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:
Community Integration and Habilitation Waiver

C. Waiver Number:IN.0378
Original Base Waiver Number: IN.0378.

D. Amendment Number:

E. Proposed Effective Date: *(mm/dd/yy)*
04/01/15

Approved Effective Date of Waiver being Amended: 10/01/14

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
HIGHLIGHTS:
• Added comprehensive CIHW Transition Plan
• Updated text in various sections to mirror clarifications and improvements made within the Family Supports Waiver (FSW) Renewal application
• Added two new services (See APPENDIX C below)
• Corrected typos as needed

Clarifications specifying whether days were "calendar" or "business" days was added within the following areas:
• Main Module: Item 6. Additional Requirements, I. Public Input
• Appendix A-6 Assessment Methods and Frequency.
• Appendix C-1/C-3 Provider Specifications for Service
  o Adult Day Services
  o Case Management
• Appendix C-4-a Budget Limits by level of support
• Appendix F-1 Opportunity to Request a Fair Hearing
• Appendix F-2-b. Description of Additional Dispute Resolution Process
• Appendix G-1-d Responsibility for Review of and Response to Critical Events or Incidents
• Appendix H-1 Systems Improvement

MAIN MODULE

• Attachment #1 Transition Plan - completed due to CMS requirements that the State address how individuals who participate in an approved waiver might be adversely affected by an amendment that eliminates or limits any services furnished under the currently approved waiver, or when existing services may be available in lesser amounts.
• Attachment #2 Home and Community-Based Settings Waiver Transition Plan - added CIHW Transition Plan and text from two public notices issued by the State soliciting public input on the Statewide Transition Plan
• Additional Needed Information (Optional) - contains two appendices to the CIHW Transition Plan
  o Appendix A SUMMARY OF NCI DATA ANALYSIS
  o Appendix B PRELIMINARY SETTING ANALYSIS BASED ON REQUIREMENTS

APPENDIX A
•Appendix A-3 Use of Contracted Entities - updated UTILIZATION MANAGEMENT FUNCTIONS:
•Appendix A-6 Assessment Methods and Frequency - clarifies assessment methods and frequency by which monitoring of the FADS and Actuarial contractors occur

APPENDIX B
• Appendix B-1-b Additional Criteria - changed "the LOC screening tool" to "a level of care assessment tool"
• Appendix B-6-d Level of Care Criteria - clarified that Confirmation of Diagnosis is required for initials only
• Appendix B-6-i Procedures to Ensure Timely Reevaluations - capitalized four references to the "State"
• Quality Improvement: Level of Care, b. Methods for Remediation/Fixing Individual Problems, i. - updated to clarify roles and responsibilities
• Appendix B-7-b Freedom of Choice, b. Maintenance of Forms - updated to include how annual freedom of choice is documented and maintained

APPENDIX C
• C-1/C-3 Service Specification
  o Adult Day Services - billable in quarter hour units only as of April 1, 2015, removed half day units and 3 hour minimum
  o Community Based Habilitation - Individual (CHIO) - effective April 1, 2015 will be limited to ten (10) hours per month for participants who also utilize RHS Daily services
  o Extended Services - added as a new service replacing Supported Employment Follow Along (SEFA) services as of April 1, 2015
  o Facility Based Habilitation(Group & Individual) - clarified language from requiring delivery in a "DDRS-approved facility" to "in the facility of a DDRS-approved provider"
  o Prevocational services - added prohibition against overlapping usage with Extended Services effective April 1, 2015
  o Support Employment Follow Along (SEFA) - to be replaced by Extended Services effective April 1, 2015
  o Residential Habilitation and Support - modified due to addition of RHS Daily services effective April 1, 2015
  o RHS Daily services - added as a new residential service with a daily rate effective April 1, 2015
  o Transportation - clarified that Transportation may be used to access places of employment
  o Workplace Assistance - reference to SEFA to be replaced with reference to Extended Services as of April 1, 2015
• Appendix C-2-a Criminal History and/or Background Investigations - clarifies that Criminal Background checks are only required by the State at initial application and that recheck does occur at specified intervals
• Appendix C-2-b - changed "the state's Bureau of Developmental Disabilities Services" to "FSSA's Bureau of Developmental Disabilities Services"
• Appendix C-2-f Open Enrollment of Providers - added clarification on how providers access the Division of Disability and Rehabilitative Services Home and Community-Based Services Waiver Provider Manual and the BQIS Helpline as in FSW Renewal

APPENDIX D
• Appendix D-1-d Service Plan Development Process - monthly reporting requirements now changed to quarterly reporting requirements for providers and clarifies roles and responsibilities
• Appendix D-1-e Risk Assessment and Mitigation - clarified that the IST determines the party or parties responsible for development of risk plan(s)
• Appendix D-1-f Informed Choice of Providers - replaced reference to the "operating agency" with "DDRS"

APPENDIX F
• Appendix F-3-b State Grievance/Complaint System, Operational Responsibility - removed extra space within the citation [IC 12- 12.5] now reading [IC 12-12.5]
• Appendix F-3-c State Grievance/Complaint System, Description of System - capitalized reference to the "State"

APPENDIX G
• Appendix G-1; G-2; and G-3 – added clarification of current roles, responsibilities and processes for incident reporting, restraints, restrictive interventions, prohibition of seclusion, medication management and administration, as well as State oversight responsibilities.
• Appendix G-1-e Response to Critical Events or Incidents, Responsibility for Oversight of Critical Incidents and Events - clarified timeframes for data aggregation related to Incident Reporting
• Appendix G-3-c Medication Management and Administration, Medication Administration by c. Waiver Providers, ii State Policy - capitalized reference to the "State"
• Quality Improvement: Health and Welfare, b. Methods for Remediation/Fixing Individual Problems - clarifies current roles and responsibilities and timelines for follow-up regarding sentinel event monitoring

APPENDIX H
• Appendix H-1-a. System improvements - revised language to reflect "ongoing" practice rather than "As we begin..."
• Appendix H-1-a.i - added reference to FSSA Finance and changed list of QIEC membership from "OMPP representative" to "OMPP HCBS Liaison"
• Appendix H-1-b. i. System Design Changes - updated to reflect current practices, system design changes and strategies and to delete repetitive text accidentally left in last bullet during Renewal

APPENDIX I
• Appendix I-1 Financial Integrity - updated to mirror clarifications made at the request of CMS within the recently submitted FSW Renewal
• Appendix I-2-a Rate Determination Methods - updated to include information on Extended Services and the RHS Daily service

APPENDIX J
• updated due to inclusion of RHS Daily services and Extended Services, and removal of SEFA

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, 6-I, Attachment #2
☑ **Appendix A – Waiver Administration and Operation**	3, 6
☑ **Appendix B – Participant Access and Eligibility**	1-b, 6-d, 6-i, QIS, 7-b
☑ **Appendix C – Participant Services**	C-1/C-3, 2-a, 2-b, 2-f
☑ **Appendix D – Participant Centered Service Planning and Delivery**	1-d, 1-e, 1-f
☐ **Appendix E – Participant Direction of Services**	
☑ **Appendix F – Participant Rights**	1, 2-b, 3-b, 3-c
☑ **Appendix G – Participant Safeguards**	1-d, 1-e, 2, 3-c, QIS,
☑ **Appendix H**	1-a, 1-b
☑ **Appendix I – Financial Accountability**	1, 2-a
☑ **Appendix J – Cost-Neutrality Demonstration**	updated all sections

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**

- [x] **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*):
Community Integration and Habilitation 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.0378
Draft ID: IN.006.03.01

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

E. Proposed Effective Date of Waiver being Amended: 10/01/14
Approved Effective Date of Waiver being Amended: 10/01/14

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**

- [x] **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID 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 Community Integration and Habilitation (CIH) Waiver provides Medicaid Home and Community-Based Services (HCBS) waiver services to participants in a range of community settings as an alternative to care in an intermediate care facility individuals with developmental disabilities(ICF/IDD) or related conditions.

The waiver serves persons with a developmental disability, intellectual disability or autism and who have substantial functional limitations, as defined under the paragraph for “Persons with related conditions” 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 cost limit established by the assessment process described under Appendix C-4-a Budget Limits by Level of Support.

GOALS and OBJECTIVES:
The CIH 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 participants independent living.

ORGANIZATIONAL STRUCTURE:
Pursuant to P.L. 109-2014, §§ 15-19, the Office of the Secretary of FSSA is now the single State Medicaid agency.

Within the FSSA and under its direction, FSSA's Office of Medicaid Policy and Planning (OMPP) is divided into four units:
1. Eligibility Unit-develops eligibility policy and programs and provides guidance and support to agency field offices related to eligibility policy, systems coordination, and customer service.
2. Pharmacy Unit- oversees contractors providing clinical services (including prior authorization), clinical analytics, drug class reviews, drug rebate administration, claims processing, and drug pricing. The Pharmacy Unit also monitors changes to federal and State law to evaluate potential impacts to pharmacy policy and drafts legislative and program policy changes to reflect such changes.
3.Quality Unit- responsible for monitoring quality performance within the state's medical assistance programs. The Quality Unit also researches policy requests from providers and recommends changes to coverage and benefits.
4. Reimbursement Unit- oversees the process of providing compensation to Indiana Medicaid providers that is in accordance with federal and State laws and the Indiana Medicaid State Plan.

In addition to its function as the Medicaid agency, the Office of the Secretary of FSSA oversees and directs several divisions. Relevant to the description of the CIH Waiver:
1. Division of Family Resources (DFR), is responsible for determining eligibility for Medicaid based on policy developed by the OMPP Eligibility Unit.
2. Operations Division- includes the Office of Hearings and Appeals and the Medical Review Team (MRT). FSSA's Operations Division also oversees contractors providing services related to prior authorization, the Medicaid Management Information System (MMIS), and managed care.
3. Office of Compliance-oversees the Medicaid Program Integrity Unit, which identifies, investigates and refers suspected fraud cases, and performs audit and investigation functions.
4. Division of Healthcare Strategies and Technology- provides data analytics, project management, and application support for all divisions and units. Additionally, the division oversees HIPAA compliance and data security throughout FSSA.
5. Division of Disability and Rehabilitative Services (DDRS)- sets care standards for the provision of needed services for children and adults with physical and cognitive disabilities and provides these individuals with continuous, lifelong support.

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 Field Office conducts intake and determines eligibility.

DDRS-approved case management agencies provide case management services to participants, including implementing the Person Centered Planning process, assisting the participant to identify members of the Individualized Support Team, and developing an Individualized Support Plan prior to developing and submitting to the State, the service plan known as the Plan of Care/Cost Comparison Budget (CCB).

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 CIH 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/IID.

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:
SPECIFIC TO THE 1ST AMENDMENT, IN.0378.R03.01

•PLACEHOLDER FOR RESULTS OF PUBLIC COMMENT on October 31, 2014 posting of Statewide Transition Plan, inclusive of the comprehensive Community Integration & Habilitation Waiver (CIHW) Transition Plan. The 30 day public comment period** ends December 1, 2014. Attachment #2: Home and Community-Based Settings Waiver Transition Plan (Main Module) includes the CIHW Transition Plan and text from two public notices issued via the DDRS List Serve and accessible to all 4,893 individuals/agencies/stakeholders who have registered to receive such notices. The October 31, 2014, and November 3, 2014, notices were also posted on the DDRS' Website.

•PLACEHOLDER FOR RESULTS OF PUBLIC COMMENT FROM November 17, 2014 POSTING of CIHW 1st Amendment. The 30 day public comment period** ends December 17, 2014. Modifications will be considered based upon public input received.
•DDRS worked with representatives of professional trade organization and with industry representatives to develop a service definition and daily rate for the new RHS Daily service. DDRS worked internally with BDDS and with the Bureau of Rehabilitative Services (BRS) to develop a definition and rate for Extended Services which is consistent with the Rehabilitation Services Administration rules.

Specific to the CIHW 1st Amendment, public input was obtained through monthly meetings with the DDRS Advisory Council, as well as work groups and committees upon which stakeholders, providers and advocates participate.

• On November 17, 2014, DDRS posted its proposed 1st Amendment to the CIH Waiver. The posting lists proposed changes and provides a 30 day public comment period.

**For both the Transition Plan and the waiver amendment, stakeholders are encouraged to provide comments, suggestions and opinions. DDRS proactively sought assistance of nationally recognized organization and two professional trade associations in promoting this opportunity for public input. Modifications of the CIHW Transition Plan will be considered based upon public input received.

SPECIFIC TO THE 2014 RENEWAL, IN.0378.R03.00

Specific to the CIH Waiver Renewal, public input was obtained through monthly meetings with the DDRS Advisory Council, as well as work groups and committees upon which stakeholders, providers and advocates participated.
• FSSA's DDRS held Quarterly Provider Meetings presenting its goals and objectives, and opening the floor for questions and comments.
• On April 25, 2014, DDRS posted its current CIH Waiver and Preliminary Transition Plan including text from two public notices issued by the State, listed proposed changes to the waiver, and provided a 30 day public comment period. Stakeholders were encouraged to provide comments, suggestions and opinions. DDRS proactively sought the assistance of a nationally recognized organization and two professional trade associations in promoting this opportunity for public input. While public input was largely in support of the changes proposed by the State, additional comments received from the public influenced this renewal. Still other suggestions remain under review and consideration for future amendments.

ONGOING AND SPECIFIC TO ALL AMENDMENTS AND RENEWALS

DDRS maintains an open door to discuss issues, concerns, ideas and suggestions with families, advocates, providers and other stakeholders.

DDRS obtains public input and collaborates with key stakeholders in the state through the following methods:
• DDRS' Executive Management Team accepts public input from nationally recognized organizations, professional trade associations, and leaders among the service providers, in addressing concerns and suggestions on behalf of the group and the participants each represents in regard to DDRS program policy and operations. This input is considered as policies are developed. With FSSA's approval, policies and updates are posted to DDRS' Website. DDRS hosts Quarterly Provider Meetings (available in person or via WebEx) for statewide service providers announcing any waiver-related policy releases or updates authorized by FSSA, and meets with individual providers as needed or requested. DDRS also meets with small groups of parents and providers and intermittently attends other organized meetings of advocacy groups.
• The monthly 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, the State Medicaid Agency, and represent a wide and diverse membership including providers, parents, self-advocates, the Department of Education, and other Bureaus within the Division; including First Steps, Vocational Rehabilitation, and the Bureau of Quality Improvement Services. The Council's mission is to recommend strategies and actions that will ensure DDRS empowers people with disabilities to be independent and self-sufficient.
• DDRS maintains an electronic helpline available 24 hours daily, serving as a source of answering general questions surrounding programs, policies and procedures and as a receptor of suggestions and ideas from any interested party.
• Public forums and Webinars are held as needed toward the dissemination of program or operational changes.

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:

State: Indianapolis

Zip: **Indiana**

Phone: 46204-2739

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

E-mail: (317) 232-7382

angela.amos@fssa.in.gov

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

Last Name: Norvell

First Name: Nicole

Title: DDRS 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: Indianapolis

State: **Indiana**

Zip: 46207-7083

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

Fax: (317) 232-1240

E-mail: Nicole.Norvell@fssa.in.gov

8. Authorizing Signature

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:

State Medicaid Director or Designee

Submission Date:

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

Last Name: Moser

First Name: Joseph

Title: Medicaid Director

Agency: Family and Social Services Administration

Address: 402 W Washington St

Address 2:

City: Indianapolis

State: **Indiana**

Zip: 46204

Phone: (317) 234-8725 **Ext:** ☐ **TTY**

Fax: (317) 234-8725

E-mail: joe.moser@fssa.in.gov

Attachments

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

This transition plan in Attachment #1 is specific to CMS requirements that the State address the following starred points** whenever individuals who participate in an approved waiver might be adversely affected by an amendment that includes certain types of changes. Specifically, when there is elimination or limitation of any services furnished under the currently approved waiver, or when existing services may be available in lesser amounts.

Requirements for this transition plan (Attachment #1):
**Describes the similarities and differences between the services covered in the approved waiver and those covered in the new or renewed/amended waiver.

SEFA versus EXTENDED SERVICES

• Today's waiver-funded Supported Employment Follow Along (SEFA) services are not necessarily outcome based. Extended Services will be. Both services provide supports that enable a participant who is paid at or above the federal minimum wage to maintain employment in an integrated, competitive community employment setting.

• Currently, SEFA provides time-limited supports that may include observation and supervision, teaching and monitoring, facilitation of natural supports, individual program development and advocating for the participant. Extended Services will not be time-limited but will be required to ensure that natural supports are secured with tangible outcomes such as a reduction in the number of hours of paid support the participant will need over time. Extended Services will also involve observation or supervision, advocacy, on-the-job training, and reinforcement of work-related personal care and social skills. Extended Services will also be able to be provided in a small group setting, when determined appropriate by the ISP team, to work on similarly needed skills such as training on public transportation, social skills and other similarly related job skills.

RESIDENTIAL HABILITATION & SUPPORT (RHS) (LEVEL 1 & LEVEL 2) versus RHS DAILY
• The transition from RHS to RHS Daily will be seamless to the waiver participant. Service delivery requirements and standards remain unchanged. Participant will see no difference between the receipt of RHS and the receipt of RHS Daily services. The change is to provide administrative relief to the service providers, in turn, enabling a greater focus and emphasis on the needs of the participant. It is expected that increased community involvement will be obtained through the utilization of the RHS daily rate and should allow for increased personal choice in daily activities.

**When services in the approved waiver will not be offered in the new or renewed/amended waiver or will be offered in lesser amount, describes how the health and welfare of persons who receive services through the approved waiver will be assured.

Supported Employment will continue to be available through Vocational Rehabilitation Services rather than as a waiver funded service. Waiver participants are not losing access to this service, but the functions of Supported Employment are more appropriate to the Rehabilitation Act of 1973 and will therefore be shifted back to the Vocational Rehabilitation program.

Limiting the number of Community Based Habilitation – Individual (CHIO) hours for users of RHS Daily services should not have a negative impact on the participant in light of the fact that the RHS Daily service should provide any services required to meet the needs of the participant through the comprehensive RHS Daily rate. Case analysis were conducted, with RHS providers, to look at actual utilization for current waiver participants to determine how many CHIO hours are currently utilized and that analysis concluded that the limitation of 10 hours per month would fall within the range of what is currently being utilized by participants.

**States whether persons served in the existing waiver also are eligible to participate in the new waiver.

There are no changes to the eligibility requirements for waiver participation within this amendment. Participants who currently meet eligibility requirements for participation in the CIHW Renewal will continue to be eligible to participate in the amended waiver.

**When the new or renewed/amended waiver includes limitations on the amount of waiver services that were not included in the approved waiver, the plan describes how the limitations will be implemented.

The State anticipates that edits will be added to its case management system to limit the number of hours of CHIO for users of RHS Daily and will prohibit utilization of Prevocational Services for users of Extended Services. Additionally, Case Managers will be trained and expected to educate participants in the availability and limitations on the amount of these services. With the approval of this amendment by CMS, the State will publish and distribute an announcement detailing the approved changes within the amendment.

**When persons served in the approved waiver will not be eligible to participate in the new or renewed/amended waiver, the plan describes the steps that the state will take to facilitate the transition of affected individuals to alternate services and

supports that will enable the individual to remain in the community.

This point is not applicable to the CIHW 1st Amendment.

**Includes the time table for transitioning individuals to the new waiver (i.e., will participants in the existing waiver transition to the new waiver all at the same time or will the transition be phased in?).

This point is not applicable to the CIHW 1st Amendment.

**Describes how the participant is informed of the opportunity to request a Fair Hearing.

With any decision issued by the State, the participant may appeal the decision. With plans of care, a Notice of Action is issued and contains instruction on how to appeal the decision, even when the decision was favorable. The Case Manager holds the responsibility to inform the participant of their appeal rights.

Attachment #2: Home and Community-Based Settings Waiver Transition Plan
Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.
Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.
To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301 (c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.
Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.
Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

INDIANA TRANSITION PLAN FOR COMPLIANCE WITH MEDICAID HCBS FINAL RULE-COMMUNITY INTEGRATION & HABILITATION WAIVER as posted November 14, 2014

PURPOSE:
In January 2014, the Center for Medicaid and Medicare Services (CMS) announced a requirement for states to review and evaluate current Home and Community Based Service (HCBS) settings , including residential and nonresidential settings, and to demonstrate how Indiana's HCBS programs comply with the new federal HCBS rules. The purpose of this Transition Plan is to ensure that individuals receiving Medicaid HCBS are integrated in and have full access to supports in the greater community, including opportunities to seek employment, work in competitive integrated settings, engage in community life, and control personal resources. Overall, the Transition Plan provides assurance that individuals receiving HCBS have the same degree of access in the community as individuals not receiving Medicaid HCBS. This Transition Plan outlines the proposed process that Indiana will be utilizing to ensure implementation of the new HCBS requirements. Stakeholders were asked to provide public input and comment in order to allow Indiana to develop a comprehensive assessment plan.

OVERVIEW:
The Community Integration and Habilitation (CIH) Waiver is administered by the Family and Social Services Administration (FSSA) through the Division of Disability and Rehabilitative Services' (DDRS) and the Bureau of Developmental Disabilities Services (BDDS). The CIH waiver provides Medicaid HCBS waiver services to participants residing in a range of community settings as an alternative to care in an intermediate care facility for persons with intellectual or developmental disabilities or related conditions. The waiver serves persons with a developmental disability, intellectual disability or any other qualifying condition 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.

The comprehensive transition plan to CMS includes:

1. Indiana's Assessment of Settings
a) Description of Indiana's Assessment process
b) National Core Indicator (NCI) Data
c) Review of Indiana's standards, rules, regulations, and/or other requirements
d) Preliminary Setting Analysis
e) Provider Survey
f) Site Specific Assessment
g) Comprehensive Settings Results

2. Indiana's State and Provider Remedial Strategies
a) Description of Indiana's Remedial Strategies
b) Revisions to Indiana Administrative Code
c) Revisions to DDRS Waiver Manual
d) Revisions to Internal Forms
e) Participant Rights and Responsibilities Policy/Procedure Modifications
f) Review and Revisions to Provider Enrollment
g) Development of a Corrective Action Process and Plan
h) Develop Process for Provider Sanctions and Dis-enrollments
i) Ongoing Monitoring of Compliance

3. Public Comment
a) Description of Public Comment Process
b) Initial Plan Development
c) Provide assurance of Public Notice
d) Public Input: summary of Comments and Modifications
e) Public Relation and Education

DESCRIPTION OF ASSESSMENT PROCESS

The Division of Disability and Rehabilitative Services (DDRS) is working with the various providers, participants, family, guardians, and other stakeholders involved in the waiver programs to gather the information needed to evaluate Indiana's current compliance with the HCBS regulations. The assessment process is being conducted utilizing national core indicator data, internal quantitative data, a systematic review of rules, regulations, policies, and procedures, provider survey, and site-specific assessments.

Currently, Indiana is still in the assessment phase, with a potential end date of April 2017. Indiana has reviewed the NCI data, completed an initial review of rules, regulations, and policies/procedures, and developed a preliminary setting analysis. In order to provide a robust foundation for effective remedial strategies and high quality stakeholder input, Indiana has elected to complete additional assessment tasks. With an extended assessment timeframe, Indiana has confidence the assessment activities will yield a more comprehensive and valid compliance results document and will guide effective remedial strategies.

ASSESSMENT OF HCBS REQUIREMENTS: NCI DATA REVIEW
Start Date: 6/2014
End Date: 8/2014- Completed
DESCRIPTION: In order to ascertain the level of compliance with the HCBS requirements, Indiana has chosen to utilize the National Core Indicators (NCI) data to begin the process by which to evaluate compliance. The core indicators are standard measures used across states to assess the outcomes of services provided to individuals and families. Indicators address key areas of concern including employment, rights, service planning, community inclusion, choice, and health and safety. This information was utilized as a starting point, only, to allow Indiana and its stakeholders to drill down to those areas of the requirement that are of concern. In addition, the programmatic surveys in Phase 2 and Phase 3 will provide a more detailed account of compliance/noncompliance in terms of HCBS settings. The data obtained from the National Core Indicators (NCI) was derived from a random sample of waiver participants across Indiana. A statistically valid sample was obtained and in person interviews were conducted with the individual and family (when available) to gather information by asking the same questions of all participants. For the analysis of compliance with the HCBS requirements, a total of 368 participants on the CIH were interviewed in the 2012-2013 reporting year.

The initial NCI data has been reviewed and analyzed. Based on the NCI data, Indiana consistently demonstrated 85% and

below in most HCBS requirement areas. Due to the consistent low level of compliance, Indiana was unable to drill down the data to focus the provider survey on specific areas of concern. However, the breakdown of NCI data will be utilized as supplemental data in the preliminary setting analysis.

The NCI findings have been integrated into Appendix A: SUMMARY OF NCI DATA ANALYSIS** of this Transition Plan.

**Due to character limitations in this text field of the waiver application, the two Appendices to the CIHW Transition Plan have been entered into the next text field named "Additional Needed Information (Optional)"

ASSESSMENT OF HCBS REQUIREMENTS: REVIEW OF INDIANA's STANDRADS, RULES, REGULATIONS, and REQUIREMENTS
Start Date: 9/2014
End Date: 10/2014- Completed
DESCRIPTION: In addition to the NCI, Indiana has chosen to review its current standards, rules, regulations, and requirements in order to ascertain Indiana's level of compliance with the HCBS requirements. Specifically, Indiana's Administrative Code (IAC 460), current BDDS' policies and procedures, provider forms, and waiver manuals were reviewed.

460 IAC sections 6-3-29.5, 6-3-32, 6-3-36, 6-3-38.5, 6-3-38.6, 6-3-54, 6-3-58, 6-4, 6-5-36, 6-8-2, 6-8-3, 6-9-3, 6-9-4, 6-9-6, 6-10-8, 6-14-2, 6-14-4, 6-17-3, 6-19-1, 6-20-2, 6-24-1 ,6-24-3, 6-29-2, 6-29-3, 6-36-2,7-3-12, 7-4-1, 7-4-3, 7-5-5, 7-5-6 , 9-3-7, 13-3-12

IC 12-27-4

Individuals Rights and Responsibilities Policy, Transition Policy, BQIS Complaints: Supported Living Services and Supports Policy, Adverse Technics Policy, BMR-ANE Policy, Environmental Requirements Policy, Use of Restrictive Interventions, Including Restraint Policy, Human Rights Committee Policy, Incident Reporting and Management Policy, Annual Training on the Protection of Individual Rights and Respecting Dignity of Individual Policy, IST Policy, Pre-Post Transition Monitoring Policy, Provider Code of Ethics Policy, DDRS Policy: Personnel Policies and Manuals, DSP Training Policy, Professional Qualifications and Requirements Policy, Protection of Individuals Rights Policy, Transition Activities Policy, 90 Day Checklist Form, Pre-Post Monitoring Checklist Form, Individualized Support Plan Form, Part 4.5 and 4.6 of the DDRS Waiver Manual, Provider Agreement Checklist Form, and data from the 90 day check list.

A 90 day check list is completed by case managers quarterly through meeting with individuals and their individualized support teams as part of the ongoing monitoring of services. Questions are specifically related to individual needs, choice and rights, as well as other issues which may be identified in regard to the satisfaction, health and welfare of the participant. The 90 day check list data was extrapolated from the case management system.

ASSESSMENT OF HCBS REQUIREMENTS: PRELIMINARY SETTING ANALYSIS BASED ON REQUIREMENTS
Start Date: 9/2014
End Date: 10/2014- Completed
The preliminary setting analysis examines the HCBS requirements and Indiana's initial level of compliance with the HCBS requirements.

This initial settings analysis is general in nature and does not imply that any specific provider or location in non-compliant solely by classification in this analysis. Final determination will depend upon information gathered through all assessment activities outlined in the comprehensive transition plan, including but not limited to onsite reviews, provider annual self-assessments, internal programmatic data, and provider/participant surveys. The review was completed by DDRS/BDDS internal staff, OMPP, and the legal department. In addition, the initial assessment will be presented to stakeholders through the public comment period.

The outcome of the review indicated that while the state does have policies and procedures that support the HCBS rules, a more in-depth analysis will be need to be completed in order to determine full compliance. Potential areas of vulnerability identified in the setting analysis include: Controlling of personal resources; optimizing individual initiative, autonomy, and independence in making life choices; privacy in their unit; and individuals sharing units having a choice of roommates in that setting.

The preliminary settings can be found in Appendix B: PRELIMINARY SETTING ANALYSIS BASED ON

REQUIREMENTS** of this Transition Plan.

**Due to character limitations in this text field of the waiver application, the two Appendices to the CIHW Transition Plan have been entered into the next text field named "Additional Needed Information (Optional)"

ASSESSMENT OF HCBS REQUIREMENTS: PROVIDER SURVEY
Anticipated Date of Completion: 4/2016
In Indiana's initial proposal, the State assumed that the analysis of the NCI data might be sufficient to delineate the specific areas in which Indiana showed noncompliance with HCBS requirements. According to NCI data that Indiana was able to utilize, the State demonstrated non-compliance with several HCBS requirements.

In order to further identify areas of compliance and non-compliance, Indiana has developed a comprehensive survey targeting HCBS requirements that will provide further data for the State's assessment. Indiana has contracted with The Indiana Institute on Disability and Community (IIDC) to design, develop, and administer a survey to individuals receiving Home and Community Based Services in Indiana.

Prior to the implementation of a statewide survey, Indiana, in conjunction with the IIDC, will administer the survey using a pilot group in order to assess the validity and reliability of the survey. Once the survey has been validated IIDC will disseminate it electronically through the participant's residential provider to ensure all participants are reached. The survey will be completed by participants when able or the person who knows them best.

At the time of survey completion the contractor, in consultation with the state, will analyze the data and provide a comprehensive report on the survey results. The aggregate results will be disseminated to stakeholders throughout the system.

ASSESSMENT OF HCBS REQUIREMENTS: SITE SPECIFIC ASSESSMENT
Anticipated Date of Completion: 9/2016
Based on the results of the preliminary settings analysis and statewide provider survey, Indiana will identify specific sites that will need further review prior to the completion of the comprehensive settings results document to validate the results on the survey. Once specific sites have been identified for validation, Indiana will rely on the clear guidance that CMS has issued around settings. Specifically, Indiana will identify any setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS. Indiana will utilize this guidance in developing and establishing criteria for engaging in site specific assessments.

During the site-specific assessments, Bureau of Developmental Disabilities (BDDS) staff and case management staff will review the results of the assessments in order to validate the results. Prior to the assessment review, Indiana will conduct a comprehensive training for all participants in order to ensure consistency of all reviews.

ASSESSMENT OF HCBS REQUIREMENTS: COMPREHENSIVE SETTINGS RESULTS AND PUBLIC TRANSPARENCY
Anticipated Date of Completion: 4/2017
Indiana will develop a comprehensive settings results document, which identifies Indiana's level of compliance with HCBS standards. This document will be disseminated to stakeholders throughout the system. The results document will encompass the results that have been garnered from the following sources:
• Stakeholder input
• NCI data
• Review of standards, rules, regulations, and requirements
• Provider Surveys
• Site Specific Assessment
• Onsite assessments (as warranted)

The data and the identified areas of noncompliance will be used to guide stakeholder groups to gather further qualitative feedback from providers, participants, and their families. This stakeholder input will be gathered through a variety of means that include but are not limited to:
• The Division of Disability and Rehabilitative Services (DDRS) advisory council
• Contractual partnerships with the Arc of Indiana to assist in gathering participant and family feedback
• Participant focus groups and/or surveys
• Focus groups with service providers, DDRS/BDDS staff, and Case Managers

Indiana will develop a comprehensive settings results document, which identifies and publically disseminates Indiana's level of compliance with HCBS settings. The document will identify and estimate the number of settings, that:
• Fully comply with the HCBS requirements
• Do not meet the HCBS requirements and will require modifications
• Cannot meet the HCBS requirements and require removal from the program and/or relocation of the individuals
• Are presumptively non-home and community-based but for which Indiana will provide justification/evidence to show that those settings do not have the characteristics of an institution and do have the qualities of home and community-based settings (CMS' heightened scrutiny process)

DESCRIPTION OF INDIANA'S REMEDIAL STRATEGIES

Based on the assessment activities and the development of the comprehensive settings results document, Indiana has developed both remedial strategies and an oversight process to ensure current and continuous compliance with HCBS requirements.

REMEDIAL STRATEGIES: REVISIONS TO INDIANA ADMINSTRATIVE CODE
Anticipated Date of Completion: 5/2018
Indiana will initiate the rule making process in order to revise Indiana's Administrative Code. Indiana will revise rules related to community integration, individual rights, and individual choice. As Indiana proceeds through the rule making process, the state will update the comprehensive plan in to reflect changes. As with all rulemaking, public comment and input will be mandatory.

REMEDIAL STRATEGIES: REVISIONS TO DDRS WAIVER MANUAL
Anticipated Date of Completion: 12/2017
In order to ensure current and ongoing compliance with the HCBS requirements, Indiana will review the DDRS Waiver Manual. Changes to the DDRS Waiver Manual may constitute changes to the FSW and CIH application. Amendments to the FSW and CIH application will be completed to maintain program consistency.

REMEDIAL STRATEGIES: REVISIONS TO FORMS
Anticipated Date of Completion: 12/2017
In order to ensure ongoing compliance and monitoring or HCBS requirements, Indiana will revise all applicable internal and external forms to meet HCBS regulations, administrative rules and policy and procedures.

REMEDIAL STRATEGIES: PARTICIPANT RIGHTS AND RESPONSIBILITIES POLICY/PROCEDURE MODIFICATIONS
Anticipated Date of Completion: 12/2017
Indiana will revise policies and procedures related to participant rights, due process, and procedural safeguards.

REMEDIAL STRATEGIES: REVIEW AND REVISIONS TO PROVIDER ENROLLMENT/PROVIDER TRAINING
Anticipated Date of Completion: 4/2018
Indiana will review and potentially revise the provider enrollment and recertification processes to address areas of non-compliance. Indiana will provide training to new and existing providers to educate them on the HCBS requirements.

REMEDIAL STRATEGIES: DEVELOPMENT OF A COORECTIVE ACTION PROCESS AND PLAN
Anticipated Date of Completion: 4/2018
The development of a provider corrective action process/plan is to ensure providers are in compliance with HCBS requirements. Once a provider has been identified as non-compliant, the state will work to develop a provider remediation process and framework of plans:
• outline and a comprehensive provider training on the HCBS requirements,
• deadlines for completion
• periodic status update requirements for significant remediation activities

REMEDIAL STRATEGIES: DEVELOP PROCESS FOR PROVIDER SANCTION AND DIS-ENROLLMENTS
Anticipated Date of Completion: 6/2018
In the event the provider has gone through remediation activities and continues to demonstrate noncompliance with HCBS requirements, the state will develop a specific process for issuing provider sanctions and dis-enrollments. The development of provider sanctions and dis-enrollment criterion is to ensure statewide compliance with HCBS requirements.

The state will formally disseminate the provider sanctions and disenrollment criterion during a public comment period.
In the event the HCBS settings are deemed noncompliant with HCBS requirements and remedial strategies were unsuccessful, a transition plan for the relocation of participants will be developed. Below are the requirements:
• Identify participants requiring transition;
• Provide reasonable notice to participants and the Individual Support Team regarding the noncompliance, action steps, and procedural safeguards;
• Provide the participant with the opportunity, information, and supports necessary to make an informed choice of an alternate setting that aligns, or will align with the regulation;
• Ensure the participants' services/supports are in place prior to the individual's transition; Identify timeline for participant transitions; and
• Provide training to local districts, case managers, and providers regarding participants requiring transition

REMEDIAL STRATEGIES: ONGOING MONITORING OF COMPLIANCE
Anticipated Date of Completion: 3/2019
Indiana will incorporate HCBS requirements into policy/procedure and internal reviews to identify areas of non-compliance. The state will also enforce ongoing program integrity and provider compliance audits.

DESCRIPTION OF PUBLIC COMMENT

This Community Integration Waiver Transition Plan is open for public comment for 30 days, November 1, 2014 – December 1, 2014. This comment period will allow all HCBS consumers, providers and stakeholders an opportunity to provide input to the plan. All public comments and dates of public notice for the statewide transition plan will be retained on record and available for review.

Indiana will seek public comment through the HCBS Website, specific Division websites, print articles in newsletters disseminated by advocacy groups and trade organizations, electronic newsletters, list serves and social media.

In addition, a communication plan will be published which will further outline DDRS plans for gathering additional public comment and input from stakeholders. DDRS is committed to a high level of transparency and will publish the planned steps to ensure that all providers, families, participants, and potential participants are given meaningful opportunity for public input.

Below is an outline of the CMS rules Indiana will follow regarding seeking public comment on significant changes to Indiana's waiver system.

• The State must seek input from the public for its proposed transition plan, which includes initial review and assessment of settings' compliance.
  o Provide assurance that a minimum 30-day advance notice of the State's Transition Plan has been provided to the public for its review and comment.
    ・This assurance can be provided by identifying in this section the actual date of the public notice
    ・Process used for providing the public notice (for example, publication in newspapers, announcement via websites, etc.).
  o CMS encourages states to seek input from a wide range of stakeholders and from impacted beneficiaries.
• Provide a summary of public comments, including comments that agree/disagree with the State's determinations about whether types of settings meet the HCBS requirements;
• Provide a summary of modifications to the Transition Plan made in response to public comment; and in the case where the State's determination differs significantly from public comment, the additional evidence the State used to confirm its determination (e.g. site visits to specific settings).
• The State must also provide in this section an assurance that the State's Transition Plan, with any modifications made as a result of public input, is posted for transparency no later than the date of submission to CMS and that all public comments

on the transition plan are retained and available for review
• This Statewide Transition Plan is open for public comment for 30 days to allow all HCBS consumers, providers and stakeholders an opportunity to provide input to the plan.

****
Below is text from the November 3, 2014 notice announcing the DDRS Quarterly Provider Meeting and offering the opportunity to provide comment on the Statewide Transition Plan (inclusive of the CIHW Transition Plan) during or after the meeting. The notice was released via DDRS listserv as well as posted to the DDRS website:
****

To: Division of Disability and Rehabilitative Services Providers
From: Nicole Norvell, DDRS Director
Re: Fort Wayne Quarterly Provider Meeting Agenda and Webinar Registration
Date: November 3, 2014

The Division of Disability and Rehabilitative Services (DDRS) invites DDRS providers to attend the Quarterly Provider Meeting on November 7, 2014, from 1-4 p.m. at the Allen County Public Library, located at 900 Library Plaza in Fort Wayne (Phone number 260-421-1200) or via a live webinar. The webinar will be recorded and made available for those who are unable to attend the live presentation.

Webinar Registration Information
Registration for this webinar is required, and attendance is limited to 150 connections and participants will be able to type in questions during the meeting.
1. Please click on the following link:
   https://ddrsprovider.fssa.in.gov/Events/Public/Register.aspx?ReturnTo=Calendar&CalendarMonth=11&CalendarYear=2014&CourseID=632
2. Enter the appropriate information
3. You will receive an auto response via email, which will include the link to the webinar.

Allen County Public Library Parking
Parking at the library will be free with a valid Allen County Public Library card. Parking will cost $1 per hour with a maximum charge of $7 for the day for those without a card and tickets must be taken inside the library for payment.

Meeting Agenda
Division of Disability and Rehabilitative Services Quarterly Provider Agenda November 7, 2014 from 1- 4 p.m. , Allen County Public Library 900 Library Plaza Fort Wayne, IN

I. First Steps
  a. Agency Agreements Update status
  b. Training System Changes
  c. Fall Quality Review visits
II. BQIS
  a. Mortality Review Committee
  b. Complaints
  c. Provider Re-approval Process
III. VR
  a. Rate Reform
  b. Community Rehabilitation Provider Application Process
  c. #Work4LifeIN Campaign
  d. Update on VR Case Coordinators
IV. BDDS Updates:
  a. Targeting – FSW
  b. Money Follows the Person Grant (MFP)
  c. OBRA Review
  d. HCBS – Overview/Training
  e. FSW Renewal
  f. Transition Plans

****
Below is text from the October 31, 2014 notice announcing the posting of the Statewide Transition Plan (inclusive of the CIHW Transition Plan) and offering the opportunity to provide comment. The notice was released via DDRS listserv as well as posted to the DDRS website:
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To: Division of Disability and Rehabilitative Services Providers and Stakeholders
From: Nicole Norvell, Director, Division of Disability and Rehabilitative Services
Re: State Wide Transition Plans for Public Comment
Date: October 31, 2014

The Family and Social Services Administration's (FSSA) Division of Disability and Rehabilitative Services (DDRS) and the Office of Medicaid Policy and Planning (OMPP) have developed two comprehensive transition documents outlining Indiana's plans to meet the Home and Community Based Services (HCBS) rules for both the Family Supports (FSW) and the Community Integration and Habilitation (CIH) Waivers.

The transition plans include information about Indiana's assessment process to date; plans for continuing assessments; how compliance will be identified; and the strategies to be utilized to come into compliance with the HCBS rules.

The plans for both waivers will be submitted to the Center for Medicare and Medicaid Services (CMS) no later than December 31, 2014 and are available for review on the DDRS Draft Policies for Public Comment webpage.
Comments and suggestions will be accepted for a period of 30 days, ending on December 1, 2014 and may be emailed to DDRSpolicies@fssa.in.gov or submitted in writing to:

Waiver Public Comment
c/o The Division of Disability and Rehabilitative Services
402 W. Washington St., Rm. W451
Indianapolis, IN 46204-2243

DDRS will also provide an opportunity for public comment during the DDRS quarterly provider meeting on November 7, 2014 and during other meetings and events being held in November, 2014.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Attachment #2 Home and Community-Based Settings Waiver Transition Plan is continued here due to character limitations in the Attachment #2 text field:

Seen below in this Additional Needed Information (Optonal) field are the two Appendices to the CIHW Transition Plan:
- Appendix A: SUMMARY OF NCI DATA ANALYSIS
- Appendix B: PRELIMINARY SETTING ANALYSIS BASED ON REQUIREMENTS

Appendix A: SUMMARY OF NCI DATA ANALYSIS

Below is a summary of the assessment plan activities that Indiana utilized to develop a comprehensive transition plan upon approval from CMS:

REQUIREMENT FROM HCBS RULE: Is integrated in and supports access to the greater community
START DATE: 6/2014
END DATE: 8/2014
ASSESSMENT ACTIVITY: Data was analyzed from the National Core Indicators and responses were categorized into the following question areas:
• If individual interacts with neighbors
• Extent to which people do certain activities in the community
• If individuals are supported to see friends and family when they want
• If individual have a way to get places they want to go

• Whether the individual has friends or relationships with persons other than paid staff or family
• If individual participates in unpaid activity in a community based setting
• If individual has a paid job in the community

This initial analysis was completed to determine Indiana's level of compliance with this requirement. While 100% compliance with HBCS rules is the goal, Indiana utilized the NCI data as a starting point to identify the current status of the program and to identify barriers that may exist and impact our compliance with the HCBS requirements. In an effort to identify the larger programmatic restrictions, Indiana identified 85% and below as the threshold for low level of compliance.

The following questions from the National Core Indicators were identified as 85% and below the low level of compliance threshold.
• If individual interacts with neighbors
• If individuals are supported to see friends and family when they want
• Whether the individual has friends or relationships with persons other than paid staff or family
• If individual participates in unpaid activity in a community based setting
• If individual has a paid job in the community

Based on the NCI data analysis, questions related to the requirement are in the process of being developed for the provider survey, participant focus groups, and/or for additional program surveys to gather more detailed information.

Upon the completion of the surveys and additional programmatic data analysis, Indiana will draw conclusions as to its level of compliance with this requirement and submit corrective action steps for approval of CMS.

REQUIREMENT FROM HCBS RULE: Provides opportunities to seek employment and work in competitive integrated settings
START DATE: 6/2014
END DATE: 8/2014
ASSESSMENT ACTIVITY: Data was analyzed from the National Core Indicators and responses were categorized into the following question areas:
• If individual has a job in the community
• If individual has a paid job in the community
• If individual does not have a job in the community, do they want one
• Of the individuals employed, if they like their job and if they want a different job
• If individual has integrated employment as a goal in their service plan
• If individual participates in unpaid activity in a community based setting

This initial analysis was completed to determine Indiana's level of compliance with this requirement. While 100% compliance with HBCS rules is the goal, Indiana utilized the NCI data as a starting point to identify the current status of the program and to identify barriers that may exist and impact our compliance with the HCBS requirements. In an effort to identify the larger programmatic restrictions, Indiana has identified 85% and below as the threshold for low level of compliance.

The following questions from the National Core Indicators were identified as 85% and below the low level of compliance threshold.
• If individual has a job in the community
• If individual has a paid job in the community
• If individual does not have a job in the community, do they want one
• Of the individuals employed, if they like their job and if they want a different job
• If individual has integrated employment as a goal in their service plan

Based on the NCI data analysis, questions related to the requirement are in the process of being developed for the provider survey, participant focus groups, and/or for additional program surveys to gather more detailed information.

Upon the completion of the surveys and additional programmatic data analysis, Indiana will draw conclusions as to its level of compliance with this requirement and submit corrective action steps for approval of CMS.

REQUIREMENT FROM HCBS RULE: Control personal resources
START DATE: 6/2014

END DATE: 8/2014
ASSESSMENT ACTIVITY: Data analysis from the National Core Indicator responses were categorized into the following question areas:
• If individual can decide how to spend his/her own money

This analysis was completed to determine Indiana's level of compliance with this requirement. While 100% compliance with HBCS rules is the goal, Indiana utilized the NCI data as a starting point to identify the current status of the program and to identify barriers that may exist and impact our compliance with the HCBS requirements. In an effort to identify the larger programmatic restrictions, Indiana has identified 85% and below as the threshold for low level of compliance.

The following question from the National Core Indicators was identified as 85% and below the low level of compliance threshold.
• If individual can decide how to spend his/her own money

Based on the NCI data analysis, questions related to the requirement are in the process of being developed for the provider survey, participant focus groups, and/or for additional program surveys to gather more detailed information.

Due to the lack of NCI questions targeting this requirement, additional questions will be added to a provider and client survey to gather more detailed information about this requirement. Topics may include:
• Participants' ability to access money for recreational use
• Participants' ability to access money to meet their personal needs
• Participants' access to personal belongings
• Participants' access to phone and internet

Upon the completion of the surveys and additional programmatic data analysis, Indiana will draw conclusions as to its level of compliance with this requirement and submit corrective action steps for approval of CMS.

REQUIREMENT FROM HCBS RULE: Ensures the individual receives services in the community with the same degree of access as individuals not receiving Medicaid HCBS
START DATE: 6/2014
END DATE: 8/2014
ASSESSMENT ACTIVITY: This information cannot be assessed from the National Core Indicators and will be included in the provider survey, participant focus groups, and/or for additional program surveys.

Upon the completion of the survey and programmatic data analysis, Indiana will draw conclusions as to its level of compliance with this requirement and submit corrective action steps for approval of CMS.

REQUIREMENT FROM HCBS RULE: Allows full access to the greater community/Engaged in community life
START DATE: 6/2014
END DATE: 8/2014
ASSESSMENT ACTIVITY: Data analysis from the National Core Indicator responses were categorized into the following question areas:
• Extent to which individuals do certain activities in the community: shopping, errands, religious practice, entertainment, exercise, etc.
• If individual wants to go somewhere, do they always have a way to get there

This analysis was completed to determine Indiana's level of compliance with this requirement. While 100% compliance with HBCS rules is the goal, Indiana utilized the NCI data as a starting point to identify the current status of the program and to identify barriers that may exist and impact our compliance with the HCBS requirements. In an effort to identify the larger programmatic restrictions, Indiana has identified 85% and below as the threshold for low level of compliance.

The following questions from the National Core Indicators were identified as 85% and below the low level of compliance threshold:
• Extent to which individuals do certain activities in the community: shopping, errands, religious practice, entertainment, exercise, etc.
• If individual wants to go somewhere, do they always have a way to get there

Due to the lack of NCI questions targeting this requirement, additional questions will be added to a provider and client survey to gather more detailed information about this requirement. Topics may include:

• The type of community activities that individuals participate in
• Who participates in the community activities with the individual
• Barriers that stop the individual from participating in community activities

Additional Data Analyzed: In regards to transportation, the data will be analyzed on each provider by the State to determine how frequently individuals are accessing the greater community. In addition, the Community Habilitation data will be reviewed in order to determine the level of engagement/access to community activities.

Upon the completion of the survey and programmatic data analysis, Indiana will draw conclusions as to its level of compliance with this requirement and submit corrective action steps for approval of CMS.

REQUIREMENT FROM HCBS RULE: Setting is chosen among setting options including non-disability specific settings and options for a private unit in a residential settings.
START DATE: 6/2014
END DATE: 8/2014
ASSESSMENT ACTIVITY: Data analysis from the National Core Indicator responses were categorized into the following question areas:
• If individual chooses their residence, work and/or day services
• Chose or had some input in choosing where they go during the day
• Chose or were aware they could request to change the staff who help them at their home, job, or day program or activity
• If individuals chose to live alone, or chose people they live with

This analysis was completed to determine Indiana's level of compliance with this requirement. While 100% compliance with HBCS rules is the goal, Indiana utilized the NCI data as a starting point to identify the current status of the program and to identify barriers that may exist and impact our compliance with the HCBS requirements. In an effort to identify the larger programmatic restrictions, Indiana has identified 85% and below as the threshold for low level of compliance.

The following questions from the National Core Indicators were identified as 85% and below the low level of compliance threshold:
• If individual chooses their residence, work and/or day services
• If individuals chose to live alone, or chose people they live with
• Chose or had some input in choosing where they go during the day
• Chose or were aware they could request to change the staff who help them at their home, job, or day program or activity

Upon the completion of the survey and programmatic data analysis, Indiana will draw conclusions as to its level of compliance with this requirement and submit corrective action steps for approval of CMS.

REQUIREMENT FROM HCBS RULE: Ensures right to privacy, dignity and respect and freedom from coercion and restraint
START DATE: 6/2014
END DATE: 8/2014
ASSESSMENT ACTIVITY: Data analysis from the National Core Indicator responses were categorized into the following question areas:
• If individual has been treated with respect by paid provider/staff
• Does individual have enough privacy; can be alone with guests, whether mail/email is read without permission, etc.
• Does individual feel safe at home? At work/day program? In neighborhood? If person does not feel safe, is there someone to talk to

This analysis was completed to determine Indiana's level of compliance with this requirement. While 100% compliance with HBCS rules is the goal, Indiana utilized the NCI data as a starting point to identify the current status of the program and to identify barriers that may exist and impact our compliance with the HCBS requirements. In an effort to identify the larger programmatic restrictions, Indiana has identified 85% and below as the threshold for low level of compliance.

All National Core Indicator questions were above the 85% threshold for this requirement.

Additional Data Analyzed: For this requirement data collected through Indiana's Bureau of Quality Improvement Services has been utilized to assess Indiana's level of compliance. This analysis will focus on Incident Reports (IRs) and rates of occurrence in the following areas:
• Allegations of abuse, neglect, exploitation

• % of those allegations substantiated
• Prohibited Interventions
• Physical Restraints This data has been analyzed at the State level to determine state level of compliance and at the provider level when assessing each individual provider.

Upon the completion of the survey and programmatic data analysis, Indiana will draw conclusions as to its level of compliance with this requirement and submit corrective action steps for approval of CMS.

REQUIREMENT FROM HCBS RULE: Optimizes autonomy and independence in making life choices
START DATE: 6/2014
END DATE: 8/2014
ASSESSMENT ACTIVITY: Data analysis from the National Core Indicator responses were categorized into the following question areas:
• Did the individual make decisions or did others make decision about: where and with whom they live, where they work, what day program they attend, their daily schedule, how to spend free time, etc.
• Self-direction queries suggest decision making competence building: Does the individual have help making decision re: budget and services; Can they change budget or services if needed; etc.
• Chose or were aware they could request to change the staff who help them at their home, job, or day program or activity
• Did you help develop your service plan

This analysis was completed to determine Indiana's level of compliance with this requirement. While 100% compliance with HBCS rules is the goal, Indiana utilized the NCI data as a starting point to identify the current status of the program and to identify barriers that may exist and impact our compliance with the HCBS requirements. In an effort to identify the larger programmatic restrictions, Indiana has identified 85% and below as the threshold for low level of compliance.

The following questions from the National Core Indicators were identified as 85% and below the low level of compliance threshold:
• Did the individual make decisions or did others make decision about: where and with whom they live, where they work, what day program they attend, their daily schedule, how to spend free time, etc.
• Self-direction queries suggest decision making competence building: Does the individual have help making decision re: budget and services; Can they changes budget or services if needed; etc.
• Chose or were aware they could request to change the staff who help them at their home, job, or day program or activity
• Did you help develop your service plan

Upon the completion of the survey and programmatic data analysis, Indiana will draw conclusions as to its level of compliance with this requirement and submit corrective action steps for approval of CMS.

REQUIREMENT FROM HCBS RULE: Facilitates choice of services and who provides them
START DATE: 6/2014
END DATE: 8/2014
ASSESSMENT ACTIVITY: Data analysis from the National Core Indicator responses were categorized into the following question areas:
• If individual would like to live somewhere else
• If individual wants to work somewhere else
• If individual wants to go somewhere else during day
• If individual chose their case manager
• If individual chose their home, job, and day program or activity staff
• If individual chose their day/work support staff

This analysis was completed to determine Indiana's level of compliance with this requirement. While 100% compliance with HBCS rules is the goal, Indiana utilized the NCI data as a starting point to identify the current status of the program and to identify barriers that may exist and impact our compliance with the HCBS requirements. In an effort to identify the larger programmatic restrictions, Indiana has identified 85% and below as the threshold for low level of compliance.

The following questions from the National Core Indicators were identified as 85% and below the low level of compliance threshold:
• If individual would like to live somewhere else
• If individual wants to work somewhere else
• If individual wants to go somewhere else during day

• If individual chose their case manager
• If individual chose their home, job, and day program or activity staff
• If individual chose their day/work support staff

Upon the completion of the survey and programmatic data analysis, Indiana will draw conclusions as to its level of compliance with this requirement and submit corrective action steps for approval of CMS.

REQUIREMENT FROM HCBS RULE: A lease or other legally enforceable agreement to protect from eviction
START DATE: 6/2014
END DATE: 8/2014
ASSESSMENT ACTIVITY: NCI data does not address this requirement. Information will be gathered through the State's Case Management system and through the provider survey, focus groups, and/or additional program surveys to assess the level of compliance with this requirement.

Information will be gathered utilizing the State's Case Management System. State staff currently review and approve all lease agreements and individuals' moves within the Case Management System. Indiana will analyze the data currently available in the system to ensure moves are approved by State Staff.

Upon the completion of the survey/focus groups, analysis of the Case Management system, and additional programmatic data, Indiana will draw conclusions as to its level of compliance with this requirement and submit corrective action steps for approval of CMS.

REQUIREMENT FROM HCBS RULE: Privacy in their unit including entrances lockable by the individual
START DATE: 6/2014
END DATE: 8/2014
ASSESSMENT ACTIVITY: Data analysis from the National Core Indicator responses were categorized into the following question areas:
• If others announce themselves before entering home
• If others announce themselves before entering bedroom
• If individual has enough privacy

This analysis was completed to determine Indiana's level of compliance with this requirement. While 100% compliance with HBCS rules is the goal, Indiana utilized the NCI data as a starting point to identify the current status of the program and to identify barriers that may exist and impact our compliance with the HCBS requirements. In an effort to identify the larger programmatic restrictions, Indiana has identified 85% and below as the threshold for low level of compliance.

The following question from the National Core Indicators was identified as 85% and below the low level of compliance threshold:
• If others announce themselves before entering bedroom

Due to NCI data not covering lockable entrances or control of keys, this information will be collected through the provider survey, focus groups, and/or additional program surveys to assess level of compliance with this requirement.

Upon the completion of the survey and programmatic data analysis, Indiana will draw conclusions as to its level of compliance with this requirement and submit corrective action steps for approval of CMS.

REQUIREMENT FROM HCBS RULE: Freedom to furnish and decorate their unit
START DATE: 6/2014
END DATE: 8/2014
ASSESSMENT ACTIVITY: NCI data does not address this requirement thus information will be collected through the provider survey to asses level of compliance with this requirement.

Upon the completion of the survey and programmatic data analysis, Indiana will draw conclusions as to its level of compliance with this requirement and submit corrective action steps for approval of CMS.

REQUIREMENT FROM HCBS RULE: Control of schedule and activities
START DATE: 6/2014

END DATE: 8/2014
ASSESSMENT ACTIVITY: Data analysis from the National Core Indicator responses were categorized into the following question areas:
• Control of daily schedule
• Control of free time use

This analysis was completed to determine Indiana's level of compliance with this requirement. While 100% compliance with HBCS rules is the goal, Indiana utilized the NCI data as a starting point to identify the current status of the program and to identify barriers that may exist and impact our compliance with the HCBS requirements. In an effort to identify the larger programmatic restrictions, Indiana has identified 85% and below as the threshold for low level of compliance.

The following question from the National Core Indicators was identified as 85% and below the low level of compliance threshold:
• Control of daily schedule

Upon the completion of the survey and programmatic data analysis, Indiana will draw conclusions as to its level of compliance with this requirement and submit corrective action steps for approval of CMS.

REQUIREMENT FROM HCBS RULE: Access to food at any time
START DATE: 6/2014
END DATE: 8/2014
ASSESSMENT ACTIVITY: NCI data does not address this requirement thus information will be collected through the provider survey to assess level of compliance with this requirement.

Upon the completion of the survey and programmatic data analysis, Indiana will draw conclusions as to its level of compliance with this requirement and submit corrective action steps for approval of CMS.

REQUIREMENT FROM HCBS RULE: Visitors at any time
START DATE: 6/2014
END DATE: 8/2014
ASSESSMENT ACTIVITY: Data analysis from the National Core Indicator responses were categorized into the following question areas:
• Whether individual can be alone with visitors or if there are some rules/restrictions

This analysis was completed to determine Indiana's level of compliance with this requirement. While 100% compliance with HBCS rules is the goal, Indiana utilized the NCI data as a starting point to identify the current status of the program and to identify barriers that may exist and impact our compliance with the HCBS requirements. In an effort to identify the larger programmatic restrictions, Indiana has identified 85% and below as the threshold for low level of compliance.

The following question from the National Core Indicators was identified as 85% and below the low level of compliance threshold:
• Whether individual can be alone with visitors or if there are some rules/restrictions

Upon the completion of the survey and programmatic data analysis, Indiana will draw conclusions as to its level of compliance with this requirement and submit corrective action steps for approval of CMS.

REQUIREMENT FROM HCBS RULE: Setting is physically accessible to the individual
START DATE: 6/2014
END DATE: 8/2014
ASSESSMENT ACTIVITY: NCI does not explicitly assess whether setting is fully accessible to person. Information will be collected through the provider survey, focus groups and/or additional program surveys to assess level of compliance.

Upon the completion of the survey and programmatic data analysis Indiana will draw conclusions as to its level of compliance with this requirement and submit corrective action steps for approval of CMS.

REQUIREMENT FROM HCBS RULE: Individuals sharing units have a choice of roommates in that setting.
START DATE: 6/2014

END DATE: 8/2014
ASSESSMENT ACTIVITY: Data analysis from the National Core Indicator responses were categorized into the following question areas:
• Chose or had some input in choosing their roommates
• If individuals chose to live alone, or chose people they live with

This analysis was completed to determine Indiana's level of compliance with this requirement. While 100% compliance with HBCS rules is the goal, Indiana utilized the NCI data as a starting point to identify the current status of the program and to identify barriers that may exist and impact our compliance with the HCBS requirements. In an effort to identify the larger programmatic restrictions, Indiana has identified 85% and below as the threshold for low level of compliance.

The following questions from the National Core Indicators were identified as 85% and below the low level of compliance threshold:
• Chose or had some input in choosing their roommates
• If individuals chose to live alone, or chose people they live with

Upon the completion of the survey and programmatic data analysis, Indiana will draw conclusions as to its level of compliance with this requirement and submit corrective action steps for approval of CMS.

Appendix B: PRELIMINARY SETTING ANALYSIS BASED ON REQUIREMENTS

CMS CRITERIA: Is integrated in and supports access to the greater community
• NCI Data Analysis: Identified as 85% and below the low level of compliance threshold.
• IAC/IC Reviewed:
  ・460 IAC 6-20-2 "community-based employment services shall be provided in an integrated setting." Needs to be modified in order to meet HCBS standards
  ・460 IAC 6-3-58 "Transportation supports" means supports, such as tickets and passes to ride on public transportation systems, that enable an individual to have transportation for access to the community
  ・460 IAC 6-3-32 ISP Needs to be modified in order to meet HCBS standards
• Policy and Procedures Reviewed:
  ・Individual Rights and Responsibilities (NEW) (4600221014) In process of being updated to support CMS regulations
  ・Transition Policy (4600316031)
• Waiver Manual/Forms Reviewed:
  ・90-day Checklist Does the individuals' routine outlined in ISP include participation in community activities and events?
  ・Pre-Post Monitoring Checklist Transportation available to meet all community access needs
• 90 Day Check List Data Analysis: The data analysis indicated that 85% of the time or better this area is checked yes on the 90 day checklist
• Outcome of Review: While the state does have policies and procedures that support the HCBS rules, a more in-depth analysis will be completed in order to ensure full compliance due to inconsistencies between NCI data and 90 day check list data.

CMS CRITERIA: Provide opportunities to seek employment and work in competitive integrated settings
• NCI Data Analysis: Identified as 85% and below the low level of compliance threshold.
• IAC/IC Reviewed: 460 IAC 6-20-2 (community-based employment services shall be provided in an integrated setting). Needs to be modified in order to meet HCBS standards
• Policy and Procedures Reviewed: Intentionally left blank.
• Waiver Manual/Forms Reviewed:
  ・90-day Checklist Is the employment section of the ISP still current and is it being routinely discussed?
  ・Confirm the individual is free from work without pay that benefits others?
• 90 Day Check List Data Analysis: The data analysis indicated that 85% of the time or better this area is checked yes on the 90 day checklist
• Outcome of Review: While the state does have policies and procedures that support the HCBS rules, a more in-depth analysis will be completed in order to ensure full compliance due to inconsistencies between NCI data and 90 day check list data.

CMS CRITERIA: Control Personal Resources
• NCI Data Analysis: Identified as 85% and below the low level of compliance threshold.
• IAC/IC Reviewed:
・460 IAC 6-17-3 Individuals Personal File
・460 IAC 6-24-3 Management of Individuals Financial Resources Needs to be modified in order to meet HCBS standards
・460 IAC 6-9-4 Personal Possessions and Clothing
• Policy and Procedures Reviewed: Individual Rights and Responsibilities (NEW) (4600221014) In process of being updated to support CMS regulations
• Waiver Manual/Forms Reviewed:
・90-day Checklist Unrestricted access to their personal possessions?
-Free to receive and open own mail?
-Free to receive and make phone calls without restrictions? Fiscal Issues (money, accounts, etc.)
・ISP -Are the Individuals' Property/Financial resources being properly managed?
• 90 Day Check List Data Analysis: The data analysis indicated that 85% of the time or better this area is checked yes on the 90 day checklist
• Outcome of Review: While the state does have policies and procedures that support the HCBS rules, a more in-depth analysis will be completed in order to ensure full compliance due to inconsistencies between NCI data and 90 day check list data.

CMS CRITERIA: Ensures the individual receives services in the community with the same degree of access as individuals not receiving Medicaid HCBS
• NCI Data Analysis: No NCI data
• IAC/IC Reviewed:
・460 IAC 7-3-12 AND 6-3-38.5 (PCP) (4) empowers an individual and the individual's family to create a life plan and corresponding ISP for the individual that: (A) is based on the individual's preferences, dreams, and needs; (B) encourages and supports the individual's long term hopes and dreams; (C) is supported by a short term plan that is based on reasonable costs, given the individual's support needs; (D) includes individual responsibility; and (E) includes a range of supports, including funded, community, and natural supports.
・460 IAC 6-20-2 community-based employment services shall be provided in an integrated setting Needs to be modified in order to meet HCBS standards
• Policy and Procedures Reviewed:
・BQIS Complaints: Supported Living Services & Supports (BQIS 4600221005)
・Individual Rights and Responsibilities (NEW) (4600221014) In process of being updated to support CMS regulations
• Waiver Manual/Forms Reviewed: 90-day Checklist Does the individual's routine outlined in the ISP include participation in community activities and events?
• 90 Day Check List Data Analysis: The data analysis indicated that 85% of the time or better this area is checked yes on the 90 day checklist
• Outcome of Review: While the state does have policies and procedures that support the HCBS rules, a more in-depth analysis will be completed in order to ensure full compliance.

CMS CRITERIA: Allow full access to the greater community/Engaged in community life
• NCI Data Analysis: Identified as 85% and below the low level of compliance threshold.
• IAC/IC Reviewed:
・460 IAC 6-9-4 System for protecting Individuals (h) A provider shall establish a system for providing an individual with the opportunity to participate in social, religious, and community activities.
・ACCESS TO THE COMMUNITY 460 IAC 6-20-2 "community-based employment services shall be provided in an integrated setting." Needs to be modified in order to meet HCBS standards
・460 IAC 6-3-58 "Transportation supports" means supports, such as tickets and passes to ride on public transportation systems, that enable an individual to have transportation for access to the community
・460 IAC 6-3-32 ISP Needs to be modified in order to meet HCBS standards
• Policy and Procedures Reviewed: Individual Rights and Responsibilities (NEW) (4600221014) In process of being updated to support CMS regulations
• Waiver Manual/Forms Reviewed:
・ISP Is adequate Transportation being provided?
・90-day Checklist Does the individual's routine outlined in the ISP include participation in community activities and events?
・Pre-Post Monitoring Checklist Transportation
• 90 Day Check List Data Analysis: The data analysis indicated that 85% of the time or better this area is checked yes on the

90 day checklist
• Outcome of Review: While the state does have policies and procedures that support the HCBS rules, a more in-depth analysis will be completed in order to ensure full compliance due to inconsistencies between NCI data and 90 day check list data.

CMS CRITERIA: Setting is chosen among setting options including non-disability specific settings and options for a private unit in residential settings
• NCI Data Analysis: Identified as 85% and below the low level of compliance threshold.
• IAC/IC Reviewed:
・460 IAC 6-4 Rule 4. Types of Supported Living Services and Supports
・460 IAC 6-29-3 Sec. 3. The provider designated in an individual's ISP as responsible for providing environmental and living arrangement support shall ensure that appropriate devices or home modifications, or both
・460 IAC 6-9-6 Transfer of individual's records upon change of provider
• Policy and Procedures Reviewed: Intentionally left blank
• Waiver Manual/Forms Reviewed: (Part 4.5 and 4.6 of Manual- FSW/CIH) Participants may choose to live in their own home, family home, or community setting appropriate to their needs. AND When priority access has been deemed appropriate and a priority waiver slot in the specific reserved capacity category met by the applicant remains open, participants may choose to live in their own home, family home, or community setting appropriate to their needs.
• 90 Day Check List Data Analysis: This information is not obtained through the 90 day checklist
• Outcome of Review: A review of policies, procedures and data assume vulnerability in this area.

CMS CRITERIA: Ensures right to privacy, dignity, and respect and freedom from coercion and restraint
• NCI Data Analysis: All National Core Indicator questions were above the 85% threshold for this requirement
• IAC/IC Reviewed:
・460 IAC 13-3-12 (IST Membership)
・460 IAC 6-8-2 - Constitutional and statutory rights
・IC 12-27-4 – Seclusion and Restraint laws
・460 IAC 6-8-3 Promoting the exercise of rights
・460 IAC 7-5-6 - Statement of agreement section
・460 IAC 6-10-8 - Resolution of disputes
・460 IAC 6-9-4 – Systems for protecting individuals
・460 IAC 6-9-3 Prohibiting violations of individual rights
• Policy and Procedures Reviewed:
・Aversive Techniques (BDDS 4601207003)
・BMR-ANE (BDDS 4601207002)
・Environmental Requirements (BDDS 460 1216039)
・Use of Restrictive Interventions, Including Restraint (BDDS 460 0228 025)
・Human Rights Committee (BDDS 460 0221 012)
・Protection of Individual Rights (4600228022)
・Incident Reporting and Management (BQIS 460 0301 008)
- TRAINING IS REQUIRED FOR ALL DSPs (4600228027)
– Annual Training on the protection of individual rights and respecting dignity of individual
・Professional Qualifications and Requirements(4600228021)
・Individual Rights and Responsibilities (NEW) (4600221014)-In process of being updated to support CMS regulations
・IST (4600228016)-Identifies other persons identified by the individual AND requires the individual to be present at all meetings
・Pre-Post Transition Monitoring (BDDS 4600530032) Health and Welfare is protected
・Provider Code of Ethics Conduct all practice with honest, integrity and fairness
・DDRS Policy: Personnel Policies and Manuals
• Waiver Manual/Forms Reviewed:
・Provider Agreement Checklist 12. Prohibiting Violations of Individual Rights
・Provider Agreement Checklist 14. Individual Freedoms
・Provider Agreement Checklist 15. Personnel Policy
-Safeguards that ensure compliance with HIPAA and all other Federal and State Privacy Laws.
・90-day Checklist
-Free from ANE?
-Informed and able to understand/exercise their rights as individual receiving services?
-Is the individual being treated with respect by the support staff?
・Pre-Post Monitoring Checklist Transportation

• 90 Day Check List Data Analysis: The data analysis indicated that 85% of the time or better this area is checked yes on the 90 day checklist
• Outcome of Review: A review of policies, procedures and data assume compliance in this area.

CMS CRITERIA: The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board (taken from Federal Register)
• NCI Data Analysis:No NCI data available
• IAC/IC Reviewed:
・460 IAC 7-3-12 (PCP) Needs to be modified in order to meet HCBS standards
・460 IAC 7-4-1 (Development of ISP)
・460 IAC 6-3-32 "Individualized support plan" or "ISP" defined
・460 IAC 6-3-38.5 "Person centered planning" defined (A) based on the individual's preferences, dreams, and needs;
・460 IAC 6-3-38.6 "Person centered planning facilitation services" defined
・460 IAC 6-5-36 Person centered planning facilitation services provider qualifications
・460 IAC 6-14-4 Training
• Policy and Procedures Reviewed:
・DSP Training (4600228027) Initial DSP training requires an approved core competency such as PSP --Respect/Rights, Choice, Competence, and Community presence and participation
・Professional Qualifications and Requirements (4600228021) Provider shall ensure that services provided to individual meet the needs of the individual
• Waiver Manual/Forms Reviewed:
・(Part 4.5 and 4.6 of Manual- FSW/CIH) Participants develop an Individual Service Plan (ISP) using a person centered planning process guided by an Individual Support Team (IST)
・90-day Checklist Does CCB/POC, ISP address the needs of the individual, implemented appropriately?
• 90 Day Check List Data Analysis: This information is not obtained through the 90 day checklist
• Outcome of Review: Due to lack of data a more in-depth analysis will be completed in order to determine compliance in this area.

CMS CRITERIA: Optimizes, but does not restrain, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
• NCI Data Analysis: identified as 85% and below the low level of compliance threshold
• IAC/IC Reviewed:
・IC 12-27 (Seclusion and Restraint)
・460 IAC 6-3-29.5 Independence assistance service
・460 IAC 6-24-1 Coordination of training services and training plan (be designed to enhance skill acquisition and increase independence)
・460 IAC 6-8-2 Constitutional and statutory rights
・460 IAC 6-8-3 promoting the exercise of rights
・460 IAC 6-36-2 Code of ethics
・460 IAC 6-3-54 "Support team" defined (1) are designated by the individual;
• Policy and Procedures Reviewed:
・Provider Code of Ethics A provider shall provide professional services with objectivity and with respect for the unique needs and values of the individual being provided services.
・Individual Rights and Responsibilities (NEW) (4600221014) In process of being updated to support CMS regulations
• Waiver Manual/Forms Reviewed: Intentionally left blank
• 90 Day Check List Data Analysis: This information is not obtained through the 90 day checklist
• Outcome of Review: A review of policies, procedures and data assume vulnerability in this area.

CMS CRITERIA: Facilitates choice of services and who provides them
• NCI Data Analysis: identified as 85% and below the low level of compliance threshold
• IAC/IC Reviewed:
・460 IAC 7-4-3 Composition of the support team
・460 IAC 7-3-12 AND 6-3-38.5 (PCP) (4) empowers an individual and the individual's family to create a life plan and corresponding ISP for the individual that: (A) is based on the individual's preferences, dreams, and needs; (B) encourages and supports the individual's long term hopes and dreams; (C) is supported by a short term plan that is based on reasonable costs, given the individual's support needs; (D) includes individual responsibility; and (E) includes a range of supports, including funded, community, and natural supports.

・460 IAC 7-5-5 (Outcome section) (4) Proposed strategies and activities for meeting and attaining the outcome, including the following: (5)The party or parties, paid or unpaid, responsible for assisting the individual in meeting the outcome. A responsible party cannot be changed unless the support team is reconvened and the ISP is amended to reflect a change in responsible party.
• Policy and Procedures Reviewed:
・Individual Rights and Responsibilities (NEW) (4600221014) In process of being updated to support CMS regulations
・IST (4600228016) Coordinate the provision and monitoring of needed supports for the individual
• Waiver Manual/Forms Reviewed:
・(Part 4.5 and 4.6 of Manual- FSW/CIH) The participant with the IST selects services, identifies service providers of their choice and develops a Plan of Care/Cost Comparison Budget (CCB). Freedom of Choice Form Provider Pick List
・90-day Checklist Provided information on their right to choose and change providers and case managers?
• 90 Day Check List Data Analysis: The data analysis indicated that 85% of the time or better this area is checked yes on the 90 day checklist
• Outcome of Review: While the state does have policies and procedures that support the HCBS rules, a more in-depth analysis will be completed in order to ensure full compliance due to inconsistencies between NCI data and 90 day check list data.

CMS CRITERIA: A lease or other legally enforceable agreement to protect from eviction (Provider owned or controlled residential setting)
• NCI Data Analysis: No NCI Data Available
• IAC/IC Reviewed:
・460 IAC 6-24-3 Management of Individual's financial resources
・460 IAC 6-9-4 Systems for protecting individuals
• Policy and Procedures Reviewed: Intentionally left blank
• Waiver Manual/Forms Reviewed:
・90-day Checklist Has the provider obtained a rental agreement in the individuals' name?
・ISP Are the Individuals' Property/Financial resources being properly managed?
• 90 Day Check List Data Analysis: Due to the majority of responses to this question on the 90 day check list being "n/a" validity of the data is unable to be determined
• Outcome of Review: A more in-depth analysis will be completed in order to ensure full compliance.

CMS CRITERIA: Privacy in their unit including entrances lockable by the individual
• NCI Data Analysis: identified as 85% and below the low level of compliance threshold
• IAC/IC Reviewed: 460 IAC 6-9-4 Systems for protecting individuals (e) A provider shall establish a system to ensure that an individual has the opportunity for personal privacy. (1) the opportunity to communicate, associate, and meet privately with persons of the individual's choosing; (2) the means to send and receive unopened mail; and (3) access to a telephone with privacy for incoming and outgoing local and long distance calls at the individual's expense
• Policy and Procedures Reviewed:
・Individual Rights and Responsibilities (NEW) (4600221014) In process of being updated to support CMS regulations
・Protection of Individual Rights (4600228022)
• Waiver Manual/Forms Reviewed: Intentionally left blank
• 90 Day Check List Data Analysis: This information is not obtained through the 90 day checklist
• Outcome of Review: A review of policies, procedures and data assume vulnerability in this area.

CMS CRITERIA: Freedom to furnish and decorate their unit
• NCI Data Analysis: NO NCI Data Available
• IAC/IC Reviewed:
・460 IAC 9-3-7 - Physical environment
・460 IAC 6-9-4 Systems for protecting individuals
• Policy and Procedures Reviewed: Individual Rights and Responsibilities (NEW) (4600221014) In process of being updated to support CMS regulations
• Waiver Manual/Forms Reviewed: Additional participant and family feedback is requested to measure this area.
• 90 Day Check List Data Analysis: This information is not obtained through the 90 day checklist
• Outcome of Review: Due to lack of data a more in-depth analysis will be completed in order to determine compliance in this area.

CMS CRITERIA: Control of schedule and activities

• NCI Data Analysis: identified as 85% and below the low level of compliance threshold
• IAC/IC Reviewed:
・460 IAC 6-3-38.5 "Person centered planning" defined
・460 IAC 6-14-2 Requirement for qualified personnel Sec. 2. A provider shall ensure that services provided to an individual: (1)meet the needs of the individual;
・460 IAC 6-19-1 Information concerning an individual Sec. 1. A provider of case management services shall have the following information about an individual receiving case management services from the provider: (1) The wants and needs of an individual, including the health, safety and behavioral needs of an individual.
・460 IAC 6-36-2 Code of ethics (1) A provider shall provide professional services with objectivity and with respect for the unique needs and values of the individual being provided services.
• Policy and Procedures Reviewed: Intentionally left blank.
• Waiver Manual/Forms Reviewed: 90-day Checklist Does the individual's routine outlined in the ISP include participation in community activities and events?
• 90 Day Check List Data Analysis: The data analysis indicated that 85% of the time or better this area is checked yes on the 90 day checklist
• Outcome of Review: While the state does have policies and procedures that support the HCBS rules, a more in-depth analysis will be completed in order to ensure full compliance due to inconsistencies between NCI data and 90 day check list data.

CMS CRITERIA: Access to food at any time
• NCI Data Analysis: NO NCI Data Available
• IAC/IC Reviewed:
・460 IAC 6-3-36 (Neglect -"Neglect" means failure to provide supervision, training, appropriate care, food, medical care, or medical supervision to an individual.”
・460 IAC 6-9-3 Prohibiting violations of individual rights (4) A practice that denies an individual any of the following without a physician's order (C) Food
• Policy and Procedures Reviewed:
・Individual Rights and Responsibilities (NEW) (4600221014)- In process of being updated to support CMS regulations
・Protection of Individual Rights (4600228022)
• Waiver Manual/Forms Reviewed: 90-day Checklist Individualized dining plan, does it include food restrictions?
• 90 Day Check List Data Analysis: The data analysis indicated that 85% of the time or better this area is checked yes on the 90 day checklist
• Outcome of Review: While the state does have policies and procedures that support the HCBS rules, a more in-depth analysis will be completed in order to ensure full compliance.

CMS CRITERIA: Visitors at any time
• NCI Data Analysis: identified as 85% and below the low level of compliance threshold
• IAC/IC Reviewed:
・460 IAC 6-9-4 (1) the opportunity to communicate, associate, and meet privately with persons of the individual's choosing;
・460 IAC 6-9-3 Prohibiting violations of individual rights Sec. 3. (a) A provider shall not: (1) abuse, neglect, exploit, or mistreat an individual; or (2) violate an individual's rights.
• Policy and Procedures Reviewed: Intentionally left blank.
• Waiver Manual/Forms Reviewed: 90-day Checklist Free to receive visitors with no restrictions?
• 90 Day Check List Data Analysis: The data analysis indicated that 85% of the time or better this area is checked yes on the 90 day checklist
• Outcome of Review: While the state does have policies and procedures that support the HCBS rules, a more in-depth analysis will be completed in order to ensure full compliance due to inconsistencies between NCI data and 90 day check list data.

CMS CRITERIA: Setting is physically accessible to the individual
• NCI Data Analysis: NO NCI Data available
• IAC/IC Reviewed:
・460 IAC 9-3-7 - Physical environment
・460 IAC 6-29-2 Safety of individuals environment
・460 IAC 6-29-3 Monitoring an individual’s environment
• Policy and Procedures Reviewed:
・Environmental Requirements (BDDS 460 1216039)

• Transition Activities (4600316031)
• Waiver Manual/Forms Reviewed: Pre-Post Monitoring Checklist
• 90 Day Check List Data Analysis: This information is not obtained through the 90 day checklist
• Outcome of Review: While the state does have policies and procedures that support the HCBS rule, a more in-depth analysis will be completed in order to ensure full compliance due to lack of data.

CMS CRITERIA: Individuals sharing units have a choice of roommates in that setting
• NCI Data Analysis: identified as 85% and below the low level of compliance threshold
• IAC/IC Reviewed: Intentionally left blank
• Policy and Procedures Reviewed: Intentionally left blank
• Waiver Manual/Forms Reviewed: Intentionally left blank
• 90 Day Check List Data Analysis: Intentionally left blank
• Outcome of Review: A review of policies, procedures and data assume vulnerability in this area.

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.
   Division of Disability and Rehabilitative Services (DDRS)
   (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:

   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:
The Family Social Services Administration (FSSA) is the single state Medicaid agency authorized to administer Indiana's Community Integration and Habilitation Waiver.

The waiver is operated by FSSA's Division of Disability and Rehabilitative Services (DDRS), a division under the single State Medicaid agency.

The FSSA's Office of Medicaid Policy and Planning (OMPP), a division under the single state Medicaid Agency, is responsible for monitoring DDRS's operation of the waiver through:

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 FSSA'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.

Ongoing and periodic reporting and analysis of data includes service utilization data, claims data, and reportable events. OMPP receives management reports from DDRS, FSSA's BQIS and the fiscal agent contractor.

These reports include:

From BQIS, the quality contractor's quarterly management report which contains aggregate data from transition reviews, incident reports, mortality reviews and trend analysis; and
From the fiscal agent, monthly and quarterly management reports.

Periodic inter-division meetings to discuss activities, issues, outcomes and needs and to jointly plan ongoing system improvements and remediation, when indicated. FSSA Management teams meet bi-weekly to review programs, recommend changes and address programming concerns. The performance of contracting entities is reviewed, discussed and addressed as needed during these meetings.

Termination of a vendor contract is possible should the contractor be unable or unwilling to meet the expectations of the State.

FSSA's OMPP exercises oversight of operation of the waiver through the following activities:

*Annually, FSSA's OMPP and FSSA's Finance supervises the development of the CMS annual waiver expenditure reports, reviews the final report with FSSA's DDRS and identifies problem areas that may need to be discussed and resolved with DDRS prior to submission by FSSA.
*Monthly, FSSA's OMPP and Finance reviews Medicaid waiver expenditure reports, after which, any identified problems will be discussed and resolved with DDRS.
*Daily, FSSA, or FSSA's Fiscal Intermediary, reviews, approves and assures payment of Medicaid claims for waiver services consistent with FSSA established policy.
*On an ongoing basis, FSSA's OMPP is responsible for oversight of all waiver activities (including 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.
*FSSA's 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 individuals with intellectual disabilities who receive Medicaid services.
*FSSA, and FSSA's fiscal agent, approves and enrolls all providers of waiver services.
*OMPP and DDRS collaborate to revise and develop the waiver application to reflect current FSSA goals and policy programs.
*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.
*FSSA 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.

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:
As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

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 FSSA and each contracted entity listed below that sets forth the responsibilities and performance requirements of the contracted entity. The contract(s) under which these 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.

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.
•Collecting and analyzing waiver paid claims data
•Compiling this data for the annual waiver reporting to CMS

UTILIZATION MANAGEMENT FUNCTIONS:
The waiver auditing function is incorporated into the Surveillance & Utilization Review (SUR) functions of the Fraud & Abuse Detection System (FADS) contract between the Medicaid agency and SUR Contractor, as detailed in Appendix I-1. Indiana's FSSA Compliance 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 FADS 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 FSSA Compliance – Program Integrity staff will periodically accompany the contractor during on-site audits.

QUALITY ASSURANCE/QUALITY IMPROVEMENT CONTRACTOR is responsible for:
The discovery and remediation activities conducted for the waiver including:
•Quality Monitoring
•Incident Review

•Mortality Review
•Risk Management
•Development of recommended mechanisms for overall systems improvement including Information Technology Development to support ongoing QA/QI
•Submission of quarterly management reporting

ACTUARIAL CONTRACTOR is responsible for
•Completing cost neutrality calculations for the waiver
•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:
FSSA's Operations Unit 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 Community Integration and Habilitation Waiver providers approved by DDRS.

•Oversight of the contractor of Quality Improvement Services includes monitoring DDRS Bureau of Quality Improvement Services (BQIS) with ongoing involvement of the Director of BQIS.
•The State Medicaid Agency has oversight responsibility of the Financial Analysis contractor.
•The oversight of the performance of Surveillance Utilization Review (SUR) Contractor's Fraud and Abuse Detection System (FADS) contract is performed by Program Integrity, under the direct supervision of the FSSA Chief Compliance Officer.

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:
FSSA Compliance exercises oversight and monitoring of the deliverables stipulated within the FADS contract in order to ensure the contracting entity satisfactorily performs waiver auditing functions under the conditions of its contract. Reporting requirements are determined as agreed upon within the fully executed contract. The FADS Contractor is required to submit recommendations for review based on their data.

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. FSSA Compliance oversees the contractor's aggregate data to identify common problems, determine benchmarks and offer data to providers to compare against aggregate data.

Final review and approval of all audits and audit-related functions falls to FSSA PI. The direction of the FADS process is a fluid process, allowing for modification and adjustment in an on-going basis to ensure appropriate focus.

The FSSA Operations Unit oversees the contracting Medicaid Fiscal Agent's monthly reports of reviews. Oversight of the Fiscal Agent also involves the DDRS/BDDS. The FSSA Operations Unit's Provider Relations Specialist position monitors the Fiscal Contractor 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 BDDS and to the Provider Relations Specialist. Providers are to be enrolled by the dedicated fiscal agent within an average 30 calendar days from receipt of the completed provider agreement paperwork. Complaints about the timeliness or performance of the Medicaid fiscal agent are relayed to the FSSA Director of Operations by FSSA's Office of Medicaid Policy and Planning, BDDS and/or by the Operations Unit's Provider Relations Specialist.

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

A BQIS executive staff position monitors this contract using the following methods to assure that the contractor performs its assigned functions in accordance with contract and waiver requirements:
• A BQIS executive staff member 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 Compliance Evaluation and Review Tools (CERT) completed, analysis of findings, and trends identified. BQIS executive staff reviews these reports and follows-up with the contractor when concerns are identified. In addition to analytical reports based on CERT findings, the contractor submits quarterly reports on their performance.
• Other indicators that the contractor reports on quarterly include Incident Review and Mortality Review. BQIS executive staff 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. BQIS executive staff participates in all risk management meetings and oversees the contractor’s interactions with others as well as monitors that it implements assigned tasks.

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 aids in monitoring expenses and supports 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 actuarial contractor includes an executive summary, detailed results, sources of data, methodologies, and assumptions.

The actuarial contract, which is currently monitored by FSSA/Finance, is not a performance based contract.

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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	Contracted Entity
Participant waiver enrollment	✓	
Waiver enrollment managed against approved limits	✓	
Waiver expenditures managed against approved levels	✓	
Level of care evaluation	✓	
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 the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

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:
AA A.5. Number and percent of provider reviews completed by DDRS within specified time frame outlined in the waiver. Numerator: Total number of provider reviews completed by DDRS within specified time frame. Denominator: Total number of provider reviews due.

Data Source (Select one):
Other
If 'Other' is selected, specify:
FSSA's BQIS/DDRS Provider Re-approval and Accreditation 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**

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:
AA A.4. Number and percent of service plan reports submitted to the OMPP by DDRS within the required time period. Numerator:Total number of service plan reports submitted to OMPP by DDRS within the required time period. Denominator: Total number of service plan reports due.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OMPP Tracking Sheet

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:
AA A.6. Number and percent of waiver policies and procedures developed by the DDRS that were approved by OMPP prior to implementation. Numerator: Total number of waiver policies and procedures approved by OMPP prior to implementation. Denominator: Total number of waiver policies and procedures implemented.

Data Source (Select one):
Presentation of policies or procedures
If 'Other' is selected, specify:
OMPP tracking sheet

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:
AA A.3. Number and percent of quarterly LOC reports submitted to OMPP by DDRS within the required time period. Numerator: Total number of quarterly LOC reports submitted by DDRS within the required time period. Denominator: Total number of quarterly LOC reports due.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OMPP Tracking Sheet

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:
AA A.2. Number and percent of active waiver participants compared to the approved waiver capacity. Numerator: Total number of active waiver participants. Denominator: Total number of CMS approved waiver slots.

Data Source (Select one):
Reports to State Medicaid Agency on delegated
If 'Other' is selected, specify:
DDRS Waiver slot 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: Actuarial 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: Actuarial Contractor	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
AA A.7. Number and percent of enrolled waiver service providers who met all provider enrollment requirements corresponding to the executed contract with the fiscal

contractor. Numerator: The total number of enrolled waiver service providers who met all provider enrollment requirements. Denominator: The total number of waiver service providers who were enrolled by the fiscal contractor.

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:
FSSA Operations Waiver 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: 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: Fiscal Contractor	☐ **Annually**
	☐ **Continuously and Ongoing**

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

Performance Measure:
AA A.8. Number and percent of providers assigned a Medicaid provider number according to the timeframe specified in the contract with the fiscal contractor. Numerator: The number of providers assigned a Medicaid provider number by the fiscal contractor according to the timeframe specified in the contract. Denominator: The total number of providers assigned a Medicaid provider number.

Data Source (Select one):
Reports to State Medicaid Agency on delegated
If 'Other' is selected, specify:
FSSA Operations and Fiscal Contractor

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: 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: Fiscal Contractor	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
AA A.1. 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):
Reports to State Medicaid Agency on delegated
If 'Other' is selected, specify:
DDRS targeted waiver slot report for CIH waiver

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:

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.
AA A.1- A.6 FSSA meets at least monthly to review and aggregate data, respond to questions, identify areas of concern and resolve issues to ensure the successful implementation of the waiver program. FSSA divisions also participate in all conference calls with CMS pertaining to the Waiver.

FSSA's divisions work to ensure that problems are addressed and corrected. FSSA's divisions participate in the data aggregation and analysis of individual performance measures throughout the waiver application. Between scheduled meetings, problems are regularly addressed through written and/or verbal communications to ensure timely remediation. FSSA discusses the circumstances surrounding an issue or event and what remediation actions should be taken.

In some cases, informal actions, such as obtaining an explanation of the circumstances surrounding the event, or verification that remediation actions have been taken, may be sufficient to deem the problem resolved. In other situations, more formal actions may be taken. This may consist of elevating the issue for a cross-division executive level discussion and remediation.

AA A.7-A.8 FSSA's Operations and OMPP staff meet at least monthly with the fiscal contractor to review reports, respond to questions, identify areas of concern and resolve issues to ensure contractual compliance. Corrective actions vary according to the scope and severity of the identified problem. In some cases, informal actions, such as obtaining an explanation of the circumstances surrounding the event, or verification that remediation actions have been taken, may be sufficient to deem the problem resolved. In

other situations, more formal actions may be taken. This may consist of a written corrective action plan (CAP).

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 one or more groups 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 or more waiver target groups, check each of the subgroups in the selected target group(s) 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**			☐

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
☑ Intellectual Disability or Developmental Disability, or Both					
	☑	Autism	0		☑
	☑	Developmental Disability	0		☑
	☑	Intellectual Disability	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 Individuals with intellectual disability (IID) 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 IID, DD or other related condition must have an onset prior to age 22 and be expected to continue. The IID, 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 use of a level of care assessment tool and an array of collateral materials when determining eligibility for waiver services.

Only individuals who are determined to require the institutional level of care specified for admission to an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) may be enrolled in the CIH Waiver.

Eligibility requirements are found within FSSA's Bureau of Developmental Disabilities Services' policy governing eligibility determination, Eligibility and ICF/DD Level of Care Determination for Developmental Disability Services.

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.

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

  - ( ) **The following dollar amount:**

    Specify dollar amount:

    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)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

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:

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:

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

  Specify:

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	9244
Year 2	

Waiver Year	Unduplicated Number of Participants
	9901
Year 3	10499
Year 4	11124
Year 5	11776

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	
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	
Emergency Placement	
Eligible individuals transitioning to the community from NF, ESN and SOF	
Eligible individuals transitioning from 100% state funded services	
Eligible individuals aging out of DOE, DCS or Children's SGL	
Eligible individuals choosing to leave ICFs/IID	
Eligible individuals determined to no longer need/receive active treatment in group home	

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):*

Emergency Placement

Purpose *(describe):*

To prioritize waiver access to eligible individuals with intellectual disabilities and require an emergency placement under the reserved waiver capacity criteria associated with one or more of the following situations:
(1) Death of a primary caregiver where alternative placement in a supervised group living setting is not available or is determined by the division director to be an inappropriate option.
(2) A situation in which the primary caregiver is at least eighty (80) years of age and alternate placement in a supervised group living setting is not available or is determined by the division director to be an inappropriate option.
(3) There is evidence of abuse or neglect in the current institutional or home placement, and alternate placement in a supervised group living setting is not available or is determined by the division director to be an inappropriate option.
(4) There are other health and safety risks, as determined by the division director, and alternate placement in a supervised group living setting is not available or is determined by the division director to be an inappropriate option.

This reserved waiver capacity category was implemented in 2011 in accordance with Indiana Public Law 229-2011, Sec. 278.

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

Describe how the amount of reserved capacity was determined:

The first emergency placement situation listed above is applicable to instances where the primary caregiver of the qualifying individual passes away and the individual is in need of immediate care that cannot be provided in any other manner. Reserved capacity in this area was calculated by reviewing the number of individuals who were granted entrance to the waiver via this category from January 2013 thru May 2014. Based on trend analysis and data indicating that the population of caregivers is growing older, it is expected that Indiana will grant sixty emergency placements for this situation during Waiver Year 1 of this renewal. Based on demographic trends seen in the age and health of primary caregivers across the State, Indiana expects to see a 5% growth trend in this, and other, emergency placement situations during subsequent years of the renewal.

Situation two is applicable to instances where a qualifying individual's primary caregiver is 80 years old, or older, can no longer care for the individual in question and the individual is in need of immediate care that cannot be provided in any other manner. Reserved capacity in this area was calculated by reviewing the number of individuals who were granted entrance to the waiver via this category from January 2013 thru May 2014. Based on trend analysis and data indicating that the population of caregivers is growing older it is expected that Indiana will grant forty emergency placements for this situation during Waiver Year 1 of this renewal. Based on demographic trends seen in the age and health of primary caregivers across the State, Indiana expects to see a 5% growth trend in this, and other, emergency placement situation during subsequent years of the renewal.

The third situation is applicable to instances where there is substantiated abuse or neglect of the qualifying individual and that individual is in need of immediate care that cannot be provided in any other manner. Reserved capacity in this area was calculated by reviewing the number of individuals who were granted entrance to the waiver via this category from January 2013 thru May 2014. Based on trend analysis it is expected that Indiana will grant ten emergency placements for this situation during Waiver Year 1 of this renewal. Indiana expects this number to remain fairly constant in subsequent years, estimating a 5% growth rate which would lead to one additional placement in each

subsequent waiver year.

The fourth, and last, emergency placement situation is applicable to those qualifying individuals whose health and safety are at substantial risk and the individual is in need of immediate care that cannot be provided in any other manner. Entrance to the waiver via this category is granted at the discretion of the division director. Reserved capacity in this area was calculated by reviewing the number of individuals who were granted entrance to the waiver via this category from January 2013 thru May 2014. Based on trend analysis, it is expected that Indiana will grant 226 emergency placements for this situation during Waiver Year 1 of this renewal. Also from the data, it is reasonable to expect a 5% increase in each subsequent waiver year.

Priority access by Reserved Waiver Capacity is made available as long as available waiver capacity exists for the current waiver year.

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

Waiver Year	Capacity Reserved
Year 1	336
Year 2	353
Year 3	371
Year 4 (renewal only)	390
Year 5 (renewal only)	410

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 to the community from NF, ESN and SOF

Purpose *(describe):*

To prioritize waiver access to eligible individuals with intellectual disabilities and who are transitioning to the community from Nursing Facilities, Extensive Support Needs Homes, or State Operated Facilities.

This reserved waiver capacity category was implemented in accordance with Indiana Public Law 73-2008. The law directed FSSA's Office of Medicaid Policy and Planning and FSSA's BDDS to amend the waiver in order that individuals specified in the law be given priority in receiving services under the waiver.

Priority access by Reserved Waiver Capacity is made available as long as available waiver capacity exists for the current waiver year.

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

Describe how the amount of reserved capacity was determined:

FSSA's Division of Disability and Rehabilitative Services (DDRS) serves an average of 1624 individuals with intellectual disabilities in nursing facility (NF) settings in any given month. Approximately 2% of those persons elect to leave the nursing facility and enter into waiver services over the course of the waiver year. Reserved capacity for Waiver Years 1 – 5 is based on this historic trend and on the number of placements made from January 2013 thru May 2014.

One of the goals for many individuals served by DDRS in Extensive Support Needs (ESN) settings is

to move into integrated community settings through waiver services. ESN homes are a method to assist individuals to learn to live in small group settings with others. Once they are ready to leave the ESN home it is often their choice to move into a home of their own in the community. Reserved capacity was determined by a review of individuals currently in ESN homes, their time in that service and data on the amount of time an individual generally spends in this setting. Additionally, a review of the number of placements made in from January 2013 thru May 2014 was taken into account.

Currently there are 27 individuals in SOF's, as identified by the Division of Mental Health and Addiction (DMHA), who qualify for services through DDRS. However, as these individuals exit the State Operated Facilities it is unlikely that many of them will initially participate in community based waiver services.

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

Waiver Year	Capacity Reserved
Year 1	55
Year 2	60
Year 3	63
Year 4 (renewal only)	65
Year 5 (renewal only)	68

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):*

To prioritize waiver access to eligible individuals with intellectual disabilities who are transitioning from 100% state funded budgets onto the Community Integration and Habilitation Waiver.

This reserved waiver capacity category was implemented in accordance with Indiana Public Law 73-2008. The law directed the FSSA's Office of Medicaid Policy and Planning and FSSA's BDDS to amend the waiver in order that individuals specified in the law be given priority in receiving services under the waiver.

Priority access by Reserved Waiver Capacity is made available as long as available waiver capacity exists for the current waiver year.

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

Describe how the amount of reserved capacity was determined:

The majority of individuals receiving services through 100% State funded services do not qualify for Medicaid under current Indiana eligibility standards. This being the case, reserved waiver capacity for Waiver Years 1 – 5 is based on the number of individuals who entered into waiver services via this category from January 2013 thru May 2014.

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

Waiver Year	Capacity Reserved
Year 1	10

Waiver Year	Capacity Reserved
Year 2	10
Year 3	10
Year 4 (renewal only)	10
Year 5 (renewal only)	10

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 aging out of DOE, DCS or Children's SGL

Purpose *(describe):*

To prioritize waiver access to eligible individuals with intellectual disabilities who will be attaining the maximum age for any of the following settings funded by the Indiana department of education (facility, residential); the Indiana department of child services (foster care, facility, residential, group home), or Indiana Medicaid (Supervised Group Living).

This reserved waiver capacity category was implemented in accordance with Indiana Public Law 73-2008. The law directed the Office of Medicaid Policy and Planning and BDDS to amend the waiver in order that individuals specified in the law be given priority in receiving services under the waiver.

Priority access by Reserved Waiver Capacity is made available as long as available waiver capacity exists for the current waiver year.

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

Describe how the amount of reserved capacity was determined:

Historically, the Department of Education (DOE) had reported a constant number of students annually who were aging out of services funded by the DOE (an average of 25 annually), while the number of students who actually selected and qualified for waiver services was expected to remain consistent with numbers previously tracked under the expiring waiver. A review of the number of participants who entered into waiver services via this category from January 2013 thru May 2014 was taken into account to determine the reserved capacity.

FSSA's DDRS and the Department of Child Services (DCS) have developed a strong partnership working toward placement of individuals with IDD into home and community based waiver settings when they age out of the foster care system. As this partnership has developed FSSA has made it a priority to serve these individuals. Given this commitment, FSSA has increased the number of reserved capacity slots in this category to reflect the growing needs of this population. In addition, a review of the number of participants who entered into waiver services via this category from January 2013 thru May 2014 was taken into account to determine the reserved capacity.

Indiana's FSSA continues to stand by its prior decision and will not increase the number of licensed ICF/IID beds in its Supervised Group Living (SGL) settings, including the number of beds that may be occupied by children. Given this, data regarding the number of participants who entered into waiver services via this category from January 2013 thru May 2014 was utilized to determine the reserved capacity.

The increase in reserved capacity from Waiver Year 1 to Waiver Year 5 is reflective of trends in the number of individuals leaving the DCS system and choosing to utilize a home and community based services waiver.

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

Waiver Year	Capacity Reserved
Year 1	75
Year 2	79
Year 3	84
Year 4 (renewal only)	90
Year 5 (renewal only)	94

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 choosing to leave ICFs/IID

Purpose *(describe):*

To prioritize waiver access to eligible individuals choosing to leave Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID) to transition into the community. At any time, an eligible individual with an intellectual and/or developmental disability may request to leave the facility/institution in which he/she currently resides in order to receive Community Integration and Habilitation (CIH) waiver funded services. Requests to transition to CIH Waiver services may be made by the current resident of a Large Private Intermediate Care Facility for Individuals with Intellectual Disabilities (LP ICF/IID), by the current resident of a licensed Supervised Group Living (SGL) setting, by the current resident of a Comprehensive Rehabilitative Management Needs Facility (CRMNF), or by the legal guardian of an eligible individual residing in any of these service settings. Additionally, for eligible individuals residing in any ICF/IID facility/institution that announces its closing, the options presented to those individuals will include the option of entering into CIH waiver services via this Reserved Waiver Capacity category.

Eligible individuals transitioning to the community from other types of facilities and institutions - Nursing Facilities, Extensive Support Need Supervised Group Living homes and State Operated Facilities - will continue to enter into CIH Waiver services through the pre-existing "Eligible individuals transitioning to the community from NF, ESN and SOF" Reserved Waiver Capacity category.

Priority access by Reserved Waiver Capacity is made available as long as available waiver capacity exists for the current waiver year.

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

Describe how the amount of reserved capacity was determined:

In 2013, FSSA's DDRS initiated a project in which residents of Large Private ICFs/IID are interviewed and informed of alternatives to institutional placement, with one alternative being the choice to leave the institution and receive waiver funded services in the community. This initiative will continue throughout Waiver Year 1 of the renewal.

In 2014, a similar initiative began for participants currently receiving services in Supervised Group Living settings. The project, known as My Life, My Choice, has interviewed over 200 individuals who had been living in SGL setting. Many of the individuals interviewed have indicated a desire to learn more about community based waiver settings so that they can decide whether to choose a community setting or remain in their SGL setting. In order to determine needed capacity for this category, Indiana reviewed the number of individuals who choose to leave SGL's and entered into waiver services via this reserved capacity category from January 2013 thru May 2014 and then

reviewed the number who indicated they wanted more information on moving to a waiver setting. From this information, Indiana determined reserved capacity for this category.

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

Waiver Year	Capacity Reserved
Year 1	102
Year 2	150
Year 3	65
Year 4 (renewal only)	65
Year 5 (renewal only)	65

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 determined to no longer need/receive active treatment in group home

Purpose *(describe):*

To prioritize waiver access to eligible individuals with intellectual disabilities and have been determined by the state department of health to no longer need or receive active treatment provided in a supervised group living setting.

This reserved waiver capacity category was implemented in accordance with Indiana Public Law 73-2008. The law directed the Office of Medicaid Policy and Planning and BDDS to amend the waiver in order that individuals specified in the law be given priority in receiving services under the waiver.

Priority access by Reserved Waiver Capacity is made available as long as available waiver capacity exists for the current waiver year.

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

Describe how the amount of reserved capacity was determined:

Historically, less than 1% of Supervised Group Living (SGL) residents required a reserved capacity priority slot under the CIH waiver due to being tagged by the Indiana State Department of Health (ISDH) as no longer being in need of active treatment/inappropriate placement. That historic trend has changed very little. Indiana reviewed utilization of this category from January 2013 thru May 2014 and determined that the number of individuals entering into waiver services via this reserved capacity category would remain consistent from Waiver Year 1 through the duration of the renewal. The State expects that its increased involvement with individuals currently residing in SGLs will ultimately result in fewer tags in the future.

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

Waiver Year	Capacity Reserved
Year 1	5
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 Community Integration and Habilitation Waiver occurs via the reserved capacity (priority) criteria noted in Appendix B-3-c.

FSSA's Division of Disability and Rehabilitative Services (DDRS), uses to a single statewide wait list for waiver services in which applicants move on a first come, first served basis onto the Family Supports Waiver (also operated by DDRS), or where capacity exists, enter into waiver services under the Community Integration and Habilitation (CIH) Waiver on the basis of need and meeting the criterion of a Reserved Waiver Capacity category found under Appendix B-3-c.

Participants receiving services under the Family Supports Waiver have the potential for movement to the CIH Waiver when an identified need exists and they are found to meet criteria for any of the existing Reserved Waiver Capacity priority categories noted in Appendix B-3 c. When such an opportunity arises and an available capacity for movement exists, the participant who meets criteria for movement will be notified. The Case Manager is expected to inform the participant of the array of services available under the Community Integration and Habilitation Waiver so that informed choice can be made. Interested participants will be assessed to determine the budget amount assigned through the objective based allocation process should the participant chose to accept the opportunity for movement. However, if the participant and his or her Individualized Support Team determine that services under the Family Supports Waiver are adequate to meet the needs of the participant, the participant and his or her guardian, if applicable, may opt to remain on the Family Supports Waiver.

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)

- ☐ **Low income families with children as provided in §1931 of the Act**
- ☑ **SSI recipients**
- ☐ **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)**
- ☑ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- ☑ **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)**
- ☑ **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:

  42 CFR 435.110 Parents and other caretaker relatives

  42 CFR 435.118 Infants and children under age 19

  42 CFR 435.145 Children for whom adoption assistance or foster care maintenance payments are made (under title IV-E of the Act)

  42 CFR 435.150 Former Foster Care Children; Sec. 1902(a)(10)(A)(i)(IX)

  42 CFR 435.226 Independent Foster Care Adolescents; Sec. 1902(a)(10)(A)(ii)(VII)

  42 CFR 435.227 Individuals under age 21 who are under State adoption assistance agreements

  Sec 1925 of the Act --Transitional Medical Assistance

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:

- [x] **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-b (SSI 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-b (SSI 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-b (SSI 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.**

The State uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances 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:

  - ( ) **SSI standard**
  - ( ) **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 the 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**
- **The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

  Specify:

  Specify the amount of the allowance (*select one*):

  - **SSI standard**
  - **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:

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 (3 of 4)

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

- **SSI standard**
- **Optional State supplement standard**
- **Medically needy income standard**
- **The special income level for institutionalized persons**
- **A percentage of the Federal poverty level**

Specify percentage:

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 formula:

Other

Specify:

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

Allowance is the same

Allowance is different.

Explanation of difference:

iii. 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 uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

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):

- (selected) **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:

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:

- (selected) **Other**

Specify:

Initial Level of Care evaluations are performed by FSSA employees from field offices of FSSA's Bureau of Developmental Disabilities Services (BDDS). These FSSA employees are BDDS Service Coordinators.

Reevaluations are performed by the participant-selected provider 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 (FSSA employees) who are Qualified Intellectual Disabilities Professionals (QIDP) as specified by the standard within 42 CFR 483.430(a) may perform the initial Level of Care determinations.

Any subsequent LOC evaluation, whether by an FSSA employee or by a provider of Case Management as a waiver funded service, must be performed by Qualified Intellectual Disabilities Professionals.

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, the FSSA employee or the provider of Case Management obtains and reviews the following:
1) Psychological records;
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 for the initial determination only.

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.

A second BDDS Service Coordinator (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/IID LOC.

An applicant/participant must meet three of six substantial functional limitations and each of four basic conditions (listed below) in order to meet LOC.
• The 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) understanding and use of 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 basic condition identified in item 1 had an age of onset prior to age 22.

Note that qualifying individuals having a diagnosis within the Autism Spectrum, including Asperger's and/or Pervasive Developmental Disorders, may receive services under the Community Integration and Habilitation (CIH) Waiver.

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:

With one exception, the process for reevaluation of level of care is the same as the initial evaluation described in Appendix B-6-d, but is performed by the waiver Case Manager as opposed to by FSSA employees/BDDS staff. The exception is that there is no requirement to obtain another 450B Confirmation of Diagnosis form at the time of reevaluation.

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 Plan of Care/Cost Comparison Budget 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 FSSA's Bureau of Developmental Disabilities Services within the State's electronic case management system and are retrievable indefinitely 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**

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

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 the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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:
LOC A.1. 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):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:
LOC Analysis of Initial CCBs – CIH Waiver 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:

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 the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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:
LOC B.1. 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:
LOC-Review On-Time/Past-Due Analysis 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:

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 the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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:
LOC C.3. Number and percent of annual 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:
Case Record Review by designated staff at FSSA's BDDS Central Office

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: Representative Sample with confidence interval 5%, but also Proportionate Random Sample
	☐ **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:
LOC C.2. 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:
Case Record Review by designated staff at FSSA's BDDS Central Office

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: Representative Sample with confidence interval 5%, but also Proportionate Random Sample
	☐ **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:
LOC C.1. Number and percent of participants whose level of care was conducted based on requirements for determining level of care in the waiver. Numerator: The total number of participants sampled whose level of care was conducted based on requirements for determining level of care in the waiver. Denominator: The total number of participants sampled.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Record Review by designated staff at FSSA's BDDS Central Office

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: Representative Sample with Confidence Interval 5%, but also Proportionate Random Sample
	☐ **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.
LOC A.1. The report is manually generated for each review period to ensure all new enrollees had a LOC evaluation completed by the State prior to waiver enrollment. Should it be discovered that any enrollee entered into waiver services without the required LOC determination, the FSSA's DDRS Central Office will remediate by determining where the process/system failure occurred, retrain and if necessary, discipline staff and/or update the electronic system that is intentionally designed to prohibit approval and entrance of new enrollees until LOC has been appropriately determined. Should violations occur, notice will be issued requiring completion of the initial LOC within 7 calendar days and any deficiencies would be documented within the case notes pertaining to the enrollee.

LOC B.1. Annual LOC re-evaluations are required at least every 365 calendar days, and more often as needed. On a monthly basis, FSSA's Division of Disability and Rehabilitative Services (DDRS), runs a report to monitor the total number of participants for whom an annual LOC determination was due in that month, the number of annual LOCs actually received for that month and the number of annual LOCs for which no annual redetermination was submitted.

The DDRS Central Office tracks late LOC determinations resulting from the monthly LOC reviews and relays these findings to the appropriate case management agency/agencies.

As the monthly LOC On-Time Analysis report is generated, designated staff from DDRS Central Office reviews and prepares a provider-specific version of the data to be sent to each Case Management agency as may be needed for remediation. The report identifies redeterminations that were completed late. The State's report is waiver specific and also identifies the specific Case Manager(s) from the specified provider agency who failed to meet the required standard. Upon receipt of the report from DDRS Central Office, the provider is required to provide explanation to the State regarding why any determinations were completed late and to ensure the actually complete any overdue LOC determinations. The remediation actions must be completed immediately and the completed report must be returned to the State within 7 calendar days, at which time the responses are researched and verified by the DDRS Central Office. The provider of Case Management is expected to retrain, discipline or dismiss Case Managers who continually fail to meet the standard. Monthly reports are compiled on a Master report for presentation to the Quality Improvement Executive Committee (QIEC). Ongoing, these results are considered as providers are evaluated for re-approval to deliver services.

Remediation may include focused reviews of case management performance, required completion of Corrective Action Plans by the case management agencies, and sanctions if required.

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

To further reduce the incidence of late LOC redeterminations, the State's case management system now allows case management agencies to produce an agency-specific report that identifies outstanding redeterminations. Likewise, within the same system, individual Case Managers have access to a daily activities task list that identifies participants on their caseloads whose redeterminations are due.

LOC C.1. and LOC C.2. and LOC C.3. The State's case management system requires a secondary review of all LOC determinations. If the secondary review of an Initial or Annual LOC would result in a denial, meaning that potential participant or current participant would not meet the requirements to enroll in or remain on the waiver, the information is submitted to BDDS Central Office for a tertiary review. When a tertiary review proves that the potential participant or current participant does in fact meet the LOC requirements, the outcome of the tertiary review determines any need for remediation steps. The system is set up if there is a "no" on any item reviewed, a corrective action is required as well as identification of the responsible party. Once the case review is complete, if there are corrective actions noted, an electronic notification is sent to the responsible party with the corrective action needing resolved as well as a target date for completion. 30 calendar days is the standard time frame for completion. A corrective action plan alerts the case manager of specific issues identified as well as a target date for action.

Patterns of inappropriate decisions by FSSA employees/Service Coordinator or Case Managers will be identified and addressed with the determiner's supervisor. If the data shows a system issue resulting in inappropriate decisions, the matter will be referred to the BDDS Executive staff to identify, address and monitor the training provided to Service Coordinators and Case Managers.

Once the action has been resolved, the responsible party notifies the case reviewer via e-mail. The case reviewer then goes into the system to verify completion. Once verified by the case reviewer, verify completion is checked and the case is closed.

Data is transferred on a weekly basis. There is a 'Hotlist" that shows the status of each case review. Corrective actions that are past the 30 day time frame are listed. The case reviewer, the district manager, as well as the field service directors have access to the hotlist for review purposes.

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 entrance into the Community Integration and Habilitation Waiver, an FSSA's Bureau of Developmental Disabilities Services (BDDS) Service Coordinator becomes 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/IID services.

The applicant or legal representative is asked to sign the "Freedom of Choice" form.

The Freedom of Choice form is initially completed by these potential HCBS waiver participants and documented 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 Community Integration and Habilitation Waiver.

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

If a potential HCBS Waiver participant is currently enrolled in a Risk-Based Managed Care program or if a current 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 a qualifying individual is offered 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 of the POC/CCB 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 Community Integration and Habilitation 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.

At least annually, freedom of choice between waiver and institutional services is documented and uploaded into the document library of the State's case management system. The annual freedom of choice document is the signature page of the participant's service plan, commonly referred to as the CCB.

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 FSSA, 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, DDRS 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 DDRS 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	Rent and Food for Unrelated Live-in Caregiver		
Statutory Service	Residential Habilitation and Support - Daily (RHS Daily)		
Statutory Service	Residential Habilitation and Support		
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	Community Transition		
Other Service	Electronic Monitoring		
Other Service	Environmental Modifications		
Other Service	Extended Services		
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	Personal Emergency Response System		
Other Service	Recreational Therapy		
Other Service	Specialized Medical Equipment and Supplies		
Other Service	Structured Family Caregiving (previously known as Adult Foster Care)		
Other Service	Transportation		
Other Service	Wellness Coordination		
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

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04050 adult day health
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
Adult Day Services (ADS)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.

*** FROM 10/01/2014 THRU 3/31/2015 ***

Individuals attend Adult Day Services on a planned basis. A maximum of 12 hours per day 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 1/2 units/day is allowed.

A 1/4 hour unit is defined as 15 minutes. Billable only if fewer than 3 hours or more than 8 hours of ADS have been provided on the same day. A maximum of 16 1/4 hour units/day are allowed.

*** FROM 4/01/2015 FORWARD ***

Individuals attend Adult Day Services on a planned basis. A maximum of 12 hours per calendar day shall be allowable, billable in 1/4 hour units defined as 15 minutes. The three levels of Adult Day Services are Basic, Enhanced and Intensive.

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:
• 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.
• Psychological 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 maximum of 12 hours per calendar 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	FSSA/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:
FSSA/DDRS Approved Adult Day Service Facilities
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Enrolled as an active Medicaid provider
Must be FSSA/DDRS-approved
Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
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 FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS Waiver Manual and FSSA/DDRS BDDS Policy Manual.

Must obtain/maintain accreditation (specific to Indiana programs) by at least one (1) of the following organizations:
(1) The Commission on Accreditation of Rehabilitation Facilities (CARF), or its successor.
(2) The Council on Quality and Leadership In Supports for People with Disabilities, or its successor.
(3) The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or its successor.
(4) The National Committee for Quality Assurance, or its successor.
(5) The ISO-9001 human services QA system.
(6) An independent national accreditation organization approved by the secretary

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):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
01 Case Management	01010 case management

Service Definition *(Scope):*

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

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 at least every 90 calendar days and as needed to discuss the ISP and any other issues needing consideration in relation to the participant.
• Completion of a DDRS-approved risk 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.
• Completing at least one monthly case note for each participant.
• Conducting face-to-face contacts with the individual (and family members, as appropriate) at least once every 90 calendar days 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	FSSA/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:
FSSA/DDRS Approved Case Management Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Enrolled as an active Medicaid provider
Must be FSSA/DDRS-approved
Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
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 FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS Waiver Manual and FSSA/DDRS BDDS Policy Manual.

Must obtain/maintain accreditation (specific to Indiana programs) by at least one (1) of the following organizations:
(1) The Commission on Accreditation of Rehabilitation Facilities (CARF), or its successor.
(2) The Council on Quality and Leadership In Supports for People with Disabilities, or its successor.
(3) The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or its successor.
(4) The National Committee for Quality Assurance, or its successor.
(5) The ISO-9001 human services QA system.
(6) An independent national accreditation organization approved by the secretary
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):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04010 prevocational services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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 occurs on a quarterly basis. 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. The appropriateness of Prevocational services is determined by dividing the previous quarter's gross earnings by the hours of attendance. If the hourly wage falls below 50% of the Federal minimum wage, Prevocational services may be continued. If the average wage exceeds 50% of the Federal minimum wage, Prevocational services should be discontinued for the next quarter.

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.

*** FROM 10/01/2014 THRU 3/31/2015 ***

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

*** FROM 4/01/2015 FORWARD ***

Prevocational services may not be utilized by an individual who is receiving Extended Services (Individuals in competitive community employment are no longer eligible for Prevocational services). Prevocational services and Extended Services are mutually exclusive and shall not overlap.
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	FSSA/DDRS Approved Prevocational Services Individual
Agency	FSSA/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:
FSSA/DDRS Approved Prevocational Services Individual
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Enrolled as an active Medicaid provider
Must be FSSA/DDRS-approved
Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
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 FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS Waiver Manual and FSSA/DDRS BDDS Policy Manual.

Must obtain/maintain accreditation (specific to Indiana programs) by at least one (1) of the following organizations:
(1) The Commission on Accreditation of Rehabilitation Facilities (CARF), or its successor.
(2) The Council on Quality and Leadership In Supports for People with Disabilities, or its successor.
(3) The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or its successor.
(4) The National Committee for Quality Assurance, or its successor.
(5) The ISO-9001 human services QA system.
(6) An independent national accreditation organization approved by the secretary
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:
FSSA/DDRS Approved Prevocational Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Enrolled as an active Medicaid provider
Must be FSSA/DDRS-approved

Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
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 FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS Waiver Manual and FSSA/DDRS BDDS Policy Manual.

Must obtain/maintain accreditation (specific to Indiana programs) by at least one (1) of the following organizations:
(1) The Commission on Accreditation of Rehabilitation Facilities (CARF), or its successor.
(2) The Council on Quality and Leadership In Supports for People with Disabilities, or its successor.
(3) The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or its successor.
(4) The National Committee for Quality Assurance, or its successor.
(5) The ISO-9001 human services QA system.
(6) An independent national accreditation organization approved by the secretary

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:
Live-in Caregiver (42 CFR §441.303(f)(8))

Alternate Service Title (if any):
Rent and Food for Unrelated Live-in Caregiver

HCBS Taxonomy:

Category 1:	Sub-Category 1:
07 Rent and Food Expenses for Live-In Caregive	07010 rent and food expenses for live-in caregiver

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

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

REIMBURSABLE ACTIVITIES:

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

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

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
Individual	FSSA/DDRS Approved Residential Habilitation and Support Provider
Agency	FSSA/DDRS Approved Residential Habilitation and Support Provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Rent and Food for Unrelated Live-in Caregiver

Provider Category:
Individual
Provider Type:
FSSA/DDRS Approved Residential Habilitation and Support Provider
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Enrolled as an active Medicaid provider
Must be FSSA/DDRS-approved
Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
460 IAC 6-5-24 Qualifications for RHS,
460 IAC 6-14-5 Direct Care Staff Qualifications,
460 IAC 6-14-4 Staff Training
Must comply with any applicable FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS Waiver Manual and FSSA/DDRS BDDS Policy Manual.

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: Rent and Food for Unrelated Live-in Caregiver

Provider Category:
Agency

Provider Type:
FSSA/DDRS Approved Residential Habilitation and Support Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Enrolled as an active Medicaid provider
Must be FSSA/DDRS-approved
Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
460 IAC 6-5-24 Qualifications for RHS,
460 IAC 6-14-5 Direct Care Staff Qualifications,
460 IAC 6-14-4 Staff Training
Must comply with any applicable FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS Waiver Manual and FSSA/DDRS BDDS Policy Manual.

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:

Residential Habilitation

Alternate Service Title (if any):

Residential Habilitation and Support - Daily (RHS Daily)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02031 in-home residential habilitation
Category 2:	**Sub-Category 2:**
08 Home-Based Services	08010 home-based habilitation
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Residential Habilitation and Support – Daily (RHS Daily) services provide up to a full day (24-hour basis) of services and supports which are designed to ensure the health, safety and welfare of the participant. RHS Daily services assist with the acquisition, improvement, and retention of skills necessary to support individuals to live successfully in their own homes; acquire and enhance natural supports; and become integrated and participate in their larger community. Services are designed to help individuals acquire and improve their self-help, socialization, and adaptive skills. Services should be directed toward increasing and maintaining natural supports, physical, intellectual, emotional, social functioning and full community participation.

INDIVIDUALS ELIGIBLE FOR RHS DAILY SERVICES

Individuals who meet all of the following criteria are eligible for RHS Daily Services:
• Individuals who have an ALGO score of 3, 4, or 5 on their Objective Based Allocation (OBA).
• Individuals who are living with housemates and are utilizing a shared staffing model.
• Individuals who are living outside of their family home.

REIMBURSABLE ACTIVITIES

• Assistance with acquiring, enhancing and building natural supports. For example, a measureable outcome would be increased hours of natural supports and a decrease in the number of hours needed for paid staff. Another measurable outcome would be the number of activities an individual participates in with non-paid (natural support) supports versus paid staff.
• Working with the participant to meet the goals they have set for themselves on their Individualized Support Plan (ISP).
• Training the participant to enhance their home-making skills; meal preparation; household chores; money management; shopping; communication skills; social skills and positive behavior.
• Provision of transportation to fully participate in social and recreational activities in the community. For example, transportation to church, the park, the library, the YMCA, classes.
• Provision of transportation to community employment and/or volunteer activities.
• Coordination and facilitation of medical and wellness services to meet the healthcare and wellness needs,

including physician consults, medications, implementation of risk plans, dining plans and wellness plans. Maintenance of each participant's health record.
• The individual must be present and receive RHS Daily services for at least a portion of any day the provider bills as a day of RHS Daily service.
• Electronic Monitoring
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
LIMITATIONS

• Individuals receiving RHS Daily Services cannot receive more than 10 hours per month of Community Habilitation Individual (CHIO) services.

• Budget Modification Requests (BMR) will not be considered or granted to individuals for loss of housemate (s). BMR's will only be considered for extraordinary Health and Safety or Behavioral issues.

• Providers will not be reimbursed separately for Electronic Monitoring Services for individuals receiving RHS Daily Services. Electronic Monitoring is built into the daily rate of RHS Daily services. Providers must adhere to all Electronic Monitoring Service Standards as defined within the Electronic Monitoring Service Definition. (Service Standards are found in the DDRS Waiver Manual)
• Providers may not bill for RHS Daily reimbursement for time when staff/paid caregiver is asleep. Only awake, engaged staff can be counted in reimbursement.
• Providers may not bill for RHS Daily reimbursement during the time when a participant is admitted to a hospital. (The care and support of a participant who is admitted to a hospital is a non-billable RHS Daily activity.)
o RHS Daily Services can be billed the day of a hospital admission and the day of discharge from a hospital if services are provided on these days; however, RHS Daily cannot be billed for other days the individual is hospitalized, even if the RHS Daily provider provided services in the hospital setting such as "sitter" services.

ACTIVITIES NOT ALLOWED

Reimbursement is not available through RHS Daily in the following circumstances:

• Services to individuals in Structured Family Caregiving services
• Services that are available under the 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	FSSA/DDRS Approved RHS Agencies
Individual	FSSA/DDRS Approved RHS Individuals

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Residential Habilitation and Support - Daily (RHS Daily)

Provider Category:

Agency

Provider Type:
FSSA/DDRS Approved RHS Agencies
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Enrolled as an active Medicaid provider
Must be FSSA/DDRS-approved
Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
460 IAC 6-5-24 Qualifications for RHS,
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 Qualifications,
460 IAC 6-14-5 Direct Care Staff Qualifications,
460 IAC 6-14-4 Staff Training, and Transportation Requirements.
Must comply with any applicable FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS Waiver Manual and FSSA/DDRS BDDS Policy Manual.

Per House Enrolled Act 1360 (P.L.154-2012), Indiana Code [IC 12-11-1.1-1] is amended to state:

o Beginning July 1, 2012, the bureau shall ensure that an entity approved to provide residential habilitation and support services under home and community based services waivers is accredited by an approved national accrediting body. However, if an entity is accredited to provide home and community based services under subdivision (1) other than residential habilitation and support services, the bureau may extend the time that the entity has to comply with this subdivision until the earlier of the following:
(A) The completion of the entity's next scheduled accreditation survey.
(B) July 1, 2015.

o In accordance with the above citation from Indiana Code [IC 12-11-1.1-1], RHS providers must obtain/maintain accreditation (specific to Indiana programs) by at least one (1) of the following organizations:

(1) The Commission on Accreditation of Rehabilitation Facilities (CARF), or its successor.
(2) The Council on Quality and Leadership In Supports for People with Disabilities, or its successor.
(3) The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or its successor.
(4) The National Committee for Quality Assurance, or its successor.
(5) The ISO-9001 human services QA system.
(6) The Council on Accreditation, or its successor.
(7) An independent national accreditation organization approved by the secretary.
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: Residential Habilitation and Support - Daily (RHS Daily)

Provider Category:
Individual

Provider Type:
FSSA/DDRS Approved RHS Individuals

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Enrolled as an active Medicaid provider
Must be FSSA/DDRS-approved
Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
460 IAC 6-5-24 Qualifications for RHS,
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 Qualifications,
460 IAC 6-14-5 Direct Care Staff Qualifications,
460 IAC 6-14-4 Staff Training, and Transportation Requirements.
Must comply with any applicable FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS Waiver Manual and FSSA/DDRS BDDS Policy Manual.

Per House Enrolled Act 1360 (P.L.154-2012), Indiana Code [IC 12-11-1.1-1] is amended to state:

o Beginning July 1, 2012, the bureau shall ensure that an entity approved to provide residential habilitation and support services under home and community based services waivers is accredited by an approved national accrediting body. However, if an entity is accredited to provide home and community based services under subdivision (1) other than residential habilitation and support services, the bureau may extend the time that the entity has to comply with this subdivision until the earlier of the following:
(A) The completion of the entity's next scheduled accreditation survey.
(B) July 1, 2015.

o In accordance with the above citation from Indiana Code [IC 12-11-1.1-1], RHS providers must obtain/maintain accreditation (specific to Indiana programs) by at least one (1) of the following organizations:

(1) The Commission on Accreditation of Rehabilitation Facilities (CARF), or its successor.
(2) The Council on Quality and Leadership In Supports for People with Disabilities, or its successor.
(3) The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or its successor.
(4) The National Committee for Quality Assurance, or its successor.
(5) The ISO-9001 human services QA system.
(6) The Council on Accreditation, or its successor.
(7) An independent national accreditation organization approved by the secretary.

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:
Residential Habilitation

Alternate Service Title (if any):
Residential Habilitation and Support

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02031 in-home residential habilitation
Category 2:	**Sub-Category 2:**
08 Home-Based Services	08010 home-based habilitation
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
*** FROM 10/01/2014 THRU 3/31/2015 ***

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

*** FROM 4/01/2015 FORWARD ***

Residential Habilitation and Support (RHS) Level 1 and Level 2 services provide up to a full day (24-hour basis) of services and/or supports for participants designated as Algo 0, 1, or 2* which are designed to ensure the health, safety and welfare of the participant, and assist in the acquisition, improvement, and retention of skills necessary to support participants to live successfully in their own homes.

Billable under one of two level-specific Billing Codes:
• RH1O – Level 1 - for intermittent use of RHS at 35 or fewer hours per week, OR
• RH2O – Level 2 - for greater than 35 hours per week of RHS

*Participants designated as Algo 3, 4 or 5 use RHS Daily services effective April 1, 2015.

REIMBURSABLE ACTIVITIES (From 10/01/2014 forward)

RHS includes the following activities:

• Direct supervision, monitoring and training to implement the Individualized Support Plan (ISP) outcomes for the participant through the following:
o Assistance with personal care, meals, shopping, errands, chore and leisure activities and transportation (excluding transportation that is covered under the Medicaid State Plan)
o Assurance that direct service staff are aware of and actively participate in the development and implementation of ISP, Behavior Support Plans and Risk Plans**
o Coordination and facilitation of medical and non-medical services to meet healthcare needs, including physician consults, medications, development and oversight of a health plan, utilization of available supports in a cost effective manner and maintenance of each participant's health record when the participant receiving RHS does not also utilize Wellness Coordination Services
o Collaboration and coordination with the wellness coordinator when the participant receiving RHS also utilizes Wellness Coordination Services.

**When Wellness Coordination services are utilized in addition to RHS services, the Wellness Coordinator is responsible for the development, oversight and maintenance of a Wellness Coordination plan as well the development, oversight and maintenance of the health-related Risk Plan, which includes training of Direct Support Professionals to ensure implementation of the health-related Risk Plans.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Reimbursable waiver funded services furnished to an adult waiver participant by any combination of relative(s) * and/or legal guardian(s) may not exceed a total of 40 hours per week. (See Activities Not Allowed for definition of relative)

Additionally:
• Providers may not bill for RHS reimbursement for time when staff/paid caregiver is asleep. Only awake, engaged staff can be counted in reimbursement. (A team may decide that a staff or contractor may sleep while with a participant, but this activity is not billable.)
• Providers may not bill for RHS reimbursement during the time when a participant is admitted to a hospital. (The care and support of a participant who is admitted to a hospital is a non-billable RHS activity.)
• RHS Level 1 and RHS Level 2 and Electronic Monitoring services are not billable concurrently/during the same time period.
• Intermittent use of RHS may not exceed thirty-five (35) hours of service per week

Activities Not Allowed

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

*** Related/relative implies any of the following natural, adoptive and/or step relationships, whether by blood or by marriage, inclusive of half and/or in-law status:
1) Aunt (natural, step, adopted)
2) Brother (natural, step, half, adopted, in-law)
3) Child (natural, step, adopted)
4) First cousin (natural, step, adopted)
5) Grandchild (natural, step, adopted)
6) Grandparent (natural, step, adopted)
7) Niece (natural, step, adopted)
8) Nephew (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)

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	FSSA/DDRS Approved RHS Agencies
Individual	FSSA/DDRS Approved RHS Individuals

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Residential Habilitation and Support

Provider Category:
Agency
Provider Type:
FSSA/DDRS Approved RHS Agencies
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
• Enrolled as an active Medicaid provider
• Must be FSSA/DDRS-approved
• Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
460 IAC 6-5-24 Qualifications for RHS,
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 Qualifications,
460 IAC 6-14-5 Direct Care Staff Qualifications,
460 IAC 6-14-4 Staff Training, and Transportation Requirements.
• Must comply with any applicable FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS Waiver Manual and FSSA/DDRS BDDS Policy Manual.

• Per House Enrolled Act 1360 (P.L.154-2012), Indiana Code [IC 12-11-1.1-1] is amended to state:

o Beginning July 1, 2012, the bureau shall ensure that an entity approved to provide residential habilitation and support services under home and community based services waivers is accredited by an approved national accrediting body. However, if an entity is accredited to provide home and community based services under subdivision (1) other than residential habilitation and support services, the bureau may extend the time that the entity has to comply with this subdivision until the earlier of the following:
(A) The completion of the entity's next scheduled accreditation survey.
(B) July 1, 2015.

o In accordance with the above citation from Indiana Code [IC 12-11-1.1-1], RHS providers must obtain/maintain accreditation (specific to Indiana programs) by at least one (1) of the following organizations:

(1) The Commission on Accreditation of Rehabilitation Facilities (CARF), or its successor.
(2) The Council on Quality and Leadership In Supports for People with Disabilities, or its successor.
(3) The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or its successor.
(4) The National Committee for Quality Assurance, or its successor.
(5) The ISO-9001 human services QA system.
(6) The Council on Accreditation, or its successor.
(7) An independent national accreditation organization approved by the secretary.

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: Residential Habilitation and Support

Provider Category:

Individual

Provider Type:

FSSA/DDRS Approved RHS Individuals

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

• Enrolled as an active Medicaid provider
• Must be FSSA/DDRS-approved
• Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
460 IAC 6-5-24 Qualifications for RHS,
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 Qualifications,
460 IAC 6-14-5 Direct Care Staff Qualifications,
460 IAC 6-14-4 Staff Training, and Transportation Requirements.
• Must comply with any applicable FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS Waiver Manual and FSSA/DDRS BDDS Policy Manual.

•
• Per House Enrolled Act 1360 (P.L.154-2012), Indiana Code [IC 12-11-1.1-1] is amended to state:

o Beginning July 1, 2012, the bureau shall ensure that an entity approved to provide residential habilitation and support services under home and community based services waivers is accredited by an approved national accrediting body. However, if an entity is accredited to provide home and community based services under subdivision (1) other than residential habilitation and support services, the bureau may extend the time that the entity has to comply with this subdivision until the

earlier of the following:
(A) The completion of the entity's next scheduled accreditation survey.
(B) July 1, 2015.

o In accordance with the above citation from Indiana Code [IC 12-11-1.1-1], RHS providers must obtain/maintain accreditation (specific to Indiana programs) by at least one (1) of the following organizations:

(1) The Commission on Accreditation of Rehabilitation Facilities (CARF), or its successor.
(2) The Council on Quality and Leadership In Supports for People with Disabilities, or its successor.
(3) The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or its successor.
(4) The National Committee for Quality Assurance, or its successor.
(5) The ISO-9001 human services QA system.
(6) The Council on Accreditation, or its successor.
(7) An independent national accreditation organization approved by the secretary.

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):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09012 respite, in-home
Category 2:	**Sub-Category 2:**
09 Caregiver Support	09011 respite, out-of-home
Category 3:	**Sub-Category 3:**
02 Round-the-Clock Services	02033 in-home round-the-clock services, other
Category 4:	**Sub-Category 4:**

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 Structured Family Caregiving 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	FSSA/DDRS Approved Respite Providers - Individual - Skilled Nursing
Agency	FSSA/DDRS Approved Licensed Home Health Agencies
Individual	FSSA/DDRS Approved Respite Providers - Individual
Agency	FSSA/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:
FSSA/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):*
Enrolled as an active Medicaid provider
Must be FSSA/DDRS-approved
Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
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 FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS Waiver Manual and FSSA/DDRS BDDS Policy Manual.

Nurses rendering waiver funded services must obtain/maintain Indiana licensure.

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:
FSSA/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):*
Enrolled as an active Medicaid provider
Must be FSSA/DDRS-approved
Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:

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 FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS Waiver Manual and FSSA/DDRS BDDS Policy Manual.

Nurses rendering waiver services must obtain/maintain Indiana licensure

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:
FSSA/DDRS Approved Respite Providers - Individual

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Enrolled as an active Medicaid provider
Must be FSSA/DDRS-approved
Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
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 FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS Waiver Manual and FSSA/DDRS BDDS Policy Manual.

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:
FSSA/DDRS Approved Respite Agencies
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Enrolled as an active Medicaid provider
Must be FSSA/DDRS-approved
Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
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 FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS Waiver Manual and FSSA/DDRS BDDS Policy Manual.
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

HCBS Taxonomy:

Category 1:	Sub-Category 1:
03 Supported Employment	03021 ongoing supported employment, individual

Category 2:	Sub-Category 2:

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*
*** FROM 10/01/2014 THRU 3/31/2015 ***
*** SUPPORTED EMPLOYMENT FOLLOW ALONG WILL BE REPLACED BY EXTENDED SERVICES AS OF 04/01/2015 ***

UNTIL 3/31/2015: 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

*** FROM 10/01/2014 THRU 3/31/2015 ***
*** SUPPORTED EMPLOYMENT FOLLOW ALONG WILL BE REPLACED BY EXTENDED SERVICES AS OF 04/01/2015 ***
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
*** FROM 10/01/2014 THRU 3/31/2015 ***
*** SUPPORTED EMPLOYMENT FOLLOW ALONG WILL BE REPLACED BY EXTENDED SERVICES AS OF 04/01/2015 ***

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

*** FROM 10/01/2014 THRU 3/31/2015 ***
*** SUPPORTED EMPLOYMENT FOLLOW ALONG WILL BE REPLACED BY EXTENDED SERVICES AS OF 04/01/2015 ***

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	FSSA/DDRS Approved Supported Employment Follow Along - Individuals
Agency	FSSA/DDRS Approved Supported Employment Follow Along Agencies

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:
FSSA/DDRS Approved Supported Employment Follow Along - Individuals

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Enrolled as an active Medicaid provider
Must be FSSA/DDRS-approved
Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
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 FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS Waiver Manual and FSSA/DDRS BDDS Policy Manual.

Must obtain/maintain accreditation (specific to Indiana programs) by at least one (1) of the following organizations:
(1) The Commission on Accreditation of Rehabilitation Facilities (CARF), or its successor.
(2) The Council on Quality and Leadership In Supports for People with Disabilities, or its successor.
(3) The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or its successor.
(4) The National Committee for Quality Assurance, or its successor.
(5) The ISO-9001 human services QA system.
(6) An independent national accreditation organization approved by the secretary

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

Certificate *(specify):*

Other Standard *(specify):*
Enrolled as an active Medicaid provider
Must be FSSA/DDRS-approved
Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
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 FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS Waiver Manual and FSSA/DDRS BDDS Policy Manual.

Must obtain/maintain accreditation (specific to Indiana programs) by at least one (1) of the following organizations:
(1) The Commission on Accreditation of Rehabilitation Facilities (CARF), or its successor.
(2) The Council on Quality and Leadership In Supports for People with Disabilities, or its successor.
(3) The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or its successor.
(4) The National Committee for Quality Assurance, or its successor.
(5) The ISO-9001 human services QA system.
(6) An independent national accreditation organization approved by the secretary
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

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11080 occupational therapy

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

Service Definition *(Scope):*
Occupational Therapy Services means services provided 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**

☑ **Legal Guardian**

Provider Specifications:

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

Other Standard *(specify):*
Enrolled as an active Medicaid provider
Must be FSSA/DDRS-approved
Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
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 FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS Waiver Manual and FSSA/DDRS BDDS Policy Manual.
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):*
Enrolled as an active Medicaid provider
Must be FSSA/DDRS-approved
Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
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 FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS Waiver Manual and FSSA/DDRS BDDS Policy Manual.

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):*
Enrolled as an active Medicaid provider
Must be FSSA/DDRS-approved
Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
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 FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS Waiver Manual and FSSA/DDRS BDDS Policy Manual.

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

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11090 physical therapy
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
Physical Therapy Services means services provided 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 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**

☑ **Relative**
☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Licensed Physical Therapist
Agency	FSSA/DDRS Approved Agency Providing Physical Therapy
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:
Individual
Provider Type:
Licensed Physical Therapist
Provider Qualifications
License *(specify):*
IC 25-27-1
Certificate *(specify):*

Other Standard *(specify):*
Enrolled as an active Medicaid provider
Must be FSSA/DDRS-approved
Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
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 FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS Waiver Manual and FSSA/DDRS BDDS Policy Manual.

Physical Therapists rendering waiver funded services must obtain/maintain Indiana licensure.
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:
FSSA/DDRS Approved Agency Providing Physical Therapy
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Enrolled as an active Medicaid provider
Must be FSSA/DDRS-approved
Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
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 FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS Waiver Manual and FSSA/DDRS BDDS Policy Manual.

Physical Therapists rendering waiver funded services must obtain/maintain Indiana licensure.

Verification of Provider Qualifications

Entity Responsible for Verification:
Initially, BDDS. For re-aproval, 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):*
Enrolled as an active Medicaid provider
Must be FSSA/DDRS-approved
Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
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 FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS Waiver Manual and FSSA/DDRS BDDS Policy Manual.

Physical Therapists rendering waiver funded services must obtain/maintain Indiana licensure.

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

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10030 crisis intervention

Category 2:	Sub-Category 2:
10 Other Mental Health and Behavioral Services	10060 counseling

Category 3:	Sub-Category 3:
10 Other Mental Health and Behavioral Services	10070 psychosocial rehabilitation

Category 4:	Sub-Category 4:
11 Other Health and Therapeutic Services	11120 cognitive rehabilitative therapy

Service Definition *(Scope):*

Psychological Therapy services means services provided 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:

• 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).
• Therapy services furnished to the participant within the educational/school setting or as a component of the participant's school day

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	FSSA/DDRS Approved Qualified Agencies
Individual	Licensed Psychologists
Individual	Marriage/Family Therapist
Individual	Mental Health Counselor

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)*:
Enrolled as an active Medicaid provider
Must be FSSA/DDRS-approved
Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
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 FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS Waiver Manual and FSSA/DDRS BDDS Policy Manual.

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:
FSSA/DDRS Approved Qualified Agencies
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Enrolled as an active Medicaid provider
Must be FSSA/DDRS-approved
Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
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 FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS Waiver Manual and FSSA/DDRS BDDS Policy Manual.
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:
Licensed Psychologists
Provider Qualifications
License *(specify):*
IC 25-33-1-5.1
Certificate *(specify):*

Other Standard *(specify):*
Enrolled as an active Medicaid provider
Must be FSSA/DDRS-approved
Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
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 FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS Waiver Manual and FSSA/DDRS BDDS Policy Manual.
Psychologists rendering waiver funded services must obtain/maintain Indiana licensure.

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):*
Enrolled as an active Medicaid provider
Must be FSSA/DDRS-approved
Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
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 FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS Waiver Manual and FSSA/DDRS BDDS Policy Manual.

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:
Mental Health Counselor

Provider Qualifications

License *(specify):*

IC 25-23.6
Certificate *(specify):*

Other Standard *(specify):*
Enrolled as an active Medicaid provider
Must be FSSA/DDRS-approved
Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
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 FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS Waiver Manual and FSSA/DDRS BDDS Policy Manual.

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

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11100 speech, hearing, and language therapy

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

Service Definition *(Scope):*
Speech-Language Therapy Services means services provided by a licensed speech pathologist.

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

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

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	FSSA/DDRS Approved Agency providing Speech/Language Therapy
Individual	Licensed Speech/Language 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: Speech /Language Therapy

Provider Category:
Agency
Provider Type:
FSSA/DDRS Approved Agency providing Speech/Language Therapy
Provider Qualifications
License *(specify):*
IC 25-35.6 licensed Speech/Language Therapist
Certificate *(specify):*

Other Standard *(specify):*

Enrolled as an active Medicaid provider
Must be FSSA/DDRS-approved
Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
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 FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS Waiver Manual and FSSA/DDRS BDDS Policy Manual.
Speech/Language Therapists rendering waiver funded services must obtain/maintain Indiana licensure.

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:
Individual

Provider Type:
Licensed Speech/Language Therapist

Provider Qualifications

License *(specify):*
IC 25-35.6

Certificate *(specify):*

Other Standard *(specify):*
Enrolled as an active Medicaid provider
Must be FSSA/DDRS-approved
Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
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 FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS Waiver Manual and FSSA/DDRS BDDS Policy Manual.
Speech/Language Therapists rendering waiver funded services must obtain/maintain Indiana licensure.

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):*
Enrolled as an active Medicaid provider
Must be FSSA/DDRS-approved
Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
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 FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS Waiver Manual and FSSA/DDRS BDDS Policy Manual.
Speech/Language Therapists rendering waiver funded services must obtain/maintain Indiana licensure.
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: 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

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10040 behavior support

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Category 4: **Sub-Category 4:**

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:

• 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**
- [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	FSSA/DDRS Approved BSS Individuals
Agency	FSSA/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:
FSSA/DDRS Approved BSS Individuals
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Enrolled as an active Medicaid provider
Must be FSSA/DDRS-approved
Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
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 FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS Waiver Manual and FSSA/DDRS BDDS Policy Manual.
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:
FSSA/DDRS Approved BSS Agencies
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Enrolled as an active Medicaid provider
Must be FSSA/DDRS-approved
Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
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 FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS Waiver Manual and FSSA/DDRS BDDS Policy Manual.

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

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04020 day habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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	FSSA/DDRS Approved Community Based Habilitation Agencies
Individual	FSSA/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:
FSSA/DDRS Approved Community Based Habilitation Agencies
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Enrolled as an active Medicaid provider
Must be FSSA/DDRS-approved
Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
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 FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS Waiver Manual and FSSA/DDRS BDDS Policy Manual.

Must obtain/maintain accreditation (specific to Indiana programs) by at least one (1) of the following organizations:
(1) The Commission on Accreditation of Rehabilitation Facilities (CARF), or its successor.
(2) The Council on Quality and Leadership In Supports for People with Disabilities, or its successor.
(3) The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or its successor.
(4) The National Committee for Quality Assurance, or its successor.
(5) The ISO-9001 human services QA system.
(6) An independent national accreditation organization approved by the secretary

Verification of Provider Qualifications

Entity Responsible for Verification:
Intially, 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:
FSSA/DDRS Approved Community Based Habilitation - Individuals

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Enrolled as an active Medicaid provider
Must be FSSA/DDRS-approved
Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
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 FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS Waiver Manual and FSSA/DDRS BDDS Policy Manual.

Must obtain/maintain accreditation (specific to Indiana programs) by at least one (1) of the following organizations:
(1) The Commission on Accreditation of Rehabilitation Facilities (CARF), or its successor.
(2) The Council on Quality and Leadership In Supports for People with Disabilities, or its successor.
(3) The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or its successor.
(4) The National Committee for Quality Assurance, or its successor.
(5) The ISO-9001 human services QA system.
(6) An independent national accreditation organization approved by the secretary

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

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04020 day habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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.

*** FROM 4/01/2015 FORWARD ***

Community Based Habilitation - Individual is limited to ten (10) hours per month for participants who also utilize RHS Daily services.

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	FSSA/DDRS Approved Agencies
Individual	FSSA/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:
FSSA/DDRS Approved Agencies
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Enrolled as an active Medicaid provider
Must be FSSA/DDRS-approved
Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
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 FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS Waiver Manual and FSSA/DDRS BDDS Policy Manual.

Must obtain/maintain accreditation (specific to Indiana programs) by at least one (1) of the following organizations:
(1) The Commission on Accreditation of Rehabilitation Facilities (CARF), or its successor.
(2) The Council on Quality and Leadership In Supports for People with Disabilities, or its successor.
(3) The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or its successor.
(4) The National Committee for Quality Assurance, or its successor.
(5) The ISO-9001 human services QA system.
(6) An independent national accreditation organization approved by the secretary

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:
FSSA/DDRS Approved Individual

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Enrolled as an active Medicaid provider
Must be FSSA/DDRS-approved
Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
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 FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS Waiver Manual and FSSA/DDRS BDDS Policy Manual.

Must obtain/maintain accreditation (specific to Indiana programs) by at least one (1) of the following organizations:
(1) The Commission on Accreditation of Rehabilitation Facilities (CARF), or its successor.
(2) The Council on Quality and Leadership In Supports for People with Disabilities, or its successor.
(3) The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or its successor.
(4) The National Committee for Quality Assurance, or its successor.
(5) The ISO-9001 human services QA system.
(6) An independent national accreditation organization approved by the secretary

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 Transition

HCBS Taxonomy:

Category 1:	Sub-Category 1:
16 Community Transition Services	16010 community transition services

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

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

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

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

REIMBURSABLE ACTIVITIES:

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

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Community Transition Services are limited to one time set-up expenses, up to $1,000.

ACTIVITIES NOT ALLOWED

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

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	FSSA/DDRS Approved Residential Habilitation and Support ("Individual" Provider Category) or Community-Based Habilitation ("Individual" Provider Category)
Agency	FSSA/DDRS Approved Residential Habilitation and Support Agencies, Structured Family Caregiving Agencies, or Community-Based Habilitation Agencies

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transition

Provider Category:
Individual

Provider Type:
FSSA/DDRS Approved Residential Habilitation and Support ("Individual" Provider Category) or Community-Based Habilitation ("Individual" Provider Category)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Enrolled as an active Medicaid provider
Must be FSSA/DDRS-approved
Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
460 IAC 6-10-5 Criminal Histories
460 IAC 6-12 Insurance,
460 IAC 6-11 Financial Status of Providers,
460 IAC 6-5-34 Community Transition Staff Qualifications
460 IAC 6-14-4 Staff Training
Must comply with any applicable FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS Waiver Manual and FSSA/DDRS BDDS Policy Manual.

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 Transition

Provider Category:
Agency
Provider Type:
FSSA/DDRS Approved Residential Habilitation and Support Agencies, Structured Family Caregiving Agencies, or Community-Based Habilitation Agencies
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Enrolled as an active Medicaid provider
Must be FSSA/DDRS-approved
Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
460 IAC 6-10-5 Criminal Histories
460 IAC 6-12 Insurance,
460 IAC 6-11 Financial Status of Providers,
460 IAC 6-5-34 Community Transition Staff Qualifications
460 IAC 6-14-4 Staff Training
Must comply with any applicable FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS Waiver Manual and FSSA/DDRS BDDS Policy Manual.
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:
Electronic Monitoring

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08010 home-based habilitation

Category 2:	Sub-Category 2:

17 Other Services 17990 other

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

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

REIMBURSABLE ACTIVITIES:

• Electronic Monitoring/Surveillance System & On-Site Response may be installed in residential settings in which all residing adult participants, their guardians and their support teams request such surveillance and monitoring in place of on-site staffing.
• Use of the system may be restricted to certain hours through the Individualized Support Plans of the participants involved.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
ACTIVITIES NOT ALLOWED:

• Electronic monitoring and surveillance systems which have not received specific approval by the Director of the Division of Disability and Rehabilitative Services (DDRS).
• Electronic Monitoring may not be used concurrently with Structured Family Caregiving services or in the Structured Family Caregiving home
• Electronic Monitoring systems intended to monitor direct care staff
• Electronic Monitoring serves as a replacement for Residential Habilitation and Support (RHS) Level 1 and Level 2 services, therefore, Electronic Monitoring and RHS services are not billable during the same time period. However, effective 04/01/2015, when all other requirements of Electronic Monitoring are followed, Electronic Monitoring becomes an allowable component of the "RHS Daily" service, but may not be billed in addition to the daily rate of the RHS Daily service.
• Electronic Monitoring systems in ICF/IID facilities licensed under IC 16-28 and 410 IAC 16.2
• Electronic Monitoring systems used in place of in-home staff to monitor minors, i.e., participants under the age of 18.
• Installation costs related to video and/or audio equipment
• Services furnished to a minor by a parent(s), step-parent(s), or legal guardian
• Services furnished to a participant by the participant's spouse

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	FSSA/DDRS Approved Electronic Monitoring Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Electronic Monitoring

Provider Category:
Agency
Provider Type:
FSSA/DDRS Approved Electronic Monitoring Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
To be approved to provide Electronic Monitoring/Surveillance System & On-Site Response services, a provider shall:
• Be an entity approved by FSSA/DDRS/BDDS to provide Residential Habilitation and Support services
• Assure that the system must be monitored by a staff person trained and oriented to the specific needs of each participant served as outlined in his or her Individualized Support Plan (ISP)
• Assure that the stand-by intervention (float) staff meet the qualifications for direct support professionals as set out in DDRS BDDS REQUIREMENTS & TRAINING FOR DIRECT SUPPORT PROFESSIONAL STAFF Polcy.

Enrolled as an active Medicaid provider
Must be FSSA/DDRS-approved
Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
460 IAC 6-10-5 Criminal Histories
460 IAC 6-12 Insurance,
460 IAC 6-11 Financial Status of Providers,
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, including DDRS Waiver Manual and DDRS BDDS Policy Manual.
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:
Environmental Modifications

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
ENVIRONMENTAL MODIFICATIONS
Those physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which the individual would require institutionalization.

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

REIMBURSABLE ACTIVITIES:

• Installation of ramps and grab bars
• Widening doorways
• Modifying existing bathroom facilities
• Installation of specialized electric and plumbing systems necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual including anti-scald devices
• Maintenance and repair of the items and modifications installed during the initial request
• Assessment and inspection
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Reimbursement for Environmental Modification Supports has a lifetime cap of $15,000.

Service and repair up to $500 per year, outside this cap, is permitted for maintenance and repair of prior modifications that were funded by a waiver service.

(If the lifetime cap is fully utilized, and a need is identified, the case manager will work with other available funding streams and community agencies to fulfill the need.)

ACTIVITIES NOT ALLOWED

• Adaptations to the home which are of general utility
• Adaptations which are not of direct medical or remedial benefit to the individual (such as carpeting, roof repair, central air conditioning)
• Adaptations which add to the total square footage of the home
• Adaptations that are not included in the comprehensive plan of care
• Adaptations that have not been approved on a Request for Approval to Authorize Services
• Adaptations to service provider owned housing. Home accessibility modifications as a service under the

waiver may not be furnished to individuals who receive residential habilitation and support services except when such services are furnished in the participant's own home.
• Compensation for the costs of life safety code modifications and other accessibility modifications may not be made with participant waiver funds to housing owned by providers.

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
Individual	Qualified contractors, architects, licensed contractors, builders, individuals, home inspectors, plumbers, licensed PT, OT, ST - Individual
Agency	FSSA/ DDRS Approved Agencies

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:
Individual

Provider Type:
Qualified contractors, architects, licensed contractors, builders, individuals, home inspectors, plumbers, licensed PT, OT, ST - Individual

Provider Qualifications

License *(specify):*
Home Inspector IC 25-20.2
Plumber IC 25-28.5
Physical Therapist IC 25-27-1
Occupational Therapist IC 25-23.5
Speech/Language Therapist IC 25-35.6

Certificate *(specify):*
Architect IC 25-4-1

Other Standard *(specify):*
Enrolled as an active Medicaid provider
Must be FSSA/DDRS-approved
Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
460 IAC 6-10-5 Criminal Histories
460 IAC 6-12 Insurance,
460 IAC 6-11 Financial Status of Providers,
460 IAC 6-5-11 Environmental Modification Qualifications
Must comply with any applicable FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS Waiver Manual and FSSA/DDRS BDDS Policy Manual.

Where licensure is required, providers rendering waiver funded services must obtain/maintain Indiana-specific licensure.

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: Environmental Modifications

Provider Category:
Agency
Provider Type:
FSSA/ DDRS Approved Agencies
Provider Qualifications
License *(specify):*
Home Health Agencies IC 16-27-1
Service provided by Licensed OT (IC 25-23.5) ,PT (IC 25-27-1),ST (IC 25-35.6)
Certificate *(specify):*

Other Standard *(specify):*
Enrolled as an active Medicaid provider
Must be FSSA/DDRS-approved
Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
460 IAC 6-10-5 Criminal Histories
460 IAC 6-12 Insurance,
460 IAC 6-11 Financial Status of Providers,
460 IAC 6-5-11 Environmental Modification Qualifications
Must comply with any applicable FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS Waiver Manual and FSSA/DDRS BDDS Policy Manual.

Where licensure is required, providers rendering waiver funded services must obtain/maintain Indiana-specific licensure.
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:
Extended Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
Extended Services are ongoing employment support services which enable an individual to maintain integrated competitive employment in a community setting. Individuals must be employed in a community-based, competitive job that pays at or above minimum wage in order to access this service.

The initial job placement, training, stabilization may be provided through Indiana Vocational Rehabilitation Services. Extended Services provide the additional work related supports needed by the individual to continue to be as independent as possible in community employment. If an employed individual has obtained community based competitive employment and stabilization without Vocational Rehabilitation's services, the participant is still eligible to receive Extended Services, as long as the participant meets the qualifications below.

Ongoing employment support services are identified in the participants' Individualized Service Plan and must be related to the participants' limitations in functional areas (i.e. self-care, understanding and use of language, learning, mobility, self-direction, capacity for independent living, economic self-sufficiency), as are necessary to maintain employment.

Reimbursable Activities

• Ensuring that natural supports at the work site are secured through interaction with supervisors and staff. A tangible outcome of this activity would be a decrease in the number of hours of extended services an individual accessed over time.
• Training for the participant, and/or the participant's employer, supervisor or coworkers, to increase the participant's inclusion at the worksite.
• Regular observation or supervision of the participant to reinforce and stabilize the job placement.
• Job-specific or job-related safety training.
• Job-specific or job-related self-advocacy skills training.
• Reinforcement of work-related personal care and social skills.
• Training on use of public transportation and/or acquisition of appropriate transportation.
• Facilitating, but not funding, driver's education training.
• Coaching and training on job-related tasks such as computer skills or other job-specific tasks.

Individual (one-on-one) services can be billed in 15 minute increments.

For Extended Services provided in a group setting, reimbursement equals the unit rate divided by the number of individuals served.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Group services may only be rendered at the discretion of the IST and in group sizes no greater than four individuals to one staff. In addition, the provider must be able to provide appropriate documentation, as outlined in the DDRS Waiver Manual, demonstrating that the ratio for each claimed timeframe of services did not exceed the maximum allowable ratio determined by the IST for each group participant, and provide documentation identifying other group participants, by using the individuals' HIPAA naming convention.

Activities Not Allowed

Reimbursement is not available under Extended Services for the following activities:
• Any non-community based setting where the majority (51% or more) of the individuals have an Intellectual or Developmental Disability.
• Sheltered work observation or participation.
• Volunteer endeavors.
• Any service that is otherwise available under the Rehabilitation Act of 1973 or Public Law 94-142.
• Public relations.
• Incentive payments made to an employer to subsidize the employer's participation in Extended Services.
• Payment for vocational training that is not directly related to the individual's Extended Service needs outlined in the ISP.
• Extended Services do not include payment for supervisory activities rendered as a normal part of the business setting.
• Extended Services provided to a minor by a parent(s), step-parent(s), or legal guardian, or spouse.
• Waiver funding is not available for the provision of vocational services delivered in facility based or sheltered work settings, where individuals are supervised for the primary purpose of producing goods or performing services.
• The provision of transportation is not a reimbursable activity within Extended Services.

*** FROM 4/01/2015 FORWARD ***

• Prevocational services may not be utilized by an individual who is receiving Extended Services (Individuals in competitive community employment are no longer eligible for Prevocational services). Prevocational services and Extended Services are mutually exclusive and shall not overlap.

NOTE: Supported Employment services continue to be available under the Rehabilitation Act of 1973 through the Vocational Rehabilitation Services (VRS) program within FSSA/DDRS's Bureau of Rehabilitation Services (BRS).

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
Individual	FSSA/DDRS Approved Extended Services - Individual
Agency	FSSA/DDRS Approved Extended Services Agencies

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Extended Services

Provider Category:
Individual

Provider Type:
FSSA/DDRS Approved Extended Services - Individual

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Enrolled as an active Medicaid provider
Must be DDRS-approved
Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
o 460 IAC 6-12 Insurance,
o 460 IAC 6-10-5 Criminal Histories,
o 460 IAC 6-11 Provider Financial Status,
o 460 IAC 6-14-5 Direct Care Staff Qualifications,
o 460 IAC 6-14-4 Staff Training,
Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals, including DDRS Waiver Manual and DDRS BDDS Policy Manual.

Must obtain/maintain Indiana accreditation by at least one (1) of the following organizations:
(1) The Commission on Accreditation of Rehabilitation Facilities (CARF), or its successor.
(2) The Council on Quality and Leadership in Supports for People with Disabilities, or its successor.
(3) The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or its successor.
(4) The National Commission on Quality Assurance, or its successor.
(5) An independent national accreditation organization approved by the secretary

In order to be eligible to perform this service a provider must meet the standards as a Community Rehabilitation Provider as outlined in Indiana Code 12-12-1-4.1.

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: Other Service
Service Name: Extended Services

Provider Category:
Agency

Provider Type:
FSSA/DDRS Approved Extended Services Agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Enrolled as an active Medicaid provider
Must be DDRS-approved
Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
o 460 IAC 6-12 Insurance,

o 460 IAC 6-10-5 Criminal Histories,
o 460 IAC 6-11 Provider Financial Status,
o 460 IAC 6-14-5 Direct Care Staff Qualifications,
o 460 IAC 6-14-4 Staff Training,
Must comply with any applicable BDDS service standards, guidelines, policies and/or manuals, including DDRS Waiver Manual and DDRS BDDS Policy Manual.

Must obtain/maintain Indiana accreditation by at least one (1) of the following organizations:
(1) The Commission on Accreditation of Rehabilitation Facilities (CARF), or its successor.
(2) The Council on Quality and Leadership in Supports for People with Disabilities, or its successor.
(3) The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or its successor.
(4) The National Commission on Quality Assurance, or its successor.
(5) An independent national accreditation organization approved by the secretary

In order to be eligible to perform this service a provider must meet the standards as a Community Rehabilitation Provider as outlined in Indiana Code 12-12-1-4.1.

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: 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

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04020 day habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
Facility Based Habilitation services are services provided outside of the Participant's home and within the facility of a DDRS-approved provider and 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 (4:1 or smaller)
• Medium (5:1 to 10:1)
• Larger (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**
- [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	FSSA/DDRS Approved Facility Based Habilitation - Individuals
Agency	FSSA/DDRS Approved Facility Based Habilitation Agencies

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:
FSSA/DDRS Approved Facility Based Habilitation - Individuals

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Enrolled as an active Medicaid provider
Must be FSSA/DDRS-approved
Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
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 FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS Waiver Manual and FSSA/DDRS BDDS Policy Manual.

Must obtain/maintain accreditation (specific to Indiana programs) by at least one (1) of the following organizations:
(1) The Commission on Accreditation of Rehabilitation Facilities (CARF), or its successor.
(2) The Council on Quality and Leadership In Supports for People with Disabilities, or its successor.
(3) The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or its successor.
(4) The National Committee for Quality Assurance, or its successor.
(5) The ISO-9001 human services QA system.
(6) An independent national accreditation organization approved by the secretary

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:
Agency

Provider Type:

FSSA/DDRS Approved Facility Based Habilitation Agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Enrolled as an active Medicaid provider
Must be FSSA/DDRS-approved
Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
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 FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS Waiver Manual and FSSA/DDRS BDDS Policy Manual.

Must obtain/maintain accreditation (specific to Indiana programs) by at least one (1) of the following organizations:
(1) The Commission on Accreditation of Rehabilitation Facilities (CARF), or its successor.
(2) The Council on Quality and Leadership In Supports for People with Disabilities, or its successor.
(3) The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or its successor.
(4) The National Committee for Quality Assurance, or its successor.
(5) The ISO-9001 human services QA system.
(6) An independent national accreditation organization approved by the secretary

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

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

04 Day Services | 04020 day habilitation

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*
Facility Based Habilitation services are services provided outside of the Participant's home and within the facility of a DDRS-approved provider and 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	FSSA/DDRS Approved Facility Based Habilitation Agencies
Individual	FSSA/DDRS Approved Facility Based Habilitiation 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:
FSSA/DDRS Approved Facility Based Habilitation Agencies
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Enrolled as an active Medicaid provider
Must be FSSA/DDRS-approved
Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
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 FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS Waiver Manual and FSSA/DDRS BDDS Policy Manual.

Must obtain/maintain accreditation (specific to Indiana programs) by at least one (1) of the following organizations:
(1) The Commission on Accreditation of Rehabilitation Facilities (CARF), or its successor.
(2) The Council on Quality and Leadership In Supports for People with Disabilities, or its successor.
(3) The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or its successor.
(4) The National Committee for Quality Assurance, or its successor.
(5) The ISO-9001 human services QA system.
(6) An independent national accreditation organization approved by the secretary

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:
FSSA/DDRS Approved Facility Based Habilitiation Individuals

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Enrolled as an active Medicaid provider
Must be FSSA/DDRS-approved
Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
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 FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS Waiver Manual and FSSA/DDRS BDDS Policy Manual.

Must obtain/maintain accreditation (specific to Indiana programs) by at least one (1) of the following organizations:
(1) The Commission on Accreditation of Rehabilitation Facilities (CARF), or its successor.
(2) The Council on Quality and Leadership In Supports for People with Disabilities, or its successor.
(3) The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or its successor.
(4) The National Committee for Quality Assurance, or its successor.
(5) The ISO-9001 human services QA system.
(6) An independent national accreditation organization approved by the secretary

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

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
04 Day Services	04060 adult day services (social model)
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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**

☑ **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	FSSA/DDRS Approved Facility Based Support Services - Individuals
Agency	FSSA/DDRS Approved Facility Based Support Services Agencies

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:
FSSA/DDRS Approved Facility Based Support Services - Individuals

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Enrolled as an active Medicaid provider
Must be FSSA/DDRS-approved
Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
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 FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS Waiver Manual and FSSA/DDRS BDDS Policy Manual.

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 Support Services

Provider Category:

Agency

Provider Type:
FSSA/DDRS Approved Facility Based Support Services Agencies
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Enrolled as an active Medicaid provider
Must be FSSA/DDRS-approved
Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
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 FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS Waiver Manual and FSSA/DDRS BDDS Policy Manual.
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: 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

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09020 caregiver counseling and/or training
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Category 4: **Sub-Category 4:**

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
Individual	FSSA/DDRS Approved Family and Caregiver Training Individuals
Agency	FSSA/DDRS Approved Family and Caregiver Training Agencies

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:
FSSA/DDRS Approved Family and Caregiver Training Individuals
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Enrolled as an active Medicaid provider
Must be FSSA/DDRS-approved
Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
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 FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS Waiver Manual and FSSA/DDRS BDDS Policy Manual.
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: Family and Caregiver Training

Provider Category:
Agency
Provider Type:
FSSA/DDRS Approved Family and Caregiver Training Agencies
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Enrolled as an active Medicaid provider
Must be FSSA/DDRS-approved
Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
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 FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS Waiver Manual and FSSA/DDRS BDDS Policy Manual.
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:
Intensive Behavioral Intervention

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10040 behavior support
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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
• 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
• 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
Agency	FSSA/DDRS Approved Intensive Behavioral Intervention Agency
Individual	FSSA/DDRS Approved Intensive Behavioral Intervention - Individual

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:
FSSA/DDRS Approved Intensive Behavioral 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):*
Enrolled as an active Medicaid provider
Must be FSSA/DDRS-approved
Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
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 FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS Waiver Manual and FSSA/DDRS BDDS Policy Manual.
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:
Individual

Provider Type:
FSSA/DDRS Approved Intensive Behavioral 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):*
Enrolled as an active Medicaid provider
Must be FSSA/DDRS-approved
Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
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 FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS Waiver Manual and FSSA/DDRS BDDS Policy Manual.

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

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

11 Other Health and Therapeutic Services 11130 other therapies

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

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.

• Individual

• Group services in group sizes no greater than four (4) participants to one (1) Music Therapist (Unit rate divided by number of participants served)

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
• Group sizes greater than four (4) participants to one (1) Music Therapist or group sizes exceeding the maximum allowable group size determined by the IST for each group 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)***:**

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	FSSA/DDRS Approved Music Therapist
Agency	Agency that Employs FSSA/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:
Individual
Provider Type:
FSSA/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):*
Enrolled as an active Medicaid provider
Must be FSSA/DDRS-approved
Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
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 FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS Waiver Manual and FSSA/DDRS BDDS Policy Manual.
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:
Agency
Provider Type:
Agency that Employs FSSA/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):*
Enrolled as an active Medicaid provider
Must be FSSA/DDRS-approved
Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
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 FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS Waiver Manual and FSSA/DDRS BDDS Policy Manual.
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:
Personal Emergency Response System

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14010 personal emergency response system (PERS)
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Category 4: **Sub-Category 4:**

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 person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals.

REIMBURSABLE ACTIVITIES:

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/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:
FSSA/DDRS Approved Personal Emergency Response System Agencies
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Enrolled as an active Medicaid provider
Must be FSSA/DDRS-approved
Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
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 FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS Waiver Manual and FSSA/DDRS BDDS Policy Manual.

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

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11130 other therapies
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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
• Individual services
• Group services in group sizes no greater than four (4) participants to one (1) Recreational Therapist (Unit rate divided by number of participants served)

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
• Group sizes greater than four (4) participants to one (1) Recreational Therapist or group sizes exceeding the maximum allowable group size determined by the IST for each group participant
• Group services when group settings were not determined to be appropriate by the IST for each group 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)***:**

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	FSSA/DDRS Approved Recreational Therapist
Agency	FSSA/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:
FSSA/DDRS Approved Recreational Therapist
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify):*
Enrolled as an active Medicaid provider
Must be FSSA/DDRS-approved
Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
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 FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS Waiver Manual and FSSA/DDRS BDDS Policy Manual.

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:
FSSA/DDRS Approved Agency That Employs Approved Recreational Therapists

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Enrolled as an active Medicaid provider
Must be FSSA/DDRS-approved
Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
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 FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS Waiver Manual and FSSA/DDRS BDDS Policy Manual.

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

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 3:	**Sub-Category 3:**
17 Other Services	17020 interpreter
Category 4:	**Sub-Category 4:**

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.

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

REIMBURSABLE ACTIVITIES:

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

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 $15,000.00 is available for vehicle modifications. In addition to the $15,000.00 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
Individual	Licensed/Certified Occupational Therapist
Individual	Licensed Physical Therapist
Agency	FSSA/DDRS Approved Medical Supply Companies, Pharmacies, Electronics/Computer Companies, Vehicle Modification Provider , Electronics Vendors
Individual	Licensed Speech/Language 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:
Individual
Provider Type:
Licensed/Certified Occupational Therapist
Provider Qualifications
License *(specify):*
IC 25-23.5 Licensure and Certification requirements
Certificate *(specify):*

Other Standard *(specify):*
Enrolled as an active Medicaid provider
Must be FSSA/DDRS-approved
Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
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 FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS Waiver Manual and FSSA/DDRS BDDS Policy Manual.

Occupational Therapists rendering waiver funded services must obtain/maintain Indiana licensure.
Verification of Provider Qualifications

Entity Responsible for Verification:
Initiall, 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):*
Enrolled as an active Medicaid provider
Must be FSSA/DDRS-approved
Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
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 FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS Waiver Manual and FSSA/DDRS BDDS Policy Manual.

Physical Therapists rendering waiver funded services must obtain/maintain Indiana licensure.
Verification of Provider Qualifications
Entity Responsible for Verification:
Ititially, 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:
FSSA/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):*
Enrolled as an active Medicaid provider
Must be FSSA/DDRS-approved
Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
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 FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS Waiver Manual and FSSA/DDRS BDDS Policy Manual.

Where licensure is required, providers rendering waiver funded services must obtain/maintain Indiana licensure.

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):*
Enrolled as an active Medicaid provider
Must be FSSA/DDRS-approved
Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
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 FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS Waiver Manual and FSSA/DDRS BDDS Policy Manual.

Speech/Language Therapists rendering waiver funded services must obtain/maintain Indiana licensure.

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):*
Enrolled as an active Medicaid provider
Must be FSSA/DDRS-approved
Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
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 FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS Waiver Manual and FSSA/DDRS BDDS Policy Manual.

Where licensure is required, providers rendering waiver funded services must obtain/maintain Indiana licensure.
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:
Structured Family Caregiving (previously known as Adult Foster Care)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02031 in-home residential habilitation

Category 2:	Sub-Category 2:
02 Round-the-Clock Services	02023 shared living, other

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

Service Definition *(Scope):*
Structured Family Caregiving (previously known as Adult Foster Care) means a living arrangement in which a participant lives in the private home of a principal caregiver who may be a non-family member (foster care) or a family member who is not the participant's spouse, the parent of the participant who is a minor, or the legal guardian of the participant.

Necessary support services are provided by the principal caregiver (family caregiver) as part of Structured Family Caregiving. Only agencies may be Structured Family Caregiving providers, with the Structured Family Caregiving settings being approved, supervised, trained, and paid by the approved agency provider. The provider agency must conduct two visits per month to the home - one by a registered nurse and one by a Structured Family Caregiving Home Manager. The provider agency must keep daily notes that can be accessed by the state. Separate payment will not be made for homemaker or chore services furnished to an individual receiving Structured Family Caregiving, since these services are integral to and inherent in the provision of Structured Family Caregiving services.

SERVICE LEVELS AND RATES

There are three service levels of Structured Family Caregiving (SFC), each with a unique rate. Beginning January 1, 2013, the Algo level assigned to the participant will drive and determine the appropriate level of SFC service and reimbursement to be utilized in service plan development at the participant's next annual anniversary date. With the phase in of this methodology, the State has committed to serve all current SFC participants at or above their pre-existing level of SFC service.
• Level 1 - Appropriate for participants choosing SFC and having an Algo level of 0 or 1
• Level 2 - Appropriate for participants choosing SFC and having an Algo level of 2
• Level 3 - Appropriate for participants choosing SFC and having an Algo level of 3, 4, 5 or 6

REIMBURSABLE ACTIVITIES

• Personal care and services
• Homemaker or chore services
• Attendant care and companion care services
• Medication oversight
• Respite for the family caregiver (funding for this respite is included in the per diem paid to the service provider, the actual service of Respite Care may not be billed in addition to the per diem)
• Other appropriate supports as described in the Individualized Support Plan
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Activities Not Allowed

• Services provided by a caregiver who is the spouse of the participant or the parent of the minor participant
• The service of Residential Habilitation and Supports is not available to participants receiving the service of Structured Family Caregiving Services.
• Transportation services through the waiver may not be used in conjunction with Structured Family Caregiving Services.

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	FSSA/DDRS Approved Structured Family Caregiving Agencies (previously knowns as AFC Agencies)

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Structured Family Caregiving (previously known as Adult Foster Care)

Provider Category:
Agency
Provider Type:
FSSA/DDRS Approved Structured Family Caregiving Agencies (previously knowns as AFC Agencies)
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Enrolled as an active Medicaid provider
Must be FSSA/DDRS-approved
Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
460 IAC 6-10-5 Criminal Histories,
460 IAC 6-12 Insurance,
460 IAC 6-11 Provider Financial Status,
460 IAC 6-5-3 Adult Foster Care qualifications
460 IAC 6-14-5 Direct Care Staff qualifications
460 IAC 6-14-4 Staff Training
Must comply with any applicable FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS Waiver Manual and FSSA/DDRS BDDS Policy Manual.

Where licensure is required, providers rendering waiver funded services must obtain/maintain Indiana licensure.

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: 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

HCBS Taxonomy:

Category 1:	Sub-Category 1:
15 Non-Medical Transportation	15010 non-medical transportation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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.

Depending upon the needs of the participant, there are three levels of transportation. The level of transportation service needed must be documented in the ISP.

- Level 1: Transportation in a private, commercial, or public transit vehicle that is not specially equipped.
- Level 2: Transportation in a private, commercial, or public transit vehicle specially designed to accommodate wheelchairs.
- Level 3: Transportation in a vehicle specially designed to accommodate a participant who for medical reasons must remain prone during transportation (e.g., ambulette).

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 for Level 1 or Level 2. Bus passes may be purchased on a monthly basis or on a per-ride basis, whichever is most cost effective in meeting the participant's transportation needs as outlined in the ISP
- 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
• May not be used in conjunction with Structured Familiy Caregiving Services

Annual limits have been added to this non-medical waiver Transportation service, the costs of which have been removed from the Day Services Building Block of the annual allocation for each participant and are now paid from a stand-alone but limited bucket outside of and in addition to the participants' annual allocation amount that is determined by their Algo level. Note that no participant is excluded from participating in non-medical waiver Transportation services.

The annual limits for each level of non-medical waiver Transportation are:
o $2500 for Level 1 Transportation
o $5000 for Level 2 Transportation
o $7500 for Level 3 Transportation

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	FSSA/DDRS Approved Transportation Provider - Agency
Individual	FSSA/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:
FSSA/DDRS Approved Transportation Provider - Agency
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Enrolled as an active Medicaid provider
Must be FSSA/DDRS-approved
Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
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 FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS Waiver Manual and FSSA/DDRS BDDS Policy Manual.

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:
FSSA/DDRS Approved Transportation Provider - Individual

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Enrolled as an active Medicaid provider
Must be FSSA/DDRS-approved
Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
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 FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS Waiver Manual and FSSA/DDRS BDDS Policy Manual.

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:

Wellness Coordination

HCBS Taxonomy:

Category 1:	Sub-Category 1:
05 Nursing	05020 skilled nursing
Category 2:	**Sub-Category 2:**
11 Other Health and Therapeutic Services	11010 health monitoring
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Wellness Coordination Services means the development, maintenance and routine monitoring of the waiver participant's Wellness Coordination Plan and the medical services required to manage his/her health care needs.

Wellness Coordination services extend beyond those services provided through routine doctor/health care visits required under the Medicaid State Plan and are specifically designed for participants requiring assistance of an RN/LPN to properly coordinate their medical needs.

Tier I: Health care needs require at least weekly* consultation/review with RN/LPN including face to face visits once a month

Tier II: Health care needs require at least weekly consultation/review with RN/LPN including face to face visits at least twice monthly.

Tier III: Health care needs require at least twice weekly consultation/review with RN/LPN including face to face visits once a week

*Weekly – a calendar week (Sunday – Saturday)

Conditions and Requirements: Necessity for Wellness Coordination services will typically be reserved for participants assessed with health scores of 5 or higher through the State's objective based allocation process. Participants assessed with health scores of 0-4 would not require assistance of an RN/LPN to coordinate medical needs. As medical events occur and/or a participant's medical needs change, the Individualized Support Team is expected to obtain reassessment for potential revision to the health score and to ensure utilization of the appropriate tier of services.

REIMBURSABLE ACTIVITIES:

Coordination of Wellness Services by the RN/LPN provider must include, but is not limited to the following:

- Completion of the State-approved risk assessment tool
- Development, oversight and maintenance of a Wellness Coordination plan
- Development, oversight and maintenance of the Risk Plan which includes:
  - Training of Direct Support Professionals to ensure implementation of Risk Plans
- Consultation with the individual's health care providers

• Face to face consultations with the individual as described in the support plan
• Consultation with the individual's support team
• Active involvement at all team meetings, reporting on the Wellness Coordination plan as it relates to the individual's full array of services as listed in the ISP.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Activities Not Allowed

Reimbursement for Wellness Coordination Services is not available under the following circumstances:
• The individual does not require Wellness Coordination services
• Wellness Coordination services are not specified in the Individualized Support Plan
• Wellness Coordination services may not be provided by a provider of waiver funded Case Management services
• Residential, vocational, and/or educational services otherwise provided under other Supported Living services cannot be billed as Wellness Coordination services
• 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	FSSA/DDRS Approved Wellness Coordination Agencies
Individual	FSSA/DDRS Approved Wellness Coordination Individuals

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Wellness Coordination

Provider Category:
Agency
Provider Type:
FSSA/DDRS Approved Wellness Coordination Agencies
Provider Qualifications
License *(specify):*
Be either a registered nurse (RN) or a licensed practical nurse (LPN) under IC 25-23-1 working under the supervision of an RN
Certificate *(specify):*

Other Standard *(specify):*
Must be enrolled as an active Medicaid provider
Must be FSSA/DDRS-approved
Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
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
**noting that Wellness Coordination is referred to as Health Care Coordination within 460 IAC 6
Must comply with any applicable FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS Waiver Manual and FSSA/DDRS BDDS Policy Manual

Nurses rendering waiver funded services must obtain/maintain Indiana licensure.

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: Wellness Coordination

Provider Category:
Individual

Provider Type:
FSSA/DDRS Approved Wellness Coordination Individuals

Provider Qualifications

License *(specify):*
Be either a registered nurse (RN) or a licensed practical nurse (LPN) under IC 25-23-1 working under the supervision of an RN

Certificate *(specify):*

Other Standard *(specify):*
Must be enrolled as an active Medicaid provider
Must be FSSA/DDRS-approved
Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
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
**noting that Wellness Coordination is referred to as Health Care Coordination within 460 IAC 6
Must comply with any applicable FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS Waiver Manual and FSSA/DDRS BDDS Policy Manual

Nurses rendering waiver funded services must obtain/maintain Indiana licensure.

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

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08030 personal care
Category 2:	**Sub-Category 2:**
03 Supported Employment	03021 ongoing supported employment, individual
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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 SEFA (until 3/31/2014)/Extended Services (from 4/01/2015 forward)

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 SEFA (until 3/31/2014)/Extended Services (from 4/01/2015 forward)
• 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
Agency	FSSA/DDRS Approved Workplace Assistance - Agencies
Individual	FSSA/DDRS Approved Workplace Assistance - Individual

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:
FSSA/DDRS Approved Workplace Assistance - Agencies
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:

Enrolled as an active Medicaid provider
Must be FSSA/DDRS-approved
Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
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 FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS Waiver Manual and FSSA/DDRS BDDS Policy Manual.

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:
Individual

Provider Type:
FSSA/DDRS Approved Workplace Assistance - Individual

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Enrolled as an active Medicaid provider
Must be FSSA/DDRS-approved
Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
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 FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS Waiver Manual and FSSA/DDRS BDDS Policy Manual.

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 Community Integration and Habilitation Waiver) must have criminal history checks.

b) Documented proof of the limited criminal history investigation is required with the initial application for approval as a new provider 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 FSSA's 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 (initial) 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 and supported by the DDRS BDDS Documentation of Criminal Histories policy. 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) FSSA's 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 Compliance Evaluation and Review Tool (CERT) used for all non-accredited providers checks that providers complete a criminal history background check on new hires and that the provider rechecks criminal history backgrounds every three years. BQIS does this on a sample basis, sampling a minimum of two staff and a maximum of 20 staff per provider. Sampled staff are randomly chosen from a census list supplied by the provider agency. 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.

Addendum:
The Criminal History/Background Check is reviewed at the following time periods:
1. Upon initial approval
2. At the one-year mark after becoming a new provider
3. Upon accreditation renewal with whichever State-approved entity the provider has selected to use.

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://mylicense.in.gov/eVerification/

b) The FSSA's 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 and documenting the screening against the registry.

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 FSSA's 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 Community Integration and Habilitation Waiver services may apply to become a provider at any time. The application approval process is managed/performed by FSSA's BDDS. As applications are received and reviewed by the BDDS, 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 BDDS 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 calendar 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 the DDRS website and by accessing the Indiana Medicaid HCBS Waiver Provider Manual and/or the Bureau of Quality Improvement Services help line, known as the BQIS Helpline.

Providers access the Indiana Medicaid (Indiana Health Coverage Programs (IHCP)) HCBS Waiver Provider Manual and/or the BQIS Helpline electronically.

The Division of Disability and Rehabilitative Services Home and Community-Based Services Waiver Provider Manual is posted on the "manuals" link of IHCP website, with a direct link of http://provider.indianamedicaid.com/ihcp/manuals/DDRS%20HCBS%20Waiver%20Provider%20Manual.pdf

The BQIS Helpline address is BQISHelp@fssa.in.gov

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**

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by 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 the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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:
QP A.2. Number and percent of waiver providers who continue to meet requirements for re-approval (tracked and reported by 1 year or 3 year re-approvals). Numerator: Total number of waiver providers who continue to meet requirements for re-approval. Denominator: Total number of waiver providers due for re-approval that waiver year.

Data Source (Select one):
Other
If 'Other' is selected, specify:
BQIS/DDRS Provider Relations Re-Approval and Accreditation Tracking Sheet

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:
QP A.1. Number and percent of new provider applicants who met state requirements to provide waiver services before they began providing waiver services. Numerator: The total number of provider applicants who met state requirements to provide services before they began to provide waiver services. Denominator: Total number of provider applicants approved.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDRS Provider Relations Spreadsheet

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:
QP A.3. Number & percent of current providers who conduct criminal background checks as required. Numerator: Total number of current providers reviewed in a waiver year that did not require a corrective action plan based on criminal background checks. Denominator: Total number of approved providers due for review in a waiver year.

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

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 the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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 the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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:
QP C.1. Number and percent of current waiver providers who meet waiver training requirements. Numerator: The total number of current waiver providers in a waiver year who did not require a corrective action plan based on training issues. Denominator: The total number of waiver providers due for review in a waiver year.

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

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: Providers will be reviewed when they have accreditation

		reviews, or once every three years.
	☐ **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: BQIS 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.
QP A.1. Providers who submit an incomplete, inaccurate or nonresponsive application are rejected. Note that for provider applications that are substantially complete and responsive, but may need additional information, a "request for information" (RFI) is sent. Providers have 30 calander days from the date of the RFI to supply the clarifying information or the application is denied. As needed, DDRS will follow up with provider and/or complete application review.

QP A.2., QP A.3. and QP C.1. Providers that do not meet state requirements or standards are required to develop corrective action plans (CAPs) to address issues identified in their compliance reviews. BQIS reviews and approves CAPs, and validates that providers are implementing these as stated.

Provider agreements require providers to share copies of their accreditation reports with DDRS. For those providers participating in CERT accreditation activities, BQIS follows up with CAPs to address areas of deficiency.

All non-compliant providers are referred to FSSA Administration for review and potential sanctioning, up to and including termination of the provider.

Reports on remediation actions on a summary basis, month to date and year to date are presented to the Quality Improvement Executive Committee (QIEC) for review.

Two data sources are used, BQIS CERT and accreditation reports, due to the change in Indiana Code.

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.

☑ **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.

A budget allocation limit is in place for the waiver participant to ensure a uniform objective method of determining the amount of funding needed to meet each participant's needs. The amount is determined using assessment information that reflects the needs of the participant. This assessment information is collected and used by the State to determine the level of supports an individual needs in order to live in a community setting. The assessment to determine the Algo level is performed as if no services were provided.

The ICAP assessment tool is used to determine an individual's level of functioning for Broad Independence and General Maladaptive Factors. The ICAP Addendum, commonly referred to as the Behavior and Health Factors, determines an individual's level of functioning on behavior and health factors. These two uniform assessments are used statewide to determine an individual's overall functioning and level of need (algorithm or "Algo" level) from which an objective based allocation limit is assigned. The assessment to determine the Algo level is performed as if no services were provided.

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

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

Adjustments to the allocation limit may also occur when the participant has a change in their needs. Individual support teams may request a review of the assigned allocation limit through their case manager via a budget review questionnaire. The individual support teams must first review the functional assessment findings and provide any other supporting documentation that might lead to an adjustment in the allocation limit. When requested, reviews are conducted by State staff within DDRS. If appropriate, adjustments and/or recommendations are provided by the DDRS review team.

In addition, a Budget Modification Review (BMR) allows the Case Manager, with agreement of the Individualized Support Team and on behalf of the participant, to request short term increases in funding beyond the allocation limit if specific conditions apply. These conditions consist of a change in medical or behavioral needs or a change in living arrangement.

The BMR provides the participant the ability to request additional funding for a short amount of time to meet their needs that are outside the original allocation limit funding amount.

An individual or their legal representative may appeal the ICAP assessment if they feel it is inaccurate. The consumer/legal guardian has the right to appeal any waiver-related decision of the State within 33 calendar days of Notice of Action (NOA). A Notice of Action (NOA) is issued with the release of each State decision pertaining to a Plan of Care/Cost Comparison Budget (CCB). Each NOA contains the appeal rights of the consumer as well as instructions for filing an appeal.

☑ **Other Type of Limit.** The State employs another type of limit.

Describe the limit and furnish the information specified above.

There are Community Integration and Habilitation Waiver services that fall in this category. Environmental Modifications has a total lifetime limit of $15,000 which applies across any and all Environmental Modifications funded by Indiana Medicaid Home and Community Based Services waiver programs administered under the State Medicaid Agency.

Similarly, Vehicle Modifications (a component of Specialize Medical Equipment and Supplies) has a lifetime limit of $15,000, applicable across all waiver programs in the state.

Family Care Giver Training is limited to $2000 annually.

Additional limits exist in that a participant may not utilize Residential Habilitation and Support services for the same time period as Electronic Monitoring is being utilized, nor may the participant utilized Residential Habilitation and Support in conjunction with Structured Family Caregiving services as these sets of services are mutually exclusive by definition.

Each limit is established based upon historical expenditure and consistent with the previous Community Integration and Habilitation Waiver limits.

On January 1, 2013, Transportation service costs were removed from the day service building block, thereby enabling participants to purchase additional day services. At the same time, with Transportation costs no longer falling under the allocation amount determined by their Algo level, annual limits were established on the total reimbursement for non-medical Transportation services. The following annual limits apply to Plans of Care/Cost Comparison Budgets (CCBs):

- • Transportation Level 1 - $2500
- • Transportation Level 2 - $5000
- • Transportation Level 3 - $7500

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

An explanation of how Indiana's residential and non-residential setting in this waiver comply with federal HCBS requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance will be offered upon completion of the state's overall assessment of HCBS settings. The assessment process includes data gathering, aggregation and analysis using both pre-existing data and data collected through provider surveys and participant and family focus groups and/or additional surveys. The assessment also includes the review and analysis of policies as areas of compliance and non-compliance are identified.

Additional information is forthcoming to substantiate that CIH waiver services are rendered in home and community based

settings. Indiana will submit within the comprehensive Transition Plan, a description of the means by which the state Medicaid agency will ascertain that all waiver settings meet federal HCB Setting requirements ongoing.

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)**
- [x] **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. Person centered planning allows the participant, the participant's legal

representative, and any other person chosen by the individual to direct the planning and allocation of resources to meet the individual's life goals. 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, aspirations, and needs 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 participant, case manager, 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 time frame of 12 consecutive months.

(b) Person-Centered Plan: 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 participant's support team. The process is directed by the participant with focus on his or her preferences, dreams, and needs. The process empowers participants to create life plans and allows the participant to direct the planning and allocation of resources to meet his or her self-directed life goals. Case Managers are responsible for the facilitation and development of the participant's Person-Centered Plan (PCP), inclusive of the following key components:
1. Personal Priorities, which includes the Personal Priority Statements and Personal Priority Narratives;
2. Relationships;
3. Communication;
4. Outcomes; and
5. Historical Narrative.

The PCP is to be updated at least annually, and is to ascertain the participant's needs, wants, and desires using person-centered planning philosophy processes. A participant's PCP should be reflective of his or her strengths, preferences related to relationships, community participation, employment, income and savings, healthcare and wellness, education, as well as long-term hopes and desires so as to develop an Individualized Support Plan (ISP) that encourages and supports the achievement of these goals. Utilized at initial intake and at least annually thereafter, the PCP 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, management of finances, and desire to be productive and employed. It is the Case Manager's responsibility to ensure the person-centered planning (PCP) process is conducted using plain language and that the process is timely, occurring at times/locations of convenience to the participant. Each participant's ISP will then be reviewed and updated at least every 90 calendar days as part of the participant's 90 Day Meeting with the IST.

All case managers are to be trained in person-centered thinking and be PCP/ISP certified.

A state-approved risk assessment tool is completed by the case manager to help identify risks related to health**,

behavior, safety and support needs for waiver participants.

**Note that when participants have State-assessed health scores of 5 or higher and opt to utilize the waiver's Wellness Coordination services, health care needs and associated risks are separately assessed and monitored by a Registered Nurse or Licensed Practical Nurse employed by their chosen Wellness Coordination provider agency. The RN/LPN, who must be actively involved in all IST meetings, develops a Wellness Coordination Plan specific to the assessed health care needs and risks, sharing the plan with the IST. As described in Appendix C-1/C-3, the Wellness Coordinator's health care related coordination and monitoring responsibilities vary according to the specified tier of Wellness Coordination services. However, as is true of all other waiver funded services, it is ultimately the responsibility of the waiver Case Manager to monitor and ensure that the Wellness Coordination activities occur as specified within the ISP and CCB.

The State will incorporate changes into the PCP process to ensure compliance with CMS 2249-F and CMS 2296-F.

(c) The participant is informed of available Community Integration and Habilitation 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 Community Integration and Habilitation 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, reviewed and/or updated. Person-centered service plans document the options based on the individuals' needs, preferences; and for residential settings, individual participant reesources available for room and board. This entire process is driven by the participant and is designed to recognize the participant's needs and desires. The Case Manager holds a series of structured conversations, beginning with the participant/ guardian and with other individuals, identified by the participant that know them well and can provide pertinent information about them, to gather initial information to support the person-centered planning process. The overall emphasis of the conversations will be to derive what is important to and what is important for the participant, with a goal of presenting a good balance of the two. The case manager facilitates the IST meeting, reviews the participant's desired outcomes, their health and safety needs and their preferences, and reviews covered services, other sources of services and support (paid and unpaid) and the budget development process using the objective based allocation for waiver services. The case manager then finalizes the ISP and completes the CCB.

(e) Coordination of Waiver Services and other services is completed by the Case Manager. Within 30 calendar 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 at least one monthly case note for each participant. At least once every 90 calendar days, 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 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 at least one associated proposed strategy/activity 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 proposed strategy/activity also identifies all paid and unpaid responsible parties and, includes the name of the provider, the service, and the staffing position(s) within the agency that are responsible for the strategy/activity. The participant may be the responsible party for a strategy/activity if they so determine. In addition, each proposed strategy/activity has a specific timeframe identified, including a minimum timeframe for review. The Plan of Care/Cost Comparison Budget (CCB) identifies: The name of the waiver-funded 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 calendar days and updated a minimum of every 365 calendar 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, FSSA's Division of Disability and Rehabilitative Services' (DDRS) Central Office runs and the Case Management Liaison monitors a monthly potential default report identifying participants whose annual CCB is due to expire and therefore subject to the creation of a potential default CCB. The report of potential defaults is sorted and distributed to the appropriate case management company or companies. At the end of the month, the actual CCB Default Report is generated, sorted and distributed to the appropriate case management company or companies 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 FSSA's 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:

At least every 90 calendar days, during 90 Day Meetings of the Individualized Support Team (IST), or more often if needed, the Case Manager and IST meet 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 risk assessment(s) are also reviewed during these meetings.

Providers of case management services use a state-approved risk assessment tool during initial assessment, at the 90 Day Meetings with the IST and when there is a change in the participant's status. Any risk issues (i.e. health**, behavioral, physical management, and environmental management) identified through completion of the State's risk assessment tool are addressed through participant-specific risk plans to proactively and reactively address the risk issue(s). The outcomes of the assessment are used to guide the IST in the development of the participant's risk plan or to review and revise the risk plan as appropriate.

The IST determines the party or parties responsible for the development or modification of the risk plan(s) and ensures that the risk plans are identified in the Individualized Support Plan, which drives the CCB.

Risks may also be addressed through non-waiver-funded resources chosen by the participant, such as specialists, support groups, or natural supports. The CCB addresses risk areas specifically in the Emergency Back-Up section of the Cost Comparison Budget.

It is the Case Managers responsibility to monitor participants' 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 the Case Manager will have reviewed whether and how providers are implementing a participants 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. 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 Community Integration and Habilitation 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.

The State maintains an extensive list of resource materials on the BQIS Resource Materials webpage to assist with risk mitigation.

** Note that when participants have state-assessed health scores of 5 or higher and opt to utilize the waiver's Wellness Coordination services, health care needs and associated risks are separately assessed and monitored by a Registered Nurse or Licensed Practical Nurse employed by their chosen Wellness Coordination provider agency. The RN/LPN, who must be actively involved in all IST meetings, develops a Wellness Coordination Plan specific to the assessed health care needs and risks, sharing the plan with the IST. As described in Appendix C-1/C-3, the Wellness Coordinator's health care related coordination and monitoring responsibilities vary according to the specified tier of Wellness Coordination services. However, as is true of all other waiver funded services, it is ultimately the responsibility of the waiver Case Manager to monitor and ensure that the Wellness Coordination activities occur as specified within the ISP and CCB.

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 FSSA's DDRS that contains information regarding all qualified waiver providers for each service on the Community Integration and Habilitation 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 Community Integration and Habilitation 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):

Pursuant to SEA 406, which became effective March 28, 2014, the Indiana Family Social Service Administration (FSSA) is now the Single State Medicaid Agency. Prior law listed The Office of Medicaid Policy and Planning (OMPP) as the single state agency. However, since the inception of FSSA, components of "Medicaid" have been administered by other divisions within FSSA. The change in law reflects what has evolved over time. Namely, FSSA is the agency that administers the Medicaid program through the combined efforts of all the staff that work for FSSA. The Division of Disability and Rehabilitative Services as well as the Office of Medicaid Policy and Planning are divisions or departments that are under the Single Medicaid Agency.

The FSSA's Office of Medicaid Policy and Planning (OMPP), a division under the single state Medicaid Agency, is responsible for monitoring DDRS's administration of the waiver thus making service plan approvals made by FSSA's Division of Disability and Rehabilitative Services (DDRS) subject to the approval of OMPP.

Division of Disability and Rehabilitative services, a division under the single state Medicaid Agency is authorized to administer Indiana's Medicaid Waiver program. Based on the terms of the waiver, OMPP reviews and approves the policies, processes, and standards for developing and approving the CIH POC. The OMPP may review and overrule the approval or disapproval of any specific POC decision that was made by DDRS.

Addendum:

All service plans are subject to the approval of the state Medicaid agency. Now that FSSA, the Medicaid agency, administers the waiver, oversight of service plans is delegated to FSSA's Division of Disability and Rehabilitative Services (DDRS). A valid sample of service plans is reviewed in depth on a routine basis. Retroactive reviews do not typically occur. Within DDRS, a valid sample of service plans to be reviewed is auto-generated daily. The case management system has been programmed to pull the current number of actively enrolled participants and populate the Raosoft® calculator for the purpose of identifying the correct sample size. The specified number of service plans is then randomly auto-selected, but it is further ensured that number of active participants from each BDDS District is appropriately represented via a proportionate random sample from the Districts. Prior to issuing formal approval of the service plans, designated staff from the FSSA's DDRS conducts in depth reviews of proposed service plans, verifying that all required components of the plan are in place and in agreement with the Individualized Support Plan (ISP). Plans are approved, denied, or returned for additional information or clarification when necessary.

While the ISP already includes natural and other non-paid supports, within the next year, the DDRS intends to explore the possibility of making system changes that will enable the addition of natural and non-paid supports to the service plan as well.

As the result of the Quality Improvement Executive Committee (QIEC) meetings where Performance Measures are monitored and discussed, FSSA's OMPP receives quarterly reports from FSSA's DDRS that contain performance-related data pertaining to oversight of the service plans.

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 service plan is updated a minimum of every 365 calendar days. The Individualized Support Plan and the Plan of Care/Cost Comparison Budget are reviewed formally a minimum of once every 90 calendar 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 State's case management 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 at least every 90 calendar 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.

At least once every 90 calendar days, 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, community integration, 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 90 Day Checklist has been automated. The process incorporates 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.

The case manager is required to enter at least one monthly case note indicating the progress and implementation of the Plan of Care (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. 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 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 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 at least once every 90 calendar days in 90 Day Meetings of the IST.

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 the State Medicaid Agency.

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 once every 90 calendar days to review and update the 90 Day Checklist with the IST.
•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 a report from the state's case management system to ensure that case managers are following up on, and closing out, any pending corrective actions for identified problems.

At least once every 90 calendar 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 participant-specific Case Notes, flagged for follow up and communicated to the noncompliant entity for resolution. Case Managers monitor occurrences of noncompliance to ensure completion of all identified outcomes for each participant, filing a formal complaint with the Bureau of Quality Improvement Services as described in Appendix F-3 when resolution is not achieved.

Note that when participants have state-assessed health scores of 5 or higher and opt to utilize the waiver's Wellness Coordination services, health care needs and associated risks are separately assessed and monitored by a Registered Nurse or Licensed Practical Nurse employed by their chosen Wellness Coordination provider agency. The RN/LPN, who must be actively involved in all IST meetings, develops a Wellness Coordination Plan specific to the assessed health care needs and risks, sharing the plan with the IST. As described in Appendix C-1/C-3, the Wellness Coordinator's health care related coordination and monitoring responsibilities vary according to the specified tier of Wellness Coordination services. However, as is true of all other waiver funded services, it is ultimately the responsibility of the waiver Case Manager to monitor and ensure that the Wellness Coordination activities occur as specified within the ISP and CCB.

Potential concerns with health and welfare that are brought to the attention of the case manager by the participant, or a reporter acting on a participant's behalf, are addressed by the case manager who investigates and provides the participant and reporter with a determination of findings or steps to be taken. That determination is to be documented and provided 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 described in Appendix G-1

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 least once every seven (7)-day (calendar days) 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, the Case Manager will file a formal complaint with the DDRS as described in Appendix F-3.

Problems as identified within the 90 Day 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.

Untimely and/or incomplete progress toward identified outcomes for each participant must be presented and discussed with the IST by the Case Manager. Issues are initially addressed within the scope of the team and provider agency, and are escalated to the DDRS via the filing of a formal Complaint, 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**

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

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 the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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:
SP A.3. 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:
Case Record Review by designated staff at FSSA's BDDS Central Office

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: Representative Sample with confidence interval 5%, but also Proportionate Random Sample
	☐ **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:
SP A.1. 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:
Case Record Review by designated staff at FSSA's BDDS Central Office

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: Representative Sample with confidence interval 5%, but also Proportionate Random Sample
	☐ **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:
SP A.4. 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 sampled.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Record Review by designated staff at FSSA's BDDS Central Office

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: Representative Sample with confidence interval 5%, but also

		Proportionate Random Sample
	☐ **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:
SP A.2. 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:
Case Record Review by designated staff at FSSA's BDDS Central Office

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: Representative Sample with confidence interval 5%, but also Proportionate Random Sample
	☐ **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 the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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:
SP B.1. 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:
Case Record Review by designated staff at FSSA's BDDS Central Office

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: Representative Sample with confidence interval 5%, but also Proportionate Random Sample
	☐ **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 the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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:
SP C.1. Number and percent of participants whose plans were reviewed and changed (as needed) when their needs changed. Numerator: Total number of participant plans that were reviewed and changed (as needed) when their needs changed. Denominator: Total number of participants from among all participants sampled whose needs changed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Record Review by designated staff at FSSA's BDDS Central Office

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: Representative Sample with confidence interval 5%, but also Proportionate Random Sample
	☐ **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:
SP C.2. 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:
INsite Default CCB 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:

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 the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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:
SP D.1. 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:
Case Record Review by State Service Coordinator

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: Representative Sample with confidence interval 5%, but also Proportionate Random Sample
	☐ **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 the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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:
SP E.2. Number and percent of waiver participants who were afforded a choice of waiver services. Numerator: Total number of sampled participants who were afforded a choice of waiver services. Denominator: Total number of participants sampled.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Record Review by State Service Coordinator

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: Representative Sample with confidence interval 5%, but also Proportionate Random Sample
	☐ **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:
SP E.1. Number and percent of enrolled participants who were afforded a choice between waiver services and institutional care. Numerator: Total number of enrolled waiver participants whose record documented they were afforded a choice between waiver services and institutional care. Denominator: Total number of enrolled waiver participants sampled.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Record Review by State Service Coordinator

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: Representative Sample with confidence interval 5%, but also Proportionate Random Sample
	☐ **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:
SP E.3. Number and percent of waiver participants who were afforded a choice of providers. Numerator: Total number of sampled participants who were afforded a choice of providers. Denominator: Total number of participants sampled.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Record Review by State Service Coordinator

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: Representative Sample with confidence interval 5%, but also Proportionate Random Sample
	☐ **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.
Designated staff from FSSA's BDDS Central Office conduct case record reviews on a monthly basis utilizing a waiver-specific valid sampling methodology. Using the BDDS Case Review Checklist for Quality Assurance, BDDS staff review files for information/assessments that identify an individual's needs and abilities. Case record reviews include review of level of Care, ISP, Plan of Care, Risk Plans, PCP and other pertinent documentation. In addition, BDDS staff review to determine that plans are based on DDRS policies and procedures. Case record reviews ensure the adequacy of service plans for waiver participants by reviewing individual specific needs identified through various assessments and ensuring service plans are based on the outcome of those materials.

For any item reviewed that does not meet criteria/standards, a corrective action is required as well as identification of the responsible party (the Case Management Agency/Case Manager or the BDDS District Office/Service Coordinator). Once the case review is complete, if there are corrective actions noted, an electronic notification is sent to the responsible party noting the corrective action needing resolved and steps to resolve as well as a target date for completion. 30 calendar days is the standard time frame for completion. Once the responsible party has completed all identified corrections, they send notification to the case reviewer who then verifies completion. Once verified, the case review is closed.

Reports are generated quarterly for review of trends and reported to Quality Improvement Executive Committee (QIEC). This process allows for identification of issues that may require additional training and education.

This methodology is applicable to the following measures, all of which use the case record review as the data source:
SP A.1.
SP A.2.
SP A.3.
SP A.4.
SP B.1.
SP C.1.
SP D.1.
SP E.1.
SP E.2.
SP E.3.

SP C.2. Annual service plans (CCBs) are required at least every 365 calendar days, with updates as needed. On a monthly basis, the Division of Disability and Rehabilitation Services (DDRS), generates a report to monitor the total number of participants for whom an annual CCB is due in that month, the number of annual CCBs actually received for that month and the number of annual CCBs for which no annual was submitted.

Designated staff from the DDRS Central Office is responsible for the review and approval of all CCBs and notifies other appropriate staff from the State Medicaid Agency of the findings resulting from the monthly report. The DDRS Central Office designee is responsible for relaying the findings to the appropriate case management agency/agencies.

The INsite Default CCB Report identifies annual service plans (CCBs) that were submitted late as well as any that remain outstanding. The report is waiver specific and also identifies the specific Case Manager(s) from the specified provider agency who failed to meet the standard. Upon receipt of the report from the designated staff from DDRS Central Office, the case management provider is required to provide explanation to the State regarding why any annual CCBs were submitted late and to complete and submit any overdue

plans. The remediation actions must be completed immediately and the completed report must be returned to the State within 7 calendar days, at which time the responses are researched and verified by the DDRS Central Office. The provider of Case Management is expected to retrain, discipline or dismiss the Case Managers who continually fail to meet the standard. Monthly reports are compiled on a Master report for presentation to the Quality Improvement Executive Committee (QIEC). Ongoing, these results are considered as providers are evaluated for re-approval to deliver services.

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 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 FSSA's Bureau of Developmental Disabilities Services' (BDDS) Intake and Assessment Process, the applicant for services under the Community Integration and Habilitation Waiver (or his/her legal representative) is advised of all available service options as well as their appeal rights in regard to each decision. Applicants who are denied entrance to the CIH Waiver receive a decision letter which includes appeal rights. The BDDS Service Coordinator (SC) provides Intake Case Management Services, which includes offering an eligible applicant the feasible alternatives available under the Community Integration and Habilitation 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 participant of any action that affects the participant's Medicaid benefits related to HCBS waivers. These actions include any denial of level of care and/or their choice of home and community based services as an alternative to institutional care. An opportunity to request a Fair Hearing is offered to participants who are denied the specific services of their choice or the provider(s) of their choice, as well as to participants whose previously authorized services are denied, suspended, reduced or terminated.

An explanation regarding a waiver service participant 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 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 33 calendar days of the decision date noted on the NOA.

Additionally, participants have the right to appeal the assessment used to determine the objective based allocation amount.

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

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 FSSA's 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 FSSA's 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 also available to participants.

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 calendar 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 calendar 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.

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:

As established per Indiana Code (IC), the FSSA's Division of Disability and Rehabilitative Services (DDRS), operates a separate complaint process system through the FSSA's Bureau of Quality Improvement Services (BQIS) [IC 12-12.5] in conjunction with the FSSA's Bureau of Developmental Disabilities Services (BDDS) [IC 12-11-1.1] and in addition to the formal, federally required Hearings and Appeals process.

DDRS, also employs a statewide waiver ombudsman per IC 12-11-13, 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 who wish to file a complaint.

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 & the guardian/family member is not satisfied with the resulting follow-up actions. Complaints may also be filed independent of the incident reporting system.

(b) & (c) PROCESS, TIMELINES & MECHANISMS FOR ADDRESSING GRIEVANCES/COMPLAINTS
DDRS's complaint process is not intended to replace the waiver's other systems to assure individuals' health & 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, 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 & resolve the issue first. If this has not produced the desired outcome BQIS will initiate a complaint investigation.
Each complaint received by BQIS is directed to the Quality Performance Center Specialist of the Quality Vendor who reviews & categorizes all initial complaints as urgent, critical, or non-critical & assigns a Quality Assurance/Quality Improvement Specialist (QA/QI Spec) to investigate the case within identified time parameters.

Issues deemed of an urgent nature are followed-up on no later than 24 hours from the time the case is assigned. When investigating complaints the QA/QI Spec will not leave the home until the individual's health & welfare has been secured. This may mean contacting Adult or Child Protective Services, local law enforcement, &/or the provider to come to the home & take necessary measures to assure the individual's health & welfare. BQIS follows-up on complaints within the identified targets below.

All activities related to complaint investigations are completed unannounced.

Depending on nature of complaint - QA/QI Specs' investigation activities could include:
•Conducting site visits to individual's home/day program site
•Conducting one-on-one interviews with individual receiving services &/or their staff, guardians, family members & any other people involved in issue being investigated
•Requesting & reviewing of documents/information from involved providers

All investigation activities are entered in the State's quality database.

BQIS uses standardized template to document/report:
•allegations received,
•allegations substantiated/not substantiated,
•for substantiated allegations:
-explanations of evidence obtained validating allegation,
-regulations that provider is not in compliance,
-key points requested as part of provider's corrective action plan (CAP); &
-due dates for submitting CAP
QA/QI Specs send providers the completed CAP template. The State's executive BQIS staff is copied on all communications related to investigations, which are sent to providers electronically.

Upon receipt, QA/QI Spec reviews CAP to determine acceptability; uses standardized CAP template to report whether each item in the CAP is accepted/not accepted. As necessary, QA/QI Spec provides explanation as to why any parts of CAP are not accepted; identifies new due date to re-submit with appropriate changes. Returns CAP template to provider.

When provider produces acceptable CAP, BQIS Quality Vendor validates implementation as communicated to the state. BQIS gives providers two opportunities to validate implementation of CAP & that involved individual(s) are experiencing positive outcomes. Validation activities may include:
•conducting site visits

•conducting interviews with involved individual(s) &/or staff, guardians, family members, & 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 & procedures
QA/QI Specs document validation activities in standardized CAP template; share with providers. QA/QI Specs refer providers to DDRS Sanctions Committee for possible sanctions after providers have had two opportunities to validate implementation of CAP & have failed to do so. BQIS Quality Vendor closes complaints when any CAPs have been accepted & validated. All investigative actions are entered & tracked in the complaint database.

TARGETS FOR COMPLETING COMPLAINT INVESTIGATIONS (in calendar days)
URGENT:
•Within 1 day of intake, QA/QI Spec receives complaint investigation assignment; initiates discovery activities
•Within 1 day of complaint assignment, QA/QI Spec performs unannounced onsite visit/phone contact initiating collection of evidence relevant to the originating complaint
•Within 15 days of date of 1st contact, QA/QI Spec completes written summary of investigative findings (allegations substantiated/not substantiated). If substantiated, request for a corrective action plan (CAP) will accompany findings
•Within 5 business days of receiving the summary of investigative findings that substantiate allegations & require a CAP, provider will submit required CAP
•Within 5 days of receiving provider's CAP, QA/QI Specialist reviews, documents decision to accept/not accept; communicates to provider whether CAP is accepted/not accepted.
•CAP is validated within 5 days of targeted validation date. Complaints are closed once CAP is validated
•If complaint cannot be validated after two attempts, complaint is forwarded to sanctions committee
•Provider is notified of complaint closure/referral to the sanctions committee electronically

CRITICAL:
•Within 1 day of intake, QA/QI Specialist receives complaint investigation assignment; initiates discovery activities
•Within 2 days of complaint assignment, QA/QI Specialist performs unannounced onsite visit/phone contact; initiates collection of evidence relevant to originating complaint
•Within 25 days of date of 1st contact, QA/QI Specialist completes written summary of the investigative findings (allegations substantiated/not substantiated). If substantiated, request for CAP accompanies findings
•Within 8 days of receiving provider's CAP, QA/QI Specialist reviews; documents decision to accept/not accept; communicates to provider whether CAP is accepted/not accepted
•CAP is validated within 8 days of targeted validation date. Complaints are closed once CAP is validated
•If complaint cannot be validated after two attempts, complaint is forwarded to sanctions committee
•Provider is notified of complaint closure/referral to the sanctions committee electronically

NON-CRITICAL:
•Within 1 days of intake, QA/QI Spec receives complaint investigation assignment; initiates discovery activities
•Within 30 days of date of 1st contact, QA/QI Spec completes written summary of investigative findings (allegations substantiated/not substantiated). If substantiated, request for CAP accompanies findings
•Within 10 days of receiving provider's CAP, QA/QI Spec reviews; documents decision to accept/not accept; communicates to provider whether CAP is accepted/not accepted. Complaints are closed once the CAP is validated
•If complaint cannot be validated after two attempts, complaint is forwarded to sanctions committee
•Provider is notified of complaint closure/referral to the sanctions committee electronically

The Statewide Waiver Ombudsman:
Per IC 12-11-13, the role of the statewide waiver ombudsman is to receive, investigate & attempt to resolve complaints & concerns that are made by or on behalf of individuals who have a developmental disability & 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, & complaints requiring coordination between legal services, DDRS services and provider services.

The ombudsman is expected to initiate contact with the complainant as soon as possible. However, precise timelines for the final resolution of each complaint are not established. While it is expected that the ombudsmen diligently & 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 & in the numbers & availability of persons who must be contacted, interviewed, or brought together to resolve the complaint. The DDRS Director is responsible for oversight of the

statewide waiver ombudsman.

With the consent of the waiver participant, the ombudsman must be provided access to the participant records, including records held by the entity providing services to the participant. When it has been determined the participant is not capable of giving consent, the statewide waiver ombudsman must be provided access to the name, address and telephone number of the participant's legal representative.

A provider of waiver services or any employee of a provider of waiver services is immune from civil or criminal liability & from actions taken under a professional disciplinary procedure for the release or disclosure of records to the statewide waiver ombudsman.

A state or local government agency or entity that has records relevant to a complaint or an investigation conducted by the ombudsman must also provide the ombudsman with access to the records.

The statewide waiver ombudsman coordinates his or her activities among the programs that provide legal services for individuals with a developmental disability, DDRS, providers of waiver services, and providers of other necessary or appropriate services, & 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, 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, DDRS & the members of Indiana's developmental disabilities commission, which has been rolled into the Interim Study Committee on Public Health, Behavioral Health, and Human Services. Trends are identified so that recommendations for needed changes in the service delivery system can be implemented.

DDRS 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 FSSA's Bureau of Developmental Disabilities Services (BDDS) Incident Reporting and Management 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.

FSSA's 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.

Addendum:
Incidents may also be reported via email or fax. DDRS' "Incident Reporting & Management" policy found at http://www.in.gov/fssa/files/Incident_Reporting_and_Management_3-1-11.pdf states the following information related to Initial incident reporting to BQIS:

"Within 24 hours of initial discovery of a reportable incident, the reporting person shall file an incident initial report

with BQIS using the DDRS approved electronic format available at https://ddrsprovider.fssa.in.gov/IFUR/ . In the event of a network malfunction, incident initial reports and incident follow-up reports may be e-mailed to to BDDSIncidentReports@fssa.in.gov, or faxed to 260-482-3507."

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.

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 copy of the State's "The Individual and Guardian Rights and Responsibilities" policy. Additionally, case management companies are required to provide each waiver participant with a link to the DDRS Waiver Manual, a resource document for participants and support teams. When requested by the participant, guardian and/or family, a paper/hard copy of the DDRS Waiver Manual will be provided by the case manager.

Participants are required to sign and date that they received the grievance procedure and a link and/or copy of the above mentioned DDRS Waiver Manual.

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.

FSSA's 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 Services, 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 (one calendar day) of notification of the sentinel event and documents this interaction via entry into the case notes portion of the incident reporting system. The Sentinel event remains open until protective measures are in place. The Incident Report remains opens until there is documentation that the provider took the appropriate actions to resolve the issue.

Case managers are responsible for following-up on all incident reports while the BQIS oversees how timely and effectively case managers respond to incident reports.

On a weekly basis the BQIS Quality Contractor risk management staff reviews all unresolved sentinel events. When documentation ensuring health and welfare is confirmed, the sentinel status is closed. The BQIS Quality Contractor submits a weekly report of unresolved sentinel events to the BDDS and BQIS executive staff and to the appropriate case management agency/agencies.

The participant's case manager, along with input from the support team, is responsible for electronically submitting follow-up reports within seven calendar days of the incident being reported and every seven calendar days thereafter until the incident is resolved to the satisfaction of the BQIS. Follow-up reports for sentinel events are required every 72 hours and every 72 hours thereafter until protective measure are in place.

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. The BQIS ensures that case managers are completing required followup reports until incidents are closed.

At the discretion of FSSA' BDDS, 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.

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 per 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 calendar days. Face to face meetings with members on the Family Supports Waiver 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 and/or consumer/guardian 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.

FSSA's 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 calendar 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 provides the Case Management provider agencies a report outlining all the incident reports that continue to be open. Designated staff from DDRS Central Office work with 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, and members of DDRS executive leadership) recommends to the DDRS Director specific sanctions to be issued against providers. The DDRS Director then communicates this decision to the provider.

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.

Addendum:
The investigation surrounding IRs is conducted by the provider but the Case Manager is responsible for ongoing follow up to ensure the investigation is completed and can be closed by the State. As such, the timeframes for

informing the participant of the investigation results would be dependent upon the unique range of activity required to complete each investigation and the policies of each individual Case Management provider. Informing the participant of the investigation results is a requirement, but one for which a time frame has not been identified. As teams meet at least once every 90 calendar days, it would be rare for the Case Manager to wait longer than 90 calendar days to report the results to the participant.

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.

FSSA's BQIS oversees incident reporting and management and works closely with FSSA's BDDS to assure that the same incidents do not continue to occur.

At least quarterly, the BQIS compiles aggregate incident data based on each of the incident types described in G-1-b of this waiver application. The types of incidents for which aggregated data has been shared with providers include:
o Arrest/Placement Removal
o Suicide Attempt
o Elopement
o Medication Errors that jeopardize health and welfare, as determined by the participant's personal physician
o Choking Episodes Requiring Intervention
o Falls with Injury
o Seizures Resulting in ER/Hospital Visit
o Bowel Impactions Resulting in ER/Hospital Visit
o Dehydration Episodes Resulting in ER/Hospital Visit
o Respiratory Events Resulting in ER/Hospital Visit
o ER Visits
o In-Patient Hospitalizations, Medical
o In-Patient Hospitalizations/ER Visits, Psychiatric
o Use of PRN Medications, Behavioral
o Use of Restrictive Techniques
o Lack of Consumer (Participant) Supports
o Sentinel Events
o Environmental Risks
- Fire, Residential/Service Delivery Site
- Problems with Habitable Residence
- Problems with Uninhabitable Residence
o Multiple 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.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. **Use of Restraints.** *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

The State does not permit or prohibits the use of restraints

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

The use of restraints 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.** 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). 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.

The State has established, provider standards prohibiting abuse, neglect, exploitation, or mistreatment of a participant, or violation a participant’s rights. As defined within the DDRS BDDS Policy Manual, “Abuse” means:
1.Intentional or willful infliction of physical injury.
2.Unnecessary physical or chemical restraints or isolation.
3.Punishment with resulting physical harm or pain.
4.Sexual molestation, rape, sexual misconduct, sexual coercion, and sexual exploitation.
5.Verbal or demonstrative harm caused by oral or written language, or gestures with disparaging or derogatory implications.
6.Psychological, mental, or emotional harm caused by unreasonable confinement, intimidation, humiliation, harassment, threats of punishment, or deprivation.

In addition to the requirements in the Incident Reporting policy, abuse may require a provider to file a police report.

Also prohibited are practices which deny a participant any of the following without a physician’s 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.

Indiana Administrative Code 460 IAC 6-18-2 Behavioral Support Plan, supported by DDRS’ Behavioral Support Plan policy, 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 90 Day Meetings 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 quarterly reports, behavior data tracking sheets and verbal input from team members. The quarterly 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.

The Indiana Administrative Code, 460 IAC 6-18-2 Behavioral support plan standards, supported by DDRS BDDS Behavioral Support Plan policy, requires that providers' staff be trained to implement the participant's specific behavior plan.

Participants' teams submit comprehensive corrective action plans to FSSA's BQIS for review and approval. BQIS then validates that these plans are being implemented as stated.

Addendum:
Behavioral Support Plans are developed and implemented as needed to avoid use of restraint whenever possible. Behavioral support providers are required to train appropriate staff /personnel of approved

providers. At minimum, personnel who are involved in the administration of restraints must meet the education and training requirements specified in 460 IAC 6-5 and 6-14 and be trained by the provider of Behavioral Support Services.

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

FSSA's 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 the 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 review at the required 90 Day Meetings.

Addendum:
Data is entered into and collected from the State's electronic Incident Reporting System. It is aggregated quarterly and normed annually, so that is reviewed as it relates to all providers. The data is then used during the provider re-approval process to evaluate providers' quality assurance/quality improvement systems and ensure policies and procedures are in place to address the use of restraints.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

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.

Indiana Administrative Code, 460 IAC 6-18-2 Behavioral support plan standards, supported by DDRS BDDS Behavioral Support Plan policy, 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 90 Day Meetings 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 quarterly reports, behavior data tracking sheets and verbal input from team members. The quarterly report covers the prior quarter progress on the behavior support plan including targeted behaviors and any need for an amendment to the plan.

Indiana Administrative Code, 460 IAC 6-9-3 Prohibiting violations of individual rights, supported by DDRS BDDS Protection of an Individual's Rights policy, 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 to include unnecessary physical or chemical restraints or isolation. Also prohibited are practices which deny a participant any of the following without a physician's 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.

Addendum:
At minimum, personnel who are involved in the administration of restraints must meet the education and training requirements specified in 460 IAC 6-5 and 6-14 and be trained by the provider of Behavioral Support Services.

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:

FSSA's 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 Meetings.

Addendum:
Data is entered into and collected from the State's electronic Incident Reporting System. It is aggregated quarterly and normed annually, so that is reviewed as it relates to all providers. The data is then used during the provider re-approval process to evaluate providers' quality assurance/quality improvement systems and ensure policies and procedures are in place to address the use of restraints.

Additionally, BQIS's quality vendor processes all IRs and reviews individuals' incidents as they are reported to look for trends/patterns. Any trends are escalated to BQIS administration for review and follow-up.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. **Use of Seclusion.** *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The State does not permit or prohibits the use of seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

Seclusion is not allowed as a behavioral intervention and is considered an act of abuse.

FSSA's DDRS, specifically BQIS, is responsible for detecting the unauthorized use of seclusion.

Per the Indiana Administrative Code, 460 IAC 6-9-3 Prohibiting violations of individual rights, "seclusion" by placing a participant alone in a room or other area from which exit is prevented is specifically prohibited from use. The DDRS BDDS policy Protection of an Individual
s Rights lists seclusion among prohibited practices. Per DDRS's Incident Reporting & Management policy, incidents to be reported to BQIS include any event or occurrence characterized by risk or uncertainty resulting in or having the potential to result in significant harm or injury to an individual. Seclusion is categorized as an aversive technique.

Per 460 IAC 6-3-2 "Abuse" defined, among other identified events or occurrences, abuse can also be defined as "Unnecessary physical or chemical restraints or isolation". Use of seclusion/isolation is a violation of rights and is monitored through the incident reporting process, the complaint process, and the case management function, specifically through review at the required 90 Day Meetings. The use of seclusion as seclusion/isolation is prohibited. For any confirmed or suspected use of seclusion, an incident report is required. Monitoring also occurs through the FSSA's DDRS provider re-approval process.

Addendum:
The state does utilize restrictive interventions, but documents within this section that seclusion is not allowed as a behavioral intervention and is considered an act of abuse.

FSSA's BQIS processes all IRs and reviews content for any reporting of seclusion. If a reported incident appears to be seclusion, detailed follow-up is requested of the provider. Additionally, the incident in question is escalated to BQIS, BDDS, and DDRS administration for review and follow-up.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c -i and G-2-c-ii.

i. **Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the State has established concerning the use of each type of 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).

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

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 Community Integration and Habilitation 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, a residential provider and/or a provider of Wellness Coordination services working with their health care provider.

Per 460 IAC 6-25-2 Coordination of health care, 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 as needed. 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 is utilized to ensure that identified areas are assessed and results communicated to the state.

A significant part of coordinating health care includes needing to document the services the person has received. As outlined in Indiana Administrative Code, 460 IAC 6-25-3 Documentation of health care services received by an individual and supported by the DDRS BDDS Requirement and Training of Direct Support Professional Staff policy, 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.

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.

Case managers conduct 90 Day Meetings 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.

Addendum:
Monitoring activities by the Case Manager address all medications actions, not just a percentage.
At each 90 Day Meeting, or more often if indicated by the Individualized Support Plan, Case Managers monitor the administration of medications with members of the Individualized Support Team:

Regarding Psychotropic Medications:
• Does the individual's record confirm the use of psychotropic medication?
• Is there informed consent and Human Rights approval for administration of the psychotropic medication to the individual?
• Is there a written titration plan that has been reviewed by the prescribing physician within the past year present for the psychotropic medication being administered?
• Is the psychotropic medication titration plan being implemented per the written plan?
• Are the behaviors for which the psychotropic medication is administered identified?
• Is the identified behavior data being documented consistently and in accordance with the titration plan?
• Does the ISP include an identified timeframe for psychiatric consults/visits?
• Has the individual seen a psychiatrist within the identified referral and follow-up timeframes?

Regarding non-Psychotropic Medications:
• Is there a written individualized medication administration plan and a medication administration record available for the individual?
• Does the medication administration record** confirm that all currently prescribed medications are being administered without error?
• Is medication being administered in compliance with the individual's medication administration plan?
• Are medications being stored per the individual's medication administration plan?
• Does observation of the individual, review of the individual's medication side effect documentation, and discussion with staff, the individual and the legal guardian if indicated, confirm the absence of medication side effects for the individual?

**For some participants, the family or legal guardian is identified as the responsible party for medication administration. As natural and un-paid providers of care, families are not required to keep medication administration records (MAR). Review of the MAR would only apply when a DDRS-approved paid provider is responsible for Medication Administration.

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.

Per Indiana Administrative Code, 460 IAC 6-25-4 Organized system for medication administration required, supported by the DDRS BDDS Individual's Personal Information: Site of Service Delivery policy, 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 FSSA's 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 quality improvement review activities. Results of the reviews are shared with FSSA's OMPP. In addition, medication management issues may be identified as a result of incident reporting, mortality reviews, the complaint process, and from anecdotal information presented through the risk management committee framework.

Providers of Case Management analyze data at the participant level, identify trends, and work with providers to develop remediation plans. FSSA's BQIS conducts the same activities but for provider-specific and systemic trend analysis. 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).

Addendum:
The state uses the following methods facilitated by FSSA's BQIS:
1. Incident reporting – all issues related medication administration are reported within the State's Incident Reporting system. Medication administration data is aggregated and reviewed at least annually by the Quality Improvement Executive Committee (QIEC). With representation from multiple entities within FSSA, (BQIS, DDRS, BDDS and OMPP), the QIEC makes recommendations for system improvement as trends surface. Provider-specific information is used during the provider re-approval process to assess the quality assurance/quality improvement system of each provider.
2. Within the Mortality Review Committee, the physician and registered nurse who serve on the Mortality Review Triage Team, review medications and potential side effects/implications to give the committee a comprehensive picture of how medical issues may have impacted the individual's overall health and well-being.

Additionally, on January 1, 2014, the state began offering Wellness Coordination services to eligible participants of the CIH Waiver. For participants who chose this service, medication management and oversight occurs at least weekly as a component of the routine consultation and review conducted by the licensed nurse coordinating the medical needs of the participant. The timely discovery and remediation of potentially harmful practices, both individually and systemically, is one expectation of this relatively new service.

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).

Indiana Administrative Code 460 IAC 6-14-4 Training and DDRS BDDS Requirements & Training of Direct Support Professional Staff policy require that all provider staff be trained in administering medication. The state has an approved curriculum available for providers to use to conduct this training.

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 (460 IAC 6-9-4 System for protecting individuals and DDRS BDDS Incident Reporting & Management policy).

Additionally, DDRS BDDS Policy Manual contains the following policies related to medication administration:

Supporting 460 IAC 6-14-4, the DDRS BDDS Requirements & Training of Direct Support Professional Staff policy requires training specific to medication administration and medication side effects, which includes but is not limited to the following training topics:
i. medication administration and side effects training by a licensed nurse; and
ii. competency in medication administration documented by a licensed nurse

This policy also requires that prior to providing services to an individual, all direct support professional staff will be trained to competency in the individual specific interventions for each individual they are working with, including but not limited to the individual's medication administration needs and the side effects for any prescribed medications.

Supporting 460 IAC 6-17-3 Individual's personal file; site of service delivery, the Individual's Personal Information: Site of Service Delivery policy requires that, at minimum, the onsite records pertaining to the participant contain all medication administration recording forms for the previous two months.

Supporting 460 IAC 6-17-4 Individual's personal file; provider's office, the Individual's Personal Information: Site of Service Delivery policy requires, that with the exception of the prior or previous two months' of documentation that is maintained at the site of service delivery as described in the "Individuals' Personal Information: Site of Service Delivery" policy, the Individual's personal information shall include at minimum include all medication administration recording forms.

Supporting 460 IAC 6-25-10 Investigation of death, the Mortality Review policy requires that the primary

services provider shall also provide a narrative review of the deceased individual's medication administration records.

Supporting 460 IAC 6-9-5 Incident reporting, the Incident Reporting & Management policy requires the reporting of any medication error or medical treatment error as follows:
a. wrong medication given;
b. wrong medication dosage given;
c. missed medication - not given;
d. medication given wrong route; or
e. medication error that jeopardizes an individual's health and welfare and requires medical attention.

This policy also requires the reporting of the use of any PRN medication related to an individual's behavior.

Supporting 460 IAC 6-10-10 Quality assurance and quality improvement system, the Quality Assurance & Quality Improvement System policy requires that whenever medication is administered to an individual by a provider, the provider must develop a process for:
i. identifying all medication errors;
ii. analyzing all medication errors and the persons responsible for them;
iii. developing and implementing a risk reduction plan to mitigate and eliminate future medication errors; and
iv. a monthly review of the risk reduction plan to assess progress and effectiveness

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 FSSA' BQIS through the incident reporting process 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, FSSA's 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 participates 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.

As entities within FSSA, 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 Individualized Support Plan (ISP) and Plan of Care/Cost Comparison Budget (POC/CCB) by the Individualized Support Team (IST).

Medication error reporting or inappropriate use of medications may be received by BQIS through the incident reporting system or the complaint system. 100% of medication errors will be reviewed by the contracted quality vendor, who will 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.

Provider performance is a factor in the DDRS/BQIS provider re-approval process described in Appendix C. Providers receive incident reporting data regarding their medication errors as compared to similar providers. Based on data analysis, providers are assigned a risk level for medication errors and as part of the re-approval process, providers must identify the systems in place to either continue to keep medication errors to a minimum, or to correct any deficiencies in their current systems which have allowed for excessive medication errors.

While the State utilizes one Appendix G Performance Measure to address sentinel events regarding medication administration errors that result in medical treatment, additional data related to a broader range of medication errors is also collected, reviewed, and analyzed by BQIS. Data trends involving medication errors are reviewed and discussed as part of the work of the Quality Improvement Executive Council (QIEC), which also includes BDDS and OMPP. At a minimum, one QIEC meeting annually is dedicated to reviewing the data related to medication errors in order to discuss and determine potential activities and remedies to address and mitigate the issue.

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 demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. **Sub-Assurances:**

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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:
HW A.1. Number and percent of incidents identified as abuse, neglect and/or exploitation. Numerator: Total number of incidents identified as abuse, neglect or exploitation that were reviewed in time period. Denominator: Total number of incidents identified as abuse, neglect or exploitation.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Incident Reporting 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: BQIS 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: BQIS Quality Contractor	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
HW A.2. Number and percent of unexplained deaths reported during time period. Numerator: Total number of unexplained deaths reviewed by the Mortality Review Committee during time period. Denominator: Total number of deaths reported during time period.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Incident Reporting 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: BQIS 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: BQIS Quality Contractor	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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:

HW B.1. Number and percent of incidents that were reported within required time periods. Numerator: Total number of incidents reported within time periods. Denominator: Total number of incident reports.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Incident Reporting 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: BQIS 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):*
BQIS Quality Contractor	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
HW B.2. Number and percent of incidents that were resolved within the stipulated time period Numerator: Total number of incidents which were resolved within the stipulated time period Denominator: Total number of incidents reported

Data Source (Select one):
Other
If 'Other' is selected, specify:
Incident Reporting 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: BQIS 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: BQIS Quality Contractor	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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:
HW C.1. Number and percent of reported uses of restraints that resulted in medical treatment. Numerator: Total number of reported uses of restraints that resulted in medical treatment. Denominator: Total number of reported uses of restraints.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Incident Reporting 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: BQIS 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: BQIS Quality Contractor	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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:
HW D.1. Number and percent of sentinel events regarding 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:
Indicent Reporting 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: BQIS 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**

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: BQIS 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.
FSSA's BQIS employs a Quality Contractor to support 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 individuals' health or welfare, and whether immediate attention is necessary.

HCBS waiver providers are then responsible for following-up on all reported incidents, regardless of incident type or severity. BQIS does not investigate any reported incidents. Instead, BQIS holds providers accountable for taking appropriate measures to secure the individual's immediate safety, implementing preventative measures, and investigating reported incidents. Case managers are then responsible for confirming that the provider took these actions. To document this, case managers use follow-up reports to document the provider's actions to safeguard the individual.

Case managers enter follow-up reports directly into the state's web-based incident management system. BQIS Quality Contractor's risk management staff review these follow-up reports to determine: 1) if the individual'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 an incident report. Case managers are required to continue providing follow-up reports at a minimum of every 7 calendar days until an incident is closed.

On a weekly basis BQIS Quality Contractor's risk management staff sends case management agencies a report listing all of the sentinel incident reports that continue to be open. On a monthly basis BQIS Quality Contractor's risk management staff provides case management agencies a report listing all of the incident reports that continue to be open. As needed, designated staff from DDRS Central Office work with the case management agencies to assure that all incident reports are addressed appropriately.

In emergency situations Indiana Administrative Code gives the state the authority to remove an individual from the provider's services, to issue a moratorium on the provider taking new consumers, 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. BQIS facilitates the DDRS Sanctions Committee, consisting of representatives of FSSA's BQIS, BDDS, and members of DDRS executive leadership, which recommends to

the DDRS Director specific sanctions to be issued against providers. The DDRS Director then communicates this decision to the provider.

Systemic incident reporting data is routinely analyzed for quality improvement purposes in QIEC and Quarterly Quality Data Assessment meetings. Remediation resulting from these meetings has included issuing new and revising current policies.

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 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 QIS 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 OIS* 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 QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

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 compile and analyze meaningful data across the program so that issues can be identified and addressed. FSSA's Division of Disability and Rehabilitative Services (DDRS) uses a centralized system to administer the day-to-day operations of the waiver program for the waivers numbered IN.0378 and IN.0387. DDRS has made, and continues to make, many efforts to assure that the information it collects from each of its monitoring activities can be aggregated so that provider-specific and systemic data can be reviewed. DDRS uses a multi-tier strategy for collecting and addressing person-specific, provider-specific, and systemic trends.

Tier I
This tier focuses on assuring that participants' issues are identified and addressed timely and appropriately. Case managers have the front-line responsibility for monitoring individuals and following-up on issues identified through their routine contacts with the individual. Case managers are also individuals' team leaders so they are in charge of facilitating participants' individualized support team (IST) meetings. The ISTs meet at least every 90 calendar days and are responsible for using providers' routinely required progress notes to assess if an individual is meeting their goals and objectives, whether the individual's support plan is effective or if it should be revised, whether any needed behavior plan/risk plan is being implemented accurately or if further staff training is necessary, etc. Information that teams use to make decisions about individuals include:

- Data from the case manager's 90-Day Meetings where a full assessment of the individual's service implementation is conducted
- Providers' quarterly/monthly summaries
- Incident reports
- Complaint investigations
- Data from case record reviews

Tier II
In this tier, data is aggregated systemically and reviewed at the state level. The Quality Improvement Executive Committee (QIEC) meets on a monthly basis to review data collected from the HCBS waivers' performance measures. Each meeting is dedicated to a defined set of performance measures. At each QIEC meeting the performance measure "owner" develops and presents a report with the data obtained in the time period being covered (typically in the form of charts and graphs), along with analysis, and remedial steps taken thus far to address areas with issues. The group then discusses the data and systemic remediation that DDRS should take to improve the quality of services being delivered and individuals' health outcomes.

Following QIEC meetings the report presented to the committee is updated with whatever further systemic remediation plans were discussed. The performance measure owner assures these plans are implemented and at the next QIEC meeting scheduled to discuss those performance measures reports to the committee progress on implementation.

Examples of systemic improvements the QIEC has made include: revising DDRS provider policies, educating providers/consumers on key health and safety issues impacting individuals with intellectual disabilities, revising the information required to report an incident, and collaborating with provider groups to obtain better training for direct care staff. In collaboration with FSSA's Office of Medicaid Policy and Planning (OMPP), DDRS shares the data reviewed and remediation actions taken with CMS in the annual CMS-372 reports and in periodic Evidence Based Reports.

QIEC membership from entities within FSSA consists of:
• DDRS Executive Staff representative
• Bureau of Quality Improvement Services (BQIS) Director
• BQIS representative
• Bureau of Developmental Disabilities Services (BDDS) Director
• BDDS Provider Relations representative
• BDDS Strategic Initiatives Liaison
• Office of Medicaid Policy and Planning representative
• HCBS Waiver Manager

Tier III
In DDRS's Quarterly Quality Data Assessment meetings, findings from all monitoring activities are reviewed and discussed. This more comprehensive review of monitoring results goes beyond the CMS performance measure data discussed at QIEC meetings. BQIS develops quarterly reports collected from the following sources:
• Incident reports
• Complaints
• Mortality reviews
• Provider compliance/accreditation
• Provider re-approvals
• National Core Indicator Project

Reports include tables and charts of provider-specific and systemic-level data and analysis of the state's performance from one quarter to the next. Data is reviewed for trends and potential remediation. Discussions at these meetings drive the need for further refining of our monitoring systems and identifying priority areas to focus limited resources. When areas have been identified as needing improvements, the data source "owner" is responsible for proposing a new system to collect and use the data. Again, in collaboration with FSSA's Office of Medicaid Policy and Planning (OMPP), the DDRS Director needs to review and approve any major changes or additions to the state's monitoring systems.

DDRS participates in the National Core Indicators (NCI) Project. Participating in the NCI Project and obtaining individuals' perspectives on how the waiver service delivery system is operating overall expands DDRS's quality assurance system. Ongoing, as we collect and analyze Indiana's interview results and make

comparisons to other states' performance, we will also be able to identify gaps between NCI data and information gathered through DDRS's other monitoring activities. NCI Project data will help DDRS establish priorities and make recommendations for improvement.

It should also be noted that while DDRS's routine system to collect and analyze data and make changes is functioning, changes in monitoring activities may be driven by outside forces such as organizational redesigns, legislative demands, and different amounts of funding available. An example of this is the legislature's approval of a bill to add accreditation to the provider qualifications for day program providers. As a result, when a provider shows evidence of an accredited service, BQIS will not conduct a provider compliance review for that service.

DDRS Mortality Review System

An important part of DDRS's quality improvement strategy is the mortality review process. BQIS conducts mortality reviews for all deaths of individuals receiving services through the Community Integration and Habilitation Waiver and the Family Supports Waiver.

As indicated in Indiana Administrative Code (IAC), 460 IAC 6-9-5 Incident reporting, all deaths of individuals receiving DDRS-funded services are required to be reported to the state through the BDDS Incident Reporting System. Upon receipt of the death report, BQIS's Mortality Review Triage Team (MRTT) assesses whether an individual's housemates may be at risk for similar circumstances. For example, if someone died due to choking, BQIS would send a Quality Assurance/Quality Improvement Specialist to the individual's home to assess staff performance in adhering to individuals' risk plans for choking. If staff do not demonstrate competency in following individuals' risk plans, the provider will be directed to complete a Corrective Action Plan (CAP) which would include immediate staff training related to risk plans. BQIS validates implementation of all CAPs, and noncompliant providers may be referred to the DDRS Sanctions Committee.

Per 460 IAC 6-25-10 Investigation of death, the provider identified in an individual's ISP as responsible for the health care of the individual is required to conduct internal investigations of individuals' deaths. The DDRS Mortality Review Policy outlines all the specific documentation that providers need to review as part of their internal investigation process. Providers send completed internal mortality investigations, along with the individual's medical history and other related documentation to the BQIS's MRTT. The MRTT reviews all deaths. Discussions include the events prior to the death, supports/services in place at the time of death, and whether additional documentation is needed for review. The MRTT also determines whether each death meets criteria to be brought before the Mortality Review Committee (MRC). The BQIS Director or any other DDRS staff with a concern can also refer deaths to the MRC.

The MRC is facilitated by the BQIS Director of Incident Management and the BQIS quality contractor's Life Cycle Specialist. Committee members include representatives from Adult Protective Services, the Department of Health, FSSA's Office of Medicaid Policy and Planning, the Indiana Coroner's Association, the Statewide Waiver Ombudsman, BDDS field service staff, and community advocates.

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

To date, the communications' topics have included Coumadin monitoring, malfunctioning feeding tubes, choking versus aspiration, pain management, medication administration, healthcare coordination, and staff training on risk plans.

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**

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☐ **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.

FSSA's DDRS uses a centralized system to monitor its HCBS waiver programs and to identify systemic changes necessary for improving the quality of individuals' services and supports. DDRS management and FSSA's Office of Medicaid Policy and Planning (OMPP) representatives participate in the routine QIEC and DDRS Quarterly Quality Data Assessment meetings to review data collected from monitoring systems and to assess monitoring activities' effectiveness in producing positive changes for individuals receiving waiver services.

Different positions play a role and have a responsibility in the processes for monitoring and assessing effectiveness of system design changes. These include:

• Case managers have the front-line responsibility for overseeing the delivery of waiver services. They are responsible for conducting a minimum of four visits with the individual each year, coordinating and facilitating individuals' support team meetings as necessary, and identifying and resolving issues with service delivery. Case managers have the potential to identify the effectiveness of system design changes by how the individuals they work with are impacted.

• BQIS-contracted complaint investigators are continually in the field following-up on allegations that individuals' health and welfare may be in jeopardy. Aggregated information and analysis compared from one quarter to the next is shared in BQIS's quarterly reports and is discussed in DDRS's Quarterly Quality Data Assessment meetings.

• BQIS-contracted incident management staff are responsible for reviewing and coding all incident reports as they are submitted into the state's web-based system. Similar to information on complaint investigations, incident data is aggregated and analyzed in BQIS's quarterly reports and discussed in QIEC and Quarterly Quality Data Assessment meetings.

• Designated staff from FSSA's BDDS Central Office conduct case record reviews to assess accuracy and appropriateness of level of care determinations, and whether individuals' service plans (ISPs) have been developed according to the state's standards for ISPs. Data is aggregated and routinely discussed in QIEC meetings.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

Quality improvement strategies are living documents that result from an ongoing process of review and refinement. Necessary changes to DDRS's monitoring systems are identified through the continual review and analysis of data in QIEC and Quarterly Quality Data Assessment meetings. Over the past few years DDRS has focused its resources on assuring that we have the processes in place to collect data on our most basic assurances and that these processes are working effectively.

Ongoing, as confidence in our data progresses, DDRS will assess and determine the potential need to establish other committees to participate in discussions reviewing DDRS's monitoring data and/or assisting

to develop remediation strategies. As needed, DDRS will submit modifications to the quality improvement strategy annually with the 372 report.

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 Indiana FSSA 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 peer comparison evaluation to identify outliers and look for potentially aberrant billing practices. The provider must provide FSSA Compliance 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 Indiana Medicaid Member's Concerns Line
•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 Indiana FSSA Compliance office. FSSA Compliance routinely monitors audit resolution and provides annual status updates to SBOA.

Addendum:
The CIH Waiver provides post payment audit. The States Post Payment audit is completed within IN FSSA SUR Fraud & Abuse Detection System (FADS). FADS is tasked with on-going monitoring and auditing of all IN Medicaid providers and provider specialties to identify fraud, waste and abuse within the program and recoup inappropriately paid funds. Peer comparison reports are run on all provider specialties, at a minimum, on a yearly basis, while select high risk provider specialties are evaluated on a quarterly basis. Outliers are identified through the peer comparison reports, and further investigation is conducted to determine if aberrant billing is identified. Additionally, SUR receives Medicaid provider and member concerns through the State's Concerns Line regarding specific providers who are potentially operating outside of compliance with IN Medicaid guidelines. The FADS team also applies the use of specific algorithms to identify potential billing anomalies through detailed claims review. Weekly meeting occur between the State and the FADS team to identify areas of concern within the program , as well as discuss means by which issues can be further investigated in the most efficient and cost-effective manner.

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. *(For waiver actions submitted before June 1, 2014, this assurance read "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. **Sub-Assurances:**

      a. ***Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.*** *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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:
FA A.2. Number and percent of claims paid for enrolled participants on the date the service was delivered. Numerator: Number of claims paid for enrolled participants on the date the service was delivered. Denominator: Number of claims submitted

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:
FSSA Operations

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: 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:
FA A.1. Number and percent of claims paid appropriately according to the reimbursement methodology in the waiver application. Numerator: Number of claims paid appropriately according to the reimbursement methodology in the waiver application Denominator: Number of claims submitted

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

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**

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:
FA A.3. Number and percent of claims paid for services that are specified in the participant's approved service plan. Numerator: Number of claims paid during review period due to services having been identified on the approved service plan. Denominator: Number of claims submitted

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:
FSSA Operations and Fiscal Agent

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:

b. ***Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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:
FA B.1. Number and percent of rates for waiver services adhering to reimbursement methodology in the approved waiver. Numerator: Total number of waiver rates that follow the approved methodology. Denominator: Total number of waiver rates.

Data Source (Select one):
Financial records (including expenditures)
If 'Other' is selected, specify:

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:

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 Community Integration and Habilitation 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.
FA A.1., FA A.2., and FA A.3. Claims reimbursement issues may be identified by a case manager, the public, a provider, contractor, or FSSA staff.

For individual cases, FSSA's Operations division and/or the Medicaid Fiscal Contractor, FSSA's Provider Relations staff, or FSSA's Office of Compliance, address the problem to resolution. This may include individual provider training, recoupment of inappropriately paid monies and if warranted, placing the provider on prepayment review monitoring for future claims submissions. If there is a billing issue involving multiple providers, FSSA will work with the Medicaid Fiscal Contractor and/or FSSA's SUR unit within the Office of Compliance, to produce an educational clarification bulletin and/or conduct training to resolve billing issues.

If the issue is identified as a systems issue, the FSSA's Division of Healthcare Strategies and Technology will extract pertinent claims data to verify the problem and determine correction needed.

If the problem indicates a larger systemic issue, it is referred to the Change Control Board for a systems fix.

Each party responsible for addressing individual problems maintains documentation of the issue and the individual resolution. Meeting minutes are maintained as applicable. Depending on the magnitude of the issue, it may be resolved directly with the provider or the participant.

FA B.1. Financial records will be used to verify that reimbursement for services is paid at the approved rate, and therefore, using the approved rate methodology.

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).

SPECIFIC TO THE 1ST AMENDMENT OF THE 3RD RENEWAL CYCLE, IN.0378,R03.01:

EXTENDED SERVICES:
Indiana replaced Supported Employment Follow Along (SEFA) services with Extended Services. The rate for Extended Services is based on the pre-existing hourly rate for Supported Employment Follow Along (SEFA) services within DDRS/BDDS and closely mirrors the recently announced rate for Supported Employment services available under the Rehabilitation Act of 1973 through the Vocational Rehabilitation Services program within DDRS' Bureau of Rehabilitation Services. SEFA under the current waiver will be replaced by Extended Services in the Renewal.

This rate is based on a requirement that the provider meet certain minimal standards of accreditation and certification. In order to qualify to provide Extended Services a provider must be accredited through one (or more) of four national accrediting organizations. Providers must also meet the standards as a Community Rehabilitation Provider as outlined in Indiana Code which sets a higher standard of knowledge and competency than services with lower rates which are performed by non-certified providers.

RHS DAILY:
Over the past several months (2014), DDRS has been working with a group of residential waiver providers to develop a daily rate for residential habilitation and support services. The group focused on how to reduce the administrative burden of providing services on an hourly basis and thus enhance outcomes and community participation for individuals receiving this service. The conclusion of the group was that a residential habilitation service that utilized a daily rate would greatly benefit a specific subset of individuals who met certain criteria.

The group collaboratively presented a summary of the costs of residential services within the industry that included salaries, benefits and administrative expenses. The group then developed a service definition and rate methodology that would fully address improved outcomes and community integration.

The State then reviewed these rates for cost effectiveness and cost neutrality and has found that they support the goals of increasing community participation and decreasing administrative burden. A final daily rate was derived after State and actuarial analysis of actual expenditures for serving consumers at Algo levels 3, 4 and 5 on an hourly basis.

ONGOING FOR ALL RENEWALS AND AMENDMENTS:
FSSA 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.

The current Rate Determination Methods were carried forward from the prior renewal and will remain in effect for this waiver as described below. FSSA's 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 actual 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. The standardized rate system was implemented in CY 2009.

Explanations of the existing Rate Development Tasks & Timelines, and the Rate Methodology are as follows:

RATE DEVELOPMENT TASKS & TIMELINES

The provider reimbursement rate initiative involved three key tasks. These tasks were: reimbursement rate methodology review and evaluation; rate development and testing; and rate revision and implementation. A description of each task is as follows:

1. Reimbursement Rate Methodology Review and Evaluation: DDRS conducted 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 involved 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 / standard fee schedule identified critical cost factors and relevant pricing benchmarks.
This fee schedule together with service utilization standards served as the basis for calibration of the Inventory for Client and Agency Planning (ICAP) to resource allocation levels. 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 its Medicaid Home and Community-Based Services (HCBS) waiver program.
There were 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 / environmental modifications and transportation, all provider reimbursement 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 & Administrative Expenses: General and Administrative costs 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.

Historical expenditures were used by DDRS as the basis for transportation rates. The average cost per person was

utilized and, at the time of the 2009 then "DD Waiver" Renewal, 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 (then DD or Autism) Waivers. Note that the DD and Autism Waivers have since been combined and renamed as the Community Integration and Habilitation Waiver.

Rate Component #3 - Other Factors: In addition, standardized cost centers were applied.

At the time of the third amendment of the prior renewal, IN.0378.R02.03, 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.

At the time of the fifth amendment of the prior renewal, IN.0378.R02.05, Wellness Coordination was added as a standalone service among the array of available services. At the request of the operating agency, industry leaders collaboratively presented a summary of the costs of Registered Nursing (RN) and Licensed Practical Nursing (LPN) services within the industry. The cost centers presented for nursing services included salary, benefits, travel reimbursement, office space/phone/utilities, office supplies, medical assessment and treatment supplies, computer equipment/access, photocopy expenses, Liability Insurance and Continuing Education Unit expenses. Further consideration was given to the typical number of paid hours as well as to those costs associated with sick time, holiday leave, paid time off and training expenses. As presented, the template for nurse coverage assumed a staffing pattern employing nurses at the ratio of two (2) LPNs per one (1) RN, which may be adjusted depending on wellness needs of the client population. A monthly rate was derived from averaging the hourly costs to employ two LPNs per one RN, and dividing the total cost for an hour of service by the total number of nurses (three for purposes of the rate calculation) providing those service hours.

The State reviewed the cost per billable hour presented by the industry in establishing the monthly rate for each tier of Wellness Coordination services. Labor and other costs were consistent with publicly available data for LPN and RN total compensation and other identified costs used to calculate the reimbursement rate.

There have been no changes to the rate methodology from the prior renewal to the current renewal.

Addendum:
The Medicaid agency now solicits public input on rate determination methods through collaboration with industry leaders in the collection and review of costs associated with the various service components. At any time, public comments may be received via the BQIS Helpline at BQISHelp@fssa.in.gov.

Information about payment rates is made available to waiver participants by their Case Manager. Current rates are continuously posted on the DDRS/BDDS website at:

http://www.in.gov/fssa/files/RatesChartDDRSWaivers.pdf

Prior to any rate changes, a bulletin of the rates is posted to IndianaMedicaid.com to advise providers of the rate changes. Once the changes occur, manuals are updated regularly to reflect the changed rates.

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 Community Integration and Habilitation Waiver contains only those reimbursable services from the Individualized Support Plan (ISP) that are available under the Community Integration and Habilitation Waiver.

FSSA/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 Community Integration and Habilitation 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 Community Integration and Habilitation Waiver services. The case management data system will not allow the addition of services beyond those services offered under the Community Integration and Habilitation 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 FSSA's BQIS as well as by the FSSA's Operations and FSSA's SUR Unit 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 FSSA's DDRS. 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:

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*:

- [x] **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:

a) The State uses the following method 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.

• Room and board expenses of non-related, live-in caregivers are based on an estimate of the cost of food and housing in typical two and three bedroom apartments. The amount paid for live-in caregiver will be up to the federal benefit level under SSI for an individual living in the home of another, or actual expenses, whichever is the lesser amount

b) This service must be an approved service and included in the Plan of Care/Cost Comparison Budget (POC/CCB) in order to be reimbursed through the Medicaid MMIS.

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-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: ICF/IID

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	60469.77	9544.39	70014.16	83065.05	5007.05	88072.10	18057.94
2	62984.57	9926.17	72910.74	85557.00	5207.33	90764.33	17853.59
3	64235.61	10323.22	74558.83	88123.71	5415.62	93539.33	18980.50
4	65518.88	10736.15	76255.03	90767.42	5632.24	96399.66	20144.63
5	66823.39	11165.60	77988.99	93490.44	5857.53	99347.97	21358.98

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 Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		ICF/IID
Year 1	9244	9244

Waiver Year	Total Unduplicated Number of Participants (from Item B -3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		ICF/IID	
Year 2	9901	9901	
Year 3	10499	10499	
Year 4	11124	11124	
Year 5	11776	11776	

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.

The amendment does not reflect any changes in average length of stay.

Projected average length of stay has been updated for the third renewal to reflect actual experience during WY 4 and updated new entrant projections.

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:

Base Year data was from Waiver Year 4 of the second renewal: October 1, 2012 - September 30, 2013.

Factor D for Waiver Year 1 of the third renewal was projected from WY 4, second renewal data in the following manner:

• Unduplicated users were projected to increase proportionately with total slots.
• Average units per user were projected to vary with average length of stay.
• Average cost per unit for WY 1 of the third renewal is illustrated at current (June 2014) reimbursement levels. This includes rate increases effective January 1, 2014: rates increased by 2% for Residential Habilitation, Respite Services and Individual Facility and Community habilitation. There was no rate increase for other services.
• From WY 1, average cost per unit was increased by 2% per year for WY 2 and subsequent years.
Adjustments for recently added services: The following services were new or recently modified, so projections for the third renewal were developed as follows:
• Facility Support: Utilization of this service began in December 2012. Expenditures from the April 2013 through March 2014 period has been used to develop projections for the renewal.
• Transportation: This service was split into three Tiers effective October 2012, and expenditures took several months to stabilize. Expenditures from the April 2013 through March 2014 period has been used to develop projections for the renewal.
• Wellness Coordination: This service began April 2014, and is a flat monthly payment, stratified by algorithm (acuity) level. We have assumed this payment will be made for all eligible enrollees.

First amendment: The following services were amended as described in the previous section, with projected implementation as of April 1, 2015:

• RHS Daily: This service will replace Residential Habilitation Services (RHS) and Electronic Monitoring for waiver clients with algo levels 3 to 5, who are living in shared settings. This excludes those living alone or

with family.
• Extended Services: This service will replace the Supported Employment Follow Along (SEFA) service. Indiana is expecting SEFA clients to transition to Extended Services.
• Adult Day Services: The half day rate for this service will be no longer be available, but all current recipients are expected to transition to the quarter hour rate for the same service.

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 updated to Waiver Year 4 of the second renewal: October 1, 2012 - September 30, 2013.

Base year data was trended at 4.0% per year. The trend has been reduced from the 6% assumption used for the second renewal. This was done in order to reflect recent historical experience, and is consistent with a reduction in trend rates used for Indiana Medicaid budgeting and forecasting.

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 updated to Waiver Year 4 of the second renewal: October 1, 2012 - September 30, 2013.

Over the last twenty years, Indiana has closed its State ICF/ID facilities. As of SFY 1997, there were approximately 1,200 residents of State Facilities. To accommodate displaced residents of State Facilities, Indiana opened small group homes with special support: Extensive Support Needs (ESN) group homes and Medically Fragile group homes (MFGH). Combined, these homes serve approximately 160 residents. The remainder of displaced State Facility residents are being served in the community, primarily on the CIHW.

To recognize the large number of waiver participants with intense needs, the CIHW population was divided into two groups: those who had transitioned from State Facilities (Transitions) and those who were diverted from entering an ICF/ID facility through access to waiver services (Diversions).

Factor G for the Transition group was developed by trending the historical Factor G from the closed State Facility from which each participant had transitioned. Each Factor G was selected from a base time period that reflected the cost of care when the facility was at full capacity (i.e. prior to the impact of downsizing and closing the facility). Each Factor G was trended by 4% per year through the period of the second renewal. This trend was reduced to 3% per year for the time period of the third renewal, consistent with the change in trend assumption for all ICF/ID facilities.

Factor G for the Diversion group was developed from incurred experience during the base period. For this purpose, experience was limited to ICF/ID expenditures excluding residents of State Facilities, ESN homes, and MFGH facilities. This is intended to represent the cost of care for less complex ICF/ID residents.

The composite Factor G was developed as a weighted average (by base year waiver enrollment) of Factor G costs for the Transition Group (9.7%) and the Diversion Group (90.3%).

Base year data is from Waiver Year 4 of the second renewal: October 2012 through September 2013.

The composite Factor G was inflated forward at 3.0% per year. The trend has been reduced from 4% assumption used for the second renewal. This was done in order to reflect recent historical experience, and is consistent with a reduction in trend rates used for Indiana Medicaid budgeting and forecasting.

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 updated to Waiver Year 4 of the second renewal: October 1, 2012 - September 30, 2013.

Base year data was trended at 4.0% per year. The trend has been reduced from the 6% assumption used for the second renewal. This was done in order to reflect recent historical experience, and is consistent with a reduction in trend rates used for Indiana Medicaid budgeting and forecasting. It remains consistent with the annual trend used for Factor D`.

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	
Rent and Food for Unrelated Live-in Caregiver	
Residential Habilitation and Support - Daily (RHS Daily)	
Residential Habilitation and Support	
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	
Community Transition	
Electronic Monitoring	
Environmental Modifications	
Extended Services	
Facility Based Habilitation - Group	
Facility Based Habilitation - Individual	
Facility Based Support Services	
Family and Caregiver Training	
Intensive Behavioral Intervention	
Music Therapy	
Personal Emergency Response System	
Recreational Therapy	
Specialized Medical Equipment and Supplies	
Structured Family Caregiving (previously known as Adult Foster Care)	
Transportation	
Wellness Coordination	
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:						**1459717.92**
Adult Day Service - half day - Level 3	half day	122	113.00	34.23	**471894.78**	
Adult Day Service - 1/4 hour - Level 3	1/4 hour	122	1807.00	2.14	**471771.56**	
Adult Day Service - 1/4 hour - Level 1	1/4 hour	50	1746.00	1.38	**120474.00**	
Adult Day Service - half day - Level 1	half day	50	110.00	21.91	**120505.00**	
Adult Day Service - half day - Level 2	half day	51	94.00	28.77	**137923.38**	
Adult Day Service - 1/4 hour - Level 2	1/4 hour	51	1494.00	1.80	**137149.20**	
Case Management Total:						**12694359.37**
Case Management	month	9233	11.00	124.99	**12694359.37**	
Prevocational Services Total:						**11209395.84**
Prevocational Services-Small Group	hour	1383	64.00	8.30	**734649.60**	
Prevocational Services-Medium Group	hour	2576	776.00	4.65	**9295238.40**	
Prevocational Services-Large Group	hour	1596	248.00	2.98	**1179507.84**	
Rent and Food for Unrelated Live-in Caregiver Total:						**8720.00**
Rent and Food for Unrelated Live-in Caregiver	month	2	8.00	545.00	**8720.00**	
Residential Habilitation and Support - Daily (RHS Daily) Total:						**157249207.92**
RHS Daily - Algo 3, 2-person	day	411	168.00	155.30	**10723154.40**	
RHS Daily - Algo 3, 3-person	day	702	168.00	155.30	**18315460.80**	
RHS Daily - Algo 3, 4-person	day	315	168.00	145.34	**7691392.80**	
RHS Daily - Algo 4, 2-person	day	731	168.00	219.01	**26896180.08**	
RHS Daily - Algo 4, 3-person	day	1111	168.00	201.09	**37533046.32**	
RHS Daily - Algo 4, 4-person	day	475	168.00	187.15	**14934570.00**	

GRAND TOTAL:	**558982523.26**
Total Estimated Unduplicated Participants:	**9244**
Factor D (Divide total by number of participants):	**60469.77**
Average Length of Stay on the Waiver:	343

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
RHS Daily - Algo 5, 2-person	day	385	168.00	238.92	15453345.60	
RHS Daily - Algo 5, 3-person	day	514	168.00	219.01	18911951.52	
RHS Daily - Algo 5, 4-person	day	203	168.00	199.10	6790106.40	
Residential Habilitation and Support Total:						269581038.82
Level 1 Residential Habilitation and Support - 35 hours or less/week	hour	2279	654.00	23.21	34593715.86	
Level 2 Residential Habilitation and Support - more than 35 hours/week	hour	6838	1756.00	19.57	234987322.96	
Respite Total:						7805207.35
Respite	hour	1329	247.00	22.89	7513940.07	
Respite Nursing Care (LPN)	1/4 hour	14	1807.00	5.86	148246.28	
Respite Nursing Care (RN)	1/4 hour	17	1175.00	7.16	143021.00	
Supported Employment Follow Along Total:						543775.96
Supported Employment Follow Along - Tier 1	month	374	4.00	175.68	262817.28	
Supported Employment Follow Along - Tier 2	month	133	4.00	351.82	187168.24	
Supported Employment Follow Along - Tier 3	month	24	3.00	527.85	38005.20	
Supported Employment Follow Along - Tier 4	month	47	42.00	28.26	55785.24	
Occupational Therapy Total:						2734.48
Occupational Therapy	1/4 hour	2	76.00	17.99	2734.48	
Physical Therapy Total:						561.72
Physical Therapy	1/4 hour	1	31.00	18.12	561.72	
Psychological Therapy Total:						8683.59
Psychological Therapy - Family	1/4 hour	1	1.00	17.27	17.27	
Psychological Therapy - Group	1/4 hour	47	19.00	3.44	3071.92	
Psychological Therapy - Individual	1/4 hour	48	15.00	7.77	5594.40	

GRAND TOTAL:	558982523.26
Total Estimated Unduplicated Participants:	9244
Factor D (Divide total by number of participants):	60469.77
Average Length of Stay on the Waiver:	343

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Speech /Language Therapy Total:						**70632.00**
Speech /Language Therapy	1/4 hour	18	218.00	18.00	**70632.00**	
Behavioral Support Services Total:						**30235344.96**
Behavior Support Services - Level 1	1/4 hour	4928	9.00	17.91	**794344.32**	
Behavior Support Services - Level 2	1/4 hour	5963	278.00	17.76	**29441000.64**	
Community Based Habilitation - Group Total:						**2490684.24**
Community Based Habilitation - small group	hour	1892	155.00	8.37	**2454586.20**	
Community Based Habilitation - medium group	hour	276	29.00	4.51	**36098.04**	
Community Based Habilitation - Individual Total:						**20758283.52**
Community Based Habilitation-Individual	hour	5408	174.00	22.06	**20758283.52**	
Community Transition Total:						**138398.52**
Community Transition	unit	158	1.00	875.94	**138398.52**	
Electronic Monitoring Total:						**1203590.99**
Electronic Monitoring	hour	119	1223.00	8.27	**1203590.99**	
Environmental Modifications Total:						**328982.15**
Environmental Modifications-Maintain	unit	7	1.00	458.92	**3212.44**	
Environmental Modifications - Equipment/Assessment/Inspection	unit	1	1.00	17.99	**17.99**	
Environmental Modifications - Install	unit	62	1.00	5254.06	**325751.72**	
Extended Services Total:						**539990.55**
Extended Services	hour	495	31.00	35.19	**539990.55**	
Facility Based Habilitation - Group Total:						**13119169.55**
Facility Based Habilitation - Small Group	hour	2954	348.00	8.32	**8552893.44**	
Facility Based Habilitation - Medium Group	hour	2281	425.00	4.67	**4527214.75**	
Facility Based Habilitation - Large Group	hour	568	23.00	2.99	**39061.36**	

GRAND TOTAL:	**558982523.26**
Total Estimated Unduplicated Participants:	**9244**
Factor D (Divide total by number of participants):	**60469.77**
Average Length of Stay on the Waiver:	343

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Facility Based Habilitation - Individual Total:						**3268454.00**
Facility Based Habilitation - Individual	hour	1240	119.00	22.15	**3268454.00**	
Facility Based Support Services Total:						**11648.00**
Facility Based Support Services	hour	16	400.00	1.82	**11648.00**	
Family and Caregiver Training Total:						**2200.00**
Family and Caregiver Training	unit	2	1.00	1100.00	**2200.00**	
Intensive Behavioral Intervention Total:						**129.60**
Intensive Behavior Intervention - Level 1	hour	1	1.00	104.60	**104.60**	
Intensive Behavior Intervention - Level 2 direct care staff	hour	1	1.00	25.00	**25.00**	
Music Therapy Total:						**2554428.60**
Music Therapy	1/4 hour	1340	177.00	10.77	**2554428.60**	
Personal Emergency Response System Total:						**83262.60**
Personal Emergency Response System-Install	unit/month	18	2.00	39.70	**1429.20**	
Personal Emergency Response System-Maintain	unit/month	198	10.00	41.33	**81833.40**	
Recreational Therapy Total:						**1222555.68**
Recreational Therapy	1/4 hour	459	248.00	10.74	**1222555.68**	
Specialized Medical Equipment and Supplies Total:						**52757.50**
Specialized Medical Equipment and Supplies	unit	25	1.00	2110.30	**52757.50**	
Structured Family Caregiving (previously known as Adult Foster Care) Total:						**6894909.27**
Level 1 Structured Family Caregiving (formerly Adult Foster Care Level 1)	day	51	273.00	51.79	**721072.17**	
Level 2 Structured Family Caregiving (formerly Adult Foster Care Level 2)	day	136	294.00	75.67	**3025589.28**	
Level 3 Structured Family Caregiving (formerly Adult Foster Care Level 3)	day	122	251.00	102.81	**3148247.82**	
Transportation Total:						**8132023.86**
Level 1 Transportation					**6153446.46**	

GRAND TOTAL:	**558982523.26**
Total Estimated Unduplicated Participants:	**9244**
Factor D (Divide total by number of participants):	**60469.77**
Average Length of Stay on the Waiver:	343

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	trip	5033	246.00	4.97		
Level 3 Transportation	trip	2	123.00	40.00	**9840.00**	
Level 2 Transportation	trip	643	162.00	18.90	**1968737.40**	
Wellness Coordination Total:						**7246010.64**
Wellness Coordination - Tier I	Month	1688	11.00	52.77	**979833.36**	
Wellness Coordination - Tier II	Month	4276	11.00	111.96	**5266150.56**	
Wellness Coordination - Tier III	Month	406	11.00	223.92	**1000026.72**	
Workplace Assistance Total:						**65664.06**
Workplace Assistance	hour	14	183.00	25.63	**65664.06**	
				GRAND TOTAL:		**558982523.26**
				Total Estimated Unduplicated Participants:		**9244**
				Factor D (Divide total by number of participants):		**60469.77**
				Average Length of Stay on the Waiver:		343

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:						**1609902.05**
Adult Day Service - half day - Level 3	half day	0	0.00	0.01	**0.00**	
Adult Day Service - 1/4 hour - Level 3	1/4 hour	131	3647.00	2.18	**1041510.26**	
Adult Day Service - 1/4 hour - Level 1	1/4 hour	53	3523.00	1.41	**263273.79**	
Adult Day Service - half day - Level 1	half day	0	0.00	0.01	**0.00**	
Adult Day Service - half day - Level 2	half day	0	0.00	0.01	**0.00**	
				GRAND TOTAL:		**623610179.18**
				Total Estimated Unduplicated Participants:		**9901**
				Factor D (Divide total by number of participants):		**62984.57**
				Average Length of Stay on the Waiver:		346

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Service - 1/4 hour - Level 2	1/4 hour	55	3015.00	1.84	305118.00	
Case Management Total:						13868234.71
Case Management	month	9889	11.00	127.49	13868234.71	
Prevocational Services Total:						12328390.60
Prevocational Services-Small Group	hour	1481	64.00	8.47	802820.48	
Prevocational Services-Medium Group	hour	2759	782.00	4.74	10226730.12	
Prevocational Services-Large Group	hour	1709	250.00	3.04	1298840.00	
Rent and Food for Unrelated Live-in Caregiver Total:						8894.40
Rent and Food for Unrelated Live-in Caregiver	month	2	8.00	555.90	8894.40	
Residential Habilitation and Support - Daily (RHS Daily) Total:						347781576.60
RHS Daily - Algo 3, 2-person	day	440	340.00	158.40	23696640.00	
RHS Daily - Algo 3, 3-person	day	752	340.00	158.40	40499712.00	
RHS Daily - Algo 3, 4-person	day	338	340.00	148.25	17036890.00	
RHS Daily - Algo 4, 2-person	day	783	340.00	223.39	59470885.80	
RHS Daily - Algo 4, 3-person	day	1189	340.00	205.11	82917768.60	
RHS Daily - Algo 4, 4-person	day	509	340.00	190.90	33037154.00	
RHS Daily - Algo 5, 2-person	day	413	340.00	243.70	34220354.00	
RHS Daily - Algo 5, 3-person	day	551	340.00	223.39	41849882.60	
RHS Daily - Algo 5, 4-person	day	218	340.00	203.08	15052289.60	
Residential Habilitation and Support Total:						135815412.04
Level 1 Residential Habilitation and Support - 35 hours or less/week	hour	2253	689.00	23.67	36743343.39	
Level 2 Residential Habilitation and Support - more than 35 hours/week	hour	2315	2143.00	19.97	99072068.65	
Respite Total:						8598492.00

GRAND TOTAL:	623610179.18
Total Estimated Unduplicated Participants:	9901
Factor D (Divide total by number of participants):	62984.57
Average Length of Stay on the Waiver:	346

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite	hour	1424	249.00	23.35	8279349.60	
Respite Nursing Care (LPN)	1/4 hour	15	1822.00	5.98	163433.40	
Respite Nursing Care (RN)	1/4 hour	18	1185.00	7.30	155709.00	
Supported Employment Follow Along Total:						0.00
Supported Employment Follow Along - Tier 1	month	0	0.00	0.01	0.00	
Supported Employment Follow Along - Tier 2	month	0	0.00	0.01	0.00	
Supported Employment Follow Along - Tier 3	month	0	0.00	0.01	0.00	
Supported Employment Follow Along - Tier 4	month	0	0.00	0.01	0.00	
Occupational Therapy Total:						2825.90
Occupational Therapy	1/4 hour	2	77.00	18.35	2825.90	
Physical Therapy Total:						572.88
Physical Therapy	1/4 hour	1	31.00	18.48	572.88	
Psychological Therapy Total:						9823.00
Psychological Therapy - Family	1/4 hour	1	1.00	17.62	17.62	
Psychological Therapy - Group	1/4 hour	50	19.00	3.51	3334.50	
Psychological Therapy - Individual	1/4 hour	51	16.00	7.93	6470.88	
Speech /Language Therapy Total:						76744.80
Speech /Language Therapy	1/4 hour	19	220.00	18.36	76744.80	
Behavioral Support Services Total:						33268035.57
Behavior Support Services - Level 1	1/4 hour	5279	9.00	18.27	868025.97	
Behavior Support Services - Level 2	1/4 hour	6386	280.00	18.12	32400009.60	
Community Based Habilitation - Group Total:						2738471.24
Community Based Habilitation - small group	hour	2026	156.00	8.54	2699118.24	

GRAND TOTAL:	623610179.18
Total Estimated Unduplicated Participants:	9901
Factor D (Divide total by number of participants):	62984.57
Average Length of Stay on the Waiver:	346

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Based Habilitation - medium group	hour	295	29.00	4.60	39353.00	
Community Based Habilitation - Individual Total:						18114480.00
Community Based Habilitation-Individual	hour	5792	139.00	22.50	18114480.00	
Community Transition Total:						150994.74
Community Transition	unit	169	1.00	893.46	150994.74	
Electronic Monitoring Total:						754882.04
Electronic Monitoring	hour	47	1903.00	8.44	754882.04	
Environmental Modifications Total:						362357.43
Environmental Modifications-Maintain	unit	7	1.00	468.10	3276.70	
Environmental Modifications - Equipment/Assessment/Inspection	unit	1	1.00	18.35	18.35	
Environmental Modifications - Install	unit	67	1.00	5359.14	359062.38	
Extended Services Total:						1179345.40
Extended Services	hour	530	62.00	35.89	1179345.40	
Facility Based Habilitation - Group Total:						14457133.44
Facility Based Habilitation - Small Group	hour	3163	351.00	8.49	9425708.37	
Facility Based Habilitation - Medium Group	hour	2443	429.00	4.76	4988703.72	
Facility Based Habilitation - Large Group	hour	609	23.00	3.05	42721.35	
Facility Based Habilitation - Individual Total:						3601536.00
Facility Based Habilitation - Individual	hour	1328	120.00	22.60	3601536.00	
Facility Based Support Services Total:						12674.35
Facility Based Support Services	hour	17	403.00	1.85	12674.35	
Family and Caregiver Training Total:						2244.00
Family and Caregiver Training	unit	2	1.00	1122.00	2244.00	
Intensive Behavioral Intervention Total:						132.19

GRAND TOTAL:	623610179.18
Total Estimated Unduplicated Participants:	9901
Factor D (Divide total by number of participants):	62984.57
Average Length of Stay on the Waiver:	346

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Intensive Behavior Intervention - Level 1	hour	1	1.00	106.69	106.69	
Intensive Behavior Intervention - Level 2 direct care staff	hour	1	1.00	25.50	25.50	
Music Therapy Total:						**2807175.70**
Music Therapy	1/4 hour	1435	178.00	10.99	2807175.70	
Personal Emergency Response System Total:						**91339.42**
Personal Emergency Response System-Install	unit/month	19	2.00	40.49	1538.62	
Personal Emergency Response System-Maintain	unit/month	213	10.00	42.16	89800.80	
Recreational Therapy Total:						**1346850.00**
Recreational Therapy	1/4 hour	492	250.00	10.95	1346850.00	
Specialized Medical Equipment and Supplies Total:						**58117.77**
Specialized Medical Equipment and Supplies	unit	27	1.00	2152.51	58117.77	
Structured Family Caregiving (previously known as Adult Foster Care) Total:						**7621439.32**
Level 1 Structured Family Caregiving (formerly Adult Foster Care Level 1)	day	55	275.00	52.83	799053.75	
Level 2 Structured Family Caregiving (formerly Adult Foster Care Level 2)	day	146	297.00	77.18	3346679.16	
Level 3 Structured Family Caregiving (formerly Adult Foster Care Level 3)	day	131	253.00	104.87	3475706.41	
Transportation Total:						**8952702.05**
Level 1 Transportation	trip	5391	248.00	5.07	6778427.76	
Level 3 Transportation	trip	2	124.00	40.80	10118.40	
Level 2 Transportation	trip	689	163.00	19.27	2164155.89	
Wellness Coordination Total:						**7916861.04**
Wellness Coordination - Tier I	Month	1808	11.00	53.83	1070571.04	
Wellness Coordination - Tier II	Month	4580	11.00	114.20	5753396.00	
Wellness Coordination - Tier III	Month	435	11.00	228.40	1092894.00	

GRAND TOTAL:	**623610179.18**
Total Estimated Unduplicated Participants:	**9901**
Factor D (Divide total by number of participants):	**62984.57**
Average Length of Stay on the Waiver:	346

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Workplace Assistance Total:						**72538.50**
Workplace Assistance	hour	15	185.00	26.14	**72538.50**	
				GRAND TOTAL:		**623610179.18**
				Total Estimated Unduplicated Participants:		**9901**
				Factor D (Divide total by number of participants):		**62984.57**
				Average Length of Stay on the Waiver:		346

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:						**1746635.33**
Adult Day Service - half day - Level 3	half day	0	0.00	0.01	**0.00**	
Adult Day Service - 1/4 hour - Level 3	1/4 hour	139	3647.00	2.23	**1130460.59**	
Adult Day Service - 1/4 hour - Level 1	1/4 hour	57	3523.00	1.44	**289167.84**	
Adult Day Service - half day - Level 1	half day	0	0.00	0.01	**0.00**	
Adult Day Service - half day - Level 2	half day	0	0.00	0.01	**0.00**	
Adult Day Service - 1/4 hour - Level 2	1/4 hour	58	3015.00	1.87	**327006.90**	
Case Management Total:						**14999593.84**
Case Management	month	10486	11.00	130.04	**14999593.84**	
Prevocational Services Total:						**13347781.08**
Prevocational Services-Small Group	hour	1570	64.00	8.64	**868147.20**	
Prevocational Services-Medium Group	hour	2926	782.00	4.84	**11074558.88**	
Prevocational Services-Large Group	hour				**1405075.00**	
				GRAND TOTAL:		**674409705.96**
				Total Estimated Unduplicated Participants:		**10499**
				Factor D (Divide total by number of participants):		**64235.61**
				Average Length of Stay on the Waiver:		346

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		1813	250.00	3.10		
Rent and Food for Unrelated Live-in Caregiver Total:						**13608.48**
Rent and Food for Unrelated Live-in Caregiver	month	3	8.00	567.02	**13608.48**	
Residential Habilitation and Support - Daily (RHS Daily) Total:						**376124972.80**
RHS Daily - Algo 3, 2-person	day	467	340.00	161.57	**25654084.60**	
RHS Daily - Algo 3, 3-person	day	797	340.00	161.57	**43782238.60**	
RHS Daily - Algo 3, 4-person	day	358	340.00	151.21	**18405281.20**	
RHS Daily - Algo 4, 2-person	day	830	340.00	227.86	**64302092.00**	
RHS Daily - Algo 4, 3-person	day	1261	340.00	209.22	**89700982.80**	
RHS Daily - Algo 4, 4-person	day	540	340.00	194.72	**35750592.00**	
RHS Daily - Algo 5, 2-person	day	438	340.00	248.57	**37017044.40**	
RHS Daily - Algo 5, 3-person	day	584	340.00	227.86	**45243881.60**	
RHS Daily - Algo 5, 4-person	day	231	340.00	207.14	**16268775.60**	
Residential Habilitation and Support Total:						**146850230.34**
Level 1 Residential Habilitation and Support - 35 hours or less/week	hour	2389	689.00	24.14	**39734946.94**	
Level 2 Residential Habilitation and Support - more than 35 hours/week	hour	2455	2143.00	20.36	**107115283.40**	
Respite Total:						**9286771.65**
Respite	hour	1510	249.00	23.81	**8952321.90**	
Respite Nursing Care (LPN)	1/4 hour	15	1822.00	6.10	**166713.00**	
Respite Nursing Care (RN)	1/4 hour	19	1185.00	7.45	**167736.75**	
Supported Employment Follow Along Total:						**0.00**
Supported Employment Follow Along - Tier 1	month	0	0.00	0.01	**0.00**	
Supported Employment Follow Along - Tier 2	month	0	0.00	0.01	**0.00**	

GRAND TOTAL:	**674409705.96**
Total Estimated Unduplicated Participants:	**10499**
Factor D (Divide total by number of participants):	**64235.61**
Average Length of Stay on the Waiver:	346

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supported Employment Follow Along - Tier 3	month	0	0.00	0.01	0.00	
Supported Employment Follow Along - Tier 4	month	0	0.00	0.01	0.00	
Occupational Therapy Total:						4324.32
Occupational Therapy	1/4 hour	3	77.00	18.72	4324.32	
Physical Therapy Total:						584.35
Physical Therapy	1/4 hour	1	31.00	18.85	584.35	
Psychological Therapy Total:						10604.15
Psychological Therapy - Family	1/4 hour	1	1.00	17.97	17.97	
Psychological Therapy - Group	1/4 hour	53	19.00	3.58	3605.06	
Psychological Therapy - Individual	1/4 hour	54	16.00	8.08	6981.12	
Speech /Language Therapy Total:						86532.60
Speech /Language Therapy	1/4 hour	21	220.00	18.73	86532.60	
Behavioral Support Services Total:						35979485.79
Behavior Support Services - Level 1	1/4 hour	5597	9.00	18.63	938448.99	
Behavior Support Services - Level 2	1/4 hour	6772	280.00	18.48	35041036.80	
Community Based Habilitation - Group Total:						2962546.37
Community Based Habilitation - small group	hour	2149	156.00	8.71	2919975.24	
Community Based Habilitation - medium group	hour	313	29.00	4.69	42571.13	
Community Based Habilitation - Individual Total:						19593287.10
Community Based Habilitation-Individual	hour	6142	139.00	22.95	19593287.10	
Community Transition Total:						163128.07
Community Transition	unit	179	1.00	911.33	163128.07	
Electronic Monitoring Total:						801924.20
Electronic Monitoring	hour	49	1903.00	8.60	801924.20	

GRAND TOTAL:	674409705.96
Total Estimated Unduplicated Participants:	10499
Factor D (Divide total by number of participants):	64235.61
Average Length of Stay on the Waiver:	346

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Environmental Modifications Total:						**391947.12**
Environmental Modifications-Maintain	unit	8	1.00	477.46	**3819.68**	
Environmental Modifications - Equipment/Assessment/Inspection	unit	1	1.00	18.72	**18.72**	
Environmental Modifications - Install	unit	71	1.00	5466.32	**388108.72**	
Extended Services Total:						**1275638.84**
Extended Services	hour	562	62.00	36.61	**1275638.84**	
Facility Based Habilitation - Group Total:						**15646275.69**
Facility Based Habilitation - Small Group	hour	3355	351.00	8.66	**10198059.30**	
Facility Based Habilitation - Medium Group	hour	2591	429.00	4.86	**5402079.54**	
Facility Based Habilitation - Large Group	hour	645	23.00	3.11	**46136.85**	
Facility Based Habilitation - Individual Total:						**3894528.00**
Facility Based Habilitation - Individual	hour	1408	120.00	23.05	**3894528.00**	
Facility Based Support Services Total:						**14471.73**
Facility Based Support Services	hour	19	403.00	1.89	**14471.73**	
Family and Caregiver Training Total:						**3433.32**
Family and Caregiver Training	unit	3	1.00	1144.44	**3433.32**	
Intensive Behavioral Intervention Total:						**134.84**
Intensive Behavior Intervention - Level 1	hour	1	1.00	108.83	**108.83**	
Intensive Behavior Intervention - Level 2 direct care staff	hour	1	1.00	26.01	**26.01**	
Music Therapy Total:						**3034972.98**
Music Therapy	1/4 hour	1521	178.00	11.21	**3034972.98**	
Personal Emergency Response System Total:						**98484.60**
Personal Emergency Response System-Install	unit/month	21	2.00	41.30	**1734.60**	
Personal Emergency Response System-Maintain	unit/month	225	10.00	43.00	**96750.00**	

GRAND TOTAL:	**674409705.96**
Total Estimated Unduplicated Participants:	**10499**
Factor D (Divide total by number of participants):	**64235.61**
Average Length of Stay on the Waiver:	346

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Recreational Therapy Total:						**1457685.00**
Recreational Therapy	1/4 hour	522	250.00	11.17	**1457685.00**	
Specialized Medical Equipment and Supplies Total:						**61475.68**
Specialized Medical Equipment and Supplies	unit	28	1.00	2195.56	**61475.68**	
Structured Family Caregiving (previously known as Adult Foster Care) Total:						**8245183.87**
Level 1 Structured Family Caregiving (formerly Adult Foster Care Level 1)	day	58	275.00	53.88	**859386.00**	
Level 2 Structured Family Caregiving (formerly Adult Foster Care Level 2)	day	155	297.00	78.73	**3624335.55**	
Level 3 Structured Family Caregiving (formerly Adult Foster Care Level 3)	day	139	253.00	106.96	**3761462.32**	
Transportation Total:						**9678491.72**
Level 1 Transportation	trip	5716	248.00	5.17	**7328826.56**	
Level 3 Transportation	trip	2	124.00	41.62	**10321.76**	
Level 2 Transportation	trip	730	163.00	19.66	**2339343.40**	
Wellness Coordination Total:						**8560962.85**
Wellness Coordination - Tier I	Month	1917	11.00	54.90	**1157676.30**	
Wellness Coordination - Tier II	Month	4856	11.00	116.48	**6221895.68**	
Wellness Coordination - Tier III	Month	461	11.00	232.97	**1181390.87**	
Workplace Assistance Total:						**74009.25**
Workplace Assistance	hour	15	185.00	26.67	**74009.25**	
				GRAND TOTAL:		**674409705.96**
				Total Estimated Unduplicated Participants:		**10499**
				Factor D (Divide total by number of participants):		**64235.61**
				Average Length of Stay on the Waiver:		346

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:						**1876859.88**
Adult Day Service - half day - Level 3	half day	0	0.00	0.01	**0.00**	
Adult Day Service - 1/4 hour - Level 3	1/4 hour	147	3647.00	2.27	**1216967.43**	
Adult Day Service - 1/4 hour - Level 1	1/4 hour	60	3523.00	1.46	**308614.80**	
Adult Day Service - half day - Level 1	half day	0	0.00	0.01	**0.00**	
Adult Day Service - half day - Level 2	half day	0	0.00	0.01	**0.00**	
Adult Day Service - 1/4 hour - Level 2	1/4 hour	61	3015.00	1.91	**351277.65**	
Case Management Total:						**16209934.40**
Case Management	month	11110	11.00	132.64	**16209934.40**	
Prevocational Services Total:						**14406335.76**
Prevocational Services-Small Group	hour	1664	64.00	8.81	**938229.76**	
Prevocational Services-Medium Group	hour	3100	782.00	4.93	**11951306.00**	
Prevocational Services-Large Group	hour	1920	250.00	3.16	**1516800.00**	
Rent and Food for Unrelated Live-in Caregiver Total:						**13880.64**
Rent and Food for Unrelated Live-in Caregiver	month	3	8.00	578.36	**13880.64**	
Residential Habilitation and Support - Daily (RHS Daily) Total:						**406490226.60**
RHS Daily - Algo 3, 2-person	day	494	340.00	164.80	**27679808.00**	
RHS Daily - Algo 3, 3-person	day	845	340.00	164.80	**47347040.00**	
RHS Daily - Algo 3, 4-person	day	380	340.00	154.24	**19927808.00**	
RHS Daily - Algo 4, 2-person	day	879	340.00	232.42	**69461041.20**	
RHS Daily - Algo 4, 3-person	day	1336	340.00	213.40	**96934816.00**	
RHS Daily - Algo 4, 4-person	day	572	340.00	198.61	**38625672.80**	
				GRAND TOTAL:		**728831987.98**
				Total Estimated Unduplicated Participants:		**11124**
				Factor D (Divide total by number of participants):		**65518.88**
				Average Length of Stay on the Waiver:		346

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
RHS Daily - Algo 5, 2-person	day	464	340.00	253.54	39998470.40	
RHS Daily - Algo 5, 3-person	day	619	340.00	232.42	48915113.20	
RHS Daily - Algo 5, 4-person	day	245	340.00	211.29	17600457.00	
Residential Habilitation and Support Total:						158722043.28
Level 1 Residential Habilitation and Support - 35 hours or less/week	hour	2531	689.00	24.63	42951247.17	
Level 2 Residential Habilitation and Support - more than 35 hours/week	hour	2601	2143.00	20.77	115770796.11	
Respite Total:						10038581.44
Respite	hour	1600	249.00	24.29	9677136.00	
Respite Nursing Care (LPN)	1/4 hour	16	1822.00	6.22	181325.44	
Respite Nursing Care (RN)	1/4 hour	20	1185.00	7.60	180120.00	
Supported Employment Follow Along Total:						0.00
Supported Employment Follow Along - Tier 1	month	0	0.00	0.01	0.00	
Supported Employment Follow Along - Tier 2	month	0	0.00	0.01	0.00	
Supported Employment Follow Along - Tier 3	month	0	0.00	0.01	0.00	
Supported Employment Follow Along - Tier 4	month	0	0.00	0.01	0.00	
Occupational Therapy Total:						4409.79
Occupational Therapy	1/4 hour	3	77.00	19.09	4409.79	
Physical Therapy Total:						596.13
Physical Therapy	1/4 hour	1	31.00	19.23	596.13	
Psychological Therapy Total:						11425.93
Psychological Therapy - Family	1/4 hour	1	1.00	18.33	18.33	
Psychological Therapy - Group	1/4 hour	56	19.00	3.65	3883.60	
Psychological Therapy - Individual	1/4 hour	57	16.00	8.25	7524.00	

GRAND TOTAL:	728831987.98
Total Estimated Unduplicated Participants:	11124
Factor D (Divide total by number of participants):	65518.88
Average Length of Stay on the Waiver:	346

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Speech /Language Therapy Total:						**92444.00**
Speech /Language Therapy	1/4 hour	22	220.00	19.10	**92444.00**	
Behavioral Support Services Total:						**38884384.79**
Behavior Support Services - Level 1	1/4 hour	5931	9.00	19.01	**1014734.79**	
Behavior Support Services - Level 2	1/4 hour	7175	280.00	18.85	**37869650.00**	
Community Based Habilitation - Group Total:						**3200400.68**
Community Based Habilitation - small group	hour	2277	156.00	8.88	**3154282.56**	
Community Based Habilitation - medium group	hour	332	29.00	4.79	**46118.12**	
Community Based Habilitation - Individual Total:						**21176966.92**
Community Based Habilitation-Individual	hour	6508	139.00	23.41	**21176966.92**	
Community Transition Total:						**176614.50**
Community Transition	unit	190	1.00	929.55	**176614.50**	
Electronic Monitoring Total:						**868833.68**
Electronic Monitoring	hour	52	1903.00	8.78	**868833.68**	
Environmental Modifications Total:						**422088.92**
Environmental Modifications-Maintain	unit	8	1.00	487.01	**3896.08**	
Environmental Modifications - Equipment/Assessment/Inspection	unit	1	1.00	19.09	**19.09**	
Environmental Modifications - Install	unit	75	1.00	5575.65	**418173.75**	
Extended Services Total:						**1377472.60**
Extended Services	hour	595	62.00	37.34	**1377472.60**	
Facility Based Habilitation - Group Total:						**16905810.06**
Facility Based Habilitation - Small Group	hour	3554	351.00	8.83	**11015018.82**	
Facility Based Habilitation - Medium Group	hour	2745	429.00	4.96	**5840920.80**	
Facility Based Habilitation - Large Group	hour	684	23.00	3.17	**49870.44**	

GRAND TOTAL:	**728831987.98**
Total Estimated Unduplicated Participants:	**11124**
Factor D (Divide total by number of participants):	**65518.88**
Average Length of Stay on the Waiver:	346

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Facility Based Habilitation - Individual Total:						**4209230.40**
Facility Based Habilitation - Individual	hour	1492	120.00	23.51	**4209230.40**	
Facility Based Support Services Total:						**15555.80**
Facility Based Support Services	hour	20	403.00	1.93	**15555.80**	
Family and Caregiver Training Total:						**3501.99**
Family and Caregiver Training	unit	3	1.00	1167.33	**3501.99**	
Intensive Behavioral Intervention Total:						**137.53**
Intensive Behavior Intervention - Level 1	hour	1	1.00	111.00	**111.00**	
Intensive Behavior Intervention - Level 2 direct care staff	hour	1	1.00	26.53	**26.53**	
Music Therapy Total:						**3279678.48**
Music Therapy	1/4 hour	1612	178.00	11.43	**3279678.48**	
Personal Emergency Response System Total:						**106679.12**
Personal Emergency Response System-Install	unit/month	22	2.00	42.13	**1853.72**	
Personal Emergency Response System-Maintain	unit/month	239	10.00	43.86	**104825.40**	
Recreational Therapy Total:						**1576050.00**
Recreational Therapy	1/4 hour	553	250.00	11.40	**1576050.00**	
Specialized Medical Equipment and Supplies Total:						**67184.10**
Specialized Medical Equipment and Supplies	unit	30	1.00	2239.47	**67184.10**	
Structured Family Caregiving (previously known as Adult Foster Care) Total:						**8890744.50**
Level 1 Structured Family Caregiving (formerly Adult Foster Care Level 1)	day	61	275.00	54.96	**921954.00**	
Level 2 Structured Family Caregiving (formerly Adult Foster Care Level 2)	day	164	297.00	80.30	**3911252.40**	
Level 3 Structured Family Caregiving (formerly Adult Foster Care Level 3)	day	147	253.00	109.10	**4057538.10**	
Transportation Total:						**10470044.34**
Level 1 Transportation					**7929968.64**	

GRAND TOTAL:	**728831987.98**
Total Estimated Unduplicated Participants:	**11124**
Factor D (Divide total by number of participants):	**65518.88**
Average Length of Stay on the Waiver:	346

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	trip	6056	248.00	5.28		
Level 3 Transportation	trip	2	124.00	42.45	**10527.60**	
Level 2 Transportation	trip	774	163.00	20.05	**2529548.10**	
Wellness Coordination Total:						**9253359.72**
Wellness Coordination - Tier I	Month	2031	11.00	56.00	**1251096.00**	
Wellness Coordination - Tier II	Month	5145	11.00	118.81	**6724051.95**	
Wellness Coordination - Tier III	Month	489	11.00	237.63	**1278211.77**	
Workplace Assistance Total:						**80512.00**
Workplace Assistance	hour	16	185.00	27.20	**80512.00**	
				GRAND TOTAL:		**728831987.98**
				Total Estimated Unduplicated Participants:		**11124**
				Factor D (Divide total by number of participants):		**65518.88**
				Average Length of Stay on the Waiver:		346

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:						**2038026.77**
Adult Day Service - half day - Level 3	half day	0	0.00	0.01	**0.00**	
Adult Day Service - 1/4 hour - Level 3	1/4 hour	156	3647.00	2.32	**1319922.24**	
Adult Day Service - 1/4 hour - Level 1	1/4 hour	64	3523.00	1.49	**335953.28**	
Adult Day Service - half day - Level 1	half day	0	0.00	0.01	**0.00**	
Adult Day Service - half day - Level 2	half day	0	0.00	0.01	**0.00**	
				GRAND TOTAL:		**786912191.18**
				Total Estimated Unduplicated Participants:		**11776**
				Factor D (Divide total by number of participants):		**66823.39**
				Average Length of Stay on the Waiver:		346

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Service - 1/4 hour - Level 2	1/4 hour	65	3015.00	1.95	382151.25	
Case Management Total:						17504090.78
Case Management	month	11762	11.00	135.29	17504090.78	
Prevocational Services Total:						15559411.68
Prevocational Services-Small Group	hour	1761	64.00	8.98	1012081.92	
Prevocational Services-Medium Group	hour	3281	782.00	5.03	12905682.26	
Prevocational Services-Large Group	hour	2033	250.00	3.23	1641647.50	
Rent and Food for Unrelated Live-in Caregiver Total:						14158.32
Rent and Food for Unrelated Live-in Caregiver	month	3	8.00	589.93	14158.32	
Residential Habilitation and Support - Daily (RHS Daily) Total:						438863857.00
RHS Daily - Algo 3, 2-person	day	523	340.00	168.10	29891542.00	
RHS Daily - Algo 3, 3-person	day	894	340.00	168.10	51095676.00	
RHS Daily - Algo 3, 4-person	day	402	340.00	157.32	21502497.60	
RHS Daily - Algo 4, 2-person	day	931	340.00	237.06	75038972.40	
RHS Daily - Algo 4, 3-person	day	1415	340.00	217.67	104721037.00	
RHS Daily - Algo 4, 4-person	day	605	340.00	202.58	41670706.00	
RHS Daily - Algo 5, 2-person	day	491	340.00	258.61	43172353.40	
RHS Daily - Algo 5, 3-person	day	655	340.00	237.06	52793262.00	
RHS Daily - Algo 5, 4-person	day	259	340.00	215.51	18977810.60	
Residential Habilitation and Support Total:						171381472.73
Level 1 Residential Habilitation and Support - 35 hours or less/week	hour	2679	689.00	25.12	46367274.72	
Level 2 Residential Habilitation and Support - more than 35 hours/week	hour	2753	2143.00	21.19	125014198.01	
Respite Total:						10844600.12

GRAND TOTAL:	786912191.18
Total Estimated Unduplicated Participants:	11776
Factor D (Divide total by number of participants):	66823.39
Average Length of Stay on the Waiver:	346

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite	hour	1693	249.00	24.78	10446182.46	
Respite Nursing Care (LPN)	1/4 hour	17	1822.00	6.34	196375.16	
Respite Nursing Care (RN)	1/4 hour	22	1185.00	7.75	202042.50	
Supported Employment Follow Along Total:						0.00
Supported Employment Follow Along - Tier 1	month	0	0.00	0.01	0.00	
Supported Employment Follow Along - Tier 2	month	0	0.00	0.01	0.00	
Supported Employment Follow Along - Tier 3	month	0	0.00	0.01	0.00	
Supported Employment Follow Along - Tier 4	month	0	0.00	0.01	0.00	
Occupational Therapy Total:						4497.57
Occupational Therapy	1/4 hour	3	77.00	19.47	4497.57	
Physical Therapy Total:						607.91
Physical Therapy	1/4 hour	1	31.00	19.61	607.91	
Psychological Therapy Total:						12396.97
Psychological Therapy - Family	1/4 hour	1	1.00	18.69	18.69	
Psychological Therapy - Group	1/4 hour	59	19.00	3.72	4170.12	
Psychological Therapy - Individual	1/4 hour	61	16.00	8.41	8208.16	
Speech /Language Therapy Total:						98568.80
Speech /Language Therapy	1/4 hour	23	220.00	19.48	98568.80	
Behavioral Support Services Total:						41974207.38
Behavior Support Services - Level 1	1/4 hour	6278	9.00	19.39	1095573.78	
Behavior Support Services - Level 2	1/4 hour	7596	280.00	19.22	40878633.60	
Community Based Habilitation - Group Total:						3455871.12
Community Based Habilitation - small group	hour	2410	156.00	9.06	3406197.60	
				GRAND TOTAL:		786912191.18
				Total Estimated Unduplicated Participants:		11776
				Factor D (Divide total by number of participants):		66823.39
				Average Length of Stay on the Waiver:		346

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Based Habilitation - medium group	hour	351	29.00	4.88	49673.52	
Community Based Habilitation - Individual Total:						22866795.48
Community Based Habilitation-Individual	hour	6889	139.00	23.88	22866795.48	
Community Transition Total:						190578.15
Community Transition	unit	201	1.00	948.15	190578.15	
Electronic Monitoring Total:						936751.75
Electronic Monitoring	hour	55	1903.00	8.95	936751.75	
Environmental Modifications Total:						453775.86
Environmental Modifications-Maintain	unit	9	1.00	496.75	4470.75	
Environmental Modifications - Equipment/Assessment/Inspection	unit	1	1.00	19.47	19.47	
Environmental Modifications - Install	unit	79	1.00	5687.16	449285.64	
Extended Services Total:						1487795.40
Extended Services	hour	630	62.00	38.09	1487795.40	
Facility Based Habilitation - Group Total:						18250181.31
Facility Based Habilitation - Small Group	hour	3763	351.00	9.01	11900525.13	
Facility Based Habilitation - Medium Group	hour	2906	429.00	5.05	6295703.70	
Facility Based Habilitation - Large Group	hour	724	23.00	3.24	53952.48	
Facility Based Habilitation - Individual Total:						4543730.40
Facility Based Habilitation - Individual	hour	1579	120.00	23.98	4543730.40	
Facility Based Support Services Total:						16672.11
Facility Based Support Services	hour	21	403.00	1.97	16672.11	
Family and Caregiver Training Total:						3572.04
Family and Caregiver Training	unit	3	1.00	1190.68	3572.04	
Intensive Behavioral Intervention Total:						140.28

GRAND TOTAL:	786912191.18
Total Estimated Unduplicated Participants:	11776
Factor D (Divide total by number of participants):	66823.39
Average Length of Stay on the Waiver:	346

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Intensive Behavior Intervention - Level 1	hour	1	1.00	113.22	113.22	
Intensive Behavior Intervention - Level 2 direct care staff	hour	1	1.00	27.06	27.06	
Music Therapy Total:						3540768.88
Music Therapy	1/4 hour	1706	178.00	11.66	3540768.88	
Personal Emergency Response System Total:						115168.82
Personal Emergency Response System-Install	unit/month	23	2.00	42.97	1976.62	
Personal Emergency Response System-Maintain	unit/month	253	10.00	44.74	113192.20	
Recreational Therapy Total:						1700887.50
Recreational Therapy	1/4 hour	585	250.00	11.63	1700887.50	
Specialized Medical Equipment and Supplies Total:						73096.32
Specialized Medical Equipment and Supplies	unit	32	1.00	2284.26	73096.32	
Structured Family Caregiving (previously known as Adult Foster Care) Total:						9602689.25
Level 1 Structured Family Caregiving (formerly Adult Foster Care Level 1)	day	65	275.00	56.06	1002072.50	
Level 2 Structured Family Caregiving (formerly Adult Foster Care Level 2)	day	173	297.00	81.91	4208617.71	
Level 3 Structured Family Caregiving (formerly Adult Foster Care Level 3)	day	156	253.00	111.28	4391999.04	
Transportation Total:						11299933.89
Level 1 Transportation	trip	6411	248.00	5.38	8553812.64	
Level 3 Transportation	trip	3	124.00	43.30	16107.60	
Level 2 Transportation	trip	819	163.00	20.45	2730013.65	
Wellness Coordination Total:						9990644.29
Wellness Coordination - Tier I	Month	2150	11.00	57.12	1350888.00	
Wellness Coordination - Tier II	Month	5447	11.00	121.19	7261341.23	
Wellness Coordination - Tier III	Month	517	11.00	242.38	1378415.06	

GRAND TOTAL:	786912191.18
Total Estimated Unduplicated Participants:	11776
Factor D (Divide total by number of participants):	66823.39
Average Length of Stay on the Waiver:	346

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Workplace Assistance Total:						**87242.30**
Workplace Assistance	hour	17	185.00	27.74	**87242.30**	
				GRAND TOTAL:		**786912191.18**
				Total Estimated Unduplicated Participants:		**11776**
				Factor D (Divide total by number of participants):		**66823.39**
				Average Length of Stay on the Waiver:		346