License *(specify):*
IC 16-27-1

Certificate *(specify):*

Other Standard *(specify):*
DDRS Approved
460 IAC 6-10-5-Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-27 Specialized Medical Equipment and Supplies Provider Qualifications

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

Verification of Provider Qualifications

Entity Responsible for Verification:
Initially, BDDS. For re-approval, BDDS or BQIS.

Frequency of Verification:
Up to 3 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Transportation

Service Definition *(Scope):*

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.

NOTE: Whenever possible, family, neighbors, friends or community agencies, which can provide Transportation Services without charge will be utilized.

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

Activities not allowed:

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

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [x] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DDRS Approved Transportation Provider - Agency
Individual	DDRS Approved Transportation Provider - Individual

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:

Agency

Provider Type:

DDRS Approved Transportation Provider - Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-30(b) and 6-34 Transportation,
460 IAC 6-14-5 Direct Care Staff qualifications,
460 IAC 6-14-4 Staff Training

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

Verification of Provider Qualifications

Entity Responsible for Verification:
Initially, BDDS. For re-approval, BDDS or BQIS.

Frequency of Verification:
Up to 3 years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:
Individual

Provider Type:
DDRS Approved Transportation Provider - Individual

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
DDRS Approved
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-30(b) and 6-34 Transportation,
460 IAC 6-14-5 Direct Care Staff qualifications,
460 IAC 6-14-4 Staff Training

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

Verification of Provider Qualifications

Entity Responsible for Verification:
Initially, BDDS. For re-approval, BDDS or BQIS.

Frequency of Verification:
Up to 3 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Workplace Assistance

Service Definition *(Scope):*

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.

Allowed Ratio - Individual, 1:1

REIMBURSABLE ACTIVITIES:

Direct supervision, monitoring, training, education, demonstration or support to assist with:
• Personal care while on the job or at the job site (may include 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

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

Reimbursement for Workplace Assistance Services is available only during the participant's hours of paid, competitive community employment

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
• 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 off site 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.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [x] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	DDRS Approved Workplace Assistance - Individual
Agency	DDRS Approved Workplace Assistance Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Workplace Assistance

Provider Category:
Individual
Provider Type:
DDRS Approved Workplace Assistance - Individual
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
DDRS-approved,
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Financial Status of Providers,
460 IAC 6-14-5 Direct Care Staff Qualifications,
460 IAC 6-14-4 Staff Training, and
Transportation Requirements

Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals.
Verification of Provider Qualifications
Entity Responsible for Verification:
Initially, BDDS. For re-approval, BDDS or BQIS.
Frequency of Verification:
Up to 3 years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Workplace Assistance

Provider Category:
Agency
Provider Type:
DDRS Approved Workplace Assistance Agencies
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
DDRS-approved,
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Financial Status of Providers,
460 IAC 6-14-5 Direct Care Staff Qualifications,
460 IAC 6-14-4 Staff Training, and
Transportation Requirements

Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals.
Verification of Provider Qualifications
Entity Responsible for Verification:
Initially, BDDS. For re-approval, BDDS or BQIS.
Frequency of Verification:
Up to 3 years.

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. **Provision of Case Management Services to Waiver Participants.** Indicate how case management is furnished to waiver participants (*select one*):
   - ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
   - ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.
     Check each that applies:
     - ☑ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
     - ☐ **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
     - ☐ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
     - ☐ **As an administrative activity.** *Complete item C-1-c.*

c. **Delivery of Case Management Services.** Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. **Criminal History and/or Background Investigations.** Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

a) All waiver providers who have direct contact with waiver participants (including every employee, officer, or agent involved in the management, administration or provision of services under the Support Services Waiver) must have criminal history checks.

b) As described within Appendix C, documented proof of the limited criminal history investigation is required and must be obtained from the Indiana central repository by the prospective provider agency before submitting the prospective provider's application for approval to provide services to the Division of Disability and Rehabilitative Services' (DDRS) Bureau of Developmental Disabilities Services (BDDS). The documented proof must be on file at the time of original provider approval for all current employees.

Criminal history documentation requirements for providers are specified under 460 IAC 6-10-5 "General Administrative Requirements for Providers". The scope of the limited criminal history check is within the state and shall verify that the employee, officer, or agent has not been convicted of the following under Indiana Code Title 35. Criminal Law and Procedure or Title 31. Family Law and Juvenile Law:
• A sex crime (IC 35-42-4)
• Exploitation of an endangered adult (IC 35-46-1-12)
• Failure to report battery, neglect, or exploitation of an endangered adult (IC 35-46-1-13) or abuse or neglect of a child (IC 31-33-22-1)
• Theft (IC 35-43-4), if the person's conviction for theft occurred less than ten (10) years before the person's employment application date, except as provided in IC 16-27-2-5(a)(5)
• Murder (IC 35-42-1-1)
• Voluntary manslaughter (IC 35-42-1-3)
• Involuntary manslaughter (IC 35-42-1-4)
• Felony battery
• A felony offense relating to a controlled substance

The provider shall also obtain a criminal history check from each county in which an employee, officer or agent involved in the management, administration or provision of services has resided within the three (3) years before the criminal history check is requested from the county.

c) The BDDS reviews applications for approval to provide waiver services as submitted by the prospective provider. In the absence of documented proof of the limited criminal history for each employee listed on the provider's organizational chart, the application shall not be approved.

BQIS's comprehensive survey tool directs surveyors to checks that providers complete a criminal history background check on new hires and that, per 460 IAC 6-15-2, the provider rechecks criminal history backgrounds every three years. BQIS does this on a sample basis – for every provider that the individual works with BQIS checks one staff person's record. For example, if an individual receives day program services and behavioral clinician services the surveyor will select one staff person's personnel record from each provider agency. BQIS has instructed surveyors to request the record for the staff person who works most closely with the individual. If the agency cannot provide documentation of conducting this background check they are

requested to develop a corrective action plan. Providers are encouraged to develop and implement systemic corrective actions.

b. Abuse Registry Screening. Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

- ○ **No. The State does not conduct abuse registry screening.**
- ◉ **Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

a) The Certified Nursing Assistant Abuse Registry is maintained by the Indiana State Department of Health and is available online at https://extranet.in.gov/webLookup/Search.aspx

b) Per 460 IAC 6-10-5(d), "Documentation of Criminal Histories", the state Bureau of Developmental Disabilities Services (BDDS) requires Certified Nursing Assistant Abuse Registry screenings for each direct care staff member employed by a provider of waiver services. Each provider or prospective provider is responsible for conducting the screening against the registry.

The Certified Nursing Assistant Abuse Registry documentation requirements for providers are specified under 460 IAC 6-10, "General Administrative Requirements for Providers".

c) The BDDS reviews applications for approval to provide waiver services as submitted by the prospective provider. In the absence of the report from the state nurse aid registry for each direct care staff employed by the provider, the application shall not be approved.

The Bureau of Quality Improvement Services (BQIS) includes the requirement of reviewing for documented proof of the report from the state nurse aid registry for each direct care staff employed by the provider within provider surveys to verify that this practice continues with new hires.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

- ◉ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- ○ **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

- **No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- **Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

- **The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

- **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

- **Other policy.**

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Prospective providers of SS Waiver services may apply to become a provider at any time. The application approval process is managed/performed by the DDRS Provider Relations unit. As applications are received and reviewed by the DDRS Provider Relations unit, the prospective provider is given the opportunity to respond to any questions or additional information requested. The staff is available, upon request, to discuss in person questions regarding the application. The Provider Relations unit works with the potential provider to ensure all required documentation is obtained. Once a prospective provider has been determined to have met the relevant provider requirements for the services they propose to provide, the provider is referred to Indiana's Medicaid fiscal agent to enroll as a Medicaid provider. (Medicaid enrollment is required for all waiver service providers.) When the provider is enrolled, DDRS is notified and the provider is added to the active provider database.

Under the state's administrative rules, the provider is given 15 days from the date of notice of denial to appeal. The

case is then assigned to an Administrative Law Judge for a hearing.

Information regarding the provider approval/enrollment process, provider qualifications required for particular services and other helpful information is also available to prospective services providers on the internet at DDRS website and by accessing the Indiana Medicaid HCBS Waiver Provider Manual, the Bureau of Developmental Disabilities Services help line, known as the BDDS Helpline and the Indiana Medicaid HCBS Guide for Consumers (courtesy of the Indiana Governor's Planning Council for People with Disabilities).

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Qualified Providers**
   i. **Sub-Assurances:**

      a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

      Performance Measures

      For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

      For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

      Performance Measure:
      The number and percent of new provider applicants who met state requirements to provide waiver services (by provider type). Numerator: The total number of enrolled providers who met state requirements to provide waiver services. Denominator: The total number of prospective providers who were enrolled to provide waiver services.

      Data Source (Select one):
      Other
      If 'Other' is selected, specify:
      Prospective provider review list

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
The number and percent of waiver providers who continue to meet waiver requirements for re-approval. Numerator: The total number of waiver providers who continue to meet waiver requirements for re-approval Denominator: The total number of waiver providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider re-approval process

Responsible Party for data	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

collection/generation *(check each that applies):*		
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of provider corrective action plans (CAPs) completed within specified time frames. Numerator: The total number of providers whose corrective action plans (CAPs) were implemented within stipulated timeframes. Denominator: The total number of providers required to complete CAPs.

Data Source (Select one):
Other
If 'Other' is selected, specify:
BQIS

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of provider applicants who conduct criminal background checks as required for approval and re-approval. Numerator: Total number of provider applicants who conducted criminal background checks. Denominator: Total number of provider applicants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider relations tracking system

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of approved provider applicants that conduct criminal background checks as required for approval and re-approval. Numerator: Total number of approved providers that conducted criminal background checks. Denominator: Total number of approved providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
STMS – provider compliance component

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified**

		Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of SS Waiver providers who meet waiver training requirements. Numerator: The total number of waiver providers who met training requirements. Denominator: The total number of waiver providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Comprehensive Survey Tool (CST)/Provider Compliance Portion

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Quality contractor	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: Every provider will be reviewed once every 3 years. Providers will be reviewed in the order in which their certification as a provider expires.
	☐ **Other**	

Specify:

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: Quality contractor	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
As individual instances of provider problems are identified, either during the process of provider reviews or as a result of a complaint investigation, providers are required to develop a corrective action plan (CAP) to address their identified deficits. BQIS staff work with BDDS provider relations staff to ensure providers are contacted, engaged in understanding requirements and deficiencies and the process for developing and submitting a CAP for each identified instance of unsatisfactory performance.

BQIS reviews and approves corrective action plans and validates that providers are implementing these as stated. All provider survey information required to support the survey process is included within the web-based automated system built by the state. In use since October 1, 2009, the fully operational automated system allows the providers access to insert their corrective actions directly into the database.

Noncompliant providers are referred to the BQIS and BDDS Directors for follow-up action, which may include being referred to the sanctions committee. Sanctions may include a freeze on serving additional participants, temporary suspension as a provider or termination of the Medicaid waiver provider agreement.

In regard to Complaint Investigations, which differ from Incident Reports fully described in Appendix G-1-b, BQIS continually prioritizes complaints so those that have very serious concerns about an individual or group of individuals' health and welfare being at risk are addressed first. When BQIS initially learns of such allegations, a visit is made to the individual(s) within 24 hours. If BQIS complaint investigators cannot travel to the site in this time frame, BQIS asks the local district BDDS office, or the case manager to visit the site and check on individuals' health and safety.

If issues are identified where consumers' health and welfare is at risk, BQIS will convey those issues and direct the provider to remediate the issue immediately and will follow-up until such action is validated.

BQIS will issue the official report within 25 days of receiving the allegations. Adult Protective Services is involved as needed. The Case Manager is to be contacted and the Individualized Support Team will meet on an as needed basis to address these issues.

DDRS is maintaining its oversight responsibilities for accredited providers as follows:
- DDRS is working closely with each of the accreditation entities to crosswalk the accreditation entity's standards to BQIS's compliance evaluation review tool which is based on IAC 460 regulations and DDRS policies. Accreditation entities have agreed to adjust their survey activities to capture any sections not reflected in their standards and to provide the data necessary for the state's CMS performance measures related to provider qualifications.
- These agreements will be finalized via State Memo prior to the end of the current CERT review cycle in 2013. Currently, all providers have received a CERT review and are not due for subsequent CERT reviews until November 2013. At that point in time, DDRS will be accepting providers' accreditation status in lieu of a CERT review.
- DDRS's provider agreements require providers to share copies of their accreditation survey report and any resulting quality improvement plans. Through the review of these reports, BQIS will follow up with providers to assure that identified performance issues are addressed on a timely basis. Without regard to accredited status, BQIS can and will intervene and require corrective action plans when necessary.
- BQIS will continue to conduct compliance evaluation reviews on all non-accredited services. For providers that provide multiple services, this means being subject to the accreditation entity's review for their day program, and any other services they wish to accredit, and to BQIS compliance reviews for all other services they provide, e.g., residential, respite, music therapy.
- BQIS is maintaining all of its other monitoring activities, including conducting complaint investigations and managing the incident reporting system, for all providers – both non-accredited and accredited.
- BQIS will be conducting compliance evaluation reviews on all newly approved providers within their first year of being approved.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. **Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

- ○ **Not applicable** - The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- ◉ **Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☑ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

Waiver expenditures are capped at $16,250.00 annually.
• The limit applies to the total cost of all waiver services authorized on the POC/CCB for a one year period.
• This limit serves as both an individual cost limit that limits enrollment of individuals to those whose projected annual cost for waiver services as specified in the initial POC/CCB is expected to be less than or equal to $16,250 and as a prospective individual budget amount for participants whose needs change during the year and whose costs increase approaching or reaching the $16,250 limit.

Participants are notified of the cost limit at the time of application for enrollment into the SS Waiver and during the development of their POC/CCB (both initial and updated). Case managers and service coordinators, as appropriate, are responsible for informing the applicant/participant of the cost limit.

Should this limit appear to be inadequate to accommodate changes in participants' needs during the approved waiver period, the state will submit a waiver amendment seeking to adjust the limit.

In the event a participant has a change in needs that will result in their waiver services costs exceeding the limit, the state will:
• Evaluate the participant for enrollment into another waiver operated by the Division of Disability and

Rehabilitative Services when the participant meets the specific reserved capacity criteria for entrance to the waiver;
• Evaluate the participant to determine if they appear to meet the eligibility criteria for participation under another waiver program operated by another Division, such as a waiver requiring Nursing Facility Level of Care and operated by the State's Division of Aging and complete a referral to the Division of Aging when the participant appears to meet criteria or upon participant request;
• Evaluate the feasibility of providing additional supports and services from other sources.

In any situation, provider of case management services, with support from the participant selected Individualized Support Team, is required to identify, inform, assist and ensure that the participant accesses and receives all Medicaid State Plan services to which he or she is entitled, as well as to ensure other available supports and community resources including natural supports are accessed as needed.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☑ **Other Type of Limit.** The State employs another type of limit.
Describe the limit and furnish the information specified above.

Vehicle Modifications (a component of Specialized Medical Equipment and Supplies)has a lifetime limit of $7,500.00. In addition to the $7,500.00 lifetime cap, $500.00 will be allowable annually for repair, replacement, or an adjustment to an existing modification that has been provided through the HCBS waiver.

Family and Caregiver Training reimbursement is limited to no more than $2,000 a year.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:
Plan of Care/Cost Comparison Budget (CCB)

a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

☐ **Registered nurse, licensed to practice in the State**

☐ **Licensed practical or vocational nurse, acting within the scope of practice under State law**

☐ **Licensed physician (M.D. or D.O)**

☑ **Case Manager** (qualifications specified in Appendix C-1/C-3)

☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
Specify qualifications:

☐ **Social Worker.**
Specify qualifications:

☐ **Other**
Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

- (●) **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

(a) The Plan of Care/Cost Comparison Budget (CCB) is developed within the Person-Centered Plan/Individualized Support Plan (PCP/ISP) Annual meeting. The participant and/or family or legal representative are present during this meeting. The Person-Centered Plan drives the Individualized Support Plan, which ultimately drives the Plan of Care/Cost Comparison Budget. (The Person-Centered Plan identifies the participant's preferences and includes what outcomes the participant wants to accomplish within a given year.) The Individualized Support Plan outlines the participant's identified outcomes and health & safety needs. The ISP is the service plan that identifies the array of services and supports, paid and unpaid from all sources that will be utilized to implement desired outcomes and ensure the participant's health and welfare while the CCB identifies those supports and services which are funded by the waiver.

(b) The participant designates the persons they wish to participate in the development of their PCP/ISP and CCB. The Case Manager is then responsible for inviting the selected persons to the meeting.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

(a)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.

(b) Person-Centered Plan/Person-Centered Description: 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 case managers are to be trained in person-centered thinking and be PCD/ISP certified.

Health and safety indicator: This 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.

(c) The participant is informed of available Autism 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 Autism Waiver and is responsible for providing the participant with information about each covered service, its definition, scope and limitations.

(d) 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 for waiver services. The case manager then finalizes the ISP and completes the CCB.

(e) 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.

(f) 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.

(g) 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.

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.

Early each month, the Division of Disability and Rehabilitative Services' (DDRS) Central Office runs and the Case Management Liaison monitors a monthly "dry run" report identifying participants whose annual CCB is due to expire and therefore subject to the creation of a potential default CCB. Later in the month, the actual CCB Default Report is generated, sorted and distributed to the appropriate case management agency or agencies for remediation. Remediation is expected to occur within seven (7) business days at which time the completed report is due to be returned to the DDRS Central Office for verification of remediation. The Liaison discusses these findings and any other relevant issues with the case management provider(s) as needed. These findings are also shared with DDRS Executive Management and the State Medicaid Agency, the Office of Medicaid Policy and Planning.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. **Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Risks are assessed based upon the following processes:

Prior to the annual meeting, the Case Manager meets with the participant and/or family members and/or legal representative to identify and/or confirm health and welfare needs. (The Meeting Issues & Requirements section of the Individualized Support Plan and the high risk assessment are reviewed during this interview.) The results of this interview are reviewed with the IST at the annual meeting.

High Risk Assessment: Individualized Support Teams complete a risk assessment document for each participant they serve. The risk issues (i.e. health, behavioral, physical management, and environmental management) identified through the assessment are then addressed through the agency and potentially through coordination with participant chosen specialists addressing the various high risk needs.

Any risk issues identified are addressed through participant-specific risk plans to proactively and reactively address the risk issue. The IST reviews the risk issues at the annual meeting and ensures that the risk plans are identified in the Individualized Support Plan, which drives the CCB. The CCB addresses risk areas specifically in the Emergency Back-Up section of the Cost Comparison Budget.

Providers of case management services use a health and safety indicator assessment tool during initial assessment, annually and when there is a change in the participant's status. The outcomes of the assessment are used to guide development of the participant's risk plan or to review and revise the risk plan as appropriate.

The State provides risk management training and health assurance training to individual providers on an as needed basis. At any time, a provider may request additional training by the State.

It is the Case Managers responsibility to monitor individuals' risks and the state's role to oversee case management activities. BDDS monitors Case Managers by reviewing documentation on the individuals that they work with. This includes review of how case managers followed up on incident reports, and review of information gathered from case managers' routine visits, where they will have reviewed and how providers are implementing an individuals' risk management plans.

When participants receive waiver services in their own homes the service plan must include a back-up plan to address contingencies such as emergencies, including the failure of a direct caregiver to appear when scheduled to provide necessary services. Back-up plans are specified within the CCB and include contacting the case management provider's 24/7 line for assistance, and may include contingency arrangements such as telephone calls to family, friends, neighbors, police or 911 emergency responders, walking to the home of a neighbor, or the use of a Personal Emergency Response System when approved on the participant's IST. Providers of case management services maintain a 24/7 emergency response system that does not rely upon the area 911 system and provides assistance to all participants of the Family Supports Waiver, formerly known as the Support Services Waiver. The 24/7 line staff assist participants or their families with addressing immediate needs and contact the participant's case manager to ensure arrangements are made to address the immediate situation and to prevent reoccurrences of the situation.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. **Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

An electronic database is maintained by the operating agency that contains information regarding all qualified waiver providers for each service on the Family Supports Waiver, formerly known as the Support Services Waiver. Case Managers are able to generate a list of all qualified providers for each service on the waiver for the participant's use. Case Managers can assist the participant with interviewing potential providers and obtaining references on potential providers, if desired by the participant.

The participant can request a change of any service provider at any time while receiving Family Supports Waiver services. The Case Manager will assist the participant with obtaining information about any and all providers available for a given service.

Case Managers are not allowed to give their personal or professional opinion on any waiver service provider. The case manager is responsible for the coordination of the transition of a provider once determined by the participant.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. **Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The Indiana Office of Medicaid Policy and Planning (OMPP) retains responsibility for service plan approvals made by the Division of Disability and Rehabilitative Services (DDRS) as defined in the MOU.

For purposes of oversight and quality control, OMPP will annually complete a review of a sample of applications and plans of care. As part of this annual sample, OMPP may request additional documentation from DDRS, the participant, the family/guardian or providers as necessary in order to make a determination regarding the adequacy and appropriateness of reviewed plans of care. OMPP will address any adverse findings from this review with DDRS by 1) ensuring the specific plans of care are referred to DDRS for revision to remedy and shortcomings 2) seeking a plan of action to address any issues that appear to be systemic and 3) monitoring implementation of plans of action to sneure satisfactory progress and completion.

The OMPP reviews and approves the policies, processes and standards for developing and approving plans of care for the Family Supports Waiver, formerly known as the Support Services Waiver.

In the instance of receipt of a complaint against DDRS from a DDRS provider, participant, family, or guardian, the POC is submitted to DDRS and is available for OMPP review.

The Medicaid agency retains administrative authority and may overrule the approval or disapproval of any specific POC CCB acted upon by the DDRS.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. **Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ○ **Every twelve months or more frequently when necessary**
- ◉ **Other schedule**

Specify the other schedule:

The plan is updated a minimum of every 365 days. The Individualized Support Plan and the Plan of Care/Cost Comparison Budget are reviewed formally a minimum of every 90 days. The participant can request a change to the Plan of Care/Cost Comparison Budget at any time.

i. **Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☐ **Medicaid agency**
- ☑ **Operating agency**
- ☐ **Case manager**
- ☑ **Other**

Specify:

Electronic documents of the Plan of Care/Cost Comparison Budget are maintained in the operating agency's data system for a minimum of 3 years.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. **Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

Case Managers are responsible for the implementation and monitoring of the service plan (ISP, POC/CCB) 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 90 Day Checklist continues to be under review for additional enhancement. The original process was changed to incorporate interviews with the participant prior to the annual meeting wherein the participant is asked about his/her satisfaction with current services. Following the participant interview, the entire support team meets to ensure everything is in place for the participant. That change, and any future enhancements, ensures that the 90 day review

is as meaningful as possible.

The case manager is required to enter a weekly case note indicating the progress and implementation of the POC. 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 POC 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.

At all times, full, immediate and unrestricted access to the individual's 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.

The Comprehensive Survey Tool (CST) will be used to review approximately 363 Family Supports Waiver (formerly known as the Support Services Waiver) service plans annually. The Bureau of Quality Improvement Services will utilize the tool to assess consistency of waiver Plan of Care/Cost Comparison Budget content with the Individualized Support Plan. Details of the CST are explained in Appendix G.

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 were not yet identified.
•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 Management supervisors, directors or other identified executive management staff within each case management provider 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 Consumer Outcome Measurement Tool (COMT), and communicated to the noncompliant entity for resolution. Case Management supervisors, directors or other identified executive management staff within each case management provider organization monitor this tool on no less than a monthly basis to ensure follow up and completion of all identified outcomes for each participant.

Complaints
Upon receipt of a complaint from a participant or a reporter acting on a participant's behalf, the case manager investigates, and provides the participant and reporter with a determination of findings within two weeks of the date of receipt of the complaint. That determination is to be provided in writing and in the participant's usual mode of communication.

If the allegation is of abuse, neglect, exploitation, mistreatment of a participant, or violation of a participant's rights, case managers take all necessary steps to ensure the safety of the participant. Any identified incidents related to the health and safety of a participant or that involves alleged or observed abuse, neglect, exploitation, mistreatment of a participant, or violation of a participant's rights are reported to the DDRS via the state Incident Reporting system.

Reporting to the state's protective services agencies also occurs in accordance with protective services reporting procedures.

Case managers review all filed incident reports, work with the provider to file any missing reports, and file all needed follow up reports at seven (7)-day intervals until the situation is determined to be closed by the Division of Disability and Rehabilitative Services (DDRS). The Case Management supervisors, directors or other identified executive management staff within each case management provider organization monitor the timeliness of follow up on incident reports by the case managers.

Upon receipt of information regarding ongoing, systemic behaviors on the part of a provider of service that are not in accordance with established standards of practice, the Case Manager will:

•Attempt to resolve the issue verbally with the provider in question
•If no resolution is made, put the issue in writing to the provider If then no resolution is made, bring the issue to the attention of the local Bureau of Developmental Disabilities (BDDS) Service Coordinator.

If there is still no resolution, file an incident report with the DDRS.

Problems as identified within the 90 Day Review Checklist are reviewed for follow up and closure a minimum of quarterly by the Case Management supervisors, directors or other identified executive management staff within each case management provider organization. Issues are initially addressed within the scope of the team and provider agency, and are escalated to the DDRS via mediation with the BDDS Service Coordinator, or via an incident report should the problems prove to be systemic and/or otherwise not resolvable at the case management level.

Untimely and/or incomplete progress as indicated on the COMT progress note system are reviewed monthly by the Case Management supervisors, directors or other identified executive management staff within each case management provider organization. Issues are initially addressed within the scope of the team and provider agency, and are escalated to the DDRS via mediation with the BDDS Service Coordinator, or via an Incident Report should the problems prove to be systemic and/or otherwise not resolvable at the case management level.

b. **Monitoring Safeguards.** *Select one:*

- (●) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Service Plan Assurance/Sub-assurances**
   i. **Sub-Assurances:**

      a. ***Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

         Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of participants who had all necessary information/assessments to identify their needs and abilities. Numerator: Total number of sampled participants who had information/assessments to identify their needs and abilities. Denominator: Total number of participants sampled.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Comprehensive Survey Tool (CST)

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of participants who had a risk assessment. Numerator:Total number of participants who had a risk assessment. Denominator:Total number of participants sampled.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Comprehensive Survey Tool (CST)

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of sampled participants whose plans address their individual goals and preferences. Numerator: Total number of sampled participants whose plans address their individual goals and preferences. Denominator: Total number of participants sampled.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Comprehensive Survey Tool (CST)

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified**

		Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of participants whose plan addressed their assessed needs and risks. Numerator: Total number of participants whose plan addressed their assessed needs and risks. Denominator: Total number of participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Comprehensive Survey Tool (CST)

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	

		☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of participants whose plans were developed based on state policies and procedures. Numerator: Total number of participants whose plans were developed based on state policies and procedures. Denominator: Total number of participant plans sampled.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Comprehensive Survey Tool (CST)

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of participants whose plans were reviewed and changed (as needed) when their needs changed. Numerator: Total number of participants plans that were reviewed and changed (as needed) when their needs changed. Denominator: Total number of participants sampled whose needs changed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Comprehensive Survey Tool (CST)

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	

		☑ **Representative Sample** Confidence Interval = 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of service plans that were updated/revised within 365 days of the previously approved annual CCB. Numerator: Total number of participants whose plans were updated/revised within 365 days of previously approved annual CCB. Denominator: Total number of waiver participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Comprehensive Survey Tool (CST)

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of participants who received the services and supports in their plans in the stipulated type, scope, amount, duration and frequency. Numerator: The total number of sampled participants who received the services and supports in their plans in the stipulated type, scope, amount, duration and frequency. Denominator: Total number of participants sampled.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Comprehensive Survey Tool (CST)

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other**

		Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

e. ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of newly enrolled participants who were afforded a choice between waiver services and institutional care. Numerator: Total number of newly enrolled waiver participants whose record documented they were afforded a choice between waiver services and institutional care. Denominator: Total number of newly enrolled waiver participants.

Data Source (Select one):
Other

If 'Other' is selected, specify:

Comprehensive Survey Tool (CST)

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*

Performance Measure:
Number and percent of waiver participants who were afforded a choice of waiver services and providers (reported separately for each). Numerator: Total number of sampled participants who were afforded a choice of waiver services and providers (reported separately for each). Denominator: Total number of participants sampled.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Comprehensive Survey Tool (CST)

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
As identified in the sub-assurances of this appendix the BQIS comprehensive survey tool (CST) includes performance indicators related to participant planning and service delivery. The CST contains a total of 35 performance indicators which each represent a set of related waiver regulations. Indicators are designed to provide a signal as to how the waiver service delivery system is impacting the participant. BQIS selects a random sample of participants to participate in the review process.

When surveyors identify that an indicator is not met for a particular sampled participant the provider(s) is required to develop a corrective action plan to address the issue.

BQIS reviews and approves corrective action plans and validates that providers are implementing these as stated. Providers have two opportunities to develop acceptable corrective action plans (CAPs). Providers that are noncompliant or that do not implement their corrective actions as stated are referred to the BQIS and BDDS Directors. Follow-up action may include being referred to the sanctions committee.

All information required to support the survey process is included within the web-based automated system built by the state. In use since October 1, 2009, the fully operational automated system allows the providers access to insert their corrective actions directly into the database.

ii. Remediation Data Aggregation
Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **Other** Specify: Contractor of Case Management services	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

- (●) **No**
- ( ) **Yes**
  Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

- ( ) **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- (●) **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- ( ) **Yes. The State requests that this waiver be considered for Independence Plus designation.**
- ( ) **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice (s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

During the Bureau of Developmental Disabilities Services' (BDDS) Intake and Assessment Process, the applicant for services under the Family Supports Waiver, formerly known as the Support Services Waiver, (or his/her legal representative) is advised of all available service options as well as their appeal rights in regard to each decision. The BDDS Service Coordinator (SC) provides Intake Case Management Services, which includes offering an eligible applicant the feasible alternatives available under the Family Supports Waiver and the choice between institutionalization or home and community-based services as described in Appendix B-7a.

Following is a description of how the individual (and/or legal representative) is offered the opportunity to request a Fair Hearing under 42 CFR PART 431, SUBPART E:

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). 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 POC/CCB and the POC/CCB is authorized by 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.

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.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. **Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

   - ○ **No. This Appendix does not apply**
   - ◉ **Yes. The State operates an additional dispute resolution process**

b. **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The Indiana Division of Disability and Rehabilitative Services (DDRS) operates a separate dispute resolution process in addition to the formal, federally-required Hearings and Appeals process. In general, this process is available when there are disagreements about service provision. Resolution of the dispute is designed to address the participant's needs. Any issues that involve a participant's health and welfare are not addressed through the dispute resolution process but are instead immediately referred to the Bureau of Quality Improvement Services (BQIS) for action in order to ensure participant health and welfare.

The Indiana Administrative Code 460 IAC 6-10-8, "Resolution of Disputes" clarifies the responsibilities and timeframes for all parties involved in a dispute. While this process was designed to handle disputes between providers in those situations where the Individualized Support Team (IST) cannot come to agreement on how best to meet the needs of the participant, the Dispute Resolution process is available.

Under these circumstances, involved parties are required to submit their issues in writing to the IST. If providers on the IST are in agreement, and the participant or family member is not, the Case Manager (CM) must represent the participant in the Dispute Resolution process. If the team is unable to come to agreement on a decision within fifteen days, the dispute is referred to the appropriate Bureau of Developmental Disabilities (BDDS) Service Coordinator (SC) within the DDRS. Dispute resolution focuses on ensuring that decisions are in accordance with the participant's desired outcomes as included in the Individualized Support Plan (ISP) and the health and welfare needs of the participant.

The SC is required to make a decision on the issue within fifteen days of the referral. Written notice is given to relevant parties. Any party adversely affected by the decision may request DDRS Administrative Review of the decision. While the dispute resolution process is available for teams to use, it is not required before a participant or guardian can file the request for a Medicaid Fair Hearing. The CM is responsible for the monitoring of services and ensuring that the participant understands that the dispute process is in no way a pre-requisite or substitute of the participant's right to Appeal or request a Fair Hearing (460 IAC 6-19-4 Distribution of Information and 6-19-6 Monitoring of Services).

The dispute resolution process is not the appropriate avenue for addressing situations resulting from a HCBS waiver provider's unilateral actions that endanger the health or welfare of a participant such that an emergency exists. Under these circumstances, BDDS takes actions to protect the health and welfare of the participant as described in rule 460 IAC 6-7-4, "Serious Endangerment of the Individual's Health and Safety (Welfare)".

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. **Operation of Grievance/Complaint System.** *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. **Operational Responsibility.** Specify the State agency that is responsible for the operation of the grievance/complaint system:

The operating agency, the Division of Disability and Rehabilitative Services (DDRS), operates a separate complaint process system through the Bureau of Quality Improvement Services (BQIS) [established in Indiana Code, IC 12-12.5] operating in conjunction with the Bureau of Developmental Disabilities Services (BDDS) [established in IC 12 -11-1.1] and in addition to the formal, federally required Hearings and Appeals process.

The operating agency, DDRS, also employs a statewide waiver ombudsman, independent of both the BQIS and the BDDS, for the benefit of participants with a developmental disability who are receiving services under the waiver and wish to file a complaint. (Indiana Code [IC 12-11-13]),

c. **Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

(a)TYPES OF GRIEVANCES/COMPLAINTS PARTICIPANTS MAY REGISTER:

BQIS accepts a broad range of complaint allegations which include but are not limited to: services not being provided according to an individual's support plan, environmental issues, human rights issues, financial issues, lack of staffing, lack of health care coordination, documentation issues, staff not being trained.

Complaints may have been reported through the state's incident reporting system and the guardian/family member is not satisfied with the resulting follow-up actions.

(b) and (c) PROCESS, TIMELINES AND MECHANISMS FOR ADDRESSING GRIEVANCES/COMPLAINTS:

DDRS's complaint process is not intended to replace the waiver's other systems to assure individuals' health and welfare (e.g., case management system, incident reporting system), but instead to provide an additional venue for issues to be addressed when the day-to-day monitoring systems have been ineffective, or appear to be ineffective. In order to give the system an opportunity to work, BQIS encourages complainants with individual-specific issues to approach their case managers to try and resolve the issue first. If this has not produced the desired outcome BQIS will initiate a complaint investigation.

The BQIS Field Director of Quality Assurance (FDQA) reviews and categorizes all initial complaints as urgent, critical, or non-critical and assigns a Quality Assurance Monitor (QAM) to investigate the case within identified time parameters.

Issues deemed of an urgent nature are followed-up on as soon as possible or no later than 24 hours. If BQIS cannot visit the individual within this timeframe, FDQA will request a case manager or BDDS service coordinator who is geographically closer to the individual to make this initial visit. When investigating urgent complaints QAMs will not leave the home until the individual's health and welfare has been secured. This may mean contacting Adult Protective Services/Child Protective, local law enforcement, and/or the provider to come to the home and take necessary measures to assure the individual's health and welfare. BQIS follows-up on complaints of a critical or non -critical nature within the identified targets below. All activities related to complaint investigations are completed unannounced.

Depending on the nature of the complaint QAMs' investigation activities could 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.

All investigation activities are entered into the complaints database.

BQIS uses a standardized template to document and report:
- allegations received,
- allegations substantiated/not substantiated,
- for substantiated allegations:
  - o explanations of the evidence obtained that validates the allegation,
  - o regulations that the provider is not in compliance,
  - o key points being requested as part of the provider's corrective action plan (CAP); and
  - o due dates for submitting the CAP.

QAMs send providers the completed CAP template. The BQIS Director is copied on all communications related to complaint investigations. All complaint communications are sent to providers electronically and in hard copy through the US Mail.

Upon receipt, the QAM reviews the CAP to determine its acceptability and uses the standardized CAP template to report whether each item in the CAP is accepted/not accepted. As necessary, the QAM will provide an explanation as to why any parts of the CAP are not accepted and identify a new due date to re-submit its CAP with the appropriate changes. The CAP template is again returned to the provider.

When the provider has produced an acceptable CAP, BQIS will validate that the provider is implementing the CAP as it has been communicated to the state. BQIS gives providers two opportunities to validate that they are implementing their CAP and as a result, that involved individual(s) are experiencing positive outcomes. Validation

activities will vary depending on the specific issues identified in the CAP but may include:
• conducting site visits
• conducting interviews with involved individual(s) and/or staff, guardians, family members, and any other involved entities
• review of individual(s) case record (i.e., individual service plan, behavior support plans, supporting tracking forms, risk plans, medication administration records,
• review of provider policy and procedures

QAMs document the results of all validation activities in the standardized CAP template and share with providers. QAMs refer providers to the DDRS Sanctions Committee for possible sanctions after providers have had two opportunities to validate implementation of their CAP and have failed to do so. BQIS closes complaints when any CAPs that have resulted from the investigation have been accepted and validated.

All actions related to complaint investigations are entered and tracked in the complaint database.

TARGETS FOR COMPLETING COMPLAINT INVESTIGATIONS:

URGENT:
• Within 25 days, QAM will receive complaint investigation assignment, initiate investigation's discovery activities, and either request the provider to submit a CAP or close the investigation as unsubstantiated.
• Within 10 days, QAM receives the provider's CAP, reviews it, documents their decision, and communicates to the provider CAP accepted/not accepted.
• Validate CAP within 5 days of targeted validation date

CRITICAL:
• Within 30 days, QAM will receive complaint investigation assignment, initiate investigation's discovery activities, and either request the provider to submit a CAP or close the investigation as unsubstantiated.
• Within 12 days, QAM receives the provider's CAP, reviews it, documents their decision, and communicates to the provider CAP accepted/not accepted.
• Validate CAP within 10 days of targeted validation date

NON-CRITICAL:
• Within 60 days, QAM will receive complaint investigation assignment, initiate investigation's discovery activities, and either request the provider to submit a CAP or close the investigation as unsubstantiated.
• Within 17 days, QAM receives the provider's CAP, reviews it, documents their decision, and communicates to the provider CAP accepted/not accepted.
• Validate CAP within 15 days of targeted validation date

The 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 particpant 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 forindividuals 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 Indiana's Developmental Disabilities Commission. 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 described in Appendix F-1.

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.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. **Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*
  If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

b. **State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

As indicated in 460 IAC 6-9-5 Incident reporting and as further defined in the Bureau of Developmental Disabilities Services (BDDS) Incident Management/Reporting Policy, reportable incidents are any event or occurrence characterized by risk or uncertainty resulting in or having the potential to result in significant harm or injury to a

participant or death of a participant. Specific critical incidents that must be reported are as follows:

1)Alleged, suspected or actual abuse, neglect or exploitation of a participant. An incident in this category must also be reported to Adult Protective Services or Child Protective Services. In cases where staff is involved, the provider shall suspend staff involved in an incident from duty pending investigation by the provider.

a)Physical abuse includes:

i) intentionally touching another person in a rude, insolent or angry manner;
ii) willful infliction of injury;
iii) unauthorized restraint or confinement resulting from physical or chemical interventions;
iv) rape.

b)Verbal and Psychological abuse includes:

i) communicating with words or actions directed to or made about a participant in that person's presence with the intent to:

a) cause the person to act against their will;
b) cause the person to be placed in fear of retaliation;
c) cause injury to the person or cause damage to the person's property;
d) cause the person to be subject to confinement or restraint;
e) cause the person to react in a negative manner; or
f) cause hatred, contempt, disgrace, humiliation, emotional distress or ridicule to the person.

c)Sexual abuse includes unwanted or forced sexual activity, sexual molestation, sexual misconduct, sexual coercion and sexual exploitation.

d)Domestic abuse occurs when a spouse, cohabitant/non-married intimate partner attempts to physically or psychologically dominate another. Domestic violence includes physical violence, sexual abuse, emotional abuse, intimidation, economic deprivation, and threats of violence.

e)Neglect includes but is not limited to failure to provide appropriate supervision, training, clean and sanitary environment, appropriate personal care, food, medical services including routine medical and specialty consultations, or medical supplies or safety devices to a participant as indicated in the Participant's Plan.

f)Exploitation includes but is not limited to unauthorized use of the personal services, the property or the identity of a participant; any other type of criminal exploitation for one's own profit or advantage or for the profit or advantage of another.

g)Peer to peer aggression includes willful intent to inflict physical harm.

2)Death of a participant. All deaths must be reported to Adult Protective Services or Child Protective Services. If the death is a result of alleged criminal activity, the death must be reported to law enforcement.

3)A service delivery site that jeopardizes the health or welfare of a participant while the participant is receiving services from the following causes:

a)A significant interruption of a major utility, such as electricity, heat, water, air conditioning, plumbing, fire alarm, carbon monoxide alarm or sprinkler system;

b)Environmental or structural problems associated with a service site that compromises the health or welfare of a participant, including but not limited to inadequate sanitation, serious lack of cleanliness, rodent or insect infestation, structural damage or failure, damage caused by flooding, tornado or other acts of nature, or environmental hazards such as toxic or noxious chemicals.

4)Fire, residential or service delivery site (e.g., day services), resulting in health or welfare concerns for a participant receiving services. This includes but is not limited to relocation, personal injury, or property loss.

5)Elopement of a participant that results in evasion of required supervision as described in the Participant's Plan as necessary for the participant's health and welfare.

6)Alleged or actual criminal activity by a participant receiving services and/or a direct support professional staff, employee, contractor or agent of a provider when the participant's services or care are affected or potentially affected; the activity occurred at a service site or during service activities; or the participant was present at the time of the activity.

7)Any physical symptom, medical or psychiatric condition or event requiring emergency intervention.

8)A new diagnosis of any chronic condition impacting the participant or requiring medical follow-up.

9)Injury to a participant when:

a)The origin or cause of the injury is unknown;

b)The injury could be indicative of abuse, neglect or exploitation; or

c)The injury requires medical evaluation or treatment.

10)A significant injury to a participant including but not limited to:

a)Fracture;

b)Burn (including sunburn) requiring more than first aid;

c)Choking that requires intervention (including but not limited to Heimlich maneuver, finger sweep)

d)Contusions larger than a quarter or a pattern of contusions;

e)Lacerations which require more than basic first aid;

f)Any occurrence of skin breakdown related to any decubitus ulcer;

g)Any injury that occurs while a participant is restrained;

h)Any injury which requires more than basic first aid.

11)A medication error or medical treatment error, except for refusal to take medications, that jeopardizes a participant's health and welfare, as determined by the participant's personal physician including but not limited to the following:

a)Medication given or treatment provided that was not prescribed or ordered for the participant;

b)Failure to administer medication or medical treatment as prescribed.

12)Use of any PRN medication related to a participant's behavior.

13)Seclusion by placing a participant alone in a room or other area from which exit is prevented.

14)Prone restraint.

15)Aversive technique.

Anyone responsible for providing services and/or supports is required to report incidents. This includes but is not limited to the following:

- Direct service providers (e.g., residential, day services, behavior support, etc.)
- Case managers
- BDDS staff
- BQIS staff

Incident reports are to be submitted within 24 hours of the occurrence of the incident or the reporter becoming aware

of or receiving information about the incident.

BQIS uses a web-based system to report and manage incident reports. All incident reports are to be submitted using this web-based system but there is also an email address that is used as a back-up in the event of network malfunction. While providers encourage their staff to report incidents through their own internal systems, anyone with an internet connection can report an incident through the state's system.

c. **Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Case Managers are required annually to educate participants on identifying and reporting incidents of abuse, neglect, and exploitation.

In accordance with Indiana waiver regulation 460 IAC 6-16-3(b)(4), when the Bureau of Quality Improvement Services (BQIS) conducts its comprehensive survey, information about whether this training occurred is assessed by talking with the participant and their family members. The expected outcome of a participant receiving this training would be for the participant to be able to 1) recognize when they are not being treated as they would like; and 2) communicate this information to someone to report it (i.e., family member, provider, case manager, BDDS service coordinator).

At intake and annually case managers have discussions with participants about how to identify and report abuse, neglect, and exploitation. At these meetings case managers provide participants a copy of the grievance procedure and "A GUIDE FOR INDIVIDUALS WORKING WITH THE BUREAU OF DEVELOPMENTAL DISABILITIES SERVICES."

This guide communicates to participants what their rights are as recipients (participants) of waiver services. Examples of the participant rights identified in the guide include:

•You have the right to be informed of your rights at least annually and in a manner in which you can understand.
•You have the right to be free from physical punishment and painful treatment.
•You have the right to be free from abuse, neglect, exploitation or mistreatment.
•You have the right to not be placed in a room or other area from which exit is prevented.
•You have the right to be treated with dignity and respect.

Participants are required to sign and date that they received the grievance procedure and the above mentioned BDDS "A GUIDE FOR INDIVIDUALS WORKING WITH THE BUREAU OF DEVELOPMENTAL DISABILITIES SERVICES".

d. **Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

BQIS is responsible for the oversight of the incident reporting system, which includes receiving and evaluating all incident reports.

Incident reviewers use the web-based complaint and incident reporting systems to evaluate each of the incident reports to determine whether or not the provider has taken appropriate and sufficient actions to remedy the situation, prevent chances for reoccurrence, and to assure the participant's immediate safety.

They also evaluate if incidents meet the criteria of being a sentinel event. Incidents of suspected abuse or neglect or exploitation of an adult or child or the death of an adult or child is reported to Adult Protective Services or Child Protective Service, as appropriate. The incident reporting system automatically generates an e-mail to the participant's BDDS service coordinator and a designated distribution list to alert them of the incident and to indicate whether or not a follow-up report is required. A follow-up report is required if immediate protective measures were not included in the initial incident report.

To ensure the participant's health and welfare the case manager makes either face-to-face or phone contact with the provider within 24 hours of notification of the sentinel event and sends documentation of this interaction to the BDDS service coordinator for entry into the case notes portion of the incident reporting system. Sentinel status will

remain unresolved until there is documentation in the BDDS case notes documenting that the provider took appropriate actions to resolve the issue. If immediate protective measures were included in the initial incident report, the BDDS service coordinator is not required to follow-up within 24 hours. They are however still notified of the incident and in most cases will contact the provider regarding the incident.

Responsibility for follow-up of incident reports was previously transitioned from the BDDS service coordinator to the case manager through an amendment to the case management contract. As that contract ends (August 31, 2012) and Case Management once again becomes a waiver funded service, case managers will continue to be responsible for following-up on all incident reports. Service coordinators oversee how timely and effectively case managers respond to incident reports.

On a weekly basis the BQIS Incident Review/Risk Management Manager reviews all unresolved sentinel events. When documentation ensuring health and welfare is confirmed the sentinel status is closed. The IR/RM Manager submits a weekly report of unresolved sentinel events to the BDDS and BQIS Directors and to the designee of each case management provider agency..

The participant's case manager, along with input from the support team, is responsible for electronically submitting follow-up reports within seven days of the incident being reported and every seven days thereafter until the incident is resolved to the satisfaction of all entities.

Follow-up reports provide the necessary documentation of actions taken to address incident-related issues. To assist with this, reports of outstanding incident reports are sent to the designees of each case management provider agency and residential providers on a monthly basis. Service coordinators ensure that case managers are completing required follow-up reports until incidents are closed.

At BDDS' discretion service coordinators may conduct a quality site review of the participant's environment to ensure that the team's proposed measures to ensure the participant's health and welfare are in place and appropriate.

Case managers continue to be responsible for notifying families/guardians of incidents reported and sharing results of the provider's investigation.

Previously, BDDS Service Coordinators were responsible for assuring that documentation on follow-up to critical incidents was included in the web-based incident management system. Case managers would contact the provider to assure immediate safety and preventative measures were taken for the participant and then email this information to BDDS Service Coordinators to copy and paste into the incident management system. In late fall 2011, DDRS identified a mechanism that allows the case managers to enter "follow-up reports" documenting their communications with providers directly into the incident management system.

To further clarify the role of the case manager,

- At a minimum, case manager face-to-face meetings with participants will take place in participants' home four times/year. Case managers shall monitor the effectiveness of ISP outcomes using documented face to face review between the participant or representative. The Case Manager shall visit the participant's residence not less than once every 90 days. Face to face meetings with members on SSW may take place outside of the residence, but must be documented in the ISP.
- For participants with high risk needs/high health needs, case managers will have additional reporting requirements, weekly contact with the participant, and monthly face-to-face visits in participants' homes.
- Case managers are responsible for ensuring the participants' immediate protection from harm when participants have had sentinel events which includes making contact with the provider within 24 hours of receiving incident.
- Pre- and post–monitoring of transitions (movement to a new residential services provider or home) are now the responsibility of the case manager.

BQIS uses its Quality Contractor to manage the state's web-based incident management system. The Quality Contractor's risk management staff have 24 hours to review incident reports and code them according to potential for impacting participants' health or welfare, and whether immediate follow-up is necessary. Providers are responsible for taking appropriate and effective measures to secure the participant's immediate safety, implementing preventative measures, and investigating reported incidents. Case managers then validate and use follow-up reports to document the provider's actions to safeguard the participant. Case managers enter follow-up reports into the state's web-based incident management system at minimum every 7 days until the incident is closed. BQIS Quality Contractor's risk management staff review these follow-up reports to determine: 1) whether the participant's immediate safety has been secured, and 2) that plans are in place to prevent reoccurrences. Only when both of these criteria are satisfied will BQIS Quality Contractor's risk management staff close the incident report.

On a weekly basis BQIS Quality Contractor's risk management staff send the Case Management provider agencies a report outlining all the incident reports that continue to be open. The BQIS Director and Assistant Director work with the Case Manager Contract Liaison and to the designee of each case management provider agency, as necessary, to assure that all incident reports are addressed appropriately.

In emergency situations Indiana Administrative Code allows the state the authority to remove a participant from the provider's services, issue a moratorium on the provider taking new participants, and/or to terminate the provider's agreement to provide waiver services. The state has also recently been granted the authority to issue civil sanctions. The DDRS Sanctions Committee (consisting of BQIS, BDDS, OMPP, and Division of Aging staff) recommends to the BQIS Director specific sanctions to be issued against providers. The BQIS Director then communicates this decision to the provider.

Effective 3/1/11, DDRS requires all uses of restrictive interventions to be reported. Incident reports are required to be submitted within 24 hours of the incident occurring or the reporter becoming aware of the incident. Providers are responsible for investigating all incidents. In addition to investigating any incidents of unauthorized restraint and restrictive practices, DDRS's policy on the use of restrictive interventions requires providers to convene a team meeting as soon as possible, but no later than 3 business days, following a behavioral emergency where a restrictive intervention was used to discuss the behavioral emergency, the emergency intervention used, and the supports needed to minimize future uses of restrictive interventions.

As a part of the State's required follow up reports, case managers indicate that they have notified the family/guardian of the incident outcome.

e. **Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

BQIS oversees incident reporting and management and works closely with BDDS to assure that the same incidents do not continue to occur. On a monthly basis the BQIS Incident Reporting/Risk Management compiles aggregate incident data based on each of the incident types described in G-1-b of this waiver application.

Reports are compiled by participant and by provider on the following "high risk" types of incident reports:
oArrest/Placement Removal
oSuicide Attempt
oElopement
oMedication Errors that jeopardize health and welfare, as determined by the participant's personal physician
oChoking Episodes Requiring Intervention
oFalls with Injury
oSeizures Resulting in ER/Hospital Visit
oBowel Impactions Resulting in ER/Hospital Visit
oDehydration Episodes Resulting in ER/Hospital Visit
oRespiratory Events Resulting in ER/Hospital Visit
oER Visits
oIn-Patient Hospitalizations, Medical
oIn-Patient Hospitalizations/ER Visits, Psychiatric
oUse of PRN Medications, Behavioral
oUse of Restrictive Techniques
oLack of Consumer (Participant) Supports
oSentinel Events
oEnvironmental Risks
- Fire, Residential/Service Delivery Site
- Problems with Habitable Residence
- Problems with Uninhabitable Residence
oMultiple Reportable Incidents

BQIS also oversees the mortality review process. All deaths are reviewed by BQIS's mortality review triage team. Deaths with suspect circumstances are reviewed by the full Mortality Review Committee (MRC). While the review of deaths takes place on an ongoing basis, the MRC meets monthly.

BQIS facilitates the Quality Improvement Executive Committee (QIEC), which is the decision-making body charged

with identifying needed system improvements, and then designing, implementing, and monitoring the effectiveness of those improvements. Committee members include representatives from all of the entities involved in overseeing waiver services which include OMPP, BQIS, and BDDS.

When trends are identified the QIEC uses a worksheet to document the opportunity for improvement, the data source that we want improved, a desired outcome that is measureable, measurement criteria, and a draft mitigation strategy that identifies people responsible and timelines for implementation, and a timeframe to measure how the identified issue has changed. If no change or negative change has occurred the plan is to develop another mitigation strategy to attempt to resolve the problem. Two meetings are held monthly - one dedicated to presenting data and the second to focus on developing which the QIEC Coordinator maintains.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 2)

a. Use of Restraints or Seclusion. *(Select one)*:

○ **The State does not permit or prohibits the use of restraints or seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints or seclusion and how this oversight is conducted and its frequency:

◉ **The use of restraints or seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. **Safeguards Concerning the Use of Restraints or Seclusion.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints or seclusion). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The State allows the use of restraints when used in conjunction with a Behavioral Support Plan and when approved by the Human Rights Committee or in an emergency situation but only to prevent significant harm to the individual or others.

Indiana code applicable to waiver services does not differentiate between personal restraints, but includes them as “restrictive interventions” in its implementation of safeguards. Drugs used as a method of restraint are also addressed as a “restrictive intervention” while requiring additional safeguards. Seclusion is not allowed as a behavioral intervention and is considered an act of abuse.

The State has established, provider standards prohibiting abuse, neglect, exploitation, or mistreatment of a participant, or violation a participant’s rights (460 Indiana Administrative Code (IAC) 6-9-3, "Prohibiting Violations of Individual Rights"). Abuse is defined under 460 IAC 6-3-2, "Abuse", and includes “Unnecessary physical or chemical restraints or isolation". "Seclusion" by placing a participant alone in a room or other area from which exit is prevented is specifically prohibited from use under the rule. Also prohibited are practices which deny a participant any of the following without a physicians order: Sleep, shelter, food, drink, physical movement for prolonged periods of time, medical care or treatment, or use of bathroom facilities.

Providers are required to limit the use of highly restrictive procedures, including physical restraint or medications to assist in the managing of behavior; and are instead to focus on behavioral supports that begin with less intrusive or restrictive methods before more intrusive or restrictive methods are used (IAC 6-18-3).

460 IAC 6-18-2, "Behavioral Support Plans” requires that behavioral support plans which utilize restrictive interventions contain:
(1) A functional analysis of the targeted behavior for which a highly restrictive procedure is designed;
(2) Documentation that the risks of the targeted behavior have been weighed against the risk of the

highly restrictive procedure;
(3) Documentation that systematic efforts to replace the targeted behavior with an adaptive skill were used and found to be not effective;
(4) Documentation that the participant, the participant's support team and the applicable human rights committee agree that the use of the highly restrictive method is required to prevent significant harm to the participant or others;
(5) Informed consent from the participant or the participant's legal representative; and
(6) Documentation that the behavioral support plan is reviewed regularly by the participant's support team.

To ensure the participant's safety the participant's support team participates in quarterly reviews with the behavioral support staff. This includes the participant, his/her parent or guardian, case manager, and applicable service providers. The team reviews the behavioral clinician's monthly reports, behavior data tracking sheets and verbal input from team members. The monthly report covers the prior quarter progress on the behavior support plan including targeted behaviors and any need for an amendment to the plan.

The state is committed to assuring the use of behavior modifying medication as a last resort, requiring the participant's support team to be in agreement with the use of medication, and to have the approval of the Human Rights Committee prior to implementation. Additional safeguards implemented when a psychoactive medication is administered on a PRN basis include:

(1) The behavioral support plan must include a hierarchy for obtaining administrative approval to administer the PRN medication, and a person-specific protocol identifying the circumstances and conditions in which the PRN medication can be administered.

(2) The behavioral support plan must include a plan of desensitization addressing the situations that precipitate use of PRNs, such as medical visits and other situations that occur on a regular basis. The plan shall also include methods for staff to monitor and document the results of the desensitization process.

(3) Monitoring and documentation of PRN administration must include an analysis of the effectiveness of each incident of administration, as well as a description of events leading up to the PRN administration, including any desensitization methods and their results. Documentation must detail the approval process, the date, time, and dosage of administration, and include a description of the participant's behavior after the administration, including any side effects or interactions with other medications.

(4) The Individualized Support Team must analyze and evaluate the effectiveness of PRN medication administration in eliminating targeted behaviors or symptoms, and address possible relationships between behavioral and medical issues. The Individualized Support Team must ensure that treatment is provided in the least restrictive manner possible and that desensitization methods have been utilized and documented per the behavioral support plan.

In an emergency, chemical restraint, physical restraint, or removal of a participant from the participant's environment may be used without the necessity of a behavioral support plan, but only to prevent harm to the participant or others. The participant's support team is then required to meet not later than five working days after the emergency chemical restraint, physical restraint, or removal of a participant from the environment in order to:

(1) Review the circumstances of the emergency chemical restraint, physical restraint, or removal of a participant;

(2) Determine the need for a functional analysis, behavioral support plan or both, and to document recommendations. If a provider of behavioral support services is not a member of the participant's support team, a provider of behavioral support services must be added to the participant's support team.

460 IAC 6-18-2, requires that providers' staff be trained to implement the participant's specific behavior plan. In addition to the oversight provided by the participant's support team and case manager, BQIS surveyors conduct comprehensive surveys for sampled participants. To assess that the participant's behavior support plan is being implemented correctly, surveyors interview the participant, talk with

his/her providers, and review any behavior support plans and accompanying documentation. When there are issues identified surveyors will direct providers to develop corrective action plans.

Participants' teams submit comprehensive corrective action plans to BQIS for review and approval. BQIS then validates that these plans are being implemented as stated.

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints or seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

BQIS, BDDS, and OMPP are responsible for overseeing the use of restrictive interventions and ensuring that State safeguards concerning their use are followed. Oversight of the use of restrictive interventions at the participant level occurs through the Individualized Support Team and as a Case Management function. Unauthorized use of restrictive interventions and violations of rights is monitored through the incident reporting process, the complaint process, and the Case Management function, specifically through the required 90 day review. Additionally, comprehensive surveys conducted on participants address behavioral support services to assure that appropriate plans are in place and implemented correctly.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 2)

b. **Use of Restrictive Interventions.** *(Select one)*:

○ **The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

◉ **The use of restrictive interventions is permitted during the course of the delivery of waiver services**
Complete Items G-2-b-i and G-2-b-ii.

i. **Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

The State allows the use of restrictive interventions when used in conjunction with a Behavioral Support Plan, or in an emergency situation only to prevent harm to the participant or others. Behavior support standards require that behavior plans employ non-aversive methods to replace maladaptive behaviors with functional and useful behaviors.

460 Indiana Administrative Code (IAC) 6-18-2, "Behavioral Support Plans", specifies the requirements for behavioral support plans, which utilize restrictive interventions when the plan contains:
(1) A functional analysis of the targeted behavior for which a highly restrictive procedure is designed;
(2) documentation that the risks of the targeted behavior have been weighed against the risk of the highly restrictive procedure;
(3) documentation that systematic efforts to replace the targeted behavior with an adaptive skill were used and found to be not effective;
(4) documentation that the participant, the participant's support team and the applicable human rights committee agree that the use of the highly restrictive method is required to prevent significant harm to the participant or others;
(5) informed consent from the participant or the participant's legal representative;
(6) documentation that the behavioral support plan is reviewed regularly by the participant's support team.

The participant's support team participates in quarterly reviews with the behavioral support staff.

To ensure the participant's safety the participant's support team participates in quarterly reviews with the behavioral support staff. This includes the participant, his/her parent or guardian, case manager, and applicable service providers. The team reviews the behavioral clinician's monthly reports, behavior data tracking sheets and verbal input from team members. The monthly report covers the prior quarter progress on the behavior support plan including targeted behaviors and any need for an amendment to the plan.

IAC 460-6-9-3 establishes a prohibition against violating participants' rights. Providers are directed to adopt policies and procedures that prohibit abuse, neglect, exploitation, and mistreatment of participants. Abuse is defined in 460 IAC 6-3-2 to include unnecessary physical or chemical restraints or isolation. Also prohibited are practices which deny a participant any of the following without a physicians order: Sleep, shelter, food, drink, physical movement for prolonged periods of time, medical care or treatment, or use of bathroom facilities.

Inappropriate restrictive measures that constitute abuse are reported immediately upon discovery to Adult Protective Services or Child Protective Services and acted upon in accordance with APS/CPS requirements. This situation would constitute a critical incident and also be subject to BDDS critical incident interventions at the participant and provider level which may include referral of a provider to the sanctions committee and identification of and selection of new providers of behavioral services by participants.

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

BQIS, BDDS, and OMPP are responsible for overseeing the use of restrictive interventions and ensuring that State safeguards concerning their use are followed. Oversight of the use of restrictive interventions at the participant level occurs through the Individualized Support Team and as a Case Management function.

Unauthorized use of restrictive interventions and violations of rights is monitored through the incident reporting process, the complaint process, and the case management function, specifically through the required 90 day review. Additionally, comprehensive surveys conducted on participants address behavioral support services to assure that appropriate plans are in place and implemented correctly.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. **Applicability.** Select one:

- ○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. **Medication Management and Follow-Up**

i. **Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Participants in the Family Supports Waiver, formerly known as the Support Services Waiver, program are served in a variety of settings. The person identified in the Individualized Support Plan is responsible for coordinating the participant's health care and may be the participant or participant's family and/or a residential provider working with their health care provider.

Coordinating health care includes ensuring the participant accesses necessary health care services including annual physical, dental and vision examinations ordered by the physician, routine examinations and screenings, and referrals to specialists (460 IAC 6-25-2). The ordering physician or other health care professional permitted to prescribe medications has responsibility for first-line management of a participant's medication.

The IST at each IST meeting reviews the participant's medications as part of the comprehensive ISP review and the case manager is responsible for ensuring that questions that arise related to medication management during this meeting are addressed by appropriately qualified individuals. This could include assisting the participant with scheduling an appointment with their prescribing physician to review their medication needs or contacting the participant's physician (with the participant's authorization) to seek clarification of their medications, dosages, side-effects and so on. A checklist developed by the state will be utilized to ensure that identified areas will be assessed and results communicated to the state.

A significant part of coordinating health care includes needing to document the services the person has received. Providers with this responsibility need to maintain the dates of health and medical services, a description of those services and an organized system for documenting that medications are administered (460 IAC 6-25-3).

The system for medication administration must include a documentation system, a system for communicating among all providers that administer medication and the monitoring of medication side effects. All providers are to have a health-related incident management system to provide an internal review process for any health related reportable incident – of which one is medication errors (460 IAC 6-25-9).

Case managers conduct 90-day visits to, in addition to other things, monitor providers' compliance with medication administration systems. The purpose of this monitoring is to detect potentially harmful practices and then to follow-up to address these practices. Case managers use a standardized checklist to conduct these monitoring visits. The incident reporting and complaint processes provide an additional monitoring resource.

When behavior modifying medications are used, the state mandates the participant's support team to be in agreement with the use of medication and have the approval of the Human Rights Committee prior to implementation. Additional safeguards implemented when a psychoactive medication is administered on a pro re nata (PRN "as needed") basis include:

1) The behavioral support plan must include a hierarchy for obtaining administrative approval to administer the PRN medication and an individualized protocol identifying the circumstances and conditions in which the PRN medication can be administered.

2) The behavioral support plan must include a plan of desensitization addressing the situations that precipitate use of PRNs, such as medical visits and other situations that occur on a regular basis. The plan shall also include methods for staff to monitor and document the results of the desensitization process.

3) Monitoring and documentation of PRN administration must include an analysis of the effectiveness of each incident of administration as well as a description of events leading up to the PRN administration, including any desensitization methods and their results. Documentation must detail the approval process, the date, time, and dosage of administration and include a description of the participant's behavior after the administration, including any side effects or interactions with other medications.

4) The Individualized Support Team must analyze and evaluate the effectiveness of PRN medication administration in eliminating targeted behaviors or symptoms and address possible relationships between behavioral and medical issues. The Individualized Support Team must ensure that treatment is provided in the least restrictive manner possible and that desensitization methods have been utilized and documented per the behavioral support plan.

ii. **Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

Through 460 IAC 6-25-4, "Organized System for Medication Administration Required", the State requires providers have an organized system for medication administration for each participant receiving medications. The provider is required to document the system in writing and distribute the document to all providers administering medication to the participant. The documentation is placed in the participant's file maintained by all providers administering medication to the participant.

This required system must contain at least the following elements:

•Identification and description of each medication required for the participant;
•Documentation that the participant's medication is administered only by trained and authorized personnel unless the participant is capable of self-administration of medication as provided for in the participant's, Individualized Service Plan (ISP);
•Documentation of the administration of medication, including administration of medication from original labeled prescription containers; the name of medication administered; the amount of medication administered; the date and time of administration; and the initials of the person administering the medication.
•The system must also include procedures for the destruction of unused medication;
•Documentation of medication administration errors;
•A system for the prevention or minimization of medication administration errors.
•When indicated as necessary by a participant's ISP, procedures for the storage of medication;
•Documentation of a participant's refusal to take medication;
•A system for communication among all providers that administer medication to a participant.
•All providers administering medication to the participant shall implement and comply with the organized system of medication administration designed by the provider.

The BDDS oversees provider compliance with state standards and requirements through the provider approval and enrollment process, followed by new provider training, through ongoing provider monitoring performed by case managers during face-to-face contact with participants and during review of the ISP and POC/CCB, and through QI review activities. Results of the reviews are shared with OMPP. In addition, medication management issues may be identified as a result of incident reporting, the BQIS survey process, mortality reviews, the complaint process, and from anecdotal information presented through the risk management committee framework.

Providers of Case Management and BDDS analyze data at the participant level, identify trends, and work with providers to develop remediation plans. BQIS conducts the same activities but for provider-specific and systemic trend analysis. BQIS asks providers for remediation plans based on findings from the CST reviews. Providers have two opportunities to develop an acceptable corrective action plan and two opportunities to validate that plan. Noncompliant providers are forwarded to the BQIS Director for progressive discipline.

Relevant DDRS entities (BDDS and BQIS) use the Quality Improvement Executive Council (QIEC) ,which includes OMPP,to develop and implement mitigation strategies to address potentially harmful practices and improve quality.

At the provider level, CAPs may be required as well as provider-specific training to address medication management issues. As with all performance-related issues and issues related to participant health and welfare, existing processes are utilized to address urgent issues (through the incident reporting system) or repeated non-compliance (through referral to the sanctions committee).

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

○ **Not applicable.** *(do not complete the remaining items)*

- **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. **State Policy.** Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

460 IAC 6-14-4, requires that all provider staff be trained in administering medication. The state has an approved curriculum available for providers to use to conduct this training.

460-IAC 6-25-3, "Documentation of Health Care Services Received by an individual", addresses the state's rules for medication administration and also includes the need for providers to maintain the dates of health and medical services, a description of those services and the need for an organized system for medication administration.

The system for medication administration must include a documentation system, a system for communication among all providers that administer medication and the monitoring of medication side effects. All providers are to have a health-related incident management system to provide an internal review process for any health related reportable incident – of which one is medication errors (IAC 6-25-9, "Health Related Incident Management").

Under 460 IAC 6-10-10, "Quality Assurance and Quality Improvement System", providers administering medications are required to have a quality assurance and quality improvement process to analyze medication errors, develop recommendations to reduce the risk of future errors, and review recommendations to assess for effectiveness.

Incident reporting policies require medication errors to be reported to BDDS as addressed under 460 IAC 6-9 -5, "Incident Reporting".

iii. **Medication Error Reporting.** *Select one of the following:*

- **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
  Complete the following three items:

  (a) Specify State agency (or agencies) to which errors are reported:

  Medication errors must be reported to BDDS through the incident reporting process under IAC 6-9-5, "Incident Reporting" and detailed within Appendix G-1-a of this application.

  (b) Specify the types of medication errors that providers are required to *record:*

  The types of medication errors required to be recorded are:

  1) Wrong medication given that places a participant's health and welfare in jeopardy as determined by the personal physician.

  2) Wrong dose given that places the participant's health and welfare in jeopardy as determined by the personal physician.

  3) Missed medication that places the participant's health and welfare in jeopardy as determined by the personal physician.

  4) Medication given outside the prescribed administrative window that jeopardizes a participant's health and welfare as determined by the personal physician.

  So that providers can conduct their own medication administration training, DDRS has an approved

Core A and B medication administration training curriculum available to assist providers' trainers. The state requires that only RNs or LPNs participate in this train-the-trainer training.

(c) Specify the types of medication errors that providers must *report* to the State:

The types of medication errors required to be reported through the incident reporting process under IAC 6-9-5, "Incident Reporting", are:

1) Wrong medication given that places a participant's health and welfare in jeopardy as determined by the personal physician.

2) Wrong dose given that places the participant's health and welfare in jeopardy as determined by the personal physician.

3) Missed medication that places the participant's health and welfare in jeopardy as determined by the personal physician. (Refusal to take medications does not require filing of an incident report but should be followed up by medical personnel and the interdisciplinary team to ensure that the health and welfare of the participant is safeguarded. This information should also be documented in the participant's record).

(4) Medication given outside the prescribed administrative window that jeopardizes a participant's health and welfare as determined by the personal physician.

- **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

iv. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

BQIS, BDDS, and OMPP are responsible for overseeing provider performance in the administration of medications.

The BDDS monitors provider compliance with state standards and requirements for medication administration through ongoing provider monitoring performed by case managers during face-to-face contact with participants and during review of the ISP and POC/CCB by the IST, as well as through QI review activities. Results of the reviews are shared with OMPP.

Medication error reporting or inappropriate use of medications may be received through the incident reporting system or the complaint system. 100% of medication errors will be reviewed by the contracted medical reviewer, who will completely evaluate each medication error and compile recommendations to address the errors at the provider and systemic level.

Depending on the specific situation and severity of the incident, immediate actions will be taken that range from provider contact, remediation through provider training and provider development of a Corrective Action Plan, up to and including referral to the sanctions committee for egregious violations of policies related to medication safeguards.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Health and Welfare**

The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of sampled participants who report that they are informed about how to report abuse, neglect, and exploitation. Numerator: Total number of sampled participants who report they were informed about how to report abuse, neglect and exploitation. Denominator: Total number of participants sampled.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Comprehensive Survey Tool (CST)

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of participants sampled whose support staff knows how to prevent, detect and report allegations of abuse, neglect, mistreatment and exploitation. Numerator: Total number of participants sampled whose support staff knows how to prevent, detect, and report allegations of abuse, neglect, and exploitation. Denominator: Total number of participants sampled.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Comprehensive Survey Tool (CST)

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of sentinel events by type of event. Numerator: Total number of sentinel events by type of event. Denominator: Total number of sentinel events.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DART

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Quality contractor	☐ **Annually**	☐ **Stratified** Describe Group:

	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of sentinel events and incidents that were reported within required time frames. Numerator: Total number of sentinel event and incidents reported within time frames. Denominator: Total number of sentinel events and incidents.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DART

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample**

		Confidence Interval =
☑ **Other** Specify: Quality contractor	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of sentinel events that were resolved within the stipulated time frame. Numerator: Total number of sentinel events that were resolved within the stipulated time frame. Denominator: Total number of sentinel events.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DART

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*

☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Quality contractor	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of incidents that were resolved within the stipulated time frames. Numerator: Total number of incidents that were resolved within the stipulated time frames. Denominator: Total number of incidents.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DART

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Quality contractor	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*

Performance Measure:
Number and percent of medication errors by type of error. Numerator: Total number of mediation errors by type of error. Denominator: Total number of medication errors.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DART

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Quality contractor	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of Corrective Action Plans (CAPS) associated with complaints that were implemented within prescribed time period. Numerator: Total number of CAPs associated with complaints that were implemented within prescribed time period. Denominator: Total number of CAPS associated with complaints.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Complaint Investigation and Resolution System (CIRS)database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:

Number and percent of medication errors that resulted in medical treatment.
Numerator: Total number of medication errors that resulted in medical treatment.
Denominator: Total number of medication errors.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DART

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Quality contractor	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of participants for whom restrictive interventions were applied where the procedures conformed with state policy. Numerator: Total number of participants for whom restrictive interventions were applied where the procedures conformed with state polices. Denominator: Total number of participants for whom restrictive procedures were applied.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Comprehensive survey tool (CST)

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
On a weekly basis the BQIS Incident Review/Risk Management Manager reviews all unresolved sentinel events. When documentation ensuring health and welfare is confirmed the sentinel status is closed. The IR/RM Manager submits a weekly report of unresolved sentinel events to the BDDS and BQIS Directors and the case management entity. The participant's case manager is responsible for electronically submitting follow-up reports within seven days of the incident being reported and every seven days thereafter until the incident is resolved to the satisfaction of all entities. Follow-up reports provide the necessary documentation of actions taken to address incident-related issues. To assist with this, reports of outstanding incident reports are sent to the case management entity and residential providers on a monthly basis.

ii. Remediation Data Aggregation
Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*

c. **Timelines**
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

- (●) **No**
- ( ) **Yes**
Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QMS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the QMS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to

undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The foundation of an effective quality improvement strategy is the capability to aggregate and analyze data across the program in order to identify which problems can and should be addressed at the system level. System-level interventions would include training of providers, changes in state policies, revisions to contractor scopes of work, and reorganization of staffing functions. While day-to-day discovery and remediation are predominantly carried out by operating agency and contractor staff, system-level improvements are identified, designed, implemented, and monitored by DDRS and OMPP leadership. This is in recognition of the fact that system improvements relate to policy decisions for which the State Medicaid agency is held accountable by CMS.

The first building block of the strategy is to identify issues at three different levels – person-specific, provider -specific, and at the program level. Based on analysis of data regarding these issues, the state can then determine which issues point to the need for system improvements. DDRS uses a strategy for addressing the three levels based on data and information from:

•Incident reports;
•The mortality review committee;
•BQIS comprehensive survey findings which includes data collected from provider compliance reviews; and
•Complaints and investigations.

Data and information from all of these sources will help DDRS maximize its resources to improve the quality of services at all levels of our system.

Tier I – Participant-Specific Issues

Case managers have the front-line responsibility for monitoring participants and following-up on issues identified through their routine contacts with the participant. When warranted, problems are reported through the incident reporting system, either by the case manager or the provider.

Currently the BQIS Incident Reporting/Risk Management (IR/RM) Manager aggregates and analyzes incident data on a monthly basis and generates reports for each BDDS district. Based on volume of incidents, repeated incidents, and incidents severely jeopardizing health and welfare, recommendations are made for individuals to be placed on BDDS high risk list for additional service coordinator attention. All recommendations are discussed in BDDS local risk management committees and service coordinators take actions to assure the participant's safety.

However, in the next several months the DDRS' reorganization will make service coordinators directly responsible for monitoring case manager performance. Service coordinators will review documentation of case managers' interactions with their individuals, including how case managers followed up on incident reports and monitored providers' implementation of individuals' risk plans. The expectation is that when case managers identify a problem they will immediately follow-up with the provider to correct it. BDDS will use case manager documentation and provider monthly summary reports to assess that individuals received all the services and supports in their ISP and that the case manager identifies issues timely and addresses and routinely monitors corrections.

The BDDS Risk List and related risk management activities will be discontinued as case managers will become responsible for tracking their participants' incident reports while also making more routine monitoring visits. These activities will be ensure case managers are aware of when individuals are having difficulties and they will be ready to take corrective actions.

Participant-specific issues are also identified and remedied through BQIS's comprehensive survey process. This review uses a tool of person-specific indicators. When indicators are not met, participants' support teams, which include case managers as team leaders, are required to develop corrective action plans. Teams have two opportunities to develop acceptable corrective action plans. Once CAPs are accepted, surveyors validate that providers have implemented the CAPs. Providers have two opportunities to illustrate that they are implementing the corrective actions as identified. If providers do not do this, the quality contractor refers the provider information and their outstanding issue to the BQIS Director. This action may result in the sanctions committee reviewing the case and providing the BQIS Director a proposal for sanctions.

Tier II – Provider-Specific Issues

DDRS is implementing its process for reviewing provider-specific monitoring data. BQIS is expanding its comprehensive survey to obtain more robust provider-specific information. As of August 1, 2010 BQIS assumed responsibility (previously delegated to DDRS Provider Relations) for reviewing every provider once every three years to check that the provider is conducting criminal background checks and that staff meet 460 IAC training requirements and general 460 IAC staffing requirements. Providers may be approved for periods of 1-3 years.

In addition, BQIS will review provider-specific data from monitoring activities and request that providers develop corrective action plans when prevalent issues have been identified.

Tier III – Systemic Trends

Besides remediating individual issues as they arise, the overarching goal of these activities is to provide a basis for identifying when a range of issues rises to the level of a needed program or system improvement. BQIS facilitates the Quality Improvement Executive Committee (QIEC) to become the decision-making body at the center of identifying needed system improvements, and then designing, implementing, and monitoring them. Committee members include representatives from all of the entities involved in overseeing waiver services, which include:

•OMPP representative
•DDRS Director
•DDRS Deputy Director
•BQIS and BDDS Directors
•BDDS Field Service Directors
•Case Management Liaison
•BQIS Incident Reporting/Risk Management Manager
•BQIS Quality Contract Program Manager

BQIS/BDDS committee members present aggregate information obtained from monitoring visits for analysis and discussion. Some meetings may be set aside to focus on a particular topic and examine the data related from each of our monitoring sources.

When trends are identified, the QIEC uses a worksheet to document the opportunity for improvement, the data source that we want improved, a desired outcome that is measureable, measurement criteria, and a draft mitigation strategy that identifies people responsible and timelines for implementation, and a timeframe to measure how the identified issue changed. If no change or negative change has occurred the plan is to develop another mitigation strategy to attempt to resolve the problem.

Two meetings are held monthly - one dedicated to presenting data and the second to focus on developing which the QIEC Coordinator maintains.

ii. System Improvement Activities

Responsible Party *(check each that applies):*	**Frequency of Monitoring and Analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Quality Improvement Committee**	☐ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

Numerous parties at all levels have responsibility for monitoring and assessing system design changes.

•Providers are responsible for reporting critical incidents through the incident reporting system. Once an incident report is received a series of follow-up activities occur. This system provides the agency with a mechanism to review with the provider the effectiveness of their systems, design changes, etc. In addition, this provides data on whether a system improvement that was designed to remedy an identified issue (e.g., a higher-than-expected number of choking incidents) was indeed effective in addressing that issue.

•Case managers have the front-line responsibility for overseeing the delivery of waiver services. In accordance with waiver regulations they are responsible for making a minimum of 4 contacts with the participant each year, coordinating and facilitating participants' support team meetings as necessary, and identifying and resolving issues with service delivery. Contractually, case managers may need to provide additional visits based on the individual's health and safety indicator results. Case managers can assess the effectiveness of system and design changes according to how these changes impact the participants they work with.

•BDDS service coordinators will oversee case management functions. Service coordinators follow case managers to ensure that case managers are monitoring implementation of individuals' risk plans and following up with teams to ensure participants are being adequately supported. This system allows the agency to monitor that case managers are assuring individuals' health and welfare. Aggregate information on case manager performance will guide where we need to revamp our systems.

•BQIS surveyors evaluate the services participants are receiving. Every month survey managers aggregate and analyze results from the comprehensive surveys to evaluate that our systems are operating efficiently. When inefficiencies are identified processes are modified accordingly.

•BQIS incident reviewers review and code all critical incidents reported. They determine when incidents are sentinel and therefore require immediate contact with the provider to assure the individual's safety.

•The QIEC includes representatives from OMPP and all relevant DDRS entities. This committee uses systemic data from all of our monitoring activities to make decisions for how to address risk trends. Mitigation strategies are developed based on analyzed data and measurement criteria are defined with timelines for periodically measuring progress.

•The sanctions committee includes representatives from OMPP, the Division of Aging, and all of DDRS entities. BDDS and BQIS have defined processes for conducting their review activities. Providers are referred to the sanctions committee when all efforts to cooperate have failed.

All of these roles and responsibilities continually evolve as we continue to analyze our data and identify opportunities for improvement. As our new monitoring activities continue to produce more data we will have better information to analyze and support changing our processes to prevent reoccurrence of negative outcomes.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The development of a fully operational quality improvement strategy is an ongoing process of review and refinement. On an annual basis, the QIEC will review the quality improvement strategy and assess whether the performance measures need to modified. For some performance measures we will have collected sufficient data to establish our baseline of what is acceptable. Other performance measures we will have continually met so will need to be modified.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The provider in accordance with their service agreement must maintain for the purposes of the service agreement an accounting system of procedures and practices that conforms to Generally Accepted Accounting Principles (GAAP). The OMPP or any other legally authorized governmental entity (or their agents) may at any time during the term of the service agreement and in accordance with Indiana Administrative Regulation conduct audits for the purposes of assuring the appropriate administration and expenditure of the monies provided to the provider through this service agreement. Additionally, DDRS may at any time conduct audits for the purpose of assuring appropriate administration and delivery of services under the service agreement.

All provider types are subject to an annual risk assessment to determine the need for an onsite, desk or self audit. The provider must provide OMPP access at any time to all records, materials, and information including all audit reports with supporting documentation. Such access must be provided until the expiration of six years from the completion date of each respective fiscal year.

Providers selected for self audit will receive an audit request letter, which thoroughly explains the process. The self-audit process allows the provider the opportunity to review their own medical record documentation and billing submissions against IHCP payments without the on-site involvement of an audit team. This allows the provider to work at a pace convenient to their office staff without interrupting service delivery. The provider will then work cooperatively with the SUR department to confirm the audit results and return any identified overpayments for claims that were determined to have been paid in error. Educational seminars are also conducted, which include educating providers on the different types of audits that the state performs throughout the year. Please see the link below to the Indiana Health Coverage Programs Provider Manual. Chapter 13 covers Utilization Review.
http://provider.indianamedicaid.com/general-provider-services/manuals.aspx

In the past, Indiana set threshold limits on self-audits, desk reviews and on-site audits. This type of business model was ineffective in identifying the most egregious providers. Our focus has moved from threshold auditing to risk based assessments. Audits are performed based on identification of aberrant billing patterns and other risk factors such as the correcting claims.

The State uses a risk-based audit approach to identify providers engaging in aberrant billing practices. Components of a risk-based approach include but are not limited to the following:
•Peer group comparison reporting
-Algorithms that specifically identify probable billing irregularities
•Dollar volume billed to Medicaid
-Year over year billing comparison reporting
•Complaints received through the SUR hotline
•Inquiries from the Medicaid Fraud Control Unit
•Safety issues noted and reported by case workers or case managers

During 2011, the State of Indiana formed the Benefit Integrity Team comprised of both state and contract staff. This team meets biweekly to review and approve audit plans, provider communications and make policy recommendations to affected program areas.

On-site audits are conducted for providers engaged in aberrant billing practices. The on-site audits are conducted to review supporting documentation for paid claims to recoup overpayments as applicable, and educate the provider. If warranted, providers are also placed on prepayment review monitoring for future claim submissions.

Under the provisions of the Single Audit Act as amended by the Single Audit Act Amendments of 1996, the State of Indiana utilizes the Indiana State Board of Accounts to conduct the independent audit of state agencies, including the Office of Medicaid Policy and Planning. OMPP routinely monitors audit resolution and provides annual status updates to SBOA.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Financial Accountability**
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

i. **Performance Measures**

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of claims paid in adherence to reimbursement methodology in the waiver application. Numerator: Total number of claims paid during review period due to having the correct rate. Denominator: Total number of claims paid during review period.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS Claims Data

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☑ **Other** Specify: Medicaid Fiscal Contractor	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of claims paid during the review period due to the participant being enrolled in the waiver on the date that the service was delivered. Numerator: Total number of claims paid during review period due to the participant being enrolled in the waiver on the date that the service was delivered. Denominator: Total number of claims paid during review period.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS Claims Data

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*

☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Medicaid Fiscal Contractor	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of claims paid for services that are specified in the participant's approved service plan. Numerator: Total number of claims paid during review period

due to services having been identified on the approved service plan. Denominator: Total number of claims paid during review period.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS Claims Data

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Medicaid Fiscal Contractor	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The State assures financial accountability through a systematic approach to the review and approval of services that are specifically coded as waiver services within the waiver case management system and the MMIS. The MMIS links to the waiver case management system in order to ensure that only properly coded services, that are approved in an individual's plan of care, are processed for reimbursement to providers who are enrolled Medicaid Support Services Waiver providers.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
When a suspected claims issue is identified the OMPP Data Unit extracts pertinent claims data to verify the problem and determine the correction needed.

Suspected instances of inappropriate claims submission may be identified by the participant, a case manager, service provider, or by waiver unit staff. For these individual cases, DDRS waiver unit staff or the Medicaid Fiscal Agent provider relations staff address the problem to resolution, depending on the root cause. If an individual problem indicates a larger systemic issue, it is referred to the Change Control Board for action, which may include the addition of specific edits to the MMIS, for example.

Each party responsible for addressing individual problems maintains documentation of the issue and the individual resolution. Meeting minutes are maintained as applicable.

ii. Remediation Data Aggregation
Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

- (●) **No**
- ( ) **Yes**

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. **Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The current rate determination methods which will remain in effect for this waiver are described below.

The Division of Disability and Rehabilitative Services (DDRS) initiated and implemented a standardized provider reimbursement rate methodology in CY 2009. This methodology requires that providers be reimbursed for specific services delivered, that the rate for each waiver service is discreet and transparent, and that the rates treat all providers in a fair and equitable fashion. While the standardized rate system was implemented in CY 2009, DDRS continues to test, refine, and update various rate assumptions, and accountability protocols. Explanations of the continuing Rate Development Tasks & Timelines and the Rate Methodology are as follows:

RATE DEVELOPMENT TASKS & TIMELINES

The provider reimbursement rate initiative currently involves three key tasks. These tasks are: reimbursement rate methodology review and evaluation; rate development and testing; and rate revision and implementation. A description of each task follows:

1. Reimbursement Rate Methodology Review and Evaluation: DDRS continues to conduct a review of current provider expenditure and utilization data, reimbursement rate methodologies, assumptions and pricing incentives, budget forecasting and cost containment strategies, risk management and risk reserve practices. This review involves the examination of provider operating expense sheets, annual audited financial reports, and focused discussions with statewide provider organizations.

2. Rate Development and Testing: Initial provider reimbursement rates were published July 2007 and implemented over a twenty-four month period. These rates were based upon the fiscal and service utilization data, provider expenditure data, and program benchmarks based upon DDRS policy. This methodology and standard fee schedule identified critical cost factors and relevant pricing benchmarks. Rate testing was initiated in January 2008 and involved only providers in BDDS District 4. Rate testing was expanded statewide to all providers in January 2009.

3. Rate Revision and Implementation: Rate implementation began in January 2008 and became effective statewide in January 2009. Rate revisions were implemented based upon evaluation and testing findings.

DESCRIPTION OF RATE STRUCTURE

DDRS converted its provider reimbursement approach from a negotiated rate system to a standardized fee-for-service system for all of its Medicaid Home and Community-Based Services (HCBS) waiver program. There are three major components to the DDRS Rate Initiative:

Rate Component #1 - Direct Care Staff Time as the Billable Unit: With the exception of adaptive equipment and transportation, all provider reimbursement for the Family Supports Waiver, formerly known as the Support Services Waiver, is based upon the amount of direct care staff time delivered to the participant by the provider. In order to

meet the conditions for payment, the participant must be Medicaid eligible, enrolled, in attendance, and receive a HCBS service; and the direct care staff must be actively employed and present to provide the HCBS service. In addition, the service provided must be consistent with the participant's individual service plan.

Rate Component #2 - Standardized Cost Centers: All provider reimbursement rates consist of four cost centers. These cost centers are:

•Direct Care Staff Compensation: Two primary job classes were used from these compensation studies. Job classifications used for Personal Support Workers are staff who perform typical duties of a developmental disabilities attendant with a high school degree and no special training. Job classifications used for Habilitation Workers are staff who perform the duties of a developmental disabilities attendant with an Associate Arts degree or Certified Nursing Assistant, or special training.

•Employee Expenses: Employment related expenditures refer to the benefits package that is offered to all employees who are involved in the care and services provided to the person with disabilities and are divided into two groups. Discretionary costs are those associated with benefits provided at the discretion of the employer and are not mandated by local, state, or federal governments. Non-discretionary costs are those related to employment expenditures that are mandated by local, State, and Federal governments and are not optional to the employer.

•Program Supervision and Indirect Expenses: Program Related Expenditures are those that are part of the operation of the setting in which residential habilitation occurs and related to the programs which occur within the setting, but are not directly tied to the direct care staff. They include program management and clinical staff costs as well as program operational expenses.

•General and Administrative Expenses: General and Administrative Expenses are those associated with operating the organization's business and administration and are not directly related to the clients or the programs that serve the clients.

Rate Component #3 - Other Factors: In addition, standardized cost centers have been applied.

• Historical expenditures were used by DDRS as the basis for transportation rates. The average cost per person was utilized and the transportation rate was applied only to people who were receiving fewer than 35 hours per week of Residential Habilitation and Support each week under Indiana's comprehensive DD or Autism Waivers. (Note: While this uniform rate for Transportation services was developed using historical expenditures from other HCBS waivers, it is available to all participants under the Family Supports Waiver.)

For the 2012 Amendment:

Historical expenditures were used by DDRS as the basis for Case Management rates, specifically through the review and analysis of the current cost of Case Management as an Administrative Service.

Participant Assistance and Care (PAC) rates were derived through review and analysis of its reimbursable activities in comparison to reimbursable activities associated with State Plan and comprehensive DD Waiver services offering components of personal care and/or residential supports.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Claims for waiver services flow directly from the providers to the Indiana Medicaid Management Information System and payments are made via Medicaid's contracted fiscal agent.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one)*:

- (●) **No. State or local government agencies do not certify expenditures for waiver services.**
- ( ) **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

a) and b) As explained in Appendix D, the Plan of Care/Cost Comparison Budget (POC/CCB) for the Family Supports Waiver, formerly known as the Support Services Waiver, contains only those reimbursable services from the Individualized Support Plan (ISP) that are available under the Family Supports Waiver.

The Division of Disability and Rehabilitative Services' (DDRS) Waiver Services Unit approves a participant's POC/CCB within the State's case management application database ensuring that only those services which are necessary and reimbursable under the Family Supports Waiver and that appear on the POC/CCB. The POC/CCB is sent to the state's fiscal agent and entered into the MMIS serving as the prior authorization for all SS Waiver services. The case management data system will not allow the addition of services beyond those services offered under the Family Supports Waiver. The case management data system has been programmed to alert the Waiver Unit when a POC/CCB is being reviewed for a participant whose Medicaid eligibility status is not currently open within an acceptable category as was discussed under Appendix B-4-b. When the appropriate Medicaid eligibility status is in place, and the POC/CCB is approved, the system generates a Notice of Action (NOA), which is sent to each authorized provider of services on the Plan. The NOA identifies the individual service recipient (the participant), the service that each provider is approved to deliver, and the rate at which the provider may bill for the service.

The case management database transmits data (typically each business night) containing all new or modified POC/CCB service and rate information to the Indiana MMIS. The POC/CCB data is utilized by the MMIS as the basis to create or modify Prior Authorization fields for billing of services against Medicaid waiver participants.

Providers submit electronic (or paper) claims directly to the MMIS. Claims are submitted with date(s) of service, service code, and billing amount. Reimbursements are only authorized and made in accordance with the Prior Authorization data. The MMIS also confirms that the waiver participant had the necessary Level of Care and Medicaid eligibility for all dates of service being claimed against.

c) Documentation and verification of service delivery consistent with paid claims is reviewed during the look behind efforts of the Bureau of Quality Improvement Services as well as by the Office of Medicaid Policy and Planning when executing Surveillance Utilization (SUR) activities.

In summary, the participant's eligibility for Medicaid and eligibility for approved dates of service are controlled through the electronic case management database system which is linked to Medicaid's claims system. All services

are approved within these systems by the operating agency. As part of the 90 day review, the case manager verifies with participant the appropriateness of services and monitors for delivery of service as prescribed in the plan of care. Modifications to the plan of care are made as necessary.

e. **Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. **Method of payments -- MMIS** (*select one*):

- (●) **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- ( ) **Payments for some, but not all, waiver services are made through an approved MMIS.**

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) **Payments for waiver services are not made through an approved MMIS.**

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

  Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. **Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- [ ] **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- [x] **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- [ ] **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☐ **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. **Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- ◉ **No. The State does not make supplemental or enhanced payments for waiver services.**
- ○ **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. **Payments to State or Local Government Providers.** *Specify whether State or local government providers receive payment for the provision of waiver services.*

- ◉ **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I -3-e.
- ○ **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish: *Complete item I-3-e.*

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

Answers provided in Appendix I-3-d indicate that you do not need to complete this section.

- **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**

- ○ **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- ◉ **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- ○ **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

- ◉ **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- ○ **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ○ **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

- ☑ **Appropriation of State Tax Revenues to the State Medicaid agency**
- ☐ **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I -2-c:

☐ **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2- c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. **Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

◉ **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.

○ **Applicable**

Check each that applies:

☐ **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2- c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. **Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

◉ **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**

- ○ **The following source(s) are used**
  Check each that applies:
  - ☐ **Health care-related taxes or fees**
  - ☐ **Provider-related donations**
  - ☐ **Federal funds**

  For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. **Services Furnished in Residential Settings.** *Select one:*

- ○ **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- ◉ **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. **Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

The State of Indiana excludes Medicaid payment for room and board for individuals receiving services under the waiver. Waiver participants are responsible for all room and board costs.

There is no consideration of the cost of room and board in developing the rates. Waiver service providers are paid a fee for each type of direct service provided; no room and board costs are included in these fees.

Based on the method for establishing the fee for each waiver service, the State of Indiana assures that no room and board costs are paid through Medicaid. Indiana provider audit procedures also review provider billing and all allowable costs to further assure no room and board payments are made.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ◉ **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- ○ **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C -3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. **Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- (●) **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ( ) **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. **Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- [ ] **Nominal deductible**
- [ ] **Coinsurance**
- [ ] **Co-Payment**
- [ ] **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. **Co-Payment Requirements.**

ii. **Participants Subject to Co-pay Charges for Waiver Services.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. **Co-Payment Requirements.**

iii. **Amount of Co-Pay Charges for Waiver Services.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. **Co-Payment Requirements.**

iv. **Cumulative Maximum Charges.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. **Other State Requirement for Cost Sharing.** Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

Level(s) of Care: ICF/MR

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	8626.49	3761.06	12387.55	78271.71	4447.81	82719.52	70331.97
2	7429.00	3923.55	11352.55	80688.02	4198.62	84886.64	73534.09
3	8319.29	4194.40	12513.69	79099.43	4590.92	83690.35	71176.66
4	10047.18	4446.06	14493.24	82263.41	4866.38	87129.79	72636.55
5	11119.03	4712.82	15831.85	85553.95	5158.36	90712.31	74880.46

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. **Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Number Unduplicated Number of Participants (from Item B -3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		ICF/MR
Year 1	5267	5267
Year 2	5669	5669
Year 3	6686	6686
Year 4	8326	8326
Year 5	9884	9884

Appendix J: Cost Neutrality Demonstration

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

b. **Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

Estimated Phase-in/Phase-out charts were completed for each waiver year in order to estimate average length of stay.

It was determined that no update was needed to the slot projections developed in August of 2010. Although waiver enrollment at the end of December 2010 was approximately 100 lower than projected, this appears to be due to delays in the Medicaid determination process.

Enrollment used in developing the cost neutrality summary, was based on data through June 2010. For the remaining nine months of WY1, approximately 76 to 77 new entrants were projected each month (40% priority 18-24 year olds, 20% from priority state line, and 40% from the waitlist).

For waiver years two through five, Indiana is requesting slots that will allow it to add 52 to 53 new consumers each month. Approximately half of these are expected to be selected based on reserved capacity/priority criteria, while the remainder will be selected based on waitlist status.

Based on historical lapse rates (4.8% per year), approximately 20 to 25 SSW enrollees are projected to lapse each year.

FOR THE 2012 SECOND AMENDMENT:

Estimated Phase-in/Phase-out charts were completed for each waiver year in order to estimate average length of stay.
The State has experienced administrative difficulties enrolling targeted individuals. These issues have been addressed in two ways: simplifying the process by removing redundancies and training additional personnel. After all additional personnel have been hired and trained, the State expects to be able to enroll at least 200 new individuals per month.

During WY 3, the State plans to "catch up" in order to fill slots authorized in the previous filing.
In addition, the State plans to boost enrollment, starting October 2012, enrolling an additional 641 in WY 3, and 1,284 per year in WY 4 and WY 5. This is in addition to slot growth already authorized in the previous filing. Higher levels of new enrollment are expected to temporarily reduce length of stay, especially during WY 3. Projections incorporate historical lapse rates of 4.8% per year.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. **Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

i. **Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

General Assumptions:
•Base Year data was generally from Waiver Year 5 of the current waiver: April 1, 2009 – March 1, 2010.
•Unduplicated users for each service were allowed to increase proportionately with total slots.
•Average units per user were allowed to vary with average length of stay.
•Average cost per unit was adjusted to the rate schedule in effect at the beginning of the renewal period, then allowed to increase at 3.5% per year.

Transition from Annual Plan to Uniform Rates:
This transition affected Community Habilitation, Facility Habilitation, Pre-Vocational Services, and Supported Employment. The transition was complete as of October 1, 2009. In order to use base period data that was fully representative of utilization patterns under Uniform Rates, the period from October 1, 2009 through September 30, 2010 was used as the base year data for these services.

Time Limitations:
•A Time limitation of 18 months continues in place for Supported Employment. This is expected to lead to a reduction in users. Ultimately, users are expected to be 4% of unique recipients, which assumes no change to the number of unique individuals who use these services.
•The time limitation on Pre-Vocational Services has been removed.
Day Services:
•Day Service group sizes were simplified as follows:
oSmall Group: includes group sizes of 2:1 through 4:1 at a rate of $8.48 per person per hour.
oMedium Group: includes group sizes of 5:1 through 10:1 at a rate of $4.72 per person per hour.
oLarge Group: includes group sizes of 11:1 through 16:1 at a rate of $3.00 per person per hour.
•These group sizes apply to Community Habilitation, Facility Habilitation and Prevocational Services.
•Where appropriate, groups from the prior waiver filing were combined. For example, recipient, utilization, and expenditures for the 2:1, 3:1, and 4:1 group sizes under Community Habilitation were all combined under Community Habilitation – Small Group.

New Group Sizes:
•Three new groups were authorized:
oCommunity Habilitation – Medium Group,
oFacility Habilitation – Large Group, and
oPre-Vocational Services – Small Group.
•Community Habilitation – Medium Group: DDRS expects approximately $400,000 in expenditures during WY2, increasing gradually to $1 million during WY5.
•Facility Habilitation – Large Group: DDRS expects approximately 20% of Pre-Vocational Large Group members to switch by the end of WY2, with gradual growth to 50% by WY5.
•Pre-Vocational Services – Small Group: DDRS expects 5% of Pre-Vocational users to be in Small Group during WY2. After WY2, this group is expected to grow with slot growth.

New Services:
•Facility Based Support: Providers expect to use this service minimally, primarily during transition times. Projections assume 5% of waiver recipients will use this service for approximately three hours per week.
•Intense Behavioral Intervention: DDRS assumes very low utilization of this service by SSW consumers, as most high need children are expected to be enrolled on the Autism or Developmentally Disabled waivers. Utilizers of this service are modeled to receive 5 hours per month of licensed level 1 support and 15 hours per week of basic level 2 support. Under this assumption, annual expenditures for a consumer using this service would average $25,000, so most SSW consumers would only be able to afford half a year under recommended program parameters.
•Workplace Personal Assistance: DDRS has assumed approximately 0.6% of SSW consumers will utilize

this service. Utilization is assumed at 10 hours per week. Under this assumption, annual expenditures for a consumer using this service would average $13,000.
•All new services are assumed to ramp up during WY1 and reach the ultimate level of utilization during WY2.

The baseline data used for State Plan Service cost projections was from the time period April 1, 2009 - March 31, 2010. Because this time period was subsequent to the January 1, 2006 implementation of Medicare Part D, the cost of Part D drugs was already excluded from the base data.

FOR THE 2012 SECOND AMENDMENT:

General Assumptions:
Base Year data was generally from Waiver Year 1 of the current filing: April 1, 2010 - March 31, 2011.
Unduplicated users for each service were allowed to increase proportionately with total slots.
Average units per user were allowed to vary with average length of stay.
Average cost per unit was adjusted to the rate schedule currently in effect, then allowed to increase at 3.5% per year.

New Services:
Case Management: This service is currently being provided outside the waiver to all SSW enrollees. Indiana proposes to again allow choice of providers. No change in average monthly cost is assumed.
Personal Assistant: It was assumed that 10% of unique recipients would use this service during WY 3, growing to 15% during WY 4 and 20% during WY 5. Average utilization is projected at 8 hours per week.

Annual expenditure cap:
The annual expenditure cap will increase to $16,250 per enrollee, effective July 1, 2012. A portion of the increase will be needed to accommodate Case Management within the waiver. It is also anticipated that those with greater needs will likely utilize a portion of the additional budget on the new Personal Assistant service. Consequently, no additional explicit adjustment is included to reflect the increase in the annual expenditure cap to $16,250 per enrollee.

ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Base Year data was from Waiver Year 5 of the current waiver: April 1, 2009 - March 31, 2010, and represents annual state plan service costs for SSW recipients. Base year data was inflated by 6.0% per year.

FOR THE 2012 SECOND AMENDMENT:

Factor D`: Base Year data was from Waiver Year 1 of the current filing: April 1, 2010 - March 31, 2011, and represents annual state plan service costs for SSW recipients. Base year data was inflated by 6.0% per year.

iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Base Year data was from Waiver Year 5 of the current waiver: April 1, 2009 - March 31, 2010. Factor G institutional costs were developed based on ICR/MR facility costs per unique recipient. Factor G was inflated forward at 4.0% per year.

FOR THE 2012 SECOND AMENDMENT:

Factor G: Base Year data was from Waiver Year 1 of the current filing: April 1, 2010 - March 31, 2011. Factor G institutional costs were developed based on ICR/MR facility costs per unique recipient. Factor G was inflated forward at 4.0% per year.

iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Base Year data was from Waiver Year 5 of the current waiver: April 1, 2009 - March 31, 2010, and represents annual state plan service costs for those residing in ICR/MR facilities. This data was inflated

forward at 6.0% per year.

FOR THE 2012 SECOND AMENDMENT:

Factor G`: Base Year data was from Waiver Year 1 of the current filing: April 1, 2010 - March 31, 2011, and represents annual state plan service costs for those residing in ICR/MR facilities. This data was inflated forward at 6.0% per year.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services	
Adult Day Services	
Case Management	
Prevocational Services	
Respite	
Supported Employment Follow Along	
Occupational Therapy	
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	
Participant Assistance and Care	
Personal Emergency Response System	
Recreational Therapy	
Specialized Medical Equipment and Supplies	
Transportation	
Workplace Assistance	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

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

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services Total:						**302099.03**
Adult Day Services - 1/4 hour - Level 1	1/4 hour	1	376.00	1.43	**537.68**	
Adult Day Services - 1/4 hour - Level 2	1/4 hour	1	406.00	1.86	**755.16**	
Adult Day Services - 1/4 hour - Level 3	1/4 hour	1	666.00	2.21	**1471.86**	
Adult Day Service - 1/2 day - Level 1	1/2 day	9	223.00	22.71	**45578.97**	
Adult Day Service - 1/2 day - Level 2	1/2 day	18	254.00	29.80	**136245.60**	
Adult Day Service - 1/2 day - Level 3	1/2 day	18	184.00	35.48	**117509.76**	
Case Management Total:						**0.00**
Case Management	month	0	0.00	0.01	**0.00**	
Prevocational Services Total:						**5470490.78**
Prevocational Services - Small Group	hour	0	0.00	0.01	**0.00**	
Prevocational Services - Medium Group	hour	0	0.00	0.01	**0.00**	
Prevocational Services - Large Group	hour	0	0.00	0.01	**0.00**	
Prevocational Services (8:1)	hour	1074	483.00	6.21	**3221387.82**	
Prevocational Services (10:1)	hour	785	228.00	4.97	**889530.60**	
Prevocational Services (12:1)	hour	738	228.00	4.14	**696612.96**	
Prevocational Services (14:1)	hour	485	162.00	3.54	**278137.80**	
Prevocational Services (16:1)	hour	472	263.00	3.10	**384821.60**	
Respite Total:						**7327434.82**
Respite Nursing Care (RN)	1/4 hour	3	237.00	8.06	**5730.66**	
Respite Nursing Care (LPN)	1/4 hour	4	147.00	6.12	**3598.56**	
Respite	hour	1768	160.00	25.87	**7318105.60**	
Supported Employment Follow Along Total:						**1648623.75**
Supported Employment Follow Along - Tier 1	month	354	10.00	182.07	**644527.80**	
Supported Employment Follow Along - Tier 2	month	158	10.00	364.15	**575357.00**	
Supported Employment Follow Along - Tier 3	month	16	10.00	546.22	**87395.20**	
Supported Employment Follow Along - Tier 4	hour	125	75.00	36.41	**341343.75**	
Occupational Therapy Total:						**3295.74**

GRAND TOTAL:	**45435716.72**
Total Estimated Unduplicated Participants:	**5267**
Factor D (Divide total by number of participants):	**8626.49**
Average Length of Stay on the Waiver:	328

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Occupational Therapy	1/4 hour	3	59.00	18.62	**3295.74**	
Physical Therapy Total:						**2387.88**
Physical Therapy	1/4 hour	4	33.00	18.09	**2387.88**	
Psychological Therapy Total:						**591.62**
Psychological Therapy - Family	1/4 hour	1	1.00	17.87	**17.87**	
Psychological Therapy - Individual	1/4 hour	1	1.00	15.99	**15.99**	
Psychological Therapy - Group	1/4 hour	16	7.00	4.98	**557.76**	
Speech/Language Therapy Total:						**15500.16**
Speech/Language Therapy	1/4 hour	4	208.00	18.63	**15500.16**	
Behavioral Support Services Total:						**3756020.10**
Behaviorial Support Services - Level 1	1/4 hour	1090	6.00	18.83	**123148.20**	
Behaviorial Support Services - Level 2	1/4 hour	1090	177.00	18.83	**3632871.90**	
Community Based Habilitation - Group Total:						**1432973.76**
Community Based Habilitation - Small Group	hour	0	0.00	0.01	**0.00**	
Community Based Habilitation - Medium Group	hour	0	0.00	0.01	**0.00**	
Community Based Habilitation - Group (2:1)	hour	438	49.00	13.48	**289307.76**	
Community Based Habilitation - Group (3:1)	hour	450	72.00	8.99	**291276.00**	
Community Based Habilitation - Group (4:1)	hour	770	164.00	6.75	**852390.00**	
Community Based Habilitation - Individual Total:						**6889439.70**
Community Based Habilitation - Individual	hour	1614	165.00	25.87	**6889439.70**	
Facility Based Habilitation - Group Total:						**3479000.61**
Facility Based Habilitation - Small Group	hour	0	0.00	0.01	**0.00**	
Facility Based Habilitation - Medium Group	hour	0	0.00	0.01	**0.00**	
Facility Based Habilitation - Large Group	hour	0	0.00	0.01	**0.00**	
Facility Based Habilitation - Group (2:1)	hour	428	65.00	15.27	**424811.40**	
Facility Based Habilitation - Group (4:1)	hour	735	239.00	7.64	**1342080.60**	
Facility Based Habilitation - Group (6:1)	hour	735	315.00	5.09	**1178462.25**	
Facility Based Habilitation - Group (8:1)	hour	597	234.00	3.82	**533646.36**	

GRAND TOTAL:	**45435716.72**
Total Estimated Unduplicated Participants:	**5267**
Factor D (Divide total by number of participants):	**8626.49**
Average Length of Stay on the Waiver:	328

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Facility Based Habilitation - Individual Total:						**1148782.50**
Facility Based Habilitation - Individual	hour	775	61.00	24.30	**1148782.50**	
Facility Based Support Services Total:						**3644583.25**
Facility Based Support Services	hour	2107	935.00	1.85	**3644583.25**	
Family and Caregiver Training Total:						**120131.97**
Family and Caregiver Training - Family	unit	79	89.00	16.67	**117206.77**	
Family and Caregiver Training - Non-Family	unit	8	5.00	73.13	**2925.20**	
Intensive Behavioral Intervention Total:						**3662165.08**
Intensive Behavioral Intervention - Level 1	hour	158	54.00	104.69	**893215.08**	
Intensive Behavioral Intervention - Level 2	hour	158	701.00	25.00	**2768950.00**	
Music Therapy Total:						**817938.72**
Music Therapy	1/4 hour	502	146.00	11.16	**817938.72**	
Participant Assistance and Care Total:						**0.00**
Participant Assistance and Care	hour	0	0.00	0.01	**0.00**	
Personal Emergency Response System Total:						**13200.36**
Personal Emergency Response System - Installation	unit	1	1.00	53.88	**53.88**	
Personal Emergency Response System - Maintenance	month	38	9.00	38.44	**13146.48**	
Recreational Therapy Total:						**490928.40**
Recreational Therapy	1/4 hour	265	166.00	11.16	**490928.40**	
Specialized Medical Equipment and Supplies Total:						**57280.85**
Specialized Medical Equipment and Supplies - Installation	unit	11	1.00	4729.99	**52029.89**	
Specialized Medical Equipment and Supplies - Maintainence	unit	3	1.00	1750.32	**5250.96**	
Transportation Total:						**1000785.66**
Transportation	trip	1266	161.00	4.91	**1000785.66**	
Workplace Assistance Total:						**4152061.98**
Workplace Assistance	hour	421	374.00	26.37	**4152061.98**	
				GRAND TOTAL:		**45435716.72**
				Total Estimated Unduplicated Participants:		**5267**
				Factor D (Divide total by number of participants):		**8626.49**
				Average Length of Stay on the Waiver:		328

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

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

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services Total:						**311818.00**
Adult Day Services - 1/4 hour - Level 1	1/4 hour	1	1.00	1.48	**1.48**	
Adult Day Services - 1/4 hour - Level 2	1/4 hour	1	1.00	1.93	**1.93**	
Adult Day Services - 1/4 hour - Level 3	1/4 hour	1	1.00	2.29	**2.29**	
Adult Day Service - 1/2 day - Level 1	1/2 day	10	240.00	22.73	**54552.00**	
Adult Day Service - 1/2 day - Level 2	1/2 day	20	199.00	29.91	**119041.80**	
Adult Day Service - 1/2 day - Level 3	1/2 day	23	170.00	35.35	**138218.50**	
Case Management Total:						**0.00**
Case Management	month	0	0.00	0.01	**0.00**	
Prevocational Services Total:						**8454448.11**
Prevocational Services - Small Group	hour	179	683.00	8.63	**1055077.91**	
Prevocational Services - Medium Group	hour	1795	683.00	4.80	**5884728.00**	
Prevocational Services - Large Group	hour	1139	436.00	3.05	**1514642.20**	
Prevocational Services (8:1)	hour	0	0.00	0.01	**0.00**	
Prevocational Services (10:1)	hour	0	0.00	0.01	**0.00**	
Prevocational Services (12:1)	hour	0	0.00	0.01	**0.00**	
Prevocational Services (14:1)	hour	0	0.00	0.01	**0.00**	
Prevocational Services (16:1)	hour	0	0.00	0.01	**0.00**	
Respite Total:						**7836807.27**
Respite Nursing Care (RN)	1/4 hour	4	699.00	6.37	**17810.52**	
Respite Nursing Care (LPN)	1/4 hour	5	845.00	6.12	**25857.00**	
				GRAND TOTAL:		**42113270.00**
				Total Estimated Unduplicated Participants:		**5669**
				Factor D (Divide total by number of participants):		**7429.00**
				Average Length of Stay on the Waiver:		339

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite	hour	1797	275.00	15.77	**7793139.75**	
Supported Employment Follow Along Total:						**587950.96**
Supported Employment Follow Along - Tier 1	month	200	6.00	181.73	**218076.00**	
Supported Employment Follow Along - Tier 2	month	123	6.00	363.86	**268528.68**	
Supported Employment Follow Along - Tier 3	month	21	4.00	545.89	**45854.76**	
Supported Employment Follow Along - Tier 4	hour	49	32.00	35.39	**55491.52**	
Occupational Therapy Total:						**3104.20**
Occupational Therapy	1/4 hour	2	83.00	18.70	**3104.20**	
Physical Therapy Total:						**19.41**
Physical Therapy	1/4 hour	1	1.00	19.41	**19.41**	
Psychological Therapy Total:						**1942.40**
Psychological Therapy - Family	1/4 hour	1	1.00	17.87	**17.87**	
Psychological Therapy - Individual	1/4 hour	1	1.00	15.99	**15.99**	
Psychological Therapy - Group	1/4 hour	18	23.00	4.61	**1908.54**	
Speech/Language Therapy Total:						**15479.04**
Speech/Language Therapy	1/4 hour	6	139.00	18.56	**15479.04**	
Behavioral Support Services Total:						**4243076.58**
Behaviorial Support Services - Level 1	1/4 hour	967	9.00	18.75	**163181.25**	
Behaviorial Support Services - Level 2	1/4 hour	1211	183.00	18.41	**4079895.33**	
Community Based Habilitation - Group Total:						**1739459.52**
Community Based Habilitation - Small Group	hour	1599	96.00	8.63	**1324739.52**	
Community Based Habilitation - Medium Group	hour	900	96.00	4.80	**414720.00**	
Community Based Habilitation - Group (2:1)	hour	0	0.00	0.01	**0.00**	
Community Based Habilitation - Group (3:1)	hour	0	0.00	0.01	**0.00**	
Community Based Habilitation - Group (4:1)	hour	0	0.00	0.01	**0.00**	
Community Based Habilitation - Individual Total:						**7514731.98**
Community Based Habilitation - Individual	hour	2406	139.00	22.47	**7514731.98**	
Facility Based Habilitation - Group Total:						**5547534.30**

GRAND TOTAL:	**42113270.00**
Total Estimated Unduplicated Participants:	**5669**
Factor D (Divide total by number of participants):	**7429.00**
Average Length of Stay on the Waiver:	339

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Facility Based Habilitation - Small Group	hour	1611	170.00	8.63	**2363498.10**	
Facility Based Habilitation - Medium Group	hour	1588	368.00	4.80	**2805043.20**	
Facility Based Habilitation - Large Group	hour	285	436.00	3.05	**378993.00**	
Facility Based Habilitation - Group (2:1)	hour	0	0.00	0.01	**0.00**	
Facility Based Habilitation - Group (4:1)	hour	0	0.00	0.01	**0.00**	
Facility Based Habilitation - Group (6:1)	hour	0	0.00	0.01	**0.00**	
Facility Based Habilitation - Group (8:1)	hour	0	0.00	0.01	**0.00**	
Facility Based Habilitation - Individual Total:						**987893.55**
Facility Based Habilitation - Individual	hour	977	45.00	22.47	**987893.55**	
Facility Based Support Services Total:						**75133.67**
Facility Based Support Services	hour	283	139.00	1.91	**75133.67**	
Family and Caregiver Training Total:						**66667.53**
Family and Caregiver Training - Family	unit	51	3.00	425.81	**65148.93**	
Family and Caregiver Training - Non-Family	unit	5	6.00	50.62	**1518.60**	
Intensive Behavioral Intervention Total:						**74399.04**
Intensive Behavioral Intervention - Level 1	hour	3	56.00	108.26	**18187.68**	
Intensive Behavioral Intervention - Level 2	hour	3	724.00	25.88	**56211.36**	
Music Therapy Total:						**1018980.00**
Music Therapy	1/4 hour	600	153.00	11.10	**1018980.00**	
Participant Assistance and Care Total:						**0.00**
Participant Assistance and Care	hour	0	0.00	0.01	**0.00**	
Personal Emergency Response System Total:						**14401.40**
Personal Emergency Response System - Installation	unit	2	1.00	37.50	**75.00**	
Personal Emergency Response System - Maintenance	month	37	10.00	38.72	**14326.40**	
Recreational Therapy Total:						**628935.30**
Recreational Therapy	1/4 hour	311	189.00	10.70	**628935.30**	
Specialized Medical Equipment and Supplies Total:						**36562.01**

GRAND TOTAL:	**42113270.00**
Total Estimated Unduplicated Participants:	**5669**
Factor D (Divide total by number of participants):	**7429.00**
Average Length of Stay on the Waiver:	339

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Medical Equipment and Supplies - Installation	unit	14	1.00	2110.24	**29543.36**	
Specialized Medical Equipment and Supplies - Maintainence	unit	3	1.00	2339.55	**7018.65**	
Transportation Total:						**2492588.28**
Transportation	trip	1852	273.00	4.93	**2492588.28**	
Workplace Assistance Total:						**461337.45**
Workplace Assistance	hour	35	483.00	27.29	**461337.45**	
				GRAND TOTAL:		**42113270.00**
				Total Estimated Unduplicated Participants:		**5669**
				Factor D (Divide total by number of participants):		**7429.00**
				Average Length of Stay on the Waiver:		339

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

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

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services Total:						**318405.86**
Adult Day Services - 1/4 hour - Level 1	1/4 hour	1	1.00	1.43	**1.43**	
Adult Day Services - 1/4 hour - Level 2	1/4 hour	1	1.00	1.86	**1.86**	
Adult Day Services - 1/4 hour - Level 3	1/4 hour	1	1.00	2.21	**2.21**	
Adult Day Service - 1/2 day - Level 1	1/2 day	11	234.00	22.72	**58481.28**	
Adult Day Service - 1/2 day - Level 2	1/2 day	23	239.00	29.80	**163810.60**	
Adult Day Service - 1/2 day - Level 3	1/2 day	18	151.00	35.36	**96108.48**	
Case Management Total:						**5850250.00**
Case Management	month	6686	7.00	125.00	**5850250.00**	
Prevocational Services Total:						**8317242.18**
Prevocational Services - Small Group	hour	888	39.00	8.54	**295757.28**	
				GRAND TOTAL:		**55622753.92**
				Total Estimated Unduplicated Participants:		**6686**
				Factor D (Divide total by number of participants):		**8319.29**
				Average Length of Stay on the Waiver:		304

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Prevocational Services - Medium Group	hour	2034	705.00	4.77	**6840036.90**	
Prevocational Services - Large Group	hour	1440	269.00	3.05	**1181448.00**	
Prevocational Services (8:1)	hour	0	0.00	0.01	**0.00**	
Prevocational Services (10:1)	hour	0	0.00	0.01	**0.00**	
Prevocational Services (12:1)	hour	0	0.00	0.01	**0.00**	
Prevocational Services (14:1)	hour	0	0.00	0.01	**0.00**	
Prevocational Services (16:1)	hour	0	0.00	0.01	**0.00**	
Respite Total:						**7942675.71**
Respite Nursing Care (RN)	1/4 hour	4	441.00	6.14	**10830.96**	
Respite Nursing Care (LPN)	1/4 hour	6	355.00	6.12	**13035.60**	
Respite	hour	2085	161.00	23.59	**7918809.15**	
Supported Employment Follow Along Total:						**1576527.29**
Supported Employment Follow Along - Tier 1	month	510	8.00	180.58	**736766.40**	
Supported Employment Follow Along - Tier 2	month	228	7.00	364.16	**581199.36**	
Supported Employment Follow Along - Tier 3	month	32	7.00	546.22	**122353.28**	
Supported Employment Follow Along - Tier 4	hour	85	45.00	35.61	**136208.25**	
Occupational Therapy Total:						**18.62**
Occupational Therapy	1/4 hour	1	1.00	18.62	**18.62**	
Physical Therapy Total:						**18.75**
Physical Therapy	1/4 hour	1	1.00	18.75	**18.75**	
Psychological Therapy Total:						**2301.47**
Psychological Therapy - Family	1/4 hour	1	1.00	17.87	**17.87**	
Psychological Therapy - Individual	1/4 hour	22	4.00	15.99	**1407.12**	
Psychological Therapy - Group	1/4 hour	22	8.00	4.98	**876.48**	
Speech/Language Therapy Total:						**14620.50**
Speech/Language Therapy	1/4 hour	6	135.00	18.05	**14620.50**	
Behavioral Support Services Total:						**4830953.28**
Behaviorial Support Services - Level 1	1/4 hour	1079	8.00	18.69	**161332.08**	
Behaviorial Support Services - Level 2	1/4 hour	1476	170.00	18.61	**4669621.20**	

GRAND TOTAL:	**55622753.92**
Total Estimated Unduplicated Participants:	**6686**
Factor D (Divide total by number of participants):	**8319.29**
Average Length of Stay on the Waiver:	304

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Based Habilitation - Group Total:						**1393442.64**
Community Based Habilitation - Small Group	hour	1781	90.00	8.64	**1384905.60**	
Community Based Habilitation - Medium Group	hour	167	12.00	4.26	**8537.04**	
Community Based Habilitation - Group (2:1)	hour	0	0.00	0.01	**0.00**	
Community Based Habilitation - Group (3:1)	hour	0	0.00	0.01	**0.00**	
Community Based Habilitation - Group (4:1)	hour	0	0.00	0.01	**0.00**	
Community Based Habilitation - Individual Total:						**10200270.46**
Community Based Habilitation - Individual	hour	3013	151.00	22.42	**10200270.46**	
Facility Based Habilitation - Group Total:						**5302069.93**
Facility Based Habilitation - Small Group	hour	1795	178.00	8.42	**2690274.20**	
Facility Based Habilitation - Medium Group	hour	1646	337.00	4.69	**2601552.38**	
Facility Based Habilitation - Large Group	hour	255	13.00	3.09	**10243.35**	
Facility Based Habilitation - Group (2:1)	hour	0	0.00	0.01	**0.00**	
Facility Based Habilitation - Group (4:1)	hour	0	0.00	0.01	**0.00**	
Facility Based Habilitation - Group (6:1)	hour	0	0.00	0.01	**0.00**	
Facility Based Habilitation - Group (8:1)	hour	0	0.00	0.01	**0.00**	
Facility Based Habilitation - Individual Total:						**1111484.20**
Facility Based Habilitation - Individual	hour	1060	47.00	22.31	**1111484.20**	
Facility Based Support Services Total:						**1.91**
Facility Based Support Services	hour	1	1.00	1.91	**1.91**	
Family and Caregiver Training Total:						**9714.31**
Family and Caregiver Training - Family	unit	19	5.00	101.74	**9665.30**	
Family and Caregiver Training - Non-Family	unit	1	1.00	49.01	**49.01**	
Intensive Behavioral Intervention Total:						**134.14**
Intensive Behavioral Intervention - Level 1	hour	1	1.00	108.26	**108.26**	
Intensive Behavioral Intervention - Level 2	hour	1	1.00	25.88	**25.88**	
Music Therapy Total:						**1281257.65**

GRAND TOTAL:	**55622753.92**
Total Estimated Unduplicated Participants:	**6686**
Factor D (Divide total by number of participants):	**8319.29**
Average Length of Stay on the Waiver:	304

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Music Therapy	1/4 hour	761	151.00	11.15	**1281257.65**	
Participant Assistance and Care Total:						**4042365.60**
Participant Assistance and Care	hour	669	260.00	23.24	**4042365.60**	
Personal Emergency Response System Total:						**15818.97**
Personal Emergency Response System - Installation	unit	3	1.00	53.89	**161.67**	
Personal Emergency Response System - Maintenance	month	45	9.00	38.66	**15657.30**	
Recreational Therapy Total:						**763239.75**
Recreational Therapy	1/4 hour	325	211.00	11.13	**763239.75**	
Specialized Medical Equipment and Supplies Total:						**12210.03**
Specialized Medical Equipment and Supplies - Installation	unit	4	1.00	2447.15	**9788.60**	
Specialized Medical Equipment and Supplies - Maintainence	unit	1	1.00	2421.43	**2421.43**	
Transportation Total:						**2637485.06**
Transportation	trip	2257	238.00	4.91	**2637485.06**	
Workplace Assistance Total:						**245.61**
Workplace Assistance	hour	1	9.00	27.29	**245.61**	
				GRAND TOTAL:		**55622753.92**
				Total Estimated Unduplicated Participants:		**6686**
				Factor D (Divide total by number of participants):		**8319.29**
				Average Length of Stay on the Waiver:		304

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

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

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services Total:						**432561.66**
				GRAND TOTAL:		**83652832.46**
				Total Estimated Unduplicated Participants:		**8326**
				Factor D (Divide total by number of participants):		**10047.18**
				Average Length of Stay on the Waiver:		319

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services - 1/4 hour - Level 1	1/4 hour	2	1.00	1.48	**2.96**	
Adult Day Services - 1/4 hour - Level 2	1/4 hour	2	1.00	1.93	**3.86**	
Adult Day Services - 1/4 hour - Level 3	1/4 hour	2	1.00	2.29	**4.58**	
Adult Day Service - 1/2 day - Level 1	1/2 day	14	246.00	23.51	**80968.44**	
Adult Day Service - 1/2 day - Level 2	1/2 day	29	250.00	30.84	**223590.00**	
Adult Day Service - 1/2 day - Level 3	1/2 day	22	159.00	36.59	**127991.82**	
Case Management Total:						**10772178.80**
Case Management	month	8326	10.00	129.38	**10772178.80**	
Prevocational Services Total:						**11258271.60**
Prevocational Services - Small Group	hour	1106	41.00	8.84	**400858.64**	
Prevocational Services - Medium Group	hour	2533	740.00	4.94	**9259634.80**	
Prevocational Services - Large Group	hour	1793	282.00	3.16	**1597778.16**	
Prevocational Services (8:1)	hour	0	0.00	0.01	**0.00**	
Prevocational Services (10:1)	hour	0	0.00	0.01	**0.00**	
Prevocational Services (12:1)	hour	0	0.00	0.01	**0.00**	
Prevocational Services (14:1)	hour	0	0.00	0.01	**0.00**	
Prevocational Services (16:1)	hour	0	0.00	0.01	**0.00**	
Respite Total:						**10742810.06**
Respite Nursing Care (RN)	1/4 hour	5	462.00	6.35	**14668.50**	
Respite Nursing Care (LPN)	1/4 hour	8	373.00	6.33	**18888.72**	
Respite	hour	2596	169.00	24.41	**10709252.84**	
Supported Employment Follow Along Total:						**2164951.56**
Supported Employment Follow Along - Tier 1	month	636	9.00	186.90	**1069815.60**	
Supported Employment Follow Along - Tier 2	month	284	7.00	376.91	**749297.08**	
Supported Employment Follow Along - Tier 3	month	40	7.00	565.34	**158295.20**	
Supported Employment Follow Along - Tier 4	hour	106	48.00	36.86	**187543.68**	
Occupational Therapy Total:						**38.54**
Occupational Therapy	1/4 hour	2	1.00	19.27	**38.54**	
Physical Therapy Total:						**38.82**

GRAND TOTAL:	**83652832.46**
Total Estimated Unduplicated Participants:	**8326**
Factor D (Divide total by number of participants):	**10047.18**
Average Length of Stay on the Waiver:	319

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Physical Therapy	1/4 hour	2	1.00	19.41	**38.82**	
Psychological Therapy Total:						**3522.70**
Psychological Therapy - Family	1/4 hour	2	1.00	18.50	**37.00**	
Psychological Therapy - Individual	1/4 hour	27	5.00	16.55	**2234.25**	
Psychological Therapy - Group	1/4 hour	27	9.00	5.15	**1251.45**	
Speech/Language Therapy Total:						**21071.04**
Speech/Language Therapy	1/4 hour	8	141.00	18.68	**21071.04**	
Behavioral Support Services Total:						**6512658.12**
Behaviorial Support Services - Level 1	1/4 hour	1344	8.00	19.35	**208051.20**	
Behaviorial Support Services - Level 2	1/4 hour	1839	178.00	19.26	**6304606.92**	
Community Based Habilitation - Group Total:						**1893905.46**
Community Based Habilitation - Small Group	hour	2217	95.00	8.94	**1882898.10**	
Community Based Habilitation - Medium Group	hour	208	12.00	4.41	**11007.36**	
Community Based Habilitation - Group (2:1)	hour	0	0.00	0.01	**0.00**	
Community Based Habilitation - Group (3:1)	hour	0	0.00	0.01	**0.00**	
Community Based Habilitation - Group (4:1)	hour	0	0.00	0.01	**0.00**	
Community Based Habilitation - Individual Total:						**13840377.60**
Community Based Habilitation - Individual	hour	3752	159.00	23.20	**13840377.60**	
Facility Based Habilitation - Group Total:						**7157120.90**
Facility Based Habilitation - Small Group	hour	2235	186.00	8.72	**3624991.20**	
Facility Based Habilitation - Medium Group	hour	2049	354.00	4.85	**3517928.10**	
Facility Based Habilitation - Large Group	hour	317	14.00	3.20	**14201.60**	
Facility Based Habilitation - Group (2:1)	hour	0	0.00	0.01	**0.00**	
Facility Based Habilitation - Group (4:1)	hour	0	0.00	0.01	**0.00**	
Facility Based Habilitation - Group (6:1)	hour	0	0.00	0.01	**0.00**	
Facility Based Habilitation - Group (8:1)	hour	0	0.00	0.01	**0.00**	
Facility Based Habilitation - Individual Total:						**1524600.00**

GRAND TOTAL:	**83652832.46**
Total Estimated Unduplicated Participants:	**8326**
Factor D (Divide total by number of participants):	**10047.18**
Average Length of Stay on the Waiver:	319

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Facility Based Habilitation - Individual	hour	1320	50.00	23.10	**1524600.00**	
Facility Based Support Services Total:						**3.96**
Facility Based Support Services	hour	2	1.00	1.98	**3.96**	
Family and Caregiver Training Total:						**12737.44**
Family and Caregiver Training - Family	unit	24	5.00	105.30	**12636.00**	
Family and Caregiver Training - Non-Family	unit	2	1.00	50.72	**101.44**	
Intensive Behavioral Intervention Total:						**277.66**
Intensive Behavioral Intervention - Level 1	hour	2	1.00	112.05	**224.10**	
Intensive Behavioral Intervention - Level 2	hour	2	1.00	26.78	**53.56**	
Music Therapy Total:						**1739447.28**
Music Therapy	1/4 hour	948	159.00	11.54	**1739447.28**	
Participant Assistance and Care Total:						**10933995.80**
Participant Assistance and Care	hour	1249	364.00	24.05	**10933995.80**	
Personal Emergency Response System Total:						**22172.84**
Personal Emergency Response System - Installation	unit	3	1.00	55.78	**167.34**	
Personal Emergency Response System - Maintenance	month	55	10.00	40.01	**22005.50**	
Recreational Therapy Total:						**1033205.76**
Recreational Therapy	1/4 hour	404	222.00	11.52	**1033205.76**	
Specialized Medical Equipment and Supplies Total:						**17676.36**
Specialized Medical Equipment and Supplies - Installation	unit	5	1.00	2532.80	**12664.00**	
Specialized Medical Equipment and Supplies - Maintainence	unit	2	1.00	2506.18	**5012.36**	
Transportation Total:						**3568700.00**
Transportation	trip	2810	250.00	5.08	**3568700.00**	
Workplace Assistance Total:						**508.50**
Workplace Assistance	hour	2	9.00	28.25	**508.50**	
				GRAND TOTAL:		**83652832.46**
				Total Estimated Unduplicated Participants:		**8326**
				Factor D (Divide total by number of participants):		**10047.18**
				Average Length of Stay on the Waiver:		319

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

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

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services Total:						**537641.74**
Adult Day Services - 1/4 hour - Level 1	1/4 hour	2	1.00	1.53	**3.06**	
Adult Day Services - 1/4 hour - Level 2	1/4 hour	2	1.00	2.00	**4.00**	
Adult Day Services - 1/4 hour - Level 3	1/4 hour	2	1.00	2.37	**4.74**	
Adult Day Service - 1/2 day - Level 1	1/2 day	17	250.00	24.34	**103445.00**	
Adult Day Service - 1/2 day - Level 2	1/2 day	34	254.00	31.92	**275661.12**	
Adult Day Service - 1/2 day - Level 3	1/2 day	26	161.00	37.87	**158523.82**	
Case Management Total:						**14558143.60**
Case Management	month	9884	11.00	133.90	**14558143.60**	
Prevocational Services Total:						**14041385.89**
Prevocational Services - Small Group	hour	1313	42.00	9.15	**504585.90**	
Prevocational Services - Medium Group	hour	3007	751.00	5.11	**11539693.27**	
Prevocational Services - Large Group	hour	2128	287.00	3.27	**1997106.72**	
Prevocational Services (8:1)	hour	0	0.00	0.01	**0.00**	
Prevocational Services (10:1)	hour	0	0.00	0.01	**0.00**	
Prevocational Services (12:1)	hour	0	0.00	0.01	**0.00**	
Prevocational Services (14:1)	hour	0	0.00	0.01	**0.00**	
Prevocational Services (16:1)	hour	0	0.00	0.01	**0.00**	
Respite Total:						**13436597.53**
Respite Nursing Care (RN)	1/4 hour	6	470.00	6.57	**18527.40**	
Respite Nursing Care (LPN)	1/4 hour	9	379.00	6.55	**22342.05**	
				GRAND TOTAL:		**109900530.58**
				Total Estimated Unduplicated Participants:		**9884**
				Factor D (Divide total by number of participants):		**11119.03**
				Average Length of Stay on the Waiver:		324

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite	hour	3082	172.00	25.27	13395728.08	
Supported Employment Follow Along Total:						2657909.67
Supported Employment Follow Along - Tier 1	month	755	9.00	193.44	1314424.80	
Supported Employment Follow Along - Tier 2	month	337	7.00	390.10	920245.90	
Supported Employment Follow Along - Tier 3	month	47	7.00	585.13	192507.77	
Supported Employment Follow Along - Tier 4	hour	126	48.00	38.15	230731.20	
Occupational Therapy Total:						39.90
Occupational Therapy	1/4 hour	2	1.00	19.95	39.90	
Physical Therapy Total:						40.18
Physical Therapy	1/4 hour	2	1.00	20.09	40.18	
Psychological Therapy Total:						4314.14
Psychological Therapy - Family	1/4 hour	2	1.00	19.15	38.30	
Psychological Therapy - Individual	1/4 hour	32	5.00	17.13	2740.80	
Psychological Therapy - Group	1/4 hour	32	9.00	5.33	1535.04	
Speech/Language Therapy Total:						25064.64
Speech/Language Therapy	1/4 hour	9	144.00	19.34	25064.64	
Behavioral Support Services Total:						8130416.75
Behaviorial Support Services - Level 1	1/4 hour	1596	8.00	20.02	255615.36	
Behaviorial Support Services - Level 2	1/4 hour	2183	181.00	19.93	7874801.39	
Community Based Habilitation - Group Total:						2354357.58
Community Based Habilitation - Small Group	hour	2632	96.00	9.26	2339742.72	
Community Based Habilitation - Medium Group	hour	246	13.00	4.57	14614.86	
Community Based Habilitation - Group (2:1)	hour	0	0.00	0.01	0.00	
Community Based Habilitation - Group (3:1)	hour	0	0.00	0.01	0.00	
Community Based Habilitation - Group (4:1)	hour	0	0.00	0.01	0.00	
Community Based Habilitation - Individual Total:						17217426.94
Community Based Habilitation - Individual	hour	4454	161.00	24.01	17217426.94	
Facility Based Habilitation - Group Total:						8924961.76

GRAND TOTAL:	109900530.58
Total Estimated Unduplicated Participants:	9884
Factor D (Divide total by number of participants):	11119.03
Average Length of Stay on the Waiver:	324

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Facility Based Habilitation - Small Group	hour	2653	189.00	9.02	**4522781.34**	
Facility Based Habilitation - Medium Group	hour	2433	359.00	5.02	**4384703.94**	
Facility Based Habilitation - Large Group	hour	376	14.00	3.32	**17476.48**	
Facility Based Habilitation - Group (2:1)	hour	0	0.00	0.01	**0.00**	
Facility Based Habilitation - Group (4:1)	hour	0	0.00	0.01	**0.00**	
Facility Based Habilitation - Group (6:1)	hour	0	0.00	0.01	**0.00**	
Facility Based Habilitation - Group (8:1)	hour	0	0.00	0.01	**0.00**	
Facility Based Habilitation - Individual Total:						**1872565.00**
Facility Based Habilitation - Individual	hour	1567	50.00	23.90	**1872565.00**	
Facility Based Support Services Total:						**4.10**
Facility Based Support Services	hour	2	1.00	2.05	**4.10**	
Family and Caregiver Training Total:						**18415.32**
Family and Caregiver Training - Family	unit	28	6.00	108.99	**18310.32**	
Family and Caregiver Training - Non-Family	unit	2	1.00	52.50	**105.00**	
Intensive Behavioral Intervention Total:						**287.38**
Intensive Behavioral Intervention - Level 1	hour	2	1.00	115.97	**231.94**	
Intensive Behavioral Intervention - Level 2	hour	2	1.00	27.72	**55.44**	
Music Therapy Total:						**2162632.50**
Music Therapy	1/4 hour	1125	161.00	11.94	**2162632.50**	
Participant Assistance and Care Total:						**18164873.70**
Participant Assistance and Care	hour	1977	369.00	24.90	**18164873.70**	
Personal Emergency Response System Total:						**27561.52**
Personal Emergency Response System - Installation	unit	4	1.00	57.73	**230.92**	
Personal Emergency Response System - Maintenance	month	66	10.00	41.41	**27330.60**	
Recreational Therapy Total:						**1287360.00**
Recreational Therapy	1/4 hour	480	225.00	11.92	**1287360.00**	
Specialized Medical Equipment and Supplies Total:						**20916.50**

GRAND TOTAL:	**109900530.58**
Total Estimated Unduplicated Participants:	**9884**
Factor D (Divide total by number of participants):	**11119.03**
Average Length of Stay on the Waiver:	324

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Medical Equipment and Supplies - Installation	unit	6	1.00	2621.45	**15728.70**	
Specialized Medical Equipment and Supplies - Maintainence	unit	2	1.00	2593.90	**5187.80**	
Transportation Total:						**4457029.44**
Transportation	trip	3336	254.00	5.26	**4457029.44**	
Workplace Assistance Total:						**584.80**
Workplace Assistance	hour	2	10.00	29.24	**584.80**	
				GRAND TOTAL:		**109900530.58**
				Total Estimated Unduplicated Participants:		**9884**
				Factor D (Divide total by number of participants):		**11119.03**
				Average Length of Stay on the Waiver:		324