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

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

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

1. Request Information

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

B. Program Title:
Family Supports Waiver

C. Waiver Number:IN.0387
Original Base Waiver Number: IN.0387.

D. Amendment Number:IN.0387.R04.06

E. Proposed Effective Date: (mm/dd/yy)

01/01/22

Approved Effective Date of Waiver being Amended: 07/16/20

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

Pursuant to a 2021 legislative mandate a 14% provider rate increase for the home and community-based services listed below is to be implemented. The increase is based on the reimbursement rate in effect as of June 30, 2019, and multiplied by 14%.

The increase will be implemented on January 1, 2022, but only with the federally approved effective date of the FS waiver amendment.

The increases may result in service changes for participants who choose to utilize any of the following services:
- adult day services
- prevocational services
- respite
- extended services
- day habilitation
- workplace assistance
- transportation services
- participant assistance and care
- facility based support

To minimize impact on individuals and families that result from the rate increases, Indiana will also increase the annual cap on the Family Support Waiver annual budgets from $17,300 to $19,614. Changes to the annual cap are updated as applicable throughout the application.

The amendment specifically complies with the legislated rate increase in the state's budget bill, Indiana House Enrolled Act 1001 found at http://iga.in.gov/static-documents/d/b/c/2/dbc2cc8e/HB1001.06.ENRS.pdf, and now Section 137 of Public Law 165, which requires providers to use at least 95% of this rate increase to pay payroll tax liabilities and to increase wages and benefits paid to direct care staff. Indiana Code 12-15-1.3-18 will be amended to reflect the 2021 legislated changes.

An authorized service provider shall use at least ninety-five percent (95%) of the amount of the increase in the reimbursement rate to pay payroll tax liabilities and to increase the wages and benefits paid to direct care staff in comparison to payroll tax liabilities, wages, and benefits paid to direct care staff as of the provider's most recent fiscal year ended on or before December 31, 2019, who:
(1) are employed by the authorized service provider to provide services in Indiana; and
(2) provide support services listed in subsection (c)(2); and
(3) are paid on an hourly basis.

If a provider does not use ninety-five percent (95%) of the increase to pay payroll tax liabilities and to increase wages and benefits paid to direct care staff, the office shall recoup part or all of the increase in the reimbursement rate that the provider receives.

MAIN
2. Brief Waiver Description - updated references to FS cap from $17,300 to $19,614
A. Attachments - Attachment #1 - updated to address potential impact of DSP wage increases
A. Attachments - Attachment #2 - Corrected typos of the word "STANDRADS" to "STANDARDS"; "publically" to "publicly"; "Additional Needed Information (Optonal)" to "Additional Needed Information (Optional)"; updated the current link for the state transition plan.
B. Additional Needed Information (Optional) - removed text specific to the waiver renewal and continued from the Public Input section where text field space was inadequate to complete the field
6. Additional Requirements - 6-I - edited Public Input specific to amendment

APPENDIX B
Appendix B-2 - updated references to FS cap from $17,300 to $19,614
Appendix B-8 - updated the link for translation opportunities to https://www.in.gov/health/minority-health/minority-health-resources/language-translation-and-migrant-programs/

APPENDIX C
Appendix C-1/C-3 - case management service definition revised and enhanced to add clarity
Appendix C-1/C-3 - occupational therapy provider specifications, corrected typo from "IC 25-23.5 (Licensure and certification requirments)" to "IC 25-23.5 (Licensure and certification requirements)"
Appendix C-1/C-3 - remote supports service definition and provider qualifications clarified, limits updated to reflect accessibility within new FS cap of $19,614, but keeping the additional amount of up to $500 accessible outside the annual cap

Appendix C-1/C-3 - removed specifications, taxonomy references and provider qualifications related to vehicle modifications from the specialized medical equipment and supplies service definition, restructuring as two standalone service definitions, one for vehicle modifications and one for specialized medical equipment and supplies.
Appendix C-1/C-3 - transportation service annual limits increased for each level of non-medical transportation so rate increases paid per trip do not reduce the total number of trips available within the revised FS spending cap of $19,614
Appendix C-4-a - additional limits/prospective individual budget amount updated to reflect new annual FS cap of $19,614

APPENDIX D
Quality Improvement a. Methods for Discovery - Removed performance measure #5 that duplicated #4
Quality Improvement b. Methods for Remediation/Fixing Individual Problems - removed reference to duplicative performance measure #5

APPENDIX G
Appendix G-1-d - clarification of the role of the case manager was edited to align with case management service definition enhancements

APPENDIX I
Appendix I-2-a - updated with reference to legislated DSP wage increases and vehicle modification rates
Appendix I-2-b - updated to reflect January 1, 2021, implementation of Electronic Visit Verification system

APPENDIX J
Appendix J-1 - projections are updated to reflect DSP wage increases
Appendix J-2 - projections are updated to reflect DSP wage increases and the addition of vehicle modifications as a standalone services, now separate from specialized medical equipment and supplies.

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**	1.Request Information; 2.Purpose; 3.Nature of Amendment A&B; Main Items 2,
☐ **Appendix A Waiver Administration and Operation**	
☒ **Appendix B Participant Access and Eligibility**	B-2; B-4-a
☒ **Appendix C Participant Services**	C-1/C-3; C-4-a
☐ **Appendix D Participant Centered Service Planning and Delivery**	
☐ **Appendix E Participant Direction of Services**	
☐ **Appendix F Participant**	

Component of the Approved Waiver	Subsection(s)
Rights	
☒ Appendix G Participant Safeguards	G-1-d
☐ Appendix H	
☒ Appendix I Financial Accountability	I-2-a; I-2-b
☒ Appendix J Cost-Neutrality Demonstration	J-1; J-2-c; J-2-d

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

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

Specify:

Revised service specifications and provider qualifications for case management services.

Reflect legislated rate increases for the following services available under the FS waiver:
- adult day services
- prevocational services
- respite
- extended services
- day habilitation
- workplace assistance
- transportation services
- participant assistance and care
- facility based support

To minimize impact on individuals and families that result from the rate increases, Indiana will also increase the annual cap on the Family Support Waiver annual budgets from $17,300 to $19,614.

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

1. Request Information (1 of 3)

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

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

Family Supports Waiver

C. Type of Request: amendment

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

○ **3 years** ◉ **5 years**

Original Base Waiver Number: IN.0387
Waiver Number:IN.0387.R04.06
Draft ID: IN.007.04.02

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/16/20
Approved Effective Date of Waiver being Amended: 07/16/20

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

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

☐ **Hospital**
Select applicable level of care

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

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

☐ **Nursing Facility**
Select applicable level of care

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

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

☒ **Intermediate Care Facility for 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:

An initial submission of a 1915(b)(4) for case management services was submitted for approval with a requested effective date of January 1st, 2022.

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:

☒ **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: FSW 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 “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 a Person-Centered Individualized Support Plan (PCISP) for service plan development. Developing the PCISP is a process based on the Charting the LifeCourse (CTLC) Framework™ which is comprised of eight principles and a set of tools that support the use and application of the principles. The CTLC framework identifies a participant’s health and safety needs in balance with his or her aspirations and preferences to develop a plan that integrates a variety of services and supports to help the participant achieve his or her good life.

The PCISP is developed by the participant with support from the case manager. Others of the participant’s choosing may also participate in the development of the PCISP. This group forms the Individual Support Team (IST). The PCISP first identifies the participant’s preferences, aspirations, and health and safety needs. Then, by addressing the participant’s identified outcomes and needs, the PCISP details what the participant wants to accomplish within a given year to achieve a good life across a variety of life domains. The cost comparison budget (CCB) identifies the services and supports that are funded by the waiver and is routinely developed to cover a time frame of twelve consecutive months. The CCB is subject to an annual waiver services cap of $19,614 as described in Appendix C-4-a.

GOALS and OBJECTIVES: FSW provides access to meaningful and necessary home and community-based services and supports, implements services and supports in a manner that respects the participant’s preferences, aspirations, and health and safety needs, ensures that services are cost-effective, facilitates the participant’s involvement in the community where he or she lives and works, facilitates the participant’s development of social relationships in his/her home and work communities, and facilitates the participant’s independent living.

ORGANIZATIONAL STRUCTURE: Pursuant to P.L. 109-2014, §§15-19, the Office of the Secretary of FSSA is the single State Medicaid agency. Within the FSSA and under its direction, FSSA’s Office of Medicaid Policy and Planning (OMPP) is divided into seven sections:
1. Eligibility Section – responsible for development of eligibility policy and providing guidance and support to agency field offices related to eligibility policy, systems coordination, and customer service.
2. Pharmacy Section – responsible for contract oversight of the pharmacy benefits manager to assist in the administration of the Medicaid drug benefit, drug utilization reviews, and retrospective review. The Pharmacy Section 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 and Outcomes Section – responsible for monitoring quality performance and program evaluation within the State’s medical assistance programs. The Quality and Outcomes Section also researches policy requests from providers and recommends changes to coverage and benefits.
4. Reimbursement Section and Actuary – responsible for coding and MMIS initiatives as well as acute care and long-term care reimbursement.
5. Provider Services Section – responsible for provider enrollment, communications, and provider relations.
6. Program Integrity Section – responsible for coordination and investigations as well as surveillance and utilization review.
7. Policy and Program Development Section – responsible for program development, coverage and benefits, and State Plan administration.

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 FSW:
1. Division of Family Resources (DFR) – responsible for receiving and processing Medicaid applications and determining eligibility.
2. Office of General Counsel – includes the Office of Hearings and Appeals and the Chief of Investigations.
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) – responsible for managing the delivery of services to children and adults with intellectual and developmental disabilities

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 IST, and developing a PCISP prior to developing and submitting to the State the CCB.

(Continued in B. Optional)

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:

Public comments were requested on the FS amendment with Draft number IN.007.04.02, with proposed effective date January 1, 2022.

The Family Supports (FS) waiver amendment was open for public comment for 30 days, July 28, 2021 - August 27, 2021, allowing all HCBS consumers, providers and stakeholders an opportunity to provide input on the amendment. The amendment was published for public comment at https://www.in.gov/fssa/ddrs/4205.htm. All public comments and dates of public notice for the FS amendment will be retained on record and available for review. In addition to posting on the DDRS website, the public notice and draft renewal were posted in the Indiana Register. Federally-recognized Tribal Governments received written notice as required.

Comments on the amendment were accepted until 4:30 p.m. EST on Friday, August 27, 2021, via email to DDRSwaivernoticecomment@fssa.IN.gov or via mail to the address below. Hard copies of the proposed amendment changes were available from local BDDS offices.

Waiver Amendment Public Comment
c/o Division of Disability and Rehabilitative Services
402 W. Washington St., #W453 P.O. Box 7083, MS26
Indianapolis, IN 46207-7083

A summary of public comments and DDRS' responses appears in the Main, B. Optional field of this amendment.

The Division of Disability and Rehabilitative Services (DDRS) is committed to a high level of transparency and ensures that all providers, families, participants, and potential participants are given meaningful opportunity for public input.

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

• Did the state fully describe the public input process?
• Was the public input process at least a 30-day period, and was it completed prior to the waiver submission to CMS?
• Did the state provide at least two (2) statements of public notice and public input procedures? Was one of them web-based?
• Did the state include a summary of the public comments that the state received during the public input process, reasons why any comments were not adopted, and any modifications to the waiver that they made as a result of the public input process?
• Did the state's posting include the entire waiver? For new waivers, was the public input process sufficient?
• For renewals and amendments with substantive changes, was the public input process sufficient in light of the scope of the proposed changes in the waiver submission?

DDRS routinely 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.
• DDRS hosts Building Bridges events which are opportunities for families and self-advocates to meet and speak with the Bureau of Developmental Disabilities Services (BDDS) state staff. These sessions are an important part of the Bureau's efforts to create direct avenues for individuals and families to share their feedback on services such as waivers and supervised group living.
• 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: Gilbert

First Name: Brian

Title: Manager, Program Administration

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

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

Address 2:

City: Indianapolis

State: **Indiana**

Zip: 46204-2739

Phone: (317) 233-3340 **Ext:** ☐ **TTY**

Fax: (317) 232-7382

E-mail: brian.gilbert@fssa.in.gov

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

Last Name: Opsahl

First Name: Kimberly

Title: DDRS Director

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

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: kimberly.opsahl@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: BRIAN GILBERT

State Medicaid Director or Designee

Submission Date: Sep 30, 2021

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

Last Name: Gilbert

First Name: Brian

Title:

Program Administration Manager

Agency:

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

Address:

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

Address 2:

City:

Indianapolis

State: **Indiana**

Zip:

46204-2739

Phone:

(317) 233-3340 **Ext:** ☐ **TTY**

Fax:

(317) 234-5076

E-mail:

Brian.Gilbert@fssa.in.gov

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- ☐ **Replacing an approved waiver with this waiver.**
- ☐ **Combining waivers.**
- ☐ **Splitting one waiver into two waivers.**
- ☐ **Eliminating a service.**
- ☒ **Adding or decreasing an individual cost limit pertaining to eligibility.**
- ☐ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- ☐ **Reducing the unduplicated count of participants (Factor C).**
- ☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- ☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- ☒ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

Main – A. Attachments – Attachment #1
Pursuant to a legislative mandate (Indiana House Enrolled Act 1001/Public Law 165 of 2021), a 14% provider rate increase for services specified below is expected to take effect January 1, 2022 and could result in service changes for individuals.

The rate increase applies to the following FS waiver services:
- adult day services
- prevocational services
- respite
- extended services
- day habilitation
- workplace assistance
- transportation services
- participant assistance and care
- facility based support

The rate increase may have an impact on the continuation of the level of services allocated in the current waiver and while it adds no specific limitation to the amount of any waiver service that may be utilized, individual choice of type and level of service may be impacted. However, to minimize impact on individuals and families that result from the rate increases, Indiana will also increase the annual cap on the Family Support Waiver annual budgets from $17,300 to $19,614.

The rate increase has no impact on which waiver program individuals served under the existing, approved waiver will be eligible to participate in once amended. All individuals will be notified of the legislated changes by their Case Manager and will be informed of the opportunity to request a Fair Hearing. As described in Appendix F-1, all State-issued decisions related to individual service plans contain an explanation of how to request a Fair Hearing.

Implementation the rate increases is contingent upon federal approval of the pending FSW and CIH amendments by the Centers for Medicare and Medicaid Services. If the waiver amendments are not approved, rate increases may not be granted.

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.

The Division of Disability and Rehabilitative Services (DDRS) opened a dialogue with all stakeholders on the need for transformation in how Indiana provides services and supports to its citizens with intellectual and developmental disabilities. Since then, we've consulted with self-advocates, families, case managers, providers and other stakeholders to better understand our collective vision for services and supports for Hoosiers with disabilities and what we can do to transform our approach to move us toward supporting individuals and families in their community. As a first step, the Division chose to focus its initial efforts on Person Centered Planning (PCP) and case management. These areas were targeted due to the central role both play in supporting individuals and families in designing meaningful plans to encourage effective supports and services to get individuals closer to their definition of a good life.

Using feedback from stakeholders, recommendations from the Case Management Innovation Group and resources from the National Community of Practice for Supporting Families, the Bureau of Developmental Disabilities Services (BDDS) introduced changes to the approach for PCP across both the Family Supports Waiver (FSW) and the Community Integration and Habilitation (CIH) waiver. Minor changes are being made to how the current case management service is delivered to better align with the changes to our PCP approach.

The Division is working on the following activities to reflect changes to Person Centered Planning and case management:
• Updating policies, procedures and guidance related to PCP and case management;
• Presenting a Statewide training series to provide concrete, face-to-face learning opportunities regarding person-centered planning and the role of case management; and
• Regular updates to stakeholders on our progress toward new person-centered planning implementation to ensure transparency and up to date information.

After receiving initial approval of the STP, Indiana submitted version seven of the STP to CMS on September 29, 2017 for final approval. On December 1, 2017, CMS requested technical corrections for consideration of final approval.

The link for the current STP version is: https://www.in.gov/fssa/da/files/HCBS_STP_v9_resub.pdf

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Prior Amendment IN.0387.R03.02
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INDIANA TRANSITION PLAN FOR COMPLIANCE WITH MEDICAID HCBS FINAL RULE-FAMILY SUPPORTS WAIVER as updated December 1, 2014 and posted at http://www.in.gov/fssa/4917.htm

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. 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 waiver being reviewed for compliance is the Family Supports Waiver (FSW) that 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 FSW waiver provides Medicaid HCBS waiver services to participants of any age residing in a range of community settings as an alternative to care in an intermediate care facility for persons with intellectual 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 Settings 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
j) Convene a Transition Taskforce

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 various providers, participants, families, 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 (NCI) data, internal quantitative data, a systematic review of rules, regulations, policies, and procedures, surveys, and site-specific assessments.

Currently, Indiana is still in the assessment phase. Indiana has reviewed the NCI data, completed an initial review of rules, regulations, and policies/procedures, and developed a preliminary settings 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 individuals and family members (as available) to gather information by asking the same questions of all participants. For the analysis of compliance with the HCBS requirements, a total of 353 participants on the FSW were interviewed in the 2012-2013 reporting year.

In reviewing NCI data, Indiana set a clear standard of 85% or greater compliance in each point reviewed in order to guide the analysis. In March 2014, CMS also issued modifications to Quality Measures and Reporting on 1915(c) Home and Community

Based Waivers. Specific to Improvements in 1915c Waiver Quality Requirements (June 15, 2014), CMS issued guidance to the States indicating that any level of performance measuring “less than 86%” compliance indicated a need for improvement and further analysis to determine the cause(s) of the performance problem. DDRS chose to use that same percentage (less than 86%, or 85%) as the threshold for low level compliance within our National Core Indicator and 90-Day Checklist data findings. National Core Indicator findings, including those specific to Indiana, are available at http://www.nationalcoreindicators.org/states/

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 this consistent low level of compliance, Indiana was unable to drill down the data to focus on specific areas of concern. However, Indiana is able to utilize the breakdown of NCI data will as supplemental data in the preliminary settings 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 FSW Transition Plan have been entered into the next text field named "Additional Needed Information (Optional)"

ASSESSMENT OF HCBS REQUIREMENTS: REVIEW OF INDIANA’s STANDARDS, RULES, REGULATIONS, and REQUIREMENTS
Start Date: 9/2014
End Date: 10/2014-Completed
In addition to the NCI data, Indiana has reviewed 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. The listings of items reviewed are below:

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 settings 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 was presented to stakeholders through the public comment period.

In addition to ascertaining Indiana's initial level of compliance with the HCBS rules, the preliminary setting analysis was also used with the goal of identifying specific policies requiring updates, documents and processes requiring modifications and areas requiring additional data tracking in order to more appropriately represent compliance.

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 FSW 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
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 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 publicly 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 CORRECTIVE 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.

REMEDIAL STRATEGIES: CONVENE A TRANSITION TASKFORCE
Anticipated Date of Completion: 3/2017

DDRS will convene a Transition Taskforce to provide technical assistance and support for individuals identified as requiring significant changes, such as, relocation, adjustments to allocation, mediations to resolve internal conflicts and compliance issues.

DESCRIPTION OF PUBLIC COMMENT

This Family Supports 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 the summary of comments received throughout the 30 day public comment period:

SUMMARY:

On October 31, 2014, Indiana posted public notice of the Family Supports Waiver Comprehensive Transition Plan, the Community Integration Waiver Comprehensive Transition Plan and the Indiana Statewide Transition Plans to the FSSA/DDRS website and to all individuals on the Division of Disability and Rehabilitative Services (DDRS) listserv. The DDRS listserv has a total of 5,078 registered individuals. Letters were also sent to every individual who is currently utilizing waiver services inviting them to participate in a webinar and phone conference to educate them of the HCBS rules and transition plans.

In addition, throughout October and November, DDRS hosted a variety of events to generate public comments on the posted Transition Plans. Events included the DDRS Quarterly Provider Meeting attended by over 167 individuals, a meeting with the Arc Self Advocates Officers, three Webinars and phone conferences for families with over 400 participants, a presentation at Indiana Association of Rehabilitation Facilities, Inc. Quarterly Conference, a podcast by the Director of DDRS with the Arc of Indiana; the DDRS Advisory Council; Quarterly Case Management Meeting and multiple meetings and announcements by local provider and advocacy groups. During the public comment period, a variety of comments were received from individuals, family members, providers and advocacy groups.

The public comment received ranged from detailed suggestions regarding the various phases of the Transition Plan to long-term remedial strategies. Indiana noted many individuals reported an overall satisfaction with the Comprehensive Transition Plans, as it ensures that individuals receiving HCBS are integrated in and have access to supports in the community.

The DDRS revised the Transition plan to explain use of 85% as baseline for compliance, to clarify language and policy goals and explain the review and potential modification of documents and process as well as to include the addition of a Transition Taskforce based on public comment. See pages 2, 3, and 7 of the FSW Transition Plan and/or pages 26, 30 and 61 of Indiana's Statewide Transition Plan posted at http://www.in.gov/fssa/4917.htm.

Below is a summary of various categories of public comment, a summary of the public comment received (with the exception of the specific system barrier comments received), and the State's responses to the comments. Anecdotal comments received about the specific system barriers affecting compliance will be utilized during the review of qualitative data in order to supplement the quantitative data review and identify potential remedial strategies.

SUBJECT: Assessment of Settings

COMMENT: Indiana identified 85% and below as the threshold for low level compliance with National Core Indicators. One commenter asked what the national standard is for compliance and how Indiana compares to other states across the country if the threshold of 85% compliance is met.

COMMENT: The Indiana demographics section of the 2013 National Core Indicators Report indicates that most interviewees resided with family. In this setting, rules and activities are generally determined by a parent or family member, making individual choice a matter of family dynamics. This situation may unintentionally skew the results related to self-determination, as well as potentially make remediation and compliance challenging. The commenter recommends that this be taken into consideration in further assessment activities and in the final determination of setting compliance.

COMMENT: One commenter was pleased with the use of NCI data to assess compliance. They felt the state's use of the NCI survey (National Core Indicators) is helpful because it demonstrates that there needs to be significant change in a broad range of topics. However, there is concern with the use of the 90-day checklist as an indicator of compliance given that in several instances the results were contradictory with the NCI data.

RESPONSE: While the State used NCI data as a preliminary assessment tool, the State acknowledges concern with contradictory data obtained by the 90 day checklist. For this reason, a more in-depth approach will be carried out through the individual experience surveys to determine HCBS compliance. The individual experience surveys will also allow for all participants settings to be analyzed, not just residential.

In March 2014, CMS also issued modifications to Quality Measures and Reporting on 1915(c) Home and Community Based Waivers. Specific to Improvements in 1915c Waiver Quality Requirements (June 15, 2014), CMS issued guidance to the States indicating that any level of performance measuring "less than 86%" compliance indicated a need for improvement and further analysis to determine the cause(s) of the performance problem. DDRS chose to use that same percentage (less than 86%, or 85%) as the threshold for low level compliance within our National Core Indicator and 90-Day Checklist data findings. National Core Indicator findings, including those specific to Indiana, are available at http://www.nationalcoreindicators.org/states/.

COMMENT: One commenter stated the transition plan read as though the assumption was everyone is out of compliance and requested language clarification, specifically how the site survey's will be assessed.

RESPONSE: Compliance cannot be assumed nor does Indiana assume that it is not in compliance. The transition plan was developed to clearly delineate Indiana's assessment and potential remediation activities.

SUBJECT: Preliminary Settings Inventory/Analysis

COMMENT: In the preliminary settings analysis, one commenter would like to see more substantive comments regarding how compliance will be determined in all instances where there is no NCI data and no 90-day checklist data.

COMMENT: Information reviewed and used for future data collection to manage accomplishment includes the 90 day checklist and pre/post transition documents, both of which are significantly in need of modification to more appropriately represent the current and future waiver recipients. It is concerning going forward if the intent is to continue to use these two documents as part of the transition process/plan. Perhaps part of the transition plan could speak to the necessary document changes in assuring they support what is being monitored and leading the team to successfully support the individual.

COMMENT: Standards, Rules, Regulations and/or Requirements should be broad in scope, being applicable to individuals of all ages. The average age of individuals served is decreasing as school age individuals are targeted, rather than deinstitutionalized individuals such as in previous decades.

COMMENT: Due to the fact that NCI data and 90 day checklists frequently contradicted each other, several areas of the initial assessment have been noted to require further study. This suggests the need to review the validity of the 90 day checklists and/or the NCI data collection process as it relates to determining compliance with CMS rules.

COMMENT: One commenter has concerns about the 90-day checklist process. Specifically, who responds to the questions; the case manager or the individual? It was recommended that a trained individual, outside of the case management team, to ensure that the data is truly person-centered, conduct Personal Outcome Measurement (POM) interviews. For the CMS Criteria that is not obtained through the 90 day checklist, it is recommended that the criteria be added to the checklist, and referenced in the

individual's person-centered plan.

RESPONSE: The State will incorporate specific components of the above suggestions into the transition plan by clarifying language and policy goals. The review and potential modification of documents and process to support the changes will be incorporated into the transition plans. Currently, both the Case Manager and the individual waiver participant (consumer)/family or guardian are to respond to questions on the 90 Day Checklist during the 90-Day Meetings of the Individualized Support Team (IST), but the Case Manager is responsible for its completion and processing. At this time, it is the responsibility of the Individual Support Team to ensure the accuracy of the 90-Day Checklist responses and there are no immediate plans to bring in outside entities.

COMMENT: One commenter suggested policy specifics be a part of a later comment period around rules and regulation changes.

COMMENT: 90 – Day Checklist
1. I see that this is used to review many of the desired outcomes. With new policies being implemented and because this is one of the main pieces of information being used to measure current and future outcomes; will there be more accountability for all Case Managers to complete this documentation with the review of the IST team state wide?
2. A Focus of training on this documentation may need to implemented through AdvoCare for all individual Case managers, as historically, many newer CMs have either overlooked this or completed it without the input of the IST.

RESPONSE: The State will review the suggestions listed above in order to identify areas of inadequacy or weakness within the 90 day check list and develop necessary modifications to assure the State's compliance with HCBS requirements. Case Managers will continue to be trained and held accountable for following proper procedure in the completion of this task. While the specific suggestions will not be incorporated into the high level Transition Plan, the State will ensure stakeholders have an opportunity to review any policy/process changes listed above and, to the greatest extent possible, the State will incorporate the suggestions within the specific processes.

SUBJECT: Validation of Preliminary Setting Inventory

COMMENT: One commenter felt that using the Indiana Institute on Disability and Community (IIDC) to complete the next phase of assessment is a wise decision. IIDC's expertise and reputation will reinforce the process as fair and credible. Further, by testing with a sub-group of individuals with disabilities, the assessment will have a high level of validity.

COMMENT: One commenter felt it was unclear if all waiver recipients will be surveyed or only Individuals receiving RHS services. They suggested DDRS should consider scaling down the implementation of a statewide survey for 17,000+ Individuals on the waiver. A large percentage of the Individuals receiving waiver services live in their family home, and these settings are considered to be site appropriate. If the goal of this survey is to identify specific sites that may need further review, it may be advantageous for DDRS to focus only upon Individuals receiving residential services or supported living services.

COMMENT: Once the survey tool is completed, the state should consider changing the implementation process. Right now, this plan outlines a provider-led process, with the provider responsible for ensuring the survey is completed for each Individual. The state will have difficulty getting full compliance with this process. Instead, the state should consider having Case Management facilitate the questions to the Individual and their support team as part of the 90 day process.

COMMENT: One commenter recommends that the Provider and Member Surveys are inclusive of individuals Receiving HCBS services, as well as those on the wait list.

RESPONSE: Final details on how, to whom, and by whom the site surveys should be administered for optimal results is still in the final planning stages and will be incorporated in future updates of the transition plan. The State will review the suggestions listed above in order to finalize the specific components and processes for the survey tool. DDRS appreciates the support expressed by various commenters. While the specific suggestions listed above will not be incorporated into the FSW transition plan, the State will incorporate the suggestions within the specific processes to the greatest extent possible.

SUBJECT: Proposed Remediation Strategies

COMMENT: The Comprehensive Transition Plan states that a Comprehensive Provider Survey will be conducted and results analyzed. The plan does not specify if (or how) results will be made available to individual providers. It would be beneficial for

providers to have timely access to survey results specific to their agency's compliance. This would allow providers to begin making systematic changes that facilitate compliance.

COMMENT: The Transition Plans call for assessment components to be completed by an individual or another person that "knows them best." It is understood that the State may likely look to providers to facilitate identifying an appropriate person to assist the individual through the assessment process. To that end, it is recommended that a single point of contact be established at each provider agency to coordinate with the support teams to determine who should be involved in individual surveys.

COMMENT: With regard to the survey tool being developed by the IIDC to target specific HCBS requirements, there is concern with vesting the administration of the survey through the residential provider. There is a concern that the provider could manipulate or influence resident responses. Due to the survey's importance, whereby its results will be used to determine sites for site specific assessments, the survey tool should be as free from bias and influence as possible. Commenter would also request that the key stakeholders be included in the survey design process. In that same vein, requests that the participant/resident survey be accessible and meaningful. For example, rather than asking generally whether the resident/participant has access to food, asking whether he or she can get a snack whenever they want.

COMMENT: The Participant Rights and Responsibilities Policy is not scheduled to be modified until 12/2017. Commenter would request that this be done earlier in the process – participants should be aware of their rights as early as possible so that they may better participate in the process going forward.

COMMENT: One commenter suggested a clearer process for sanctions and provider dis-enrollments. Specifically, timeframes for notice, action steps and procedural safe guards to ensure consumers and their teams are provided adequate notice.

COMMENT: One commenter suggested the remedial section of the plan is lacking. It appears to be primarily policy change or provider corrective action/sanctions. The state should realize that this is the most important part of the plan and should be afforded enough time for implementation. As noted previously, the state appears to be taking over half of the allowable time to identify the issues but the real work lies in correcting and taking action to make changes in Individuals' lives. Please allow enough time within this plan for the remedial work.

COMMENT: One commenter suggested a BDDS transition task force will need to be established for Individuals identified that will require major changes including relocation, adjustments to allocations, and mediation to resolve internal conflicts and compliance issues that cannot be handled by the Individual and their team. In addition, any system that is developed should allow for external support and consultation for situations that are too difficult for the Individual and their support team to handle without mediation or additional funding. It would be helpful for a process to be developed to request on-site consultations or team assistance.

COMMENT: These remedial strategies leave the Individual and the team out of this process entirely. For a true person-centered approach, most remedial issues, once identified, should be handled at the Individual and support team level.

RESPONSE: It is the State's intent to include the individual and team throughout the assessment and remediation process. Timelines allow for all settings to be assessed and remedial strategies to be addressed upon completion of identified issues. Final details on how, to whom, and by whom the site surveys will be administered and assessed, is still in the final planning stages and will be incorporated in future updates of the transition plan. The suggestion of a transition taskforce will be incorporated into the transition plan to allow for additional ongoing supports and consultation during the transition process. The State acknowledges that Remedial Strategies and processes may need to be altered based upon the pilot surveys as well as the actual survey findings, but assessments must be completed prior to determining how those strategies may need to change. While the process for sanctions and provider disenrollment's was not added to the high level Transition Plan, the State will incorporate the suggestions within specific policies and procedures.

The State will review the suggestions listed above in order to finalize the specific components and processes for the survey tool. DDRS fully intends the survey to be meaningful and free from bias. Additionally, policies and procedures will be updated timely and appropriately once the survey findings have been analyzed and compared to the HCBS requirements.

SUBJECT: System Recommendations

COMMENT: A few commenters provided specific suggestions regarding system recommendations. Specific suggestions are listed below:
• Ensure choice in living situations and staff

• Ensure meaningful employment opportunities for individuals
• Provide more options in services that are individualized
• Ensure control of personal resources
• Wider range of residential opportunities
• Address the shortage of qualified Direct Care Staff
• System constraints will need to be addressed
• Address the limited access to community
• Extra protections for individuals without Legal Guardians or advocates should be considered
• Ensure a more collaborative effort between Case Management and community disability organizations

RESPONSE: The State acknowledges the concern with the system issues listed above. Through the individual experience survey and subsequent review of the HCBS requirements, Indiana will gather data on the current status of the system and identify areas of noncompliance. To the greatest extent possible, the specific comments listed above will be incorporated within the survey(s) to assess the current status of Indiana's HCBS settings.

NOTE:

Attachment #2 Home and Community-Based Settings Waiver Transition Plan is continued in the next text field named "Additional Needed Information (Optional)" due to character limitations in the Attachment #2 text field:

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

****
The following addendum is included per the direction of CMS
****
The state assures that this waiver amendment or renewal will be subject to any provisions or requirements included in the state's most recent and/or approved home and community-based settings Statewide Transition Plan. The state will implement any CMCS required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

2. Brief Waiver Description is continued here due to character limitations in the Brief Waiver Description text field:

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 FSW 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 PCISP and CCB, and as the basis to identify opportunities for ongoing quality improvement.

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 FSW Transition Plan:
Appendix A: SUMMARY OF NCI DATA ANALYSIS
Appendix B: PRELIMINARY SETTING ANALYSIS BASED ON REQUIREMENTS

SUMMARY OF PUBLIC COMMENTS AND DDRS RESPONSES RELATED TO THIS AMENDMENT FOLLOWS:

Public Comment on 2021 Amendments – DDRS Response

As announced on Wednesday, July 28, 2021, BDDS issued a public notice on the intent to submit proposed 1915(b)(4) selective contracting waiver application and proposed amendments to the Community Integration and Habilitation waiver and Family Supports Waiver to the Centers for Medicare and Medicaid Services for consideration. These proposed changes are part of BDDS Case Management Innovation and Waiver Redesign work. The 30-day public comment period ran from July 28, 2021, through August 27, 2021. Required Tribal notice issued July 28, 2021, has a 60-day comment period ending September 26, 2021.

During the public comment period, 21 comments were received from 17 commenters.

Case Management §1915(b)(4) waiver amendment

The 1915(b)(4) allows states to use selective contracting on a fee for service basis for specific Medicaid services. As part of our waiver redesign efforts and in response to the stakeholder feedback that pointed to the necessary enhancements to the service of case management, BDDS desires to utilize this waiver fee for service structure to enhance our case management service.

The Bureau of Developmental Disabilities Services (BDDS) serves over 30,000 individuals with intellectual and developmental disabilities and case managers currently act as the coordinators of services and supports. These roles also submit budget requests to increase service dollars, and often coordinate other Medicaid services, and non-Medicaid resources for the individuals in our services. Ensuring fidelity in the stewardship of these public funds is a critical function of these entities.

In general, we received 9 comments related to the 1915 (b)(4). Some were in disagreement with this change, and some who are in strong support of it. Supporters liked consistency of service delivery, the development of a quality guide, and consistency of training of case managers. Those opposed were generally concerned about having enough case managers in the system to support everyone, the need for more supervisors, and general disagreement with the state's approach to enforce compliance with case management companies.

DDRS Response:
As presented by DDRS/BDDS, there is no plan or intent to reduce the number of case managers or to reduce or limit individual

choice among case management contractors. Individuals will continue to have the right to change case management providers and/or case managers at any time. Each selected contractor will be expected to meet all requirements, provide high quality services, provide statewide coverage, employ, train, and properly support its qualified case managers and non-case load carrying staff.

Family Supports and Community Integration and Habilitation 1915(c) waiver amendments

Case Management Service Definition – We received 13 comments in regard to the updates in the case management service definition. Supporters of the changes highlighted the importance of smaller caseloads, the necessity of face to face visits every 90 days and the needed clarity of consistent quality standards. Those who opposed the changes cited the requirement of face to face visits every 90 days interferes with family life, school-related and other activities. In addition, commenters cited case managers do not have broad access to review records making it difficult to communicate with team members and that the average caseload sizes with no increase in rate create a fiscal impact to the case management providers.
DDRS response:
As an agent of the state, case managers have full access to review any and all records necessary to perform their duties as outlined in the service definition and in accordance with IAC 460. The requirement for the average of 45 caseloads is an average among only full-time case managers which is within the current average range of cases per caseload.

Transportation Caps – We received 3 comments on the changes to transportation. It was suggested that a need to increase the transportation cap under the FS due to no other funding options beyond cap/no other FS service provides a transportation element was necessary. 1 commenter believes DDRS may be discriminating against individuals with physical disabilities and asked that DDRS consider setting a universal transportation rate to be “billed” to FSW participants using the service, and make up the difference, as an agency, in the discrepancy between the “billed” sum and the reimbursement rate due to the provider of Tier 2 or Tier 3 services for transportation equity.
DDRS Response:
Based on these comments, we are including an increase in the transportation service cap within the FS to ensure that the number of trips allowed is not decreased from what was allowable prior to the rate increase.

Vehicle Modifications – Three comments were received on the vehicle modifications. All were in support of the revised/standalone definition of VMODs and increases to lifetime caps. Commenters suggested the need to allow lowered floor conversions in addition to outdated raised roof conversions.
DDRS Response:
Based on these comments, we are including lowered floor/door conversions and vehicle ramps as options under VMODs.

Remote Supports – We received a total of 6 comments in regard to the updates to the remote supports definition. All were in support of the service while citing a need to further enhance the service definition for clarity. A commenter also stated Algo 4-6 criteria requiring line of sight supervision is a deterrent for choosing Remote Supports.
DDRS Response:
Based on these comments, we are modifying Remote Supports definition to incorporate portions of suggested language from the Coalition for the Advancement and Integration of Remote Support Services. DDRS is working to re-promulgate Indiana Administrative Code as is required to incorporate changes to Algo criteria.

14% rate increase – We received 4 comments on the legislative directed 14% rate increase. All were in support of the increase however; 1 supporter also fears the increase could result in harm to other service systems by drawing staff away from other service areas where staffing shortages also exist. Concerns were cited that the increase was not applied to DSP’s who work as contractors.
DDRS Response:
Rate increases within the amendments are proposed to align with legislation largely supported by advocacy efforts. The legislation did not include applicability to contracted staff.

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 Individualized 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 Family Supports Waiver (FSW).

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 are 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 participants 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 complaints, 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 Division of 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 participants 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 of provider rates and any activities reimbursed through administrative funds and coverage and criteria for all Medicaid services, including state plan services.

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;
• Enrollment of qualified providers for waiver services;
• Conducting periodic training and providing technical assistance to waiver providers on waiver requirements;
• Timely submission of monthly and quarterly reports for all contracted activities;
• Collecting and analyzing waiver paid claims data
• Compiling waiver claims data to meet CMS annual waiver reporting requirements.

UTILIZATION MANAGEMENT FUNCTIONS:
The State of Indiana's Program Integrity (PI) has an agreement with the FSSA Audit Group to investigate allegations of Medicaid HCBS waiver provider fraud, waste, and abuse. PI and FSSA Audit are part of FSSA Quality & Compliance so there is a natural level of collaboration and cooperation between the two groups. FSSA Audit's auditors are knowledgeable of each waiver's service definitions, documentation standards, provider qualifications, and any required staffing ratios making them well equipped to investigate allegations of wrongdoing in the waiver programs. PI does not have staff with this kind of expertise.

PI receives allegations of Medicaid provider fraud, waste, and abuse and tracks these in its case management system. When it receives an allegation regarding a waiver provider, PI forwards it to FSSA Audit to begin their research and audit process. To begin investigating these allegations, FSSA Audit works with PI to vet the providers with the Medicaid Fraud Control Unit (MFCU). Once it receives MFCU's clearance FSSA Audit determines how to best validate the accuracy of the allegation.

FSSA Audit conducts its audit activities and develops a findings report for the provider which may include a corrective action plan and request for overpayment. FSSA Audit shares copies of its findings reports with PI so PI can track that the allegation was reviewed and follow-up action taken as necessary.

On a more proactive level, FSSA Audit also routinely meets with each of the State Medicaid Agency's units that operate the waivers to identify and conduct audits on providers that have been identified as potentially not billing correctly.

QUALITY ASSURANCE/QUALITY IMPROVEMENT CONTRACTOR is responsible for:
The discovery and remediation activities conducted for the waiver, including:
• Complaint investigation;
• Incident review;
• Mortality review;
• Case record review;
• Compliance evaluation review tool (CERT);
• National core indicator (NCI) surveys;
• Data driven review; and
• Certain aspects of provider re-approval.

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 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 FSW providers approved by DDRS.

• The DDRS Bureau of Quality Improvement Services (BQIS), with ongoing involvement of the Director of BQIS, conducts monitoring and oversight of the contractor of Quality Assurance/Quality Improvement.
• 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 Program Integrity. The direction of the FADS process is a fluid process, allowing for modification and adjustment in an on-going basis to ensure appropriate focus.

FSSA oversees the contracting Medicaid Fiscal Agent's monthly reports of reviews. Oversight of the Fiscal Agent also involves the DDRS/BDDS. The FSSA 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 FSSA's Office of Medicaid Policy and Planning and BDDS.

The majority of primary functions of the BQIS are completed by a contractor. Specifically, the Quality Improvement/Quality Assurance contractor is responsible for incident review, mortality review, complaint investigation, compliance evaluation review tool (CERT), case record review, data driven review, NCI surveys, and certain aspects of provider re-approval.

A BQIS executive staff position monitors this contract using a combination of compliance and quality assurance methods to ensure that contractors perform waiver operational and administrative functions in accordance with waiver requirements.
• A BQIS executive staff member meets with the contractor’s leadership on a bi-weekly basis to review and follow-up on outstanding issues.
• BQIS staff has weekly phone conferences with the contractor’s mortality review staff and complaint staff to review and follow-up on specific cases and issues.
• On a quarterly basis BQIS receives reports indicating the number of CERTs 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, complaint investigation, data driven review, case record 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 oversees the contractor’s interactions with others, as well as monitors that the contractor 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.

Appendix A: Waiver Administration and Operation

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

Function	Medicaid Agency	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 States quality improvement strategy, provide information in the following fields to detail the States 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:
1. Number and percent of waiver policies and procedures developed by 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):
Other
If 'Other' is selected, specify:
Presentation of policies or procedures; 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:
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):
Other
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:
3. Number and percent of waiver participants enrolled into the waiver in accordance with state-established criteria. Numerator: Total number of participants enrolled in accordance with state criteria. Denominator: Total number of waiver participants enrolled.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDRS targeted waiver slot report for FSW.

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**

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

Performance measures 1, 2, and 3: 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.

ii. Remediation Data Aggregation

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

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

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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**			☐
	☐	**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 Family Supports Waiver (FSW).

Eligibility requirements are found within the Family and Social Services Administration (FSSA) Bureau of Developmental Disabilities Services (BDDS) 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.

Individuals will be allowed a total cost limit of $19,614 per year for any combination of services selected under FSW. Individuals must utilize $1,575 of this budget for Case Management Services. The State reasonably expects that targeted individuals have available services and supports from sources other than the waiver (for example, natural supports, family caregivers, educational settings, or other public programs and supports) which, in combination with the waiver services, will be sufficient to ensure their health, safety and welfare.

As needed, the State will actively pursue other resources (including Medicaid State Plan services, natural supports, other community resources and the potential eligibility and movement to other waivers) for which the participant may be eligible.

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

◉ **The following dollar amount:**

Specify dollar amount: 19614

The dollar amount *(select one)*

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

Specify the formula:

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

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

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

All potentially eligible waiver participants who:
• meet ICF/IID LOC; and
• have been targeted from the FSW waiting list, or are found to meet reserved waiver capacity (priority) criteria with an available budgeted slot granting entry into FSW, are afforded the opportunity to develop a plan of care. The plan of care is based upon results of the Person-Centered Planning process and development of the Person-Centered/Individualized Support Plan by the applicant/participant-selected Individualized Support Team (as described in Appendix D), which is submitted to the State for review and determination.

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

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

☐ **The participant is referred to another waiver that can accommodate the individual's needs.**

☐ **Additional services in excess of the individual cost limit may be authorized.**

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

☒ **Other safeguard(s)**

Specify:

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

• Evaluate the participant for enrollment into another waiver administered by FSSA's Division of Disability and Rehabilitative Services (DDRS) when the participant meets the specific reserved waiver capacity criteria for entrance to that waiver
• Evaluate the participant to determine if they meet the eligibility criteria for participation under another waiver program administered by another Division within FSSA, such as a waiver requiring Nursing Facility Level of Care and administered by FSSA's Division of Aging. If so, complete a referral to the Division of Aging when the participant appears to meet criteria or upon participant request.

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

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	24173
Year 2	26231
Year 3	28181
Year 4	30028
Year 5	31777

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	

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
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
2: Eligible individuals transitioning from 100% state funded services
3:Eligible children who are either: 1) A child of an active member/veteran of the armed forces of the United States, defined in IC 5-9-4-2; 2) A child of an active member/veteran of the National Guard
1: Eligible individuals age 18-24 with permanent separation from their educational setting

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):*

2: Eligible individuals transitioning from 100% state funded services

Purpose *(describe):*

Individuals who are utilizing services that are funded by a 100% State funding appropriation are given priority for FSW as their Medicaid eligibility allows.

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:

Projections are based on historic usage over the past five years and on estimated impact Medicaid eligibility changes will have on individuals utilizing State funded services. As Indiana continues to review it's 100% state funded services it believes that there will not be a significant increase in individuals moving to a Waiver in Year 1.

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	5
Year 5	5

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):*

3:Eligible children who are either: 1) A child of an active member/veteran of the armed forces of the United States, defined in IC 5-9-4-2; 2) A child of an active member/veteran of the National Guard

Purpose *(describe):*

Qualified/eligible individual(s) who is the child of an active member or veteran of the armed forces of the United States or the National Guard are given priority for a FSW as their Medicaid eligibility allows. 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:

Projections are based on review of current enrollees.

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

Waiver Year	Capacity Reserved
Year 1	10
Year 2	10
Year 3	10
Year 4	10
Year 5	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):*

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

Purpose *(describe):*

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

Describe how the amount of reserved capacity was determined:

This reserved waiver capacity was determined based on prior experience over the past two waiver years and on analysis of trends surrounding the FSW Waiting List. As Indiana has reduced the amount of time individuals are on the Waiting List it has seen a significant increase in youth under the age of 18 being "targeted" for the FSW. Because Indiana is enrolling so many individuals in this age range prior to their time in an educational setting ending, it is finding that there is a lower incident of use in this priority category. Indiana is committed to serving this transitional population and will continue to prioritize slots for these individuals but it is finding that fewer slots are needed to serve this group.

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.

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

Waiver Year	Capacity Reserved
Year 1	35
Year 2	35
Year 3	35
Year 4	35
Year 5	35

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 FSW is governed on a first come, first served basis by the applicant's signed and dated application for waiver services. Applicants are added to the single statewide wait list until they are first in line for an available, funded waiver slot. Entrance to FSW may also occur via the reserved capacity (priority) criteria noted in Appendix B-3-c when requests are reviewed and approved by BDDS Executive staff.

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**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [ ] **Optional state supplement recipients**
- [x] **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

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

Specify percentage:

- [ ] **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- [x] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**

☒ **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:

☒ **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 spend down 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 7)

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. 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:

Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☒ **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 uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (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 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

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 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

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 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

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-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.

Answers provided in Appendix B-5-a indicate the selections in B-5-b also apply to B-5-e.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

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 (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

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. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

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

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

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 a government agency under contract with the Medicaid agency.**

Specify the entity:

◉ **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.

Addendum:
Level of care evaluation by an FSSA employee is considered a case management function. While FSSA no longer utilizes the level 2 case management services specified within the below citation from Indiana Administrative Code, the ongoing qualifications for case management are found within the Sec. 5. (a) (1) through (3) references to Level 1 case management services. Among those qualifications is the requirement that the case manager meet the experience requirements for a qualified intellectual disability professional, or QIDP, (formerly known as a qualified mental retardation professional, or QMRP, which is the language that still appears in 460 IAC 6).

When hiring an FSSA/BDDS staff member who will be completing level of care, BDDS requires the following:

460 IAC 6-5-5 Case management services provider qualifications

Sec. 5. (a) To be approved to provide case management services as a Level 1 case management services provider, an applicant shall meet the following requirements:
(1) Have a bachelor's degree, be a registered nurse licensed under IC 25-23-1, or be employed by the state in a PAT III position.
(2) Meet the experience requirements for a qualified mental retardation professional in 42 CFR 483.430(a).
(3) Complete a course of case management orientation that is approved by the BDDS.
(b) To be approved to provide case management services as a Level 2 case management services provider, an applicant shall meet the following requirements:
(1) Have at least a four (4) year college degree with no direct care experience; or
(2) Have a high school diploma, or equivalent, and have a least five (5) years experience working with persons with mental retardation or other developmental disabilities; and
(3) Be supervised by a Level 1 case management services provider who is supervising no more than four (4) other Level 2 case management services providers.
(4) Complete a course of case management orientation that is approved by the BDDS.
(c) For an entity to be approved to provide case management services, the entity shall certify that, if approved, the entity will provide case management services using only persons who meet the qualifications set out in this section. (Division of Disability and Rehabilitative Services; 460 IAC 6-5-5; filed Nov 4, 2002, 12:04 p.m.: 26 IR 757; readopted filed Sep 26, 2008, 11:11 a.m.: 20081015-IR-460080618RFA; readopted filed Aug 11, 2014, 11:20 a.m.: 20140910-IR-460140241RFA)

As referenced in the above 460IAC 6-5-5 citation, the Code of Federal Regulations citation, the 42 CFR §483.430 paragraphs (a) and (b)(5) pertain to QIDP qualifications:
§483.430 Condition of participation: Facility staffing.
(a) Standard: Qualified intellectual disability professional. Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional who—
(1) Has at least one year of experience working directly with persons with intellectual disability or other developmental disabilities; and
(2) Is one of the following:
(i) A doctor of medicine or osteopathy.
(ii) A registered nurse.
(iii) An individual who holds at least a bachelor's degree in a professional category specified in paragraph (b)(5) of this section.

Paragraph (b) is the “Standard: Professional program services”. Within the referenced “professional category specified in paragraph (b)(5)”, item (b)(5) states that, “Professional program staff must be licensed, certified, or registered, as applicable, to provide professional services by the State in which he or she practices. Those professional program staff who do not fall under the jurisdiction of State licensure, certification, or registration requirements, specified in §483.410(b), must meet the following qualifications:” Numerous professions such as Occupational Therapists and Speech-Language Pathologists are cited within this section, but those with potential relevance to conducting level of care

evaluations would include social workers and human services professionals, whose educational requirements are stated as follows:

(vi) To be designated as a social worker, an individual must—
(A) Hold a graduate degree from a school of social work accredited or approved by the Council on Social Work Education or another comparable body; or
(B) Hold a Bachelor of Social Work degree from a college or university accredited or approved by the Council on Social Work Education or another comparable body.

AND

(x) To be designated as a human services professional an individual must have at least a bachelor's degree in a human services field (including, but not limited to: sociology, special education, rehabilitation counseling, and psychology).

DDRS/BDDS only permits staff meeting the requirements of a QIDP to make eligibility/level of care determinations.

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

To complete a waiver level of care determination, 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 each of four basic conditions (listed below) and three of six substantial functional limitations in order to meet LOC.

- The basic conditions are:
  1) an impairment/confirmed diagnosis of intellectual disability, cerebral palsy, epilepsy, autism, or condition similar to intellectual disability,
  2) the impairment/basic condition identified is expected to continue without a foreseeable end,
  3) the impairment/basic condition identified had an onset prior to age 22,
  4) the impairment/basic condition results in at least three of six substantial functional limitations.
- 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.

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 Cost Comparison Budget (CCB) when a LOC redetermination has not been completed within required time frames.

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

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

are maintained:

Records are maintained by BDDS 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 States quality improvement strategy, provide information in the following fields to detail the States 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:
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 – FSW 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.

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDRS targeted waiver slot report for FS 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:

Performance Measure:

3.Number and percent of participants whose annual level of care was conducted based on requirements for determining level of care in the waiver. Numerator: The total number of participants whose annual level of care was conducted based on

requirements for determining level of care in the waiver. Denominator: The total number of participants due for an annual level of care.

Data Source (Select one):
Other
If 'Other' is selected, specify:
LOCsi Detail Report - annuals

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**

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

Performance Measure:
4. Number and percent of initial levels of care completed accurately. Numerator: The total number of participants whose initial level of care was completed accurately. Denominator: The total number of participants with an initial level of care.

Data Source (Select one):
Other
If 'Other' is selected, specify:
LOCsi Detail Report - initials

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 States 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.

Performance measures 1 through 4: 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 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.

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

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 so that 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. Thirty 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 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**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	☐ **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 FSW, an FSSA's 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 service coordinator is responsible for obtaining the BDDS signature page form with the "Freedom of Choice" section completed and uploading the form into the State's case management system.

The signed form reflects the individual/participant/guardian's choice between waiver services and nonwaiver/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 RiskBased Managed Care. In Indiana, the Risk-Based Managed Care programs and HCBS waiver programs are mutually exclusive.

A 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 CCB is developed. The CCB is used for waiver participants at the time of initial determinations, updates, and annual re-determinations. Although a BDDS signature page form documenting freedom of choice is obtained with each service plan update, a statement regarding freedom of choice is also contained in Section I of the CCB form. The waiver participant/guardian signs and dates this section of the 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 FSW 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 uploaded into the State's case management system by the BDDS 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 State's case management system.

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 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 State of Indiana offers a variety of links for potential translation opportunities at https://www.in.gov/health/minority-health/minority-health-resources/language-translation-and-migrant-programs/, a webpage titled Language, Translation, & Migrant Programs.

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

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	**Adult Day Services**		
Statutory Service	**Case Management**		
Statutory Service	**Prevocational Services**		
Statutory Service	**Respite**		
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 (Terminated Eff. 7/31/2020)**		
Other Service	**Community-Based Habilitation-Individual (Terminated Eff. 7/31/2020)**		
Other Service	**Day Habilitation**		
Other Service	**Environmental Modifications**		
Other Service	**Extended Services**		
Other Service	**Facility Based Habilitation-Group (Terminated Eff. 7/31/2020)**		
Other Service	**Facility Based Support Services**		
Other Service	**Facility-Based Habilitation-Individual (Terminated Eff. 7/31/2020)**		
Other Service	**Family and Caregiver Training**		
Other Service	**Intensive Behavioral Intervention**		
Other Service	**Music Therapy**		
Other Service	**Participant Assistance and Care**		
Other Service	**Personal Emergency Response System**		
Other Service	**Recreational Therapy**		
Other Service	**Remote Supports**		
Other Service	**Specialized Medical Equipment and Supplies**		
Other Service	**Transportation**		

Service Type	Service		
Other Service	Vehicle Modifications		
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: 04 Day Services

Sub-Category 1: 04050 adult day health

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition *(Scope):*

Category 4:

Sub-Category 4:

Adult day services (ADS) are community-based group programs designed to support participants as specified through the PCISP. These programs encompass both the health and social service needs to ensure the optimal functioning of the participant. Meals and/or nutritious snacks are required. The meals provided as part of these services do not constitute a “full nutritional regimen (i.e., three meals per day).

However, each meal must meet 1/3 of the daily Recommended Dietary Allowance. These services must be provided in a non-institutional, community-based setting in one of three available levels of service: basic, enhanced or intensive.

Participants attend ADS on a planned basis. A maximum of 12 hours per day shall be allowable.

A 1/2 day unit is defined as one unit of three hours to a maximum of five hours/day. Two units is more than five hours to a maximum of eight 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 three hours or more than eight hours of ADS have been provided on the same day. A maximum of 16 1/4 hour units/day are allowed.

Reimbursable activities:

Basic ADS (Level 1) includes:
• Person-centered monitoring and/or support for 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.
• Monitoring medication or medication administration.
• Appropriate structure and support for those with mild cognitive impairment.
• Minimum staff ratio: One staff for each eight participants.

Enhanced ADS (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.
• Dispensing or supervision of the dispensing of medication.
• Psychological needs assessed and addressed, including counseling as needed for participants and caregivers.
• Therapeutic structure, support, and intervention for those with mild to moderate cognitive impairments.
• Minimum staff ratio: One staff for each six participants.

Intensive ADS (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 participants.

ADS may be used in conjunction with Transportation Services.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

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

ADS 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**
- ☒ **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 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 Documentation of Criminal Histories;
 • 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance;
 • 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers;
 • 460 IAC 6-5-2 Adult Day Services Provider Qualifications;
 • 460 IAC 6-14-5 Requirements for Direct Care Staff;
 • 460 IAC 6-14-4 Training;
 • 460 IAC 6-34-1 through 460 IAC 34-3 Transportation Services.
- Must obtain/maintain accreditation (specific to Indiana programs) by at least one (1) of the following organizations:
 • The Commission on Accreditation of Rehabilitation Facilities (CARF), or its successor.
 • The Council on Quality and Leadership In Supports for People with Disabilities, or its successor.
 • The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or its successor.
 • The National Committee for Quality Assurance, or its successor.
 • The ISO-9001 human services QA system.
 • 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
Category 2:	**Sub-Category 2:**

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

Service Definition *(Scope):*

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

Case management provides an array of services that assist individuals in gaining access to needed waiver and other Medicaid State plan services, as well as medical, social, educational, and other services, regardless of the funding source for the services or community supports to which access is gained. Case managers advocate alongside the individual to ensure their access and opportunities for participation in all paid and unpaid services, programs, and settings which allow for building social capital, skill development, and personal fulfillment.

Case management services includes annual planning and assessment and ongoing case management support.

REIMBURSABLE ACTIVITIES

A. Annual planning and assessment – initial and annual activities outlined by BDDS that support the individual in:
i. Establishing a person-centered, strengths based PCISP that supports the individual's vision of a good life through offering opportunities for
integrated supports. The individual must be present and supported to facilitate development of the plan to the greatest extent possible;
ii. Developing an annual budget in support of the PCISP; and
iii. Determining continued eligibility for services.

B. Ongoing case management services are based on the principles of person-centered thinking and driven by the PCISP. Person-centered practices include:
i. Convening IST meetings at least semi-annually. IST meetings may be held in a manner desired by the individual and guardian, if applicable;
individual and guardian, if applicable, must be present for all IST meetings
ii. Conducting face-to-face contacts with the individual and guardian, if applicable, for the purpose of relationship building and knowledge of
individual at least once semi-annually and as needed.
a. At least one visit each year must be held in the home of the waiver individual.
b. For individuals residing in provider owned and/or controlled settings (as defined by CMS and DDRS), case managers must ensure at least one
visit each year is unannounced.
c. Face-to-face visits must be intentional interactions and may not be held as drop-in visits at a day program.
d. IST meetings and face-to-face contacts are both required in a manner that ensures interaction at least every 90 days.
iii. Regularly reviewing and updating the PCISP including when:
a. The needs or circumstances of the individual have changed;
b. Services are added or changed;
c. At the request of the individual and guardian, if applicable;
d. For nonannual team meetings, to record team discussions on outcomes and any related plan changes.
iv. Identifying, assessing, and addressing risks initially and as needed.
v. Updating service plans and timely submission of budget requests consistent with the individual's PCISP.
vi. Monitoring service delivery and utilization to ensure that services are being delivered in accordance with the PCISP.
vii. Monitoring individuals' health and safety.
viii. Assessing individuals' satisfaction and service outcomes and sharing the results with BDDS at least annually.
ix. Completing and processing the Monitoring Checklist within BDDS established timeline.
x. Completing, submitting, and following up on incident reports as established by BQIS.
xi. Completing case notes and necessary PCISP revisions documenting each encounter with or on behalf of the individual within 7 calendar days at a
minimum. Case managers must have at least one documented meaningful encounter monthly to support billing.
xii. Disseminating information including the PCISP, all Notices of Action and forms to the individual, guardian, if applicable, and the IST.
xiii. Maintaining files in accordance with State standards
xiv. In the absence of a residential provider, conduct mortality reviews in accordance with 460 Indiana Administrative Code 6 and BDDS/BQIS policy and
guidance

NOTE: Timeframes related to required activities, service standards and/or responsibilities of the case manager are

specified in the DDRS HCBS Waivers module which is located at
https://www.in.gov/medicaid/files/ddrs%20hcbs%20waivers.pdf

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 or otherwise have a financial investment in any other waiver service.
• The case management entity may not subcontract with another agency or case manager for the provision of direct case management services.
• Case managers may not be contractors of the case management entity.
• Caseload average in excess of 45 across the case management entity's active, full-time case managers who carry caseloads.
• The case management entity may not bill in a month for solely non-case management related activities or tasks such as mailing greeting cards or holiday text messages, for example
• Reimbursement is not available through case management services for the following activities or any other activities that do not fall under the previously listed definition:
o Services delivered to persons who do not meet eligibility requirements established by DDRS/BDDS.
o Counseling services related to legal issues. Such issues shall be directed to the Indiana Disability Rights, the designated Protection and Advocacy agency under the Developmental Disabilities Act and Bill of Rights Act, P.L. 100-146.
o Case management conducted by a legal guardian or person related through blood or marriage to any degree to the individual.

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 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 be eligible to provide case management services in every county.
• Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
  o 460 IAC 6-10-5 Documentation of Criminal Histories;
  o 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance;
  o 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers;
  o IAC 6-19-1 through 460 IAC 6-19-9 Case Management, and
  o 460 IAC 6-5-5 Case Management Services Provider Qualifications.
• Must obtain/maintain accreditation (specific to Indiana programs) by at least one (1) of the following organizations:
  o The Commission on Accreditation of Rehabilitation Facilities (CARF), or its successor.
  o The Council on Quality and Leadership in Support for People with Disabilities, or its successor.
  o The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or its successor.
  o The ISO-9001 human services QA system.
  o The Council on Accreditation, or its successor.
  o An independent national accreditation organization approved by the secretary.

• Must develop and enforce a code of ethics aligned with 460 IAC 6-14-7 and BDDS policy, practices and guidance.
• Maintain a sufficient number of Case Managers to provide statewide coverage while maintaining an average caseload size of no more than forty-five (45) cases across full-time Case Managers who actively provide case management services to Individuals receiving waiver services. A full-time Case Manager is defined as a Case Manager with a caseload of at least 21 cases. The State will monitor adherence to this caseload limit on a quarterly basis.
• Ensure, ongoing, that criminal background checks are conducted for every employee hired or associated with the approved case management entity as stated Indiana Administrative Code, Indiana Code and BDDS policy.

Compliance

• Retain at least one full-time employee to actively monitor and ensure all areas of compliance and quality.
  o Persons in this role may not carry a case load of more than 10 cases.
  o Persons in this role may not do quality and compliance reviews on their own caseload.
  o Persons in this role will monitor and identity any violation of rules, regulations, or established requirements that are discovered and report them to BQIS through the incident reporting system as outlined in Indiana Administrative Code, Indiana Code and BQIS policy.
• Have a mechanism for monitoring the quality of services delivered by case managers that aligns with BDDS practices; and addressing any quality issues that are discovered and reporting them to BDDS/BQIS.
• All DDRS-approved case management agencies specifically agree to comply with the provisions of the Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq. and 47 U.S.C. 225).
• Case management entities must:
  o Ensure compliance with any applicable FSSA/DDRS/BDDS/BQIS service standards, guidelines, policies and/or manuals, including policies, written agreements and the DDRS HCBS Waivers Provider Reference Module on the IHCP Provider Reference Materials webpage;
  o Ensure case managers meet with waiver individuals on a regular basis or as requested by the individual to develop, update, and support the execution of person-centered individualized support;
  o Require initially and annually, that each case manager employed by the DDRS-approved case management agency obtain proof of competency demonstrated through successful completion of the DDRS/BDDS- case management training curriculum and certification exam;
  o Ensure case managers complete and demonstrate competency of the BDDS required training;
  o Ensure case managers complete the required hours of BDDS approved, case management entity provided, training;
  o Ensure that case managers are trained in the person-centered planning process aligned with BDDS and BQIS' mission, vision and values, including participation in any BDDS person-centered trainings;

o Ensure case managers shall have the ability to employ whatever tools necessary to effectively and efficiently communicate with each individual by whatever means is preferred by the individual; and
o Ensure case managers meet with one or more of the following qualification standards:
- Hold a bachelor's degree in one of the following specialties from an accredited college or university:
• Social work, Psychology, Sociology, Counseling, Gerontology, Nursing, Special education, Rehabilitation, or related degree if approved by the FSSA/DDRS/OMPP;
• Be a registered nurse with one-year experience in human services; or
• Hold a bachelor's degree in any field with a minimum of one year full-time, direct experience working with persons with intellectual/developmental disabilities.
- Holding a master's degree in a related field may substitute for required experience.
- The case manager must meet the requirements for a qualified intellectual disability professional in 42 CFR 483.430(a).

Technology

Case management entities must:
• Provide and maintain a 24/7 emergency response system that does not rely upon the area 911 system and provides assistance to all waiver individuals. The 24/7 line staff must assist individuals or their families with addressing immediate needs and contact the individual's case manager to ensure arrangements are made to address the immediate situation and to prevent reoccurrences of the situation;
• Maintain sufficient technological capability to submit required data electronically in a format and through mechanisms specified by the State; and
• Ensure each case manager is properly equipped with a cell phone, smart phone, or similar device that allows the case manager to be accessible as needed to the individuals he or she serves.

Conflict-Free Case Management

• Indiana maintains a conflict-free case management policy. This covers conflict of interest in terms of provision of services as well as in relationship to the individual being served. Conflict-free means:
o Case management agencies may not be an approved provider of any other waiver service;
o The owners of one case management agency may not own multiple case management agencies;
o The owners of one case management agency may not be a stakeholder of any other waiver service agency; and
o There may be no financial relationship between the referring case management agency, its staff, and the provider of other waiver services.
o Case managers may not be financially influenced in the course of their service delivery
• In addition, case managers must not be:
o Related by blood or marriage to the individual;
o Related by blood or marriage to any paid caregiver of the individual;
o Financially responsible for the individual; or
o Authorized to make financial or health-related decisions on behalf of the individual.

Note: Case management services are mandatory for all waiver individuals.

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 provide learning and work experiences, including volunteer work, where the participant can develop general, non-job-task-specific strengths and skills that contribute to employability in integrated community settings.

Participants receiving prevocational services must have employment-related goals in their PCISP. Prevocational services are intended to develop and teach general skills that lead to competitive and integrated employment including:
• Ability to communicate effectively with supervisors, co-workers and customers.
• Generally accepted community workplace conduct and dress.
• Ability to follow directions.
• Ability to attend to tasks.
• Workplace problem solving skills and strategies.
• General workplace safety and mobility training.

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 PCISP 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 transferable employment skills acquisition.

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

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**

☒ **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 Prevocational Agency
Individual	FSSA/DDRS Approved Prevocational Services Individual

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 Documentation of Criminal Histories;
• 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance;
• 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers;
• 460 IAC 6-5-20 Prevocational Services Provider Qualifications;
• 460 IAC 6-14-5 Requirements for Direct Care Staff;
• 460 IAC 6-14-4 Training.

-Must comply with any applicable FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS BDDS policies and the FSSA/DDRS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

-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:

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 Documentation of Criminal Histories;
• 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance;
• 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers;
• 460 IAC 6-5-20 Prevocational Services Provider Qualifications;
• 460 IAC 6-14-5 Requirements for Direct Care Staff;
• 460 IAC 6-14-4 Training.

-Must comply with any applicable FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS BDDS policies and the FSSA/DDRS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

-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:

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 because of the absence or need for relief of those persons who normally provide care for the participant. 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/support.
• 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 support 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 services 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 (PCISP.
• 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**
☒ **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 Licensed Home Health Agencies
Individual	FSSA/DDRS Approved Respite Providers - Individual - Skilled Nursing
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:
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 Documentation of Criminal Histories;
• 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance;
• 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers;
• 460 IAC 6-5-26 Respite Care Services Provider Qualifications;
• 460 IAC 6-5-14 Heath Care Coordination Services Provider Qualifications;
• 460 IAC 6-14-5 Requirements for Direct Care Staff;
• 460 IAC 6-14-4 Training.

-Must comply with any applicable FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS BDDS policies and the FSSA/DDRS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

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 - 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 Documentation of Criminal Histories;
• 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance;
• 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers;
• 460 IAC 6-5-26 Respite Care Services Provider Qualifications;
• 460 IAC 6-5-14 Heath Care Coordination Services Provider Qualifications;
• 460 IAC 6-14-5 Requirements for Direct Care Staff;
• 460 IAC 6-14-4 Training.

-Must comply with any applicable FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS BDDS policies and the FSSA/DDRS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

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:

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 Documentation of Criminal Histories;
• 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance;
• 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers;
• 460 IAC 6-5-26 Respite Care Services Provider Qualifications;
• 460 IAC 6-5-14 Heath Care Coordination Services Provider Qualifications;
• 460 IAC 6-14-5 Requirements for Direct Care Staff;
• 460 IAC 6-14-4 Training.

-Must comply with any applicable FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS BDDS policies and the FSSA/DDRS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

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 Documentation of Criminal Histories;
• 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance;
• 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers;
• 460 IAC 6-5-26 Respite Care Services Provider Qualifications;
• 460 IAC 6-5-14 Heath Care Coordination Services Provider Qualifications;
• 460 IAC 6-14-5 Requirements for Direct Care Staff;
• 460 IAC 6-14-4 Training.

-Must comply with any applicable FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS BDDS policies and the FSSA/DDRS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

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 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.

This waiver service is only provided to individuals ages 21 and over. All medically necessary occupational therapy services for children under age 21 are covered in the state plan benefit pursuant to the EPSDT benefit.

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

If participants under age 21 choose to utilize Occupational Therapy, they should access Occupational Therapy services through EPSDT.

ACTIVITIES NOT ALLOWED

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Licensed Occupational Therapist
Agency	FSSA/DDRS Approved Agency Providing Occupational 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: Occupational Therapy

Provider Category:
Individual
Provider Type:

Licensed 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 Documentation of Criminal Histories;
• 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance;
• 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers;
• 460 IAC 6-5-17 Occupational Therapy Services Provider Qualifications.

-Must comply with any applicable FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS BDDS policies and the FSSA/DDRS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

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:

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 Documentation of Criminal Histories;
• 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance;
• 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers;
• 460 IAC 6-5-17 Occupational Therapy Services Provider Qualifications.

-Must comply with any applicable FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS BDDS policies and the FSSA/DDRS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

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 Documentation of Criminal Histories;
• 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance;
• 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers;
• 460 IAC 6-5-17 Occupational Therapy Services Provider Qualifications.

-Must comply with any applicable FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS BDDS policies and the FSSA/DDRS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

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 means services provided by a licensed physical therapist.

• 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.

This waiver service is only provided to individuals ages 21 and over. All medically necessary physical therapy services for children under age 21 are covered in the state plan benefit pursuant to the EPSDT benefit.

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

If participants under age 21 choose to utilize Physical Therapy services, they should access Physical Therapy services through EPSDT.

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**
☒ **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 Agency Providing Physical Therapy
Individual	Licensed Physical Therapist
Agency	Home Health Agencies

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

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 Documentation of Criminal Histories,
• 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance,
• 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers,
• 460 IAC 6-5-18 Physical Therapy Services Provider Qualifications

-Must comply with any applicable FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS BDDS policies and the FSSA/DDRS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

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:

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 Documentation of Criminal Histories,
• 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance,
• 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers,
• 460 IAC 6-5-18 Physical Therapy Services Provider Qualifications

-Must comply with any applicable FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS BDDS policies and the FSSA/DDRS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

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:

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 Documentation of Criminal Histories,
• 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance,
• 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers,
• 460 IAC 6-5-18 Physical Therapy Services Provider Qualifications

-Must comply with any applicable FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS BDDS policies and the FSSA/DDRS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

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 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

This waiver service is only provided to individuals ages 21 and over. All medically necessary psychological therapy services for children under age 21 are covered in the state plan benefit pursuant to the EPSDT benefit.

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

If participants under age 21 choose to utilize Psychological Therapy, they should access Psychological Therapy services through EPSDT.

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**

☒ **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 Qualified Agencies
Individual	Mental Health Counselor
Individual	Licensed Psychologists
Individual	Clinical Social Worker

Provider Category	Provider Type Title
Individual	Marriage/Family Therapist

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 Documentation of Criminal Histories,
• 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance,
• 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers,
• 460 IAC 6-5-21 Therapy Services Provider Qualifications

-Must comply with any applicable FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS BDDS policies and the FSSA/DDRS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Up to 3 years.

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Mental Health Counselor

Provider Qualifications

License *(specify):*

IC 25-23.6

Certificate *(specify):*

Other Standard *(specify):*

-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 Documentation of Criminal Histories,
• 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance,
• 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers,
• 460 IAC 6-5-21 Therapy Services Provider Qualifications

-Must comply with any applicable FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS BDDS policies and the FSSA/DDRS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Up to 3 years.

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Licensed Psychologists

Provider Qualifications

License *(specify):*

IC 25-33-1-5.1

Certificate *(specify):*

Other Standard *(specify):*

-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 Documentation of Criminal Histories,
• 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance,
• 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers,
• 460 IAC 6-5-21 Therapy Services Provider Qualifications

-Must comply with any applicable FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS BDDS policies and the FSSA/DDRS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

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:

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 Documentation of Criminal Histories,
• 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance,
• 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers,
• 460 IAC 6-5-21 Therapy Services Provider Qualifications

-Must comply with any applicable FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS BDDS policies and the FSSA/DDRS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

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 Documentation of Criminal Histories,
• 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance,
• 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers,
• 460 IAC 6-5-21 Therapy Services Provider Qualifications

-Must comply with any applicable FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS BDDS policies and the FSSA/DDRS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

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 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.

This waiver service is only provided to individuals ages 21 and over. All medically necessary speech/language therapy services for children under age 21 are covered in the state plan benefit pursuant to the EPSDT benefit.

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

If individuals under age 21 choose to utilize Speech/Language Therapy, they should access Speech/Language Therapy services through EPSDT.

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**
- ☒ **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Licensed Speech/Language Therapist
Agency	FSSA/DDRS Approved Agency providing Speech/Language 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: 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 Documentation of Criminal Histories,
• 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance,
• 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers,
• 460 IAC 6-5-28 Speech-Language Therapy Services Provider Qualifications

-Must comply with any applicable FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS BDDS policies and the FSSA/DDRS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

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:

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 Documentation of Criminal Histories,
• 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance,
• 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers,
• 460 IAC 6-5-28 Speech-Language Therapy Services Provider Qualifications

-Must comply with any applicable FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS BDDS policies and the FSSA/DDRS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

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 Documentation of Criminal Histories,
• 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance,
• 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers,
• 460 IAC 6-5-28 Speech-Language Therapy Services Provider Qualifications

-Must comply with any applicable FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS BDDS policies and the FSSA/DDRS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

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 supports are an array of services designed to assist individuals who are experiencing or are likely to experience challenges accessing, and actively participating in the community as a result of behavioral, social, or emotional challenges.

Behavioral support services are intended to empower individuals and families (by leveraging their strengths and unique abilities) to achieve self-determination, interdependence, productivity, integration and inclusion in all facets of community life, across all environments, across the lifespan.

REIMBURSABLE ACTIVITIES:

• Completing the functional behavioral assessment: this includes observation, environmental assessment, record reviews, interviews, data collection, complete psychosocial and biomedical history to identify targeted behaviors, the function of those behaviors, and to hypothesize the underlying need for new learning. Based on the principals of person-centered thinking and positive behavioral support, the assessment process should inform the recommendations for development of the behavioral support plan.
• Developing a comprehensive behavioral support plan and subsequent revisions: this includes devising proactive and reactive strategies designed to support the participant. Any restrictive techniques employed as part of the behavioral support plan must be approved by a human rights committee, be time-limited, and regularly reviewed for elimination or reduction of the restrictive techniques to ensure appropriate reduction in these interventions over time.
• Obtaining consensus of the IST that the behavioral support plan is feasible for implementation and uses the least restrictive methods possible.
• Supporting the participant in learning new, positive behaviors as outlined in the behavioral support plan. This may include coping strategies, improving interpersonal relationships, or other positive strategies to reduce targeted behaviors and increase quality of life.
• Consulting with team members to achieve the outcomes of assessment and behavioral support planning.
• Concurrent service delivery of behavioral support services with other approved Medicaid services is allowable under the following conditions:
  o The service being provided concurrently with behavioral support services is not similar in nature, does not have a similar purpose, and does not promote similar outcomes to behavioral support services.
  o The need for the concurrent service is clearly documented in the behavioral support plan, and outlines the individualized assessed need, and how the behavioral support service will support or contribute to the specified need.

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

ACTIVITIES NOT ALLOWED

• Restrictive techniques - any techniques not approved by the IST and the human rights committee.
• Therapy services provided to the participant within the educational/school setting or as a component of the participant’s school day.
• Services provided to a minor by a parent(s), step-parent(s), or legal guardian.
• Services provided 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 behavioral supports.

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

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☒ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

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

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 Documentation of Criminal Histories,
• 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance,
• 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers,
• 460 IAC 6-5-4 Behavioral Support Services Provider Qualifications,
• 460 IAC 6-18-1 to 460 IAC 6-18-7 Behavioral Support Services

-Must comply with any applicable FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS BDDS policies and the FSSA/DDRS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

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:

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 Documentation of Criminal Histories,
• 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance,
• 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers,
• 460 IAC 6-5-4 Behavioral Support Services Provider Qualifications,
• 460 IAC 6-18-1 to 460 IAC 6-18-7 Behavioral Support Services

-Must comply with any applicable FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS BDDS policies and the FSSA/DDRS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

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 (Terminated Eff. 7/31/2020)

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):*

** Standalone COMMUNITY-BASED HABILITTION-GROUP services terminate at the end of 7/31/2020, to become an available component of the newly combined DAY HABILITATION services effective 8/1/2020. **

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**
☒ **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 Community Based Habilitation - Individuals
Agency	FSSA/DDRS Approved Community Based Habilitation Agencies

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community-Based Habilitation-Group (Terminated Eff. 7/31/2020)

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 BDDS policies and the FSSA/DDRS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

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-Group (Terminated Eff. 7/31/2020)

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 BDDS policies and the FSSA/DDRS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

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 (Terminated Eff. 7/31/2020)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04020 day habilitation

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

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

Service Definition *(Scope):*

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

** Standalone COMMUNITY-BASED HABILITTION-INDIVIDUAL services terminate at the end of 7/31/2020, to become an available component of the newly combined DAY HABILITATION services effective 8/1/2020 **

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:

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

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

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

☐ **Participant-directed as specified in Appendix E**

☒ **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 Community Based Habilitation - Individuals
Agency	FSSA/DDRS Approved Community Based Habilitation Agencies

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community-Based Habilitation-Individual (Terminated Eff. 7/31/2020)

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 BDDS policies and the FSSA/DDRS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

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 (Terminated Eff. 7/31/2020)

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 BDDS policies and the FSSA/DDRS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

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:

Day Habilitation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04020 day habilitation

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

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

Service Definition *(Scope):*

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

Day habilitation (effective 8/1/2020) are services that are specified in the PCISP and support learning and assistance in the areas of: self-care, sensory/motor development, socialization, daily living skills, communication, community living, and social skills. Day habilitation activities are intended to build relationships and natural supports.

Services are provided in a variety of settings in the community or in a facility owned or operated by an FSSA/DDRS-approved provider. Settings are non-residential and separate from a participant's private residence or other residential living arrangements.

Ratio Sizes:
• 1:1 Individual
• 2:1 to 4:1 Small Group
• 5:1 to 10:1 Medium Group
• 11:1 to 16:1 Large Group (applies only to a facility setting)

REIMBURSABLE ACTIVITIES:

Person-centered monitoring, training, education, demonstration, or support to assist the participant 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 a participant habilitation outcome.
• Activities that do not foster the acquisition and retention of skills.
• Activities that would typically be a component of a person's residential life or services, such as: shopping, banking, household errands, appointments, etc.
• Services furnished to a minor by parent(s), step parents(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**

☒ **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 day habilitation service providers, which include community-based habilitation service providers and facility-based habilitation service providers.
Individual	FSSA/DDRS-approved day habilitation service providers, which include community-based habilitation service providers and facility-based habilitation service providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Day Habilitation

Provider Category:

Agency

Provider Type:

FSSA/DDRS-approved day habilitation service providers, which include community-based habilitation service providers and facility-based habilitation service providers.

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 Documentation of Criminal Histories,
• 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance,
• 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers,
• 460 IAC 6-14-5 Requirements for Direct Care Staff,
• 460 IAC 6-14-4 Training,
• 460 IAC 6-5-14 Health Care Coordination Services Provider Qualifications, and
• 460 IAC 6-5-30 Transportation Services Provider Qualifications

-Must comply with any applicable FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS BDDS policies and the FSSA/DDRS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

-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: Day Habilitation

Provider Category:

Individual

Provider Type:

FSSA/DDRS-approved day habilitation service providers, which include community-based habilitation service providers and facility-based habilitation service providers

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 Documentation of Criminal Histories,
• 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance,
• 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers,
• 460 IAC 6-14-5 Requirements for Direct Care Staff,
• 460 IAC 6-14-4 Training,
• 460 IAC 6-5-14 Health Care Coordination Services Provider Qualifications, and
• 460 IAC 6-5-30 Transportation Services Provider Qualifications

-Must comply with any applicable FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS BDDS policies and the FSSA/DDRS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

-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:

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:**

Service Definition *(Scope):*

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

Environmental modifications are those physical adaptations to the home, required by the PCISP, which are necessary to ensure the health, welfare and safety of the participant, or which enable the participant to function with greater independence in the home.

DDRS' waiver services staff 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 participant 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 per waiver.

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 participant (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 PCISP.
• 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 participants who live in homes owned by a service provider.
• 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**
☒ **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 Agencies**
Individual	**Qualified contractors, architects, licensed contractors, builders, individuals, home inspectors, plumbers, licensed PT, OT, ST - Individual**

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):*

As applicable:
Home Health Agencies - IC 16-27-1
Occupational Therapy - IC 25-23.5
Physical Therapy - IC 25-27-1
Speech/Language Therapy - 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 Documentation of Criminal Histories,
• 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance,
• 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers,
• 460 IAC 6-5-11 Environmental Modification Supports Provider Qualifications

Must comply with any applicable FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS BDDS policies and the FSSA/DDRS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

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 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: 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):*

As applicable:
Home Inspector - IC 25-20.2
Plumber - IC 25-28.5
Home Health Agencies - IC 16-27-1
Occupational Therapy - IC 25-23.5
Physical Therapy - IC 25-27-1
Speech/Language Therapy - 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 Documentation of Criminal Histories,
- 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance,
- 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers,
- 460 IAC 6-5-11 Environmental Modification Supports Provider Qualifications

Must comply with any applicable FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS BDDS policies and the FSSA/DDRS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

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 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 participant to maintain integrated competitive employment in a community setting. Participants 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 participant to continue to be as independent as possible in community employment. If an employed participant 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 PCISP 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.

Documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.). Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
1. Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment; or
2. Payments that are passed through to users of supported employment services.

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 a participant 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 support 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.
• Travel by the provider to the job site is allowable as part of the delivery of this service.

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.

With the exception of 1:1 on the job coaching, support and observation, the potential exists for all components of the extended services service definition to be applicable to either an individual waiver participant or to a group of participants. However, specific examples of activities that might be rendered in a group setting would include instructing a group of individuals on professional appearance requirements for various types of employment, reinforcement of work-related personal care or social skills, knowing how to get up in time to get ready for and commute to work. Groups could receive job-specific or job-related safety training, self-advocacy training, or training on the use of public transportation. A group could receive training on computer skills or other job-specific tasks when group participants have similar training needs.

Additional Information:

• Participants may also utilize workplace assistance during any hours of competitive integrated employment in conjunction with their use of extended services.
• Extended services are not time limited.
• Community settings are defined as non-residential, integrated settings that are in the community. Services may not

be rendered within the same building(s) alongside other non-integrated participants.
• Competitive integrated employment is defined as full or part-time work at minimum wage or higher, with wages and benefits similar to those without disabilities performing the same work, and fully integrated with coworkers without disabilities.
• Participants may be self-employed, working from their own homes, and still receive extended services when the work is competitive and could also be performed in an integrated environment by and among persons without intellectual/developmental disabilities.

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 HCBS Waivers Provider Reference Module on the IHCP Provider Reference Materials webpage, 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 participant's extended service needs outlined in the PCISP.
• 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.
• The provision of transportation of an individual participant is not a reimbursable activity within extended services.
• 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.
• Group supports delivered to participants who are utilizing different support options. For example, one individual in the group is using Extended Services and another individual in the same group setting is using day habilitation services. This type of activity would not be allowed.

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**
- ☒ **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 Extended Services Agencies
Individual	FSSA/DDRS Approved Extended Services - Individual

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 FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS BDDS policies and the FSSA/DDRS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

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:
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 FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS BDDS policies and the FSSA/DDRS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

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 (Terminated Eff. 7/31/2020)

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):*

** Standalone FACILITY-BASED HABILITTION-GROUP services terminate at the end of 7/31/2020, to become an available component of the newly combined DAY HABILITATION services effective 8/1/2020 **

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**

☒ **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 Facility Based Habilitation Agencies
Individual	FSSA/DDRS Approved Facility Based Habilitation-Individuals

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Facility Based Habilitation-Group (Terminated Eff. 7/31/2020)

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 BDDS policies and the FSSA/DDRS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

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 (Terminated Eff. 7/31/2020)

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 BDDS policies and the FSSA/DDRS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

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 structured, comprehensive, non-residential programs that provide health, social, recreational, and therapeutic activities, as well as optional educational and life skill opportunities as described in the PCISP. Participants attend on a planned basis.

These services must be provided in a congregate 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, support 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
Agency	FSSA/DDRS Approved Facility Based Support Services Agencies
Individual	FSSA/DDRS-approved facility-based habilitation service providers

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 Documentation of Criminal Histories,
• 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance,
• 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers,
• 460 IAC 6-14-5 Requirements for Direct Care Staff,
• 460 IAC 6-14-4 Training,
• 460 IAC 6-5-14 Health Care Coordination Services Provider Qualifications, and
• 460 IAC 6-5-30 Transportation Services Provider Qualifications

-Must comply with any applicable FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS BDDS policies and the FSSA/DDRS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Up to 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Facility Based Support Services

Provider Category:

Individual

Provider Type:

FSSA/DDRS-approved facility-based habilitation service providers

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 Documentation of Criminal Histories,
• 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance,
• 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers,
• 460 IAC 6-14-5 Requirements for Direct Care Staff,
• 460 IAC 6-14-4 Training,
• 460 IAC 6-5-14 Health Care Coordination Services Provider Qualifications, and
• 460 IAC 6-5-30 Transportation Services Provider Qualifications

-Must comply with any applicable FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS BDDS policies and the FSSA/DDRS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

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 (Terminated Eff. 7/31/2020)

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

** Standalone FACILITY-BASED HABILITTION-INDIVIDUAL services terminate at the end of 7/31/2020, to become an available component of the newly combined DAY HABILITATION services effective 8/1/2020 **

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.
• 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**

☒ **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 Facility Based Habilitation - Individuals
Individual	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-Individual (Terminated Eff. 7/31/2020)

Provider Category:

Agency

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 BDDS policies and the FSSA/DDRS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

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 (Terminated Eff. 7/31/2020)

Provider Category:

Individual

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 BDDS policies and the FSSA/DDRS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

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:

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 provide education and support directly to the family caregiver of a participant in order to increase the confidence and stamina of the caregiver to support the participant. Education and training activities are based on the family/caregiver's unique needs and must be specifically identified in the PCISP.

Reimbursable activities:

• Educational materials or training programs, workshops, and conferences for caregivers that are directly related to the caregiver's role in supporting the participant in areas specified in the PCISP that relate to:
• Understanding the disability of the participant;
• Achieving greater competence and confidence in providing supports;
• Developing and accessing community and other resources and supports;
• Developing or enhancing key parenting strategies;
• Developing advocacy skills; and Supporting the participant in developing self-advocacy skills.
• Education and training does not include counseling and must be aimed at assisting caregivers who support the participant to understand and address participant needs as specified in the PCISP.

The services under the Family and Caregiver Training are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

Reimbursement for this service is limited to no more than $5,000/year.

Activities not allowed:
• Educational materials or training programs, workshops, and conferences that are not related to the caregiver's ability to support the individual.
• Education and training may not be provided in order to train providers, even when those providers will subsequently train caregivers.
• Training provided to caregivers who receive reimbursement for training costs within their Medicaid line item reimbursement rates.
• Cost of travel, meals, and overnight lodging while attending the training program, workshop, or conference.

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 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 Documentation of Criminal Histories,
• 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance,
• 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers,
• 460 IAC 6-5-13 Family and Caregiver Training Services Provider Qualifications,
• 460 IAC 6-23-1 Requirements for Provision of Services, and
• 460 IAC 6-34 Tr460 IAC 6-14-4 Training

-Must comply with any applicable FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS BDDS policies and the FSSA/DDRS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

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 Documentation of Criminal Histories,
• 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance,
• 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers,
• 460 IAC 6-5-13 Family and Caregiver Training Services Provider Qualifications,
• 460 IAC 6-23-1 Requirements for Provision of Services, and
• 460 IAC 6-34 Tr460 IAC 6-14-4 Training

-Must comply with any applicable FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS BDDS policies and the FSSA/DDRS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

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:**

Service Definition *(Scope):*

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

Intensive behavioral intervention (IBI) services focus on developing effective behavior management strategies for participants whose challenging behavioral issues put them at risk of placement in a more restrictive residential setting. IBI services teach the participant, families and other caregivers how to respond to and deal with intense and challenging behaviors. IBI services are designed to reduce a participant's behaviors and improve independence and inclusion in the community. The need for IBI services is determined by a functional and behavioral needs assessment of the participant. IBI services are specified in the PCISP.

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 participant.

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 participant to perform an action;
(b) Behavior: a response from the participant, including anything from successful performance, non-compliance, to 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 participants 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.

The services under Intensive Behavioral Intervention are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

If individuals under age 21 choose to utilize IBI-type services they should access equivalent service such as Applied Behavior Analysis (ABA) under EPSDT.

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**
☒ **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 Intensive Behavior Intervention - Individual
Agency	FSSA/DDRS Approved Intensive Behavior Intervention Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Intensive Behavioral Intervention

Provider Category:
Individual
Provider Type:

FSSA/DDRS Approved Intensive Behavior Intervention - Individual

Provider Qualifications

License *(specify):*

For IBI Director:

Psychologist licensed under IC 25-33, or
Psychiatrist Licensed under IC 25-22.5

Certificate *(specify):*

For IBI Case Supervisor:

IBI Case Supervisor must be a Board Certified Behavior Analyst (BCBA) or Board Certified Assistant Behavior Analyst (BCABA)

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 Documentation of Criminal Histories,
• 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance,
• 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers,
• 460 IAC 6-14-5 Requirements for Direct Care Staff,
• 460 IAC 6-14-4 Training

-Must comply with any applicable FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS BDDS policies and the FSSA/DDRS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Up to 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Intensive Behavioral Intervention

Provider Category:

Agency

Provider Type:

FSSA/DDRS Approved Intensive Behavior Intervention Agency

Provider Qualifications

License *(specify):*

For IBI Director:

Psychologist licensed under IC 25-33, or
Psychiatrist Licensed under IC 25-22.5

Certificate *(specify):*

For IBI Case Supervisor:
IBI Case Supervisor must be a Board Certified Behavior Analyst (BCBA) or Board Certified Assistant Behavior Analyst (BCABA)

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 Documentation of Criminal Histories,
• 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance,
• 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers,
• 460 IAC 6-14-5 Requirements for Direct Care Staff,
• 460 IAC 6-14-4 Training

-Must comply with any applicable FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS BDDS policies and the FSSA/DDRS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

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:**

Service Definition *(Scope):*

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

Music therapy is services provided for the systematic application of music in the treatment of the physiological and psychosocial aspects of a participant'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 prevent or reduce the likelihood of certain behaviors that interrupt or interfere with a participant's daily life.

• 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 Music Therapy 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.

The services under Music Therapy are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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"
• 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**
☒ **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 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 Documentation of Criminal Histories,
• 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance,
• 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers,
• 460 IAC 6-5-15 Music Therapy Services Provider Qualifications

-Must comply with any applicable FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS BDDS policies and the FSSA/DDRS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

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 Documentation of Criminal Histories,
• 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance,
• 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers,
• 460 IAC 6-5-15 Music Therapy Services Provider Qualifications

-Must comply with any applicable FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS BDDS policies and the FSSA/DDRS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Up to 3 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Participant Assistance and Care

HCBS Taxonomy:

Category	Sub-Category
Category 1: 08 Home-Based Services	**Sub-Category 1:** 08010 home-based habilitation
Category 2: 08 Home-Based Services	**Sub-Category 2:** 08030 personal care
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Participant assistance and care (PAC) services are provided in order to allow participants with developmental disabilities to remain and live successfully in their own homes, function and participate in their communities, and avoid institutionalization. PAC services support and enable the participant in activities of daily living, self-care, and mobility with hands-on assistance, prompting, reminders, support, and monitoring needed to ensure the health and safety of the participant.

A relative of the participant may be a provider of PAC. The decision that a relative is the best choice of persons to provide these services is a part of the person-centered planning process and is documented in the PCISP. When the provider is a relative, there is an annual review by the IST to determine whether the participant's relative should continue to be the provider of PAC

Reimbursable Activities:

Activities may include any task or tasks of direct benefit to the participant that would generally be performed independently by persons without developmental disabilities or by family members for or on behalf of persons with developmental disabilities.

Examples of activities include but are not limited to the following:
• Assistance with personal care, meals, shopping, errands, scheduling appointments, chores and leisure activities (excluding the provision of transportation).
• Assistance with mobility – including but not limited to transfers, ambulation, use of assistive devices.
• Assistance with correspondence and bill paying.
• Escorting the participant to community activities and appointments.
• Support and person-centered monitoring of the participant.
• Reinforcement of behavioral support.
• Adherence to risk plans.
• Reinforcement of principles of health and safety.
• Completion of task list.

Participating on the IST for the development or revision of the PCISP (staff must attend the IST meeting in order to claim reimbursement).

Available individually or as a shared service:

• Shared/group services in group sizes no greater than four (4) participants to one (1) paid staff member of the PAC provider (unit rate divided by number of PAC participants sharing service).

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

Reimbursable waiver funded PAC services furnished to a waiver participant by a paid relative and/or legal guardian may not exceed a total of 40 hours per week per paid relative and/or legal guardian caregiver. (Definition of a relative follows the below Activities Not Allowed)

ACTIVITIES NOT ALLOWED

PAC services will not be provided to household members other than to waiver participant(s).

Reimbursement is not available through PAC 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.
• When Indiana Medicaid State plan services are available for the same task(s).
• When services provided are available under the Rehabilitation Act of 1973 or section 602(16) & (17) of Individual with Disabilities Education Act.
• For homeschooling, special education and related activities.
• When the participant is admitted to an institutional facility (e.g., acute hospital, nursing facility, ICF/IID).
• For homemaker or maid service.
• As a substitute for care provided by a registered nurse, licensed practical nurse, licensed physician, behaviorist, licensed therapist or other health professional.
• Excludes transportation.
• Group sizes greater than four (4) participants to one (1) paid staff member from the provider of PAC services, or group sizes exceeding the maximum allowable group size determined by the IST for each group participant.
• Group supports delivered to individuals who are utilizing different support options. For example, one individual in the group is using PAC and another individual in the same group setting is using Day Habilitation. This type of activity would not be allowed.

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

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 Participant Assistance and Care Individuals

Provider Category	Provider Type Title
Agency	FSSA/DDRS-Approved Participant Assistance and Care Agencies

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Participant Assistance and Care

Provider Category:
Individual
Provider Type:

FSSA/DDRS-Approved Participant Assistance and Care 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 Documentation of Criminal Histories
• 460 IAC 6-11 Financial Status
• 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance
• 460 IAC 6-14-4 Training
• 460 IAC 6-14-5 Requirements for Direct Care Staff

-Training in completion of Task List
-Must comply with any applicable FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS BDDS policies and the FSSA/DDRS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

Verification of Provider Qualifications

Entity Responsible for Verification:

Initially, BDDS. For reapproval, BDDS or BQIS.

Frequency of Verification:

Up to 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Participant Assistance and Care

Provider Category:

Agency

Provider Type:

FSSA/DDRS-Approved Participant Assistance and Care 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 Documentation of Criminal Histories
• 460 IAC 6-11 Financial Status
• 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance
• 460 IAC 6-14-4 Training
• 460 IAC 6-14-5 Requirements for Direct Care Staff

-Training in completion of Task List
-Must comply with any applicable FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS BDDS policies and the FSSA/DDRS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

Verification of Provider Qualifications

Entity Responsible for Verification:

Initially, BDDS. For reapproval, BDDS or BQIS.

Frequency of Verification:

Up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Personal Emergency Response System

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 that enables participants to secure help in an emergency. The participant may also wear a portable “help” button to allow for mobility. The system is connected to the participant’s phone and programmed to signal a response center once a “help” button is activated. The response center is staffed by trained professionals.

REIMBURSABLE ACTIVITIES:

• PERS is limited to those participants 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 support.
• 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 PERS when the participant requires constant support to maintain health and safety.

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 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 Documentation of Criminal Histories,
• 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance,
• 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers,
• 460 IAC 6-5-18 Personal Emergency Response System Supports Provider Qualifications

-Must comply with any applicable FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS BDDS policies and the FSSA/DDRS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

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 are a medically approved recreational program to restore, remediate, or rehabilitate an individual in order to:
(1) Improve the participant's functioning and independence; and
(2) Reduce or eliminate the effects of a participant's disability.

REIMBURSABLE ACTIVITIES:

• Organizing and directing adapted sports, dramatics, arts and crafts, social activities, and other recreation services designed to restore, remediate or rehabilitate.
• Planning, reporting and write-up when in association with the actual one-on-one direct care/therapy service delivery with the waiver participant.
• Individual services.
• Group services in group sizes no greater than four (4) participants to one (1) Recreational Therapist (Unit rate divided by number of Recreational Therapy 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**

☒ **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 Agency That Employs Approved Recreational Therapists
Individual	FSSA/DDRS Approved Recreational Therapist

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 BDDS policies and the FSSA/DDRS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

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:
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 Documentation of Criminal Histories,
• 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance,
• 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers,
• 460 IAC 6-5-22 Recreational Therapy Services Provider Qualifications

-Must comply with any applicable FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS BDDS policies and the FSSA/DDRS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

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:

Remote Supports

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):*

Remote supports includes a wide range of technology-based services that allows for trained remote support professionals (RSPs) to deliver live support to an individual at a remote location in place of onsite staffing. Remote Supports are delivered by awake, alert remote support professionals whose primary duties are to provide remote supports from the provider's secure remote supports facility. To ensure safety and HIPAA compliance, this facility should have appropriate, stable, and redundant connections. This should include, but is not limited to, backup generators, multiple internet service connections, battery backups, etc.

Remote supports include the provision of oversight and monitoring within the residential setting of adult waiver participants and individuals 14 to 17 years of age through the use of technology, two-way communication systems and sensors. For minors, remote supports are used to foster developmentally appropriate independence and not to replace typical parental supervision.

Remote Supports can be provided one-on-one or as a group service.

Remote Supports may be used with either paid or unpaid backup support as specified in the individual's service plan. Backup support is when a trained person is responsible for responding in-person/on-site in the event of an emergency or when an individual receiving remote supports otherwise needs assistance or the equipment used for delivery of remote supports stops working for any reason.

Paid backup support is provided on a paid basis by a provider of participant assistance and care that is both the primary point of contact for the Remote Support vendor and the entity to send paid staff person(s) on-site when needed.

Unpaid backup support may be provided by a family member, friend, or other person who the individual chooses.

REIMBURSABLE ACTIVITIES:
- Monitoring, oversight and support by the remote support professional.
- Initial and ongoing training, education, and technical assistance of paid and unpaid back up support intervention to prepare for prompt engagement with the individual(s) and/or immediate deployment to the residential setting
- Updates of remote support equipment and technology when the equipment and technology require regular information technology supports.
- Installation of remote supports equipment and technology is allowable in the residential or family home settings or unpaid back up support person location when necessary to provide remote support services in place of onsite staffing.
- When all service standards are met, the service provider shall be reimbursed at the full unit rate for each hour that the remote supports service is rendered. The unit rate for each hour of remote supports service utilization shall be divided by and among the number of waiver participants present in the home during any portion of the hour for which reimbursement is requested.

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

If the individual desires to withdraw consent, he or she would notify the case manager. As informed consent is a prerequisite for utilization of remote supports services, a meeting of the IST would be needed to discuss available options for any necessary alternate supports. All residing adult and youth participants, their guardians and their support teams impacted by the decision to withdraw consent must be immediately informed of the decision and use of remote supports in the setting must be discontinued.

PCISPs should reflect how individuals want to inform visitors of the use of remote supports in the setting if video monitoring is being utilized under this service. Use of the system may be restricted to certain hours through the PCISPs of the individuals involved.

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

ACTIVITIES NOT ALLOWED:

• Remote supports systems intended to monitor direct care staff.
• Remote Supports serves as a potential replacement for use of participant assistance and care (PAC) services; therefore, remote supports and PAC services are not billable during the same time period.
• Remote supports systems in ICFs/IID licensed under IC 16-28 and 410 IAC 16.2.
• Remote supports systems used in place of in-home staff.
• Cameras are not permitted in bathrooms or bedrooms.
• Services furnished to a minor by a parent(s), stepparent(s), or legal guardian.
• Services furnished to an individual by the individual's spouse.
• Remote supports are accessed within the FSW's $19,614 annual cost limit/spending cap. An additional $500 of remote supports may be accessed outside of the annual cap.

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 Remote Support Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Remote Supports

Provider Category:
Agency
Provider Type:

FSSA/DDRS Approved Remote Support Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

To be approved to provide remote supports services, a provider shall:

• Be an entity approved by FSSA/DDRS/BDDS to provide remote supports services.
• Assure that the system must be monitored by a staff person trained and oriented to the specific needs of each individual served as outlined in his or her PCISP.
• Assure that the paid support staff meet the qualifications for direct support professionals as set out in DDRS BDDS policy on requirements and training for direct support professional staff.
- If the backup support is unpaid, natural supports such as family, a guardian or a person the individual chooses; the need for backup support to meet qualifications for direct support professionals would not be applicable.
• Assure that the individual, family, guardian, team, and backup provider, if applicable, are trained on the use of Remote Supports equipment.

-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 Documentation of Criminal Histories,
• 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance,
• 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers,

-Must comply with any applicable FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS BDDS policies and the FSSA/DDRS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

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	14031 equipment and technology

Category 2: 17 Other Services

Sub-Category 2: 17020 interpreter

Category 3:

Sub-Category 3:

Service Definition *(Scope):*

Category 4:

Sub-Category 4:

Specialized medical equipment and supplies include:

a) Devices, controls, or appliances, specified in the PCISP that enable participants to increase their ability to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.
b) Items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items.
c) Other durable and non-durable medical equipment not available under the State plan that is necessary to address participant functional limitations.

DDRS' waiver services staff 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.
• Communications devices.
• Interpreter services or equipment necessary to access and participate in the home and community that are not otherwise provided as a reasonable accommodation per state and federal law.

Service Standards

The following service standards apply to specialized medical equipment and supplies:
• Equipment and supplies must be of direct medical or remedial benefit to the individual.
• All items shall meet applicable standards of manufacture, design, and installation.
• Any individual item costing more than $500 requires an evaluation by a qualified professional such as a physician, nurse, occupational therapist, physical therapist, speech and language therapist, or rehabilitation engineer.

• Annual maintenance service is available and is limited to $500 per year. If the need for maintenance exceeds $500, the case manager will work with other available funding streams and community agencies to fulfill the need.

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

The following are limitations on specialized medical equipment and supplies services:
• Service and repair up to $500 per year are permitted for maintenance and repair of previously obtained specialized medical equipment that was funded by a HCBS waiver. If the need for maintenance exceeds $500, the case manager will work with other available funding streams and community agencies to fulfill the need.
• Specialized medical equipment and supplies has a lifetime cap of $7,500

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 reflected in the PCISP .
• Equipment and services that have not been approved on a Request for Approval to Authorize services (RFA).
• Equipment and services that do not address needs identified in the person-centered planning process.

The services under the Family Supports waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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	Home Health Agencies
Individual	Licensed/Certified Occupational Therapist
Individual	Licensed Speech/Language Therapist
Individual	Licensed Physical Therapist
Agency	FSSA/DDRS Approved Medical Supply Companies, Pharmacies, Electronics/Computer Companies, Electronics Vendors

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 Documentation of Criminal Histories
• 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance
• 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers
• 460 IAC 6-5-27 Specialized Medical Equipment and Supplies Supports Provider Qualifications

-Must comply with any applicable FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS BDDS policies and the FSSA/DDRS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

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/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 Documentation of Criminal Histories
• 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance
• 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers
• 460 IAC 6-5-27 Specialized Medical Equipment and Supplies Supports Provider Qualifications

-Must comply with any applicable FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS BDDS policies and the FSSA/DDRS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

Occupational Therapists rendering waiver funded services must obtain/maintain Indiana 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: 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 Documentation of Criminal Histories
• 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance
• 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers
• 460 IAC 6-5-27 Specialized Medical Equipment and Supplies Supports Provider Qualifications

-Must comply with any applicable FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS BDDS policies and the FSSA/DDRS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

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:

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 Documentation of Criminal Histories
• 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance
• 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers
• 460 IAC 6-5-27 Specialized Medical Equipment and Supplies Supports Provider Qualifications

-Must comply with any applicable FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS BDDS policies and the FSSA/DDRS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

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: Other Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:

Agency

Provider Type:

FSSA/DDRS Approved Medical Supply Companies, Pharmacies, Electronics/Computer Companies, Electronics Vendors

Provider Qualifications

License *(specify):*

IC 25-26-13-18 Pharmacy (as applicable)

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 Documentation of Criminal Histories
• 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance
• 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers
• 460 IAC 6-5-27 Specialized Medical Equipment and Supplies Supports Provider Qualifications

-Must comply with any applicable FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS BDDS policies and the FSSA/DDRS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

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:

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:**

Service Definition *(Scope):*

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

Transportation services are services to transfer participants in a vehicle from the point of pick-up to a destination point. Transportation services enable participants to access non-medical community services, resources/destinations, or places of employment, as well as maintain or improve their mobility within the community, increase independence and community participation and prevent institutionalization as specified by the PCISP.

Depending upon the needs of the participant, there are three levels of transportation. The level of transportation service needed must be documented in the PCISP.
• 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 PCISP and provided by an DDRS-approved provider of residential habilitation and support (RHS) (RHS is a service currently available only under the Community Integration and Habilitation waiver), day 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 PCISP.
• May be used in conjunction with other services, including day 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.

Annual limits have been added to this non-medical waiver Transportation service.

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 under the FS waiver are:
o $2995 for Level 1 Transportation
o $5985 for Level 2 Transportation
o $8977.50 for Level 3 Transportation

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

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☒ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
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 Documentation of Criminal Histories,
• 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance,
• 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers,
• 460 IAC 6-5-30 Transportation Services Provider Qualifications, 460 IAC 6-5-31 Transportation Supports Provider Qualifications, and 460
IAC 6-34-1 to 460 IAC 6-34-3 Transportation Services,
• 460 IAC 6-14-5 Requirements for Direct Care Staff, and
• 460 IAC 6-14-4 Training

-Must comply with any applicable FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS BDDS policies and the FSSA/DDRS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

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 Documentation of Criminal Histories,
• 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance,
• 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers,
• 460 IAC 6-5-30 Transportation Services Provider Qualifications, 460 IAC 6-5-31 Transportation Supports Provider Qualifications, and 460 IAC 6-34-1 to 460 IAC 6-34-3 Transportation Services,
• 460 IAC 6-14-5 Requirements for Direct Care Staff, and
• 460 IAC 6-14-4 Training

-Must comply with any applicable FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS BDDS policies and the FSSA/DDRS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

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:

Vehicle 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):*

Vehicle modifications are the addition of adaptive equipment or structural changes to a motor vehicle that will provide the individual with a safe and accessible mode of transportation that increases their ability to access their home and community.

REIMBURSABLE ACTIVITIES

Justification and documentation is required to demonstrate that the modification is necessary in order to meet the individual's identified need(s). The following are allowable under vehicle modifications:
A. Wheelchair lifts;
B. Wheelchair tie-downs (if not included with lift);
C. Wheelchair/scooter hoist;
D. Wheelchair/scooter carrier for roof or back of vehicle;
E. Raised roof and raised door openings;
F. Power transfer seat base;
G. Lowered floor and lowered door openings;
H. Wheelchair ramp for vehicle;
I. Maintenance is limited to $1,000.00 annually for repair and service of items that have been funded through a HCBS waiver. Requests for service must differentiate between parts and labor costs. Pricing must be consistent with the fair market price for such modification(s).
If the need for maintenance exceeds $1,000.00, the case manager will work with other available funding streams and community agencies to fulfill the need. When service costs exceed the annual limit, those parts and labor costs funded through the waiver must be itemized clearly to differentiate the waiver service provision from those parts and labor provided through a non-waiver funding source.
J. Items requested which are not listed above, must be reviewed and a decision rendered by the State division director or State agency designee.

Reimbursement is available for modifications that satisfy each of the following:
• Service and documentation standards outlined within DDRS policy
• Allowable under current Medicaid waiver guideline
• Not available under the Rehabilitation Act of 1973, as amended
• Included in the individual’s approved plan of care
• Authorized on the RFA and linked to the plan of care
• Included on a State-approved and signed NOA
• Completed by an approved Medicaid waiver service provider (that is approved to perform this service)

SERVICE STANDARDS

A. The vehicle to be modified must meet all of the following:
1. The individual or primary caregiver is the titled vehicle owner;
2. The vehicle is registered and/or licensed under state law;
3. The vehicle has appropriate insurance as required by state law;
4. The vehicle is the individual's sole or primary means of transportation;
5. The vehicle is less than 10 years old and has less than 100,000 miles on the odometer
6. The vehicle is not registered to or titled by a Family and Social Services Administration (FSSA) approved provider.
7. Only one vehicle per an individual may be modified;

B. Many automobile manufacturers offer a rebate for individuals purchasing a new vehicle requiring modifications for accessibility. To obtain the rebate the individual is required to submit to the manufacturer documented expenditures of modifications. If the rebate is available, it must be applied to the cost of the modifications.

C. Requests for modifications may be denied if DDRS determines the documentation does not support the service requested.

D. All vehicle modifications must be approved prior to services being rendered.

All vehicle modification shall be authorized only when it is determined to be medically necessary and/or shall have direct medical or remedial benefit for the waiver individual. Requests to upgrade products or to use materials

exceeding the individual's basic needs will not be approved.

This determination includes the following considerations:
– The modification is the most cost effective or conservative means to meet the individual's specific need(s).
– The modification is individualized, specific, and consistent with, but not in excess of, the individual's need(s).
– Two modification bids must be obtained for all modifications over $1,000.
– If two bids cannot be obtained, it must be documented to show what efforts were made to secure the two bids and explain why fewer than two bids were obtained (for example, provider name, dates of contact, response received).

DOCUMENTATION STANDARDS

The PCISP must reflect the identified direct benefit or need for VMOD determined to support the individual in accessing their community.

Documentation/explanation within the request for approval to authorize services (RFA) must include:
• the specific modification being requested to the vehicle, including a picture of the modification
• 2 bids if the cost exceeds $1,000.00: The individual chooses which approved/certified providers will submit bids or estimates for this service. The provider with the lowest bid will be chosen, unless there is strong written justification detailing why a provider with a higher bid should be selected.
• Warranty information of the modification
• Copy of the vehicle registration
• Copy of the vehicle insurance

Provider Standards:
• Provider of services must maintain receipts for all incurred expenses related to the modification;
• All bids must be itemized.
• Must be in compliance with FSSA and Division specific guidelines and/or policies.

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

A cap of $15,000.00 is available for one (1) vehicle per every ten (10) year period for an individual's household. In addition to the applicable cap, $1,000.00 will be allowable annually for repair, replacement, or an adjustment to an existing modification that was funded by a Home and Community Based Services (HCBS) waiver.

ACTIVITIES NOT ALLOWED
Examples/descriptions of modifications/items not covered include, but are not limited to the following:
A. Repair or replacement of modified equipment damaged or destroyed in an accident;
B. Alarm systems;
C. Auto loan payments;
D. Insurance coverage;
E. Driver's license, title registration, or license plates;
F. Emergency road service;
G. Routine maintenance and repairs related to the vehicle itself.
H. Specialized Medical Equipment or Home Modification items are not allowed.
I. Leased vehicles

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 Vehicle Modification Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Vehicle Modifications

Provider Category:
Agency
Provider Type:

FSSA/DDRS Approved Vehicle Modification 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 6-10-5 Documentation of Criminal Histories,
460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance,
460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers
460 IAC 6-5-27 Specialized Medical Equipment and Supplies Supports Provider Qualifications

Must comply with any applicable FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS BDDS policies and the FSSA/DDRS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

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:

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 Extended Services.

May be utilized with each hour the participant is engaged in paid competitive community employment.

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

Reimbursement for Workplace Assistance Services is available only during the participant's hours of paid, competitive community employment.

Activities Not Allowed:

Reimbursement is not available through workplace assistance services under the following circumstances:
• When services are furnished to a minor child by the parent(s) or step-parent(s) or legal guardian.
• When services are furnished to a participant by that participant's spouse.
• Any service that is otherwise available under the Rehabilitation Act of 1973 or Public Law 94-142.
• During volunteer activities.
• In a facility setting.
• In conjunction with sheltered employment.
• During activities other than paid competitive community employment.
• Workplace assistance should complement but not duplicate services being provided under Extended Services.
• Workplace assistance is not to be used for observation or supervision of the participant for the purpose of teaching job tasks or to ascertain the success of the job placement.
• Workplace assistance is not to be used for off-site monitoring when the monitoring directly relates to maintaining a job.
• Workplace assistance is not to be used for the provision of skilled job trainers who accompany the participant for short-term job skill training at the work site to help maintain employment
• Workplace assistance is not to be used for regular contact and/or follow-up with the employers, participants, parents, family members, guardians, advocates or authorized representatives of the participants, or other appropriate professional or informed advisors, in order to reinforce and stabilize the job placement.
• Workplace assistance is not to be used for the facilitation of natural supports at the work site.
• Workplace assistance is not to be used for Individual program development, writing tasks analyses, monthly reviews, termination reviews or behavioral intervention programs.
• Workplace assistance is not to be used for advocating for the participant.
• Workplace assistance is not to be used for staff time in traveling to and from a work site.

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

☐ **Participant-directed as specified in Appendix E**
☒ **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 Workplace Assistance - Individual
Agency	FSSA/DDRS Approved Workplace Assistance Agencies

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Workplace Assistance

Provider Category:
Individual
Provider Type:

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 Documentation of Criminal Histories,
• 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance,
• 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers,
• 460 IAC 6-14-5 Requirements for Direct Care Staff,
• 460 IAC 6-14-4 Training,
• 460 IAC 6-5-30 Transportation Services Provider Qualifications, and
• 460 IAC 6-5-31 Transportation Supports Provider Qualifications.

-Must comply with any applicable FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS BDDS policies and the FSSA/DDRS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Up to 3 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Workplace Assistance

Provider Category:

Agency

Provider Type:

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 Documentation of Criminal Histories,
• 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance,
• 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers,
• 460 IAC 6-14-5 Requirements for Direct Care Staff,
• 460 IAC 6-14-4 Training,
• 460 IAC 6-5-30 Transportation Services Provider Qualifications, and
• 460 IAC 6-5-31 Transportation Supports Provider Qualifications.

-Must comply with any applicable FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS BDDS policies and the FSSA/DDRS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

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.*

☐ **As a primary care case management system service under a concurrent managed care authority.** *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 Family Supports 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 Family and Social Services Administration's (FSSA) DDRS 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. If an employee, officer, or agent resides in a county that does not offer a criminal history check, the Indiana limited criminal history is sufficient, or providing a current copy of the Mycase record indicating no record. The provider must verify that a county criminal history check or Indiana limited criminal history was completed.

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 required to develop and implement systemic corrective actions.

Additionally, the criminal history/Background Check is reviewed at the following time periods:
1. Upon initial approval; and
2. At the one-year mark after becoming a new provider

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 State of Indiana has a registry of professional licenses that is available online at https://mylicense.in.gov/eVerification/
b) The FSSA's BDDS requires each provider or prospective provider conduct and document the screening against this license verification website.
c) BDDS reviews applications for approval to provide waiver services as submitted by the prospective provider. In the absence of the license verification for each direct care staff employed by the provider, the application shall not be approved.

Indiana's abuse registry is hosted by the Indiana Professional Licensing Agency (IPLA) at https://www.in.gov/pla/ but as is explained at https://www.in.gov/isdh/24562.htm, the registry is maintained by the Indiana State Department of Health (ISDH).

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.*

a) Legally responsible persons or other relatives may be employed by or contract with a DDRS-approved service provider to render waiver-funded personal care or similar services to an adult waiver participant, but payment is made only to the approved service provider, never directly to the legally responsible person or relative. In no circumstance does the State allow the legally responsible person or relative to be employed by or contract with a DDRS-approved waiver service provider to render services to a waiver participant who is a minor, or to a waiver participant who is an adult but is the spouse of the legally responsible person or relative rendering personal care or similar services. Payment for personal care or similar waiver services is never made directly to the legally responsible person or relative by the State, but those same persons are not prohibited from rendering personal care or similar services as employees or contractors of DDRS-approved provider agencies as specified above and in alignment with the waiver service definitions and limitations found in Appendix C of the waiver.

b) Personal care services are defined in 42 CFR §440.167. It should be noted that the state does NOT pay for "ordinary care" as defined in CMS guidance found in the Version 3.5 Instructions, Technical Guide and Review Criteria. Per the CMS guidance, the prohibition is based on the presumption that legally responsible individuals may not be paid for supports that they are ordinarily obligated to provide, such as personal care or similar services by a parent of a minor child who is a waiver participant or personal care or similar services by the spouse of a waiver participant.

As defined by CMS, "extraordinary care" would include care exceeding the range of activities that a legally responsible individual would ordinarily perform in the household on behalf a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant to avoid institutionalization. Although the state allows reimbursement of relatives and legally responsible individuals who provide personal care or similar services to adult waiver participants, the state does NOT pay for "extraordinary care" by a parent of a minor child who is a waiver participant or the care of a spouse who is a waiver participant.

c) As with all other waiver-funded services, service delivery is authorized via the Notice of Action (NOA) issued by the state upon approval of the participant's cost comparison budget (CCB). Providers are required ensure that waiver services are provided as authorized and to document service delivery, allowing access to that documentation at any time by the state or its agents, including the case manager. As explained in Appendix I-2-d of the waiver application, the state uses a billing validation process to ensure claims are paid only for necessary services that were properly authorized and actually provided to the participant within the authorized timeframe. Billing is subject to audit by the state in look behind efforts of BQIS as well as by the FSSA's surveillance and utilization unit.

☐ **Self-directed**

☒ **Agency-operated**

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:

Legally responsible persons or other relatives may be employed by or contract with a DDRS-approved service provider to render waiver-funded services to an adult waiver participant, but payment is made only to the approved service provider, never directly to the legally responsible person or relative. The legally responsible person or other relative must meet the same qualifications, receive the same training and be held to the same standards as all other employees of the DDRS-approved provider agency.

In no circumstance does the State allow the legally responsible person or relative to be employed by or contract with a DDRS-approved waiver service provider to render services to a waiver participant who is a minor, or to a waiver participant who is an adult but is the spouse of the legally responsible person or relative rendering services. Payment for waiver services is never made directly to the legally responsible person or relative by the State, but those same persons are not prohibited from rendering services as employees or contractors of DDRS-approved provider agencies as specified above and in alignment with the waiver service definitions and limitations found in Appendix C of the waiver.

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 Family Supports Waiver (FSW) services may apply to become a provider at any time. The application approval process is managed/performed by BDDS. As applications are received and reviewed by 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.

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, BDDS 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 to appeal the denial of the approval. The case would be 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 BQIShelp 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 DDRS HCBS Waiver Provider Manual is posted on the "manuals" link of IHCP website, with a direct link of https://www.in.gov/medicaid/providers/469.htm. The BQIS Helpline address is BQISHelp@fssa.in.gov.

In the first year as a provider, the organization/provider will undergo a CERT. The CERT is a set of standards that providers must follow to remain an approved provider. All new providers of BDDS waiver services are scheduled for a CERT in the first 12 months following approval of their application. The CERT process provides a collaborative opportunity between provider agencies and the State to ensure policies, procedures, and employee files, related to approved services, are in compliance with requirements.

Providers of specific services are re-approved by DDRS at least once every three years as required by 460 IAC Article 6. A provider's performance is not only measured by data in the recently modified DDRS/BQIS provider re-approval process outlined on the BQIS website but incorporates a process where providers articulate the systems (e.g. policies, procedures, protocols, etc.) that exist, as required by 460 IAC Article 6, and how their policies, procedures, and protocols are implemented in a consistent manner, to ensure the health, safety, and welfare of the individuals they serve. Additionally, the providers explain their specific processes for identifying problems when they occur and the procedures utilized in addressing those problems.

Providers are notified by BQIS when due for re-approval and are expected to fully cooperate in the process by submitting all requested forms and participating in discussions as needed as BQIS facilitates the process. During the re-approval process, providers are asked to verify the list of services for which they are approved and desire to continue to provide. The Re-approval Completion Guide is attached to their notice to aid in successful completion of the review.

Another attachment, the Provider Review Profile (PRP) is a detailed data-driven report specific to the provider's organization and consisting of information from complaints and incident reports. For first-time re-approvals, this also included data from the CERT. The PRP is structured to provide a comparison in multiple risk areas. The PRP allows the provider to assess their organization's data against a benchmark of a relatively similar providers (e.g. client count, Algo levels). The analysis of this data is pivotal in reviewing the organizations performance. The provider is also supplied with an Excel Spreadsheet of all incident reports included in the PRP to support the organization in analyzing its data.

Following review of the PRP, the Re-approval Assessment must be completed by the provider. Providers are asked a series of questions, by category, to assess how performance is monitored and how service level improvement(s) are made based on the data. Additional questions are focused on the broader subject of providing quality care and services, including how the organization will implement changes and what corrections are necessary to achieve the desired results.

As part of the re-approval process, providers offering services that require national accreditation are required to submit the most current accreditation documentation.

Providers are given 30 calendar days after the date notice is issued to electronically submit to BQIS all documentation on the Submission Checklist (another attachment provided with the notice).

Once submitted, BQIS will review the completed Re-approval Assessment and contact the agency within 20 business days after the provider's due date. Providers may be asked to meet in person or via telephone for the purpose of BQIS explaining any clarifying questions that require further explanation or detail by the provider. The provider through the submission of a re-approval addendum will submit the clarifying information.

Through a data and an operational analysis review of each provider, BQIS utilizes the information obtained through the re-approval process to ensure providers are evaluated fairly and consistently; and service-specific performance is reviewed regarding the providers' implementation of the participant's service plan, the health and welfare of the participant, quality assurance/quality improvement systems that ensure all needed policies and procedures are in place to address restraints, seclusion/isolation, medication errors, and all forms of abuse, neglect and exploitation.

Following the review and recommendations for re-approval, providers are granted re-approval for a period established at six, 12 or 36 months. A six month re-approval is considered probationary and includes a 90-day moratorium against serving additional new participants during that timeframe.

Re-approved providers must submit a newly executed signed Provider Agreement to BQIS.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States 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:
1. Number and percent of providers who are approved by the Medicaid agency.
Numerator: Number of providers approved by the Medicaid agency. Denominator: Number of providers referred to the Medicaid agency after approval by BDDS.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Gainwell Reports

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

Data Aggregation and Analysis:

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

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

Performance Measure:
2. Number and percent of providers who submitted a signed DDRS Medicaid Waiver Provider Agreement upon renewal. Numerator: Number of providers who submitted a signed DDRS Medicaid Waiver Provider Agreement upon renewal. Denominator: Total number of providers approved for renewal.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider Reverification 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:
3. Number and percent of current providers reviewed in a waiver year who conduct criminal background checks as required. Numerator: Total number of current providers reviewed in a waiver year who conduct criminal background checks as required. Denominator: Total number of current providers reviewed in a waiver year.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Onsite quality review

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:	☐ **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:

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:
4. Number and percent of current waiver providers reviewed in a waiver year who meet waiver training requirements. Numerator: Total number of current waiver providers reviewed in a waiver year who conduct training as required. Denominator: Total number of current waiver providers reviewed in a waiver year.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Onsite quality review

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

(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:	☐ **Annually**

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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.

Performance measure 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 calendar 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. Only BDDS approved applications are referred to the Medicaid Agency for final approval.

Performance Measure 2. Upon renewal of approval by DDRS, the provider has 30 days to submit a signed Medicaid Waiver Provider Agreement. The provider agreement contains language that the provider must agree to while operating as a Medicaid waiver provider. The renewal of approval is not final until a signed provider agreement is received by DDRS.

Performance Measures 2, 3, and 4. Providers that do not meet state requirements or standards are required to develop 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.
Periodic reports on remediation actions are presented to the QIEC for review.

The data sources that are used are CERT reviews, onsite quality reviews, or provider re-approval tracking sheets.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

○ **Not applicable**- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

◉ **Applicable** - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the

amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☒ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

Waiver expenditures are capped at $19,614 annually.
• The limit applies to the total cost of all waiver services authorized on the CCB for a one year period.
• This limit may serve as both an individual cost limit that limits enrollment of individuals to those whose projected annual cost for waiver services as specified in the initial CCB is expected to be less than or equal to $19,614 and as a prospective individual budget amount for participants whose needs change during the year and whose costs increase approaching or reaching the $19,614 limit.

Participants are notified of the cost limit at the time of application for enrollment into FSW and during the development of the CCB (both initial and updated). Case managers and service coordinators, as appropriate, are responsible for informing the applicant/participant of the cost limit.

Should this limit appear to be inadequate to accommodate changes in participants' needs during the approved waiver period, the State will submit a waiver amendment seeking to adjust the limit.

In the event a participant has a change in needs that will result in their waiver services costs exceeding the limit, the State will:
• Evaluate the participant for enrollment into FSW administered by DDRS when the participant meets the specific reserved waiver capacity criteria for entrance to the waiver;
• Evaluate the participant to determine if they appear to meet the eligibility criteria for participation under another waiver program administered by another division of FSSA, such as a waiver requiring nursing facility level of care and administered by FSSA's Division of Aging and complete a referral to the Division of Aging when the participant appears to meet criteria or upon participant request;
• Evaluate the feasibility of providing additional supports and services from other sources.

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

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☒ **Other Type of Limit.** The state employs another type of limit.
Describe the limit and furnish the information specified above.

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for individuals under age 21 who are enrolled in Medicaid. Therefore, individuals under age 21 who are enrolled in an HCBS waiver program are entitled to all EPSDT services.

Occupational therapy, physical therapy, speech and language therapy, psychological therapy, and IBI are not being eliminated from Indiana's HCBS waivers. Rather, eligible participants should access these services through EPSDT. This will ensure that participants are not receiving duplicative services.

All services are limited to additional services not otherwise covered under the State plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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.

The State has a HCBS Waiver Transition Plan for settings that do not meet requirements at time of submission available in Module 1, Attachment 2.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Person-Centered Individualized Support Plan (PCISP) and Cost Comparison Budget (CCB)

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

- ☐ **Registered nurse, licensed to practice in the state**
- ☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**
- ☐ **Licensed physician (M.D. or D.O)**
- ☒ **Case Manager** (qualifications specified in Appendix C-1/C-3)
- ☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
  Specify qualifications:
- ☐ **Social Worker**
  Specify qualifications:

☐ **Other**
Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

◉ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

○ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

(a) Indiana utilizes a Person-Centered Individualized Support Plan (PCISP) for service plan development. The PCISP is based upon the Charting the LifeCourse FrameworkTM (CTLC Framework), which is comprised of eight principles and a set of tools that support the use and application of the principles. Developing the PCISP is a process based on the CTLC framework that identifies a participant's health and safety needs in balance with his or her aspirations and preferences to develop a plan that integrates a variety of services and supports to help the participant achieve his or her good life. The PCISP identifies the array of services and supports, both paid and unpaid, from all sources that will be utilized to implement desired outcomes and ensure the participant's health and welfare.

(b) The participant designates the persons he or she wishes to participate in the development of his or her PCISP. 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) and (b)
The PCISP development process begins after informal and formal assessments are conducted using a combination of intake and referral data, standardized assessment tools, and direct observation of the participant. The PCISP is developed by the participant with support from the case manager. Providers are also required to sign and receive a copy of the person centered plan, the PCISP. Others of the participant's choosing may also participate in the development of the PCISP. This group forms the Individualized Support Team (IST). The PCISP first identifies the participant's preferences, aspirations, and health and safety needs. Then, by addressing the participant's identified outcomes and needs, the PCISP details what the participant wants to accomplish within a given year to achieve a good life across a variety of life domains. The PCISP documents how services and supports will be delivered to support the participant to meet his or her desired outcomes while addressing health and safety needs.

Case managers must have face-to-face contact with the waiver participant at least every 90 days and one unannounced home visit per year for participants residing in provider- owned or controlled settings. IST meetings are required at least semi-annually, or when requested by the participant, family, the bureau of developmental disability services (BDDS), or other team members. However, face-to-face contact and team meeting requirements for participants with high risk or health needs remain unchanged from those previously stated in Appendix D, at least every 90 days but more often as determined by the IST.
The PCISP is updated at least annually, with a goal of determining the participant's needs, wants, and desires using person-centered planning philosophy processes. To be person-centered, the plan should be reflective of the participant's strengths and preferences related to relationships, community participation, employment, income and savings, health and wellness, and education.

The participant has the right and power to command and direct the entire PCISP process with focus on his or her preferences, dreams, and needs. The process empowers participants to create life plans and allows participants to direct the planning and allocation of resources to meet their self-directed life goals. The cost comparison budget (CCB) identifies the services and supports that are funded by the waiver and is routinely developed to cover a time frame of 12 consecutive months. The CCB is developed by the participant-chosen case manager 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.

Utilized at initial intake and at least annually thereafter, the PCISP 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 a person-centered planning process is conducted using plain language and that the process is timely, occurring at times/locations of convenience to the participant. Each participant's PCISP will then be reviewed at least every 90 calendar days during visits by the case manager. Needed updates are brought to the attention of the IST, which will meet more frequently than the required semi-annual basis if necessary.

The case manager reviews and documents risk assessment information gathered by the IST during the PCISP process to help identify risks related to health, behavior, safety, and support needs for waiver participants.

Case managers must have face-to-face contact with the waiver participant at least every 90 days and one unannounced home visit per year for individuals residing in provider-owned or controlled settings. In addition, IST meetings are required at least semi-annually, or when requested by the individual, family, BDDS, or other team members. However, face-to-face contact and team meeting requirements for individuals with high risk or health needs must occur at least every 90 days or more often as determined by the IST.

The State has incorporated changes into the person-centered process to ensure compliance with CMS 2249-F and CMS 2296-F.

(c) The participant is informed of available Family Supports Waiver (FSW) services at the time of application, during enrollment and development of the PCISP and CCB, and on an ongoing basis throughout the year as needed. The participant's case manager is knowledgeable in all services available on FSW and is responsible for providing the participant with information about each covered service, its definition, scope, and limitations.

d) The CCB is developed based upon the outcomes of the initial, annual, or subsequent meeting of the IST during which the PCISP is developed, reviewed, and/or updated. Person-centered service plans document the options based on the participant's needs, preferences, and, for residential settings, individual participant resources 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 follows the PCISP process discussed under items (a) and (b) above. The overall emphasis of the process will be to determine what is important to and what is important for the participant, with a goal of presenting a good balance of the two within the service plan. The case manager facilitates the IST meeting, reviews the participant's desired outcomes, his or her health and safety needs and preferences, and reviews covered services, other sources of services and support (paid and unpaid), and the budget development process for waiver services. The case manager then finalizes the PCISP 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 PCISP 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 review is completed by the case manager with the participant. The IST is advised of any concerns or needs for updates that may require scheduling of additional team meetings by the case manager. 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 PCISP and the CCB. The case manager reviews these reports for consistency with the PCISP and CCB and works with providers as needed to address findings from this review.

(f) The PCISP identifies the services needed by the participant to pursue his or her desired outcomes and to address his or her health and safety needs. The PCISP identifies all paid and unpaid services and supports, and includes the name of the provider, the service, and the responsible staffing position(s) within the chosen service agency or agencies for waiver-funded services. The participant may be responsible for outcomes of the PCISP if they so determine. The CCB identifies the following: 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 PCISP and CCB are reviewed a minimum of every 90 calendar days by the case manager and updated a minimum of every 365 calendar days with involvement of the IST. The participant may request a change to the CCB at any point. Changes may include a new service provider, a change in the type of service, or a change in the amount of service. If a change to the PCISP 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 case manager makes any subsequent updates to the CCB 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 of services on the auto-converted CCB is determined by the cost of services and supports appearing on the most recently approved but expiring CCB. The auto-converted CCB ensures that there is no loss of services. The case manager is subsequently contacted and required to complete the annual planning process and PCISP and CCB revision.

Case managers and supervisors monitor CCBs that are due to expire through the case management system. In addition, supervisors run reports of the number of CCBs that are about to expire for case management monitoring and quality assurance purposes.

(h) The participant has the right and power to command and direct the entire PCISP process with focus on his or her preferences, dreams, and needs. The process empowers participants to create life plans and allows participants to direct the planning and allocation of resources to meet their self-directed life goals.

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:

As noted, the case manager ensures completion of risk assessment information gathered by the IST and documented by the case manager in the PCISP process to help identify risks related to health, behavior, safety and support needs for waiver participants.

During face-to-face visits with the participant that occur at least every 90 calendar days or more often if needed, the case manager reviews the PCISP, including any risk assessment(s) incorporated in the PCISP, to ensure the participant's needs are being met.

Case management providers schedule additional IST meetings as necessary when a change in the participant's status is identified. Any risk issues (i.e. health, behavioral, physical management, and environmental management) identified through the PCISP process 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(s) or to review and revise the risk plan(s) as appropriate.

Risk identification and the need for a risk plan is based on a documented assessed need through formal or informal assessments. It is the shared responsibility of the IST to monitor a participant's risks. Risk plans and any associated restrictions are proportionate to the assessed risk, and risk plans are reviewed at least annually.

BDDS monitors case managers by reviewing documentation on the individuals that they work with. This includes a review of how case managers are reviewing risk management plans as well as how they are documenting and following up on incident reports during routine visits with the participant.

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, 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 PCISP. 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 FSW. 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 Bureau of Quality Improvement Services (BQIS) Resource Materials webpage to assist with risk mitigation.

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 DDRS that contains information regarding all qualified waiver providers for each service on the FSW. Case managers are able to generate a list of all qualified providers for each service on the waiver for the participants' 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 FSW 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):

FSSA is the Single State Medicaid Agency. FSSA is the agency that administers the Medicaid program through the combined efforts of all the staff that work for FSSA.

OMPP and DDRS are divisions within FSSA.

All service plans are subject to the approval of the state Medicaid agency. Oversight of service plans has been delegated to 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 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 PCISP. Plans are approved, denied, or returned for additional information or clarification when necessary.

The PCISP and the service plan include natural and other non-paid supports.

As the result of the Quality Improvement Executive Committee (QIEC) meetings where performance measures are monitored and discussed, OMPP receives quarterly reports from 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 PCISP and the CCB are reviewed by the case manager at least once every 90 calendar days. The participant can request a change to the CCB 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 CCB are maintained in the State's case management data system for a minimum of three 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 PCISP and CCB, and for monitoring 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 current concerns and progress, as well as implementation of the PCISP, are reviewed.

At least once every 90 calendar days, a monitoring checklist, is an automated tool that is utilized by the case manager in order to systematically review the PCISP and status of the CCB. In addition, the monitoring checklist facilitates the review of reports from providers or from 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 that may be identified in regard to the satisfaction and health and welfare of the participant.

The process incorporates interviews with the participant before the annual meeting in which the participant is asked about his or her satisfaction with current services. The IST meets at least semi-annually to ensure everything is in place for the participant.

The case manager is required to electronically document at least one monthly case activity note indicating the progress and implementation of the PCISP.

The case manager 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 implementation of the plan 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 BQIS.

The monitoring and follow up method used by the case manager may 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 by the case manager and at least semi-annually in meetings of the IST.

At all times, full, immediate and unrestricted access to the participant'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 entity 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 the monitoring checklist, obtaining agreement of the IST for any needed updates.
• Case managers 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, case managers identify the timeframe and person responsible for corrective action, communicate this information to the IST, 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 entity 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 monitoring checklist, case managers document the participant's progress 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, indicating any need 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 BQIS as described in Appendix F-3, when resolution is not achieved.

The case manager must address any reports or concerns about the health and welfare of a participant that are brought to the attention of the case manager by the participant, or someone reporting on a participant's behalf. The case manager must investigate the matter, notify the participant or other reporter with a determination of findings or steps to be taken, and document the findings.

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.

If the allegation is of abuse, neglect, or exploitation, of a participant, case managers take all necessary steps to ensure the safety of the participant. Any incidents related to the health and safety of a participant or that involve alleged or observed abuse, neglect, or exploitation, are reported to the DDRS via the state Incident Reporting system described in Appendix G-1.

Case managers are required to report to adult protective services or child protective services as applicable.

BQIS holds the waiver service provider responsible for taking appropriate and effective measures to secure the participant's immediate safety, implementing preventative measures, and investigating reported incidents. Case managers review all filed incident reports, work with the provider to file any missing reports, and are then responsible for confirming that the provider took the required actions. To verify this, case managers use follow-up reports to document the provider's actions to safeguard the participant. Case managers enter their follow-up reports directly into the state's web-based incident management system.

BQIS Quality Contractor's incident reviewers review these follow-up reports to determine the following: 1) if 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 incident reviewers close an incident report. Case managers are required to continue providing follow-up reports at a minimum of every seven calendar days until an incident is closed. The case management supervisors, directors, or other identified executive management staff within each case management entity 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 BDDS service coordinator.

If there is still no resolution, the case manager will file a formal complaint with DDRS as described in Appendix F-3.

Problems as identified within the monitoring 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 entity.

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 may be escalated to 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.

The state wide waiver ombudsman is available to receive, investigate, and attempt to resolve complaints and concerns that are made by or on behalf of participants who have a developmental disability. Complaints may be received via the toll free number 1-800-622-4484, via e-mail, in hard copy format or by referral. Types of complaints received include complaints initiated by families and/or participants, complaints involving rights or issues of participant choice, and complaints requiring coordination between legal services, DDRS services and provider services.

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 States quality improvement strategy, provide information in the following fields to detail the States 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:
1. Percent of sampled individuals who report that their services and supports are helping them to live a good life. Numerator: Number of sampled individuals who report that their services and supports are helping them to live a good life. Denominator: Total number of sampled individuals.

Data Source (Select one):
Other
If 'Other' is selected, specify:
National Core Indicators (NCI)

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; Confidence Interval = 95%; Proportional and stratified across state districts
	☐ **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: Human Services Research Institute	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
2. Number and percent of sampled participants whose PCISP addresses their needs and abilities. Numerator: Number of sampled participants whose PCISP addresses their needs and abilities. Denominator: Total number of sampled participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Record 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: Representative Sample; Confidence Interval = 95%; Proportional and stratified across state districts
	☐ **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:
3. Number and percent of sampled participants whose PCISP included a risk assessment. Numerator: Total number of sampled participants whose PCISP included a risk assessment. Denominator: Total number of sampled.

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

Case Record 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: Representative Sample; Confidence Interval = 95%; Proportional and stratified across state districts
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
4. Number and percent of sampled individuals whose PCISP addressed their assessed risks (as applicable). Numerator: Total number of sampled individuals whose PCISP addressed their assessed risks (as applicable). Denominator: Total number of individuals sampled.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Record 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: Representative Sample; Confidence Interval = 95%; Proportional and stratified across state districts
	☐ **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.

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants 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:
6. Number and percent of sampled individuals whose PCISP was reviewed and changed (as needed) when their needs changed. Numerator: Total number of sampled individuals whose PCISP was reviewed and changed (as needed) when their needs changed. Denominator: Total number of sampled individuals.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Record 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**	☐ **Annually**	☐ **Stratified**

Specify:		Describe Group:
	☒ **Continuously and Ongoing**	☒ **Other** Specify: Representative Sample; Confidence Interval = 95%; Proportional and stratified across state districts
	☐ **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:

7. Number and percent of PCISPs that were updated/revised within 365 days of the

previously approved annual CCB. Numerator: Total number of participants whose PCISPs were updated/revised within 365 days of previously approved annual CCB. Denominator: Total number of waiver participants due for an annual PCISP.

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**

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

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:
8. Number and percent of participants who received the waiver services and supports in their PCISPs in the stipulated type, scope, amount, duration, and frequency. Numerator: The total number of sampled participants who received the waiver services and supports in their plans in the stipulated type, scope, amount, duration, and frequency. Denominator: Total number of sampled participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Monitoring Checklist

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**	☐ **Weekly**	☐ **100% Review**

Agency		
☐ **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**

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

e. ***Sub-assurance: Participants are afforded choice: 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:
9. Number and percent of newly enrolled participants who were afforded a choice between waiver services and institutional care. Numerator: Total number of newly enrolled participants whose record documents that the participant was afforded a choice between waiver services and institutional care. Denominator: Total number of sampled, newly enrolled participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Record 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**	☐ **Annually**	☐ **Stratified**

Specify:		Describe Group:
	☒ **Continuously and Ongoing**	☒ **Other** Specify: Representative Sample; Confidence Interval = 95%; Proportional and stratified across state districts
	☐ **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:

10. Number and percent of sampled participants who responded that the case

manager asks what the participant wants as part of service plan. Numerator: Number of sampled participants who responded that the case manager asks what the participant wants as part of service plan. Denominator: Total number of sampled participants who responded.

Data Source (Select one):
Other
If 'Other' is selected, specify:
National Core Indicators (NCI)

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; Confidence Interval = 95%; Proportional and stratified across state districts
	☐ **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: Human Services Research Institute	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
11. Number and percent of participants who were afforded a choice of waiver service providers. Numerator: Total number of sampled participants who were afforded a choice of waiver service providers. Denominator: Total number of sampled participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Record 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**	☐ **Annually**	☐ **Stratified**

Specify:		Describe Group:
	☒ **Continuously and Ongoing**	☒ **Other** Specify: Representative Sample; Confidence Interval = 95%; Proportional and stratified across state districts
	☐ **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 States 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.

For measures 1, 2, 4, 9, and 11, BQIS conducts monthly case record reviews utilizing a waiver-specific valid sampling methodology. BQIS staff review waiver participant records for case manager compliance with Indiana Administrative Code rules related to the PCISP. Additional aspects of the case record review include: review of the PCISP, risk assessment (embedded in the PCISP), identified risk plans, annual choice of waiver services, non-waiver services or to not receive ICF/ID Medicaid services (BDDS signature page/freedom of choice section), signed pick lists for each service, and an updated PCISP when a participant's conditions or circumstances change.

For any item reviewed that is not in compliance, a corrective action plan is required and an electronic notification is sent to the responsible party that includes a description of the corrective action, steps to resolve, and due date. BQIS verifies implementation of the corrective action and either closes the case record review or issues a second attempt for implementation by the responsible party.

Reports are provided quarterly to BQIS for trends related to case record reviews. This process allows for identification of issues that may require additional training and education.

For measure 6, performance measure data is reviewed on a quarterly basis by the QIEC in which OMPP is a member. In addition, all reports associated with the waiver performance measures are uploaded to OMPP's SharePoint site on a quarterly basis. The BQIS data manager is responsible for data aggregation and ensuring all information is submitted to the OMPP SharePoint site as required. The BQIS data manager is retrained or disciplined if the standard is continually not met.

For measure 7, annual service plans (CCBs) must be developed every 365 calendar days, with interim updates as needed.

Case managers and supervisors monitor CCBs that are due to expire through the case management system. In addition, supervisors run reports of the number of CCBs that are about to expire for case management monitoring and quality assurance purposes. When reports show late annual CCBs, the case management entity is required to provide an explanation to the State regarding the reasons why any annual CCBs were submitted late. The case management entity must immediately complete and submit any overdue plans to the State, as well as complete any remediation actions. Additionally, the case management entity must submit a report to the State within seven calendar days, at which time the responses are researched and verified by DDRS. The case management entity is expected to re-train, discipline, or dismiss the case managers who continually fail to meet the standard. Monthly reports are compiled on a master report for presentation to QIEC. Ongoing, these results are taken into consideration as providers are evaluated for re-approval to deliver services.

For measures 3 and 10, a PCISP is developed to support the participant in attaining a good life. Indiana utilizes the NCI In-Person Survey to assess whether a participant's services and supports identified in the PCISP are supporting him or her in moving towards a good life. A face-to-face survey is conducted in which the participant is asked a series of questions regarding satisfaction. One of the questions is specific to whether the participant believes the services and supports help him or her live a good life. The NCI response data is collected during the survey process but the specific participant is not identified. The data is reviewed on a quarterly basis by QIEC and when a trend is identified, guidance and education for the entire stakeholder community is developed and communicated. DDRS has conducted training on the LifeCourse Framework™ and the implementation of the PCISP.

For measure 8, a monitoring checklist report is generated on a quarterly basis. Case managers are responsible for entering the responses in the annual monitoring checklist. A CAP is issued when the case manager determines the service plan does not meet the needs of the participant. BQIS conducts follow-up with case managers who have not implemented the CAP within 90 days of issuance. In addition, case managers are provided guidance on when a CAP should be issued.

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**

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

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.

Family Supports Waiver (FSW) applicants and any guardian or legal representatives are provided information regarding the right to appeal all decisions by the Bureau of Developmental Disabilities Services (BDDS) during the waiver intake, assessment, and eligibility determination processes. Applicants and any guardian or legal representatives are advised of the decisions that they may choose to appeal. State Form 46015 Form HCBS 5 is used to notify waiver applicants and participants of any action that affects the participant's Medicaid benefits related to waiver eligibility or service delivery. These actions include the participant's choice of home and community based services (HCBS) as an alternative to institutional care, the assessment used to determine the objective based allocation amount, a denial of a level of care, a service, a choice of a provider, or a denial, suspension, reduction, or termination of a previously authorized service. Notice of the individual's right to appeal must be provided to the individual at the time of any adverse action, including any denial, reduction, suspension or termination of service.

Waiver applicants and participants are informed of their right to appeal BDDS decisions via a Notice of Action (NOA). The NOA includes a description of appeal rights, the BDDS decisions that an individual may appeal, timeliness requirements, a description of appeal process and procedures, and the option for applicants and participants to have representation by an attorney, relative, or other spokesperson. NOAs are generated from and stored within the electronic eligibility system. In addition, waiver case managers provide a copy of the NOA that includes appeal rights to each participant and eligible prospective participant, and any guardian or legal representative, as appropriate.

Upon request, the case manager assists the participant in preparing the written request for an appeal. The case manager 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 case manager documents the request for an appeal in a case note and at the Family and Social Services Administration (FSSA) 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 Division of Disability and Rehabilitative Services (DDRS) operates a separate dispute resolution process that is available when there is a disagreement about service provision. Resolution of the dispute is designed to address the participant's needs.

Any issues that involve a participant's health and welfare are not addressed through the dispute resolution process but are instead immediately referred to the Bureau of Quality Improvement Services (BQIS) for action in order to ensure participant health and welfare.

The Indiana Administrative Code (IAC) 460 IAC 6-10-8 describes this dispute resolution process:
The parties to the dispute will first attempt to resolve the dispute informally through an exchange of information and proposed resolution(s). If the parties are not able to resolve the dispute within 15 days, each party must submit to the Individualized Support Team (IST) a description of the dispute, their positions, and their efforts to resolve the dispute. The IST will provide a decision and the parties must abide by that decision. If an IST cannot resolve the matter within 15 days after the dispute is referred to the IST, then the parties must refer the matter to the individual's service coordinator for resolution of the dispute. The service coordinator will make a decision within 15 days after the dispute is referred to the service coordinator and give the parties notice of the service coordinator's decision pursuant to Indiana Code (IC) 4-21.5. Any party adversely affected or aggrieved by the service coordinator's decision may request administrative review of the service coordinator's decision within 15 days after the party receives written notice of the service coordinator's decision. Administrative review shall be conducted pursuant to IC 4-21.5.

The dispute resolution process is available for the IST to use, but it is not required before a participant or guardian can file the request for an appeal. The case manager is responsible for the monitoring of services and ensuring that the participant understands that the dispute process is not a pre-requisite or substitute for the participant's right to request an appeal. 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:

DDRS operates a separate complaint process system through BQIS per IC 12-12.5 in conjunction with BDDS (IC 12-11-1.1).

DDRS also employs a statewide waiver ombudsman per IC 12-11-13, independent of both BQIS and 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

The following types of complaints may be generated through this system and are received by BQIS:
• Services not being provided according to a Person-Centered Individualized Support Plan (PCISP);
• Environmental issues;
• Human rights issues;
• Financial issues;
• Lack of staffing;
• Lack of health care coordination;
• Documentation issues; and
• Staff not trained.

(b) and (c) PROCESS, TIMELINES, & MECHANISMS FOR ADDRESSING GRIEVANCES/COMPLAINTS

The DDRS complaint process is not a prerequisite or substitute for the participant's right to request an appeal. In order to give the system an opportunity to work, BQIS encourages complainants with individual-specific issues to approach their case managers to try to resolve the issues first. If this has not produced the desired outcome, BQIS will initiate a complaint investigation.

BQIS forwards complaints to the quality vendor who reviews and categorizes the complaints as urgent, critical, or non-critical. The quality vendor assigns a quality assurance/quality improvement specialist (QA/QI Specialist) to investigate the case within identified timeframes.

Complaint investigation activities include:
• Conducting site visits to the participant's home or day program site;
• Conducting one-on-one interviews with the participant and/or their staff, guardians, family members, and any other people involved in the complaint; and
• Requesting and reviewing documentation from involved providers.

TARGETS FOR COMPLETING COMPLAINT INVESTIGATIONS (in calendar days)

URGENT:
• Within one day of intake, QA/QI Specialist receives complaint investigation assignment and initiates discovery activities.
• Within one day of complaint assignment, QA/QI Specialist performs unannounced onsite visit/phone contact initiating collection of evidence relevant to the originating complaint.
• Within 15 days of date of first contact, QA/QI Specialist completes written summary of investigative findings (allegations substantiated/not substantiated). If substantiated, request for a corrective action plan (CAP) will accompany findings.
• Within five business days of receiving the summary of investigative findings that substantiate allegations & require a CAP, provider will submit required CAP.
• Within five days of receiving provider's CAP, QA/QI Specialist reviews; documents decision to accept/not accept; and communicates to provider whether CAP is accepted/not accepted.
• CAP is validated within five 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 electronically of complaint closure/referral to the sanctions committee.

CRITICAL:
• Within one day of intake, QA/QI Specialist receives complaint investigation assignment and initiates discovery activities.
• Within two days of complaint assignment, QA/QI Specialist performs unannounced onsite visit/phone contact and initiates collection of evidence relevant to originating complaint.
• Within 25 days of date of first contact, QA/QI Specialist completes written summary of the investigative findings (allegations substantiated/not substantiated). If substantiated, request for CAP accompanies findings.
• Within eight days of receiving provider's CAP, QA/QI Specialist reviews; documents decision to accept/not accept; and communicates to provider whether CAP is accepted/not accepted.
• CAP is validated within eight 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 one day of intake, QA/QI Specialist receives complaint investigation assignment and initiates discovery activities.
• Within 30 days of date of first contact, QA/QI Specialist completes written summary of investigative findings (allegations substantiated/not substantiated). If substantiated, request for CAP accompanies findings.
• Within ten days of receiving provider's CAP, QA/QI Specialist reviews; documents decision to accept/not accept; and 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, and attempt to resolve complaints and concerns that are made by or on behalf of participants who have a developmental disability. Complaints may be received via the toll free number 1-800-622-4484, via e-mail, in hard copy format, or by referral. Types of complaints received include complaints initiated by families and/or participants, complaints involving rights or issues of participant choice, and complaints requiring coordination between legal services, DDRS services, and provider services.

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

With the consent of the participant, the ombudsman must be provided access to the participant records, including records held by the entity providing services to the participant. When it has been determined the participant is not capable of giving consent, the statewide waiver ombudsman must be provided access to the name, address, and telephone number of the participant's legal representative.

A provider of waiver services or any employee of a provider of waiver services is immune from civil or criminal liability and from actions taken under a professional disciplinary procedure for the release or disclosure of records to the statewide waiver ombudsman.

A state or local government agency or entity that has records relevant to a complaint or an investigation conducted by the ombudsman must also provide the ombudsman with access to the records.

The statewide waiver ombudsman coordinates his or her activities among the programs that provide legal services for individuals with a developmental disability, DDRS, providers of waiver services, and providers of other necessary or appropriate services, and ensures 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, and the members of Indiana's developmental disabilities commission. Trends are identified so that recommendations for needed changes in the service delivery system can be implemented.

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).

Incidents that require reporting are listed below and are defined as any event or occurrence characterized by risk or uncertainty resulting in or having the potential to result in significant harm or injury to a participant or death of a participant.

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 (APS) or the department of child services (DCS) as applicable. The provider shall suspend staff involved in an incident from duty pending investigation by the provider. If APS has reason to believe that a participant is an endangered adult, they will investigate the complaint or cause the complaint to be investigated by law enforcement or another agency and make a determination as to whether the participant is an endangered adult.

- “Abuse” is defined as:
  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.
- “Neglect” is defined as a 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 Person-Centered Individualized Support Plan (PCISP).
- “Exploitation” is defined as an 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.

2) Death of a participant. All deaths must be reported to APS or DCS as applicable. If the death is a result of alleged criminal activity, the death must be reported to law enforcement.

3) A service delivery site that compromises the health and safety of a participant while the participant is receiving services:

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 and safety of a participant, including but not limited to inappropriate 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 and safety concerns for a participant receiving services. This includes but is not limited to relocation, personal injury, or property loss.

5) Elopement of a participant where a provider or service delivery site fails to provide the required support as described in the PCISP as necessary for the participant’s health and safety.

6) Suspected or actual criminal activity by a staff member, employee, or agent of a provider, or a participant receiving services.

7) An event with the potential for causing significant harm or injury and requiring medical or psychiatric treatments or services to or for a participant receiving services.

8) Injury to a participant when the origin or cause of injury is unknown and may be indicative of abuse or requires medical intervention beyond first aid.

9) A significant injury to a participant including:

a) A fracture;or

b) A burn greater than first degree;or

d) Contusions or lacerations.

10) An injury that occurs while a participant is restrained.

11) A medication error except for refusal to take medications, including the following:
a) Medication given that was not prescribed or ordered for the participant;
b) Failure to administer medication as prescribed, including:
• Incorrect dosage;
• Medication administered incorrectly;
• Missed medication; and
• Failure to give medication at the appropriate time.

12) Inadequate staff support for a participant, including inadequate supervision, with the potential for:
a) Significant harm or injury to a participant; or
b) Death of a participant.

13) Use of any aversive technique, including but not limited to:
a) Seclusion;
b) Painful or noxious stimuli; and
c) Denial of a health-related necessity.

14) Use of any physical or mechanical restraint.

15) A fall resulting in injury requiring more than first aid.

16) Admission of a participant to a nursing facility, including respite stays.

17) Inadequate medical support for a participant, including failure to obtain:
a) Necessary medical services;
b) Routine dental or physician services; or
c) Medication timely resulting in missed medications.

18) Use of any PRN medication related to a participant's behavior. An incident report related to the use of PRN medication related to a participant's behavior must include the following information:
a) The length of time of the participant's behavior that resulted in the use of the PRN medication related to the participant's behavior.
b) A description of what precipitated the behavior resulting in the use of PRN medication related to the participant's behavior.
c) A description of the steps that were taken prior to the use of the PRN medication to avoid the use of a PRN medication related to the participant's behavior.
d) If a PRN medication was used before a medical or dental appointment, a description of the desensitization plan in place to lessen the need for a PRN medication for a medical or dental appointment.
e) The criteria the provider has in place for use of a PRN medication related to a participant's behavior.
f) A description of the provider's PRN medication protocol related to a participant's behavior, including the provider's:
(i) Notification process regarding the use of a PRN medication related to a participant’s behavior; and
(ii) Approval process for the use of a PRN medication related to a participant's behavior.
g) The name and title of the staff approving the use of the PRN medication related to the participant's behavior.
h) The medication and dosage that was approved for the PRN medication related to the participant's behavior.
i) The date and time of any previous PRN medication given to the participant related to the participant's behavior based on current records.

An incident described in this section must be reported by a provider or an employee or agent of a provider who:
• Is providing services to the participant at the time of the incident; or
• Becomes aware of or receives information about an alleged incident.

An initial report regarding an incident must be submitted within 24 hours of:
• The occurrence of the incident; or
• The reporter becoming aware of or receiving information about an incident.

The case manager must submit a follow-up report to the Bureau of Developmental Disabilities Services (BDDS) concerning the incident at the following timeframes:

- Within seven days of the date of the initial report; and
- Every seven days thereafter until the incident is resolved.

All information required to be submitted to BDDS must also be submitted to the case manager.

The Bureau of Quality Improvement Services (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 they may also be submitted via email or fax. While providers encourage their staff to report incidents through their own internal systems, anyone with an internet connection can report an incident through the State's system.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

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 Division of Disability and Rehabilitative Services (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.

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.

Incident reviewers also evaluate whether 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 APS or DCS, 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 safety, the case manager makes either a face-to-face or phone contact with the provider within 24 hours of notification of the sentinel event and documents this interaction via a follow-up report submitted in the State's web-based incident reporting system within 72 hours of the incident. 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 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 safety 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. All incident information, including open, closed, and sentinels, is posted in the BDDS case management system on the case manager's dashboard.

The participant's case manager, along with input from the Individual Support Team (IST), is responsible for electronically submitting follow-up reports within seven 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. BQIS ensures that case managers are completing required follow-up reports until incidents are closed.

At the discretion of 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 safety 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 managers will meet with participants four times per year, not less than once every 90 calendar days. Case managers shall monitor the effectiveness of the PCISP outcomes using documented review between the participant or representative. Three of the four meetings may take place outside the home. One unannounced visit in the home is required for waiver participants residing in provider owned or controlled settings.
• Case managers are responsible for ensuring the participant's immediate protection from harm when participants have had sentinel events which includes making contact with the provider and/or waiver participant/guardian within 24 hours or receiving incident.
• Pre- and post-monitoring of transitions (movement to a new residential services provider or home) are the responsibility of the case manager.

BQIS uses its quality contractor to manage the state's web-based incident management system. The quality contractor's risk management staff have 24 hours to review incident reports and code them according to potential for impacting participants' health or safety, 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 seven 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.

All incident information, including open, closed, and sentinels, is posted in the BDDS case management system on the case manager's dashboard.

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 also has 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 three 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.

The investigation surrounding an incident report (IR) is conducted by the provider but the case manager is responsible for ongoing follow up to ensure the investigation is completed and the incident 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 manager. 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.

BQIS oversees incident reporting and management and works closely with BDDS to assure that the same incidents do not continue to occur.

At least quarterly, 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 emergency room (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 the Office of Medicaid Policy and Planning (OMPP), BQIS, and BDDS.

When trends are identified, the QIEC uses a worksheet to document the opportunity for improvement, the data source to be 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 participant or others.

An “emergency situation” means the occurrence of an unanticipated challenging/dangerous behavior (a behavior presenting imminent serious danger to the individual receiving services or others) exhibited by a participant that has not occurred before, or that has occurred no more than one time during a six month period.

In order for a provider to initiate an emergency intervention, the provider must first establish a written plan which includes all of the following components:
• The specific, defined emergency interventions to be used;
• Any appropriately trained staff that is authorized to select and initiate in emergency intervention;
• The training needed for staff prior to implementing emergency interventions; and
• Directions for documenting: a description of the emergency, a description of the emergency intervention implemented, the person/s implementing the emergency intervention, the duration of the emergency intervention, the participant’s response to the emergency intervention.

Additionally, a restrictive intervention may be used in an emergency situation without being planned when all of the following are present:
• An unanticipated behavioral emergency exists;
• A participant’s behavior poses an imminent threat of harm to self or others;
• There is no approved behavior support plan for the participant that addresses the behavioral emergency, or there is an approved plan but it has been found to be ineffective and a more restrictive intervention is indicated based upon the participant’s behavioral emergency; and
• The intervention chosen is determined to be the least restrictive measure required to quell the unanticipated behavioral emergency.

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.

In addition to the requirements in the Incident Reporting policy, abuse may require a provider to file a police report.

Also prohibited are practices that violate a participant’s rights. The prohibited practices include: denying 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; corporal punishment inflicted by the application of painful stimuli to the body, which includes: forced physical activity, hitting, pinching, the application of painful or noxious stimuli, the use of electric shock, or the infliction of physical pain; seclusion; verbal abuse including: screaming, swearing, name-calling, belittling, or other verbal activity that may cause damage to an individual’s self-respect or dignity; and work or chores benefiting others without pay unless authorized by the US Department of Labor, the services occur in the participant’s own residence as a normal and customary part of housekeeping and maintenance duties, or the participant desires to volunteer in the community.

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 policy requires that behavioral support plans that utilize restrictive interventions contain the following:
(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 IST 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 IST.

To ensure the participant's safety the IST participates in 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's progress on the behavioral support plan including targeted behaviors and any need for an amendment to the 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 IST 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 IST, a provider of behavioral support services must be added to the IST.

Indiana policy requires that providers' staff be trained to implement the participant's specific behavior plan.

ISTs submit comprehensive corrective action plans to BQIS for review and approval. BQIS then validates that these plans are being implemented as stated.

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 6-5-4 and 6-14-4 and be trained by the provider of behavioral support services.

Addendum:

The State's list of excluded (aversive) techniques includes but is not limited to:
1. Contingent exercise
2. Contingent noxious stimulation
3. Corporal punishment
4. Negative practice
5. Overcorrection
6. Seclusion
7. Visual or facial screening
8. Any other technique that:
   a) incorporates the use of painful or noxious stimuli;
   b) incorporates denial of any health related necessity; or
   c) degrades the dignity of a participant.

Additionally, any restrictive intervention used for convenience of discipline, prone restraint where an individual is face down on their stomach, or any aversive technique and mechanical restraint (unless the mechanical restraint is ordered as a medical restraint by a licensed physician or dentist) are also excluded.

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:

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 IST 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, as well as review during required team meetings.

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. Behavioral support standards require that behavior plans employ non-aversive methods to replace maladaptive behaviors with functional and useful behaviors.

Indiana 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 IST 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 IST.

The IST participates in team meetings with the behavioral support staff.

To ensure the participant's safety, the IST participates in quarterly reviews with the behavioral support staff. This includes the participant and 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 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.

Inappropriate restrictive measures that constitute abuse are reported immediately upon discovery to APS or DCS. 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 and selection of new providers of behavioral services by participants.

At a minimum, personnel who are involved in the administration of restraints must meet the education and training requirements specified in 460 IAC 6-5-4 and 6-14-4 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:

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 IST 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, as well as review during required team meetings.

Data is entered into and collected from the State's electronic Incident Reporting system. It is aggregated quarterly and normed annually, so that it 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.

BQIS is responsible for detecting the unauthorized use of seclusion.

Indiana policy specifies that "seclusion" means placing a participant alone in a room or other area from which exit is prevented is specifically prohibited from use. BDDS policy lists seclusion among prohibited practices. Per DDRS's incident reporting and 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 a participant. Seclusion is categorized as an aversive technique.

Per Indiana policy, "abuse" includes unnecessary physical or chemical restraints or isolation, and the use of seclusion/isolation is a violation of rights. Monitoring occurs through the incident reporting process, the complaint process, and the case management function, as well as review during required IST 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 DDRS provider re-approval process.

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.

BQIS reviews all incident reviews 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-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- ○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Participants in the Family Supports Waiver (FSW) program are served in a variety of settings. The person identified in the PCISP 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 participant assistance and care.

Per Indiana policy, 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 meeting reviews the participant's medications as part of the comprehensive PCISP 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. Per Indiana 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 visits with participants and ISTs 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 IST to be in agreement with the use of medication and have the approval of the human rights committee prior to implementation.

Monitoring activities by the case manager address all medications actions, not just a percentage. At each semi-annual IST meeting, or more often if indicated by the PCISP, case managers monitor the administration of medications with members of the IST:

Regarding psychotropic medications:
- Does the participant's record confirm the use of psychotropic medication?
- Is there informed consent and human rights committee approval for administration of the psychotropic medication to the participant?
- 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 PCISP 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 medication administration plan and a medication administration record available for the participant?
- 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 participant's medication administration plan?
• Does observation of the participant, review of the participant'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 participant?

**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 460 IAC 6-25-4, 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 PCISP;
- 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.
- 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 PCISP, 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; and
- All providers administering medication to the participant shall implement and comply with the organized system of medication administration designed by the provider.

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 PCISP and Cost Comparison Budget (CCB), and through quality improvement review activities. Results of the reviews are shared with 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.

Case managers analyze data at the participant level, identify trends, and work with providers to develop remediation plans. BQIS conducts the same activities but for provider-specific and systemic trend analysis. 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, corrective action plans (CAP) 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 safety, existing processes are utilized to address urgent issues (through the incident reporting system) or repeated non-compliance (through referral to the sanctions committee).

The State uses the following methods facilitated by BQIS:

1. Incident reporting – all issues related to medication administration are reported within the State's Incident Reporting system. Medication administration data is aggregated and reviewed at least annually by the 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 participant's overall health and well-being.

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 policy requires that all provider staff be trained in administering medication. The state has an approved curriculum available for providers to use to conduct this training.

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 and the BDDS incident reporting and management policy).

Additionally, the following DDRS policies contain information related to medication administration:

460 IAC 6-14-4 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.

460 IAC 6-17-3 requires that, at minimum, the onsite records pertaining to the participant contain all medication administration recording forms for the previous two months.

460 IAC 6-17-4 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.

460 IAC 6-25-10 requires that the primary services provider shall also provide a narrative review of the deceased individual's medication administration records.

460 IAC 6-9-5 and the DDRS Incident Reporting & Management policy require the reporting of any medication error, except for refusal to take medications, including the following:
a) Medication given that was not prescribed or ordered for the participant;
b) Failure to administer medication as prescribed, including:
- Incorrect dosage;
- Medication administered incorrectly;
- Missed medication; and
- Failure to give medication at the appropriate time.

This policy also requires the reporting of the use of any PRN medication related to an individual's behavior.

460 IAC 6-10-10 and the DDRS Quality Assurance & Quality Improvement System policy require 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 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:*

Any medication error, except for refusal to take medications, including the following:

a) Medication given that was not prescribed or ordered for the participant;
b) Failure to administer medication as prescribed, including:
- Incorrect dosage;
- Medication administered incorrectly;
- Missed medication; and
- Failure to give medication at the appropriate time.

Providers must conduct medication administration training. While providers can conduct their own medication administration training, DDRS has an approved Core A and B medication administration training curriculum available to assist providers' trainers. For this specific training, the State requires that only RNs or LPNs participate in this train-the-trainer training.

(c) Specify the types of medication errors that providers must *report* to the state:

Any medication error, except for refusal to take medications, including the following:

a) Medication given that was not prescribed or ordered for the participant;
b) Failure to administer medication as prescribed, including:
- Incorrect dosage;
- Medication administered incorrectly;
- Missed medication; and
- Failure to give medication at the appropriate time.

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

BQIS, BDDS, and OMPP are responsible for overseeing provider performance in the administration of medications.

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 PCISP and CCB by the IST.

Medication error reporting or inappropriate use of medications may be received by BQIS through the incident reporting system or the complaint system. On a quarterly basis, a trend analysis of medication error data is completed by BQIS and the data is reviewed by the QIEC. There is also a data driven process focused on medication errors where providers review data, compile recommendations to address, and implement plans for improvement.

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 CAP, 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. On a quarterly basis, data trends involving medication errors are reviewed and discussed as part of the work of the QIEC, which also includes BDDS and OMPP. QIEC identifies potential activities and remedies to address and mitigate identified issues.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States 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:
1. Percent of substantiated complaint allegations of abuse, neglect, or exploitation where the corrective action was implemented. Numerator: Number of substantiated complaint allegations of abuse, neglect, or exploitation where the corrective action was implemented. Denominator: Number of substantiated complaint allegations of abuse, neglect, or exploitation requiring corrective action.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Weekly Complaint 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: 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:
2. Percent of waiver participants who report that staff are respectful. Numerator: Number of sampled waiver participants who report staff are respectful. Denominator: Number of sampled waiver participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
National Core Indicators (NCI)

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 =

		Representative Sample; Confidence Interval = 95%; Proportional and stratified across state districts
☐ **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: Human Services Research Institute	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
3. Percent of waiver participants who do not feel afraid or scared in their home or day program. Numerator: Number of sampled waiver participants who report they do not feel afraid or scared in their own home or day program. Denominator: Number of sampled waiver participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
National Core Indicators (NCI)

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 = Representative Sample; Confidence Interval = 95%; Proportional and stratified across state districts
☐ **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: Human Services Research Institute	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
4. Number and percent of unsubstantiated incidents of abuse, neglect, and/or exploitation by staff. Numerator: Total number of unsubstantiated incidents of abuse, neglect, or exploitation by staff. Denominator: Total number of alleged incidents of abuse, neglect, or exploitation by staff.

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**	☐ **Annually**	☐ **Stratified**

Specify: BQIS Quality Contractor		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:
5. Number and percent of unexpected deaths reviewed by the mortality review triage team according to policy. Numerator: Total number of unexpected deaths reviewed by the mortality review triage team according to policy. Denominator: Total number of unexpected deaths.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Mortality Review Triage Team

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:

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:
6.Number and percent of incidents that were reported within 24 hours of knowledge of the incident. Numerator: Total number of incidents reported within 24 hours of knowledge of the incident. Denominator: Total number of incident reports submitted.

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:
7. Percent of participants with 3 or less critical incidents within the last 365 days. Numerator: Number of waiver participants with 3 or less critical incidents within the last 365 days. Denominator: Number of waiver participants.

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**

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

Performance Measure:
8. Number and percent of incidents that were resolved within the stipulated time period. Numerator: Total number of incidents 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:
9. Number and percent of reported uses of restraints by staff that did not result in medical treatment. Numerator: Total number of reported uses of restraints by staff

that did not result in medical treatment. Denominator: Total number of reported uses of restraints by staff.

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**

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:

Performance Measure:
10. Percent of restraints implemented by staff that were in accordance with state regulations and policy. Numerator: Total number of restraints implemented by staff that were in accordance with state regulations and policy. Denominator: Total number of restraints implemented by staff.

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:	☐ **Annually**	☐ **Stratified** Describe Group:

BQIS Quality Contractor		
	☒ **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:
11. Percent of reported incidents by staff that were not coded as a prohibitive intervention (i.e. seclusion, aversive technique, prone restraint, etc.). Numerator: Total number of reported incidents by staff not coded as a prohibitive intervention. Denominator: Total number of reported incidents by staff.

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:

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:
12. Number and percent of medication errors by staff that did not result in medical treatment. Numerator: Total number of medication errors by staff that did not result in medical treatment. Denominator: Total number of medication errors by staff. (No medical treatment includes: No apparent injury, Assessment only, and First Aid)

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:
13. Number and percent of participants who report having a primary doctor or practitioner. Numerator: Total number of sampled participants who report having a primary doctor or practitioner. Denominator: Total number of sampled participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
National Core Indicators (NCI)

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 = Representative Sample; Confidence Interval = 95%; Proportional and stratified across state districts
☐ **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: Human Services Research Institute	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
14.Number and percent of sampled participants who report having a complete physical exam in the past year. Numerator: Total number of sampled participants who report having a complete physical exam in the past year. Denominator: Total number of sampled participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
National Core Indicators (NCI)

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 =

		Representative Sample; Confidence Interval = 95%; Proportional and stratified across state districts
☐ **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: Human Services Research Institute	☒ **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 States 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.

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 seven calendar days until an incident is closed.

On a weekly basis BQIS quality contractor's risk management staff send case management agencies a report listing all of the sentinel incident reports that continue to be open. All incident information, including open, closed, and sentinels, is posted in the BDDS case management system on the case manager's dashboard. 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 also has the authority to issue civil sanctions. BQIS facilitates the DDRS sanctions committee, consisting of representatives of BQIS, BDDS, and members of DDRS executive leadership, which recommends to 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 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**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **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 3)

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; and

- 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 3)

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. The Division of Disability and Rehabilitative Services (DDRS) uses a centralized IT system to administer the day-to-day operations of the waiver program for the Family Supports Waiver (FSW) (IN.0378) and the Community Integration and Habilitation (CIH) Waiver (IN.0387). DDRS has made, and continues to make, many efforts to ensure 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 ensuring that participants' issues are identified and addressed timely and appropriately. Case managers have the front-line responsibility for monitoring participants and following-up on issues identified through their routine contacts with the participant. Case managers also take a lead role in facilitating participants' individualized support team (IST) meetings. The ISTs meet at least every 90 calendar days and are responsible for using the progress notes from providers' to assess if a participant is meeting his or her goals and objectives, whether the Person-Centered Individualized Support Plan (PCISP) 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.

Information that ISTs use to make decisions about participants include:
- Data from the case manager's required IST meetings where a full assessment of the participant's service implementation is conducted;
- Providers' quarterly summaries;
- Incident reports;
- Complaint investigations; and
- 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 performance measures for the FSW and CIH waivers. 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 participants' 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 ensures that these remediation plans are implemented and then follows up with those performance measure reports at the next QIEC meeting.

Examples of systemic improvements the QIEC has made include: revising DDRS provider policies, educating providers/consumers on key health and safety issues impacting participants 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 the 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 the Family and Social Services Administration (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 services representative
- BDDS field operations liaison
- BDDS case management liaison

- OMPP representative
- Home and community-based services (HCBS) liaison

DDRS participates in the National Core Indicators (NCI) project to obtain participant perspectives on how the waiver service delivery system is operating overall. These data expand DDRS's quality assurance system. Ongoing, as we collect and analyze Indiana's interview results and make comparisons to other states' performance, we will be better 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.

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 FSW and the CIH waivers.

As described in Indiana Administrative Code (460 IAC 6-9-5) on 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 a participant'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 participant's home to assess staff performance in adhering to risk plans related to choking. If an issue was identified, the provider would 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 a participant's PCISP as responsible for the health care of the participant is required to conduct internal investigations of participant deaths. The DDRS mortality review policy describes 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 participant'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 quality contractor's life cycle specialist. Committee members include representatives from BQIS, Adult Protective Services (APS), the Department of Health, OMPP, Indiana coroner's association, Statewide waiver ombudsman, BDDS field service staff, and community advocates.

Based on its 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 a participant'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 communication topics have included Coumadin monitoring, malfunctioning feeding tubes, choking versus aspiration, pain management, medication administration, healthcare coordination, staff training on risk plans, and the fatal four in individuals with developmental and intellectual disabilities.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Quality Improvement Committee**	☐ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

DDRS uses a centralized IT system to monitor its HCBS waiver programs and to identify systemic changes necessary for improving the quality of participants' services and supports. DDRS management and OMPP representatives participate in the routine QIEC DDRS leadership 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 participant each year, coordinating and facilitating IST 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 participants they work with are impacted.
• BQIS-contracted complaint investigators are continually in the field following up on allegations that participants' 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 leadership 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 DDRS leadership meetings.
• Designated staff from the BQIS quality contractor conduct case record reviews to assess whether PCISPs have been developed according to the state's standards for PCISPs. 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 DDRS leadership meetings. Over the past few years DDRS has focused its resources on ensuring that we have the processes in place to collect data on our most basic assurances and that these processes are working effectively.

As needed, DDRS will submit modifications to the quality improvement strategy annually with the 372 report.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- (●) **No**
- ( ) **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ( ) **HCBS CAHPS Survey :**
- ( ) **NCI Survey :**
- ( ) **NCI AD Survey :**
- ( ) **Other** *(Please provide a description of the survey tool used):*

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).*

FSSA PI has an agreement with the FSSA Audit Unit to investigate allegations of potential HCBS waiver provider fraud, waste, and abuse. PI and FSSA Audit maintain a natural level of collaboration and cooperation between the two groups. FSSA Audit's staff are knowledgeable of the different HCBS definitions, documentation standards, provider qualifications, and any required staffing ratios so it makes sense for them to audit allegations of wrongdoing in the waiver programs. The state does not require providers to secure an independent audit of their financial statements.

Select analytics are periodically rerun in an attempt to identify if provider billing patterns have changed/improved based on previous audit and/or provider education. Additional audit action may be taken for providers who continue to be identified as potential issues in these algorithms. If providers are again selected for audit, a similar audit process as previously described would occur.

Process for Conducting Audits:
PI receives allegations of provider fraud, waste, and abuse and tracks these in its case management system. When it receives an allegation regarding a waiver provider, PI forwards it to FSSA Audit to begin their research and audit process. FSSA Audit works with PI to vet the providers with the Indiana Medicaid Fraud Control Unit (MFCU). Once it receives MFCU's clearance FSSA Audit determines how to best validate the accuracy of the allegation.

FSSA Audit may decide to conduct a statistically valid random sample of consumers and then PI's Fraud & Abuse Detection System (FADS) vendor will pull a sample for their audit. The size of a random sample audit is dependent on the universe(s) size, claim/claim line payments, and other statistical criteria. The sample size is ultimately determined utilizing a tool developed by FADS contractors as well as their statistical consultants. Depending on the concerns identified during the risk assessment FADS will recommend an approach and/or scope for the audit:

Targeted Probe Audit Sample – A sample of sufficiently small size designed to focus on specific services, members, time frames, or other scenarios that have been identified as higher risk for fraud, waste, and/or abuse to determine potential outcomes of audit findings or payment error issues. If the probe identifies material issues, statistical sampling is used to expand the testing and quantify overpayments.

Random Sample Audit – The goal of the random sample is to identify potential payment errors and extrapolate those errors to the entire universe of claims.

FSSA Audits are performed onsite and include a review of:
- *Providers' source documents. This include documents that supports paid claims (e.g. employee signed service notes, logs, etc.).*
- *Payroll records. Dates/times/locations of service per claims are compared to related time cards and payroll registers.*
- *Employee background and qualifications. Personnel files are reviewed for documentation of criminal background checks, licenses (if applicable), and search of the HHS/OIG exclusions list.*

FSSA Audit conducts its audit activities and develops a findings report containing accuracy-related issues, missing documentation, internal control deficiencies, and training issues. Providers submit corrective action plans. Any overpayments are set up for recoupment. Audit reports are distributed to provider leadership and appropriate FSSA executives. Periodically, PI is advised of any systemic issues identified. FSSA Audit Services seeks PI's advice on audit reporting and direction on technical questions.

For audits performed based on referrals such as incorrect billing, the reporting varies. If the audit finds the provider made unintentional errors, the typical audit reporting process is followed. However, if the referred audit identifies potential, intentional errors that may be credible allegations of fraud, the provider is referred to PI for further action.

The FSSA PI section utilizes a Provider Peer Comparison Tool (J-SURS) which compares providers to peers of like specialty to identify outliers to conduct on-going monitoring of IHCP providers. At a minimum, all provider types are profiled yearly, while higher-risk provider types are profiled on a quarterly basis. The results of the profiles are reviewed by PI staff to determine which providers may need further investigation and these results are discussed in weekly team meetings with PI's Fraud Abuse and Detection (FADS) group.

PI regularly utilize random-sampling and extrapolation in conducting audits of IHCP providers; however, the approach and sampling is determined by the allegation necessitating the audit. The frequency of utilizing this approach is fluid, based upon the providers in queue for audit as well as the proposed audits included in the yearly FADS Audit Workplans. If the audit has a narrow scope the review will be conducted on all identified claims. If the issue involves a large number of

claims, or if the review is a provider-focused, comprehensive review, PI has the ability to utilize statistically-valid random sampling and extrapolation to determine any potential overpayments from the IHCP.

PI audits include a review of provider records to ensure compliance with applicable state and federal guidelines, as well as policies published by the IHCP. Review scope may vary depending on provider type/specialty and/or concerns/allegations identified. At a minimum, the review includes:

- *Compliance with applicable documentation requirements. This may include documents such as reconciliation of the records to timesheet and/or other payroll records, vehicle insurance (e.g., transportation providers), etc.*
- *Employee background and qualifications. This may include a review of personnel files for documentation of licenses (if applicable), TB test records, etc.*

For each review, PI prepares a detailed claim-level review checklist that lists all claims included in the review, outlines the scope of the review, and identifies all findings or educational items noted during the review.

FADS investigations/audits can be initiated based on referrals received from different sources/agencies. PI receives information from the following sources which could potentially lead to additional action including audit action:

1. *IHCP Provider and Member Concerns Line;*
2. *Other agencies (MFCU);*
3. *Analyses/Analytics performed by the PI Investigations team*
4. *Analytics performed by FADS contractors.*

Depending on the allegations/information received regarding the provider(s), PI may conduct a Preliminary Investigation, utilizing the Credible Allegation of Fraud (CAF) tool developed by FADS contractors to determine next steps.

In certain instances, PI refers the provider(s) in question to FADS contractors for additional analysis which may include performing a Risk Assessment. The Risk Assessment tool, developed by FADS contractors, is utilized to gather information on a specific provider's background as well as billing patterns utilizing claims data and other research databases, focusing on any potential issues identified during the referral process. FADS contractors utilize this tool to assist in the decision making process when recommending the next appropriate action to be taken for the provider(s) in question.

There are differences in post-payment review methods, scope and frequency based upon audit type, provider type/specialty, background information, and state rules/regulations. PI can audit IHCP providers either through a narrow scope in which all identified claims are reviewed or a provider-specific full review. PI has the ability to utilize statistically-valid random sampling and extrapolation to determine any potential overpayments from the IHCP.

The providers are notified of the potential errors upon receipt of the Draft Audit Findings letter, where no medical records are reviewed prior to identification of the problematic claims. If PI decides to conduct a more comprehensive review of an IHCP provider, PI request a full medical record review. The audit can be conducted through a medical record request desk audit, or as an on-site review. The on-site audit can be announced or unannounced, based upon the circumstances behind the audit recommendation.

Depending on multiple factors, risk assessments typically result in one of the following recommended actions (dependent upon the severity of the allegations and other information uncovered during the risk assessment):

- *No further action – No issues uncovered warranting further action.*
- *Provider education – No major issues identified that would result in patient harm or overpayments; however, it may be apparent that the provider as well as the Medicaid Program would benefit from additional education for the provider on proper/best billing practices.*
- *Provider self-audit – Specific concern(s) were identified resulting in a recommended limited-scope audit; however, the concern(s) are in an area which the State is comfortable with the provider conducting the audit to ensure compliance. FADS contractors subsequently perform validation review of the provider self-audit results. If FADS contractors determine they are not in agreement with a high percentage of the provider's self-audit results during the validation review, they will recommend the audit be escalated to a desk review and all records within the provider self- audit sample are evaluated by the contractor.*
- *Provider desk audit – Concern(s) were identified resulting in the need for medical record review (could be full or limited scope). However, the severity of the concerns do not currently warrant an on-site review. Certain provider records, including medical records, are requested for selected claims and clinical staff (if necessary) conduct a review of the services billed to ensure compliance with IHCP guidelines. Providers are allowed thirty (30) days to submit the requested information.*
- *Provider on-site audit (announced or unannounced) – Severity of the concern(s) has resulted in a recommendation of an*

on-site audit. Providers are generally given shorter notice (or no notice if warranted) of the pending on-site audit. If notice is provided, it can range from a few days to a few of weeks depending on several factors (i.e., type of facility, audit concerns, etc.). Requested information is collected on-site. A facility tour as well as provider/staff interviews are also conducted during on-site reviews. FADS contractors, including clinical staff, are included in on-site reviews and assist with conducting interviews. State Program Integrity personnel often also participate in on-site reviews.

• Referral to MFCU – Payment suspension recommended as the potential intent of fraudulent behavior was identified. Depending on the allegations/information received regarding the provider(s), the SUR Unit may conduct a Preliminary Investigation, utilizing the Credible Allegation of Fraud (CAF) tool developed by FADS contractors to determine the appropriate next steps, if any.

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.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:
The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(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:
1. 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:

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***	☐ ***Weekly***	☒ ***100% Review***

Agency		
☐ ***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:*	☐ ***Annually***
	☒ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

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

Performance Measure:
2. 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:* *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:
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 service 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:

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:*

Fiscal Contractor		
	☐ ***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:
4. 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):*
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:
Financial records (including expenditures)

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:*	☐ ***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 a person-centered individualized support plan (PCISP), are processed for reimbursement to providers who are enrolled Medicaid Family Supports Waiver providers.

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the States 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.*

Performance measures (PM) 1., 2., and 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.

PM 4. 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).*

January 1, 2022 amendment IN.0387.R04.03:

Pursuant to State of Indiana legislative mandate in Indiana's biennium budget legislation (Indiana House Enrolled Act 1001/Public Law 165 of 2021), a 14% rate increase will be implemented for the following services under this waiver amendment:

- *adult day services*
- *prevocational services*
- *respite*
- *extended services*
- *day habilitation*
- *workplace assistance*
- *transportation services*
- *participant assistance and care*
- *facility based support*

The rate determination methodology continues to rely on the methodology utilized in 2009 with the 14% increase to specific services based on the legislative mandate. The original rate determination methodology is outlined below.

The unit rates for vehicle modifications are now separated from the unit rates for specialized medical equipment and supplies, and both are based on current market values.

****

A previously separate component of Case Management is now rolled into the reimbursement rate of the service. An annual per member per year reimbursement for additional person centered planning activities revolving around the LifeCourse Framework for Supporting Families was rolled into the rate for Case Management services.

The rate determination methodology continues to rely on the methodology utilized in 2009 and outlined below.

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.

EXTENDED SERVICES
For the new service Extended Services, the Extended Services rate in question was built upon the same cost centers and cost factors that have been utilized by DDRS since 2007 in the development of the existing rate for SEFA.

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.

Rate testing was initiated in January 2008 and involved only providers in BDDS District 4. Rate testing was expanded statewide to all providers in January 2009.

3. Rate Revision and Implementation: Rate implementation began in January 2008 and became effective statewide in January 2009. Rate revisions were implemented based upon evaluation and testing findings.

DESCRIPTION OF RATE STRUCTURE

DDRS converted its provider reimbursement approach from a negotiated rate system to a standardized fee-for-service system for all of its Medicaid Home and Community-Based Services (HCBS) waiver program.

There 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 and transportation, all provider reimbursement for the Family Supports Waiver is based upon the amount of direct care staff time delivered to the participant by the provider. In order to meet the conditions for payment, the participant must be Medicaid eligible, enrolled, in attendance, and receive a HCBS service; and the direct care staff must be actively employed and present to provide the HCBS service. In addition, the service provided must be consistent with the participant's person-centered/individualized support 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 were part of the operation of the setting in which residential habilitation occurred and related to the programs which occur within the setting, but are not directly tied to the direct care staff. They included 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 were not directly related to the clients or the programs that serve the clients.

Rate Component #3 - Other Factors: In addition, standardized cost centers were applied.

Historical expenditures were used by DDRS as the basis for transportation rates. The average cost per person was utilized and the transportation rate was applied only to people who were, at that time, receiving fewer than 35 hours per week of Residential Habilitation and Support each week under Indiana's comprehensive DD or Autism Waivers. (Note: While this uniform rate for Transportation services was developed using historical expenditures from other HCBS

waivers, Transportation is available to all participants under the Family Supports Waiver and the rate was carried forward from the other HCBS waivers.)

Participant Assistance and Care (PAC) rates were derived through review and analysis of its reimbursable activities in comparison to reimbursable activities associated with State Plan and what were at that time the comprehensive "DD Waiver" services offering components of personal care and/or residential supports.

Additionally, 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.

FSW services for which the state's standard rate methodology applies:
• Adult Day Services
• Behavioral Support Services
• Day Habilitation
• Music Therapy
• Occupational Therapy
• Participant Assistance and Care
• Personal Emergency Response System
• Physical Therapy
• Prevocational Services
• Psychological Therapy
• Recreational Therapy
• Respite
• Specialized Medical Equipment and Supplies
• Speech/Language Therapy
• Transportation
• Workplace Assistance

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.

The State has an Electronic Visit Verification (EVV) system that complies with the requirements of the federal 21st Century Cures Act as passed by Congress and signed into law on December 3, 2016. The state system was implemented January 1, 2021.

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 Cost Comparison Budget (CCB) for the Family Supports Waiver, contains only those reimbursable services from the Person-Centered Individualized Support Plan (PCISP) that are available under the Family Supports Waiver.

FSSA's Division of Disability and Rehabilitative Services (DDRS) waiver services staff approve a participant's CCB within the State's case management application database ensuring that only those services which are necessary and reimbursable under the Family Supports Waiver and that appear on the CCB. The CCB is sent to the state's fiscal agent and entered into the MMIS serving as the prior authorization for all Family Supports Waiver services. The case management data system will not allow the addition of services beyond those services offered under the Family Supports Waiver. The case management data system has been programmed to alert DDRS waiver services staff when a 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 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 CCB service and rate information to the Indiana MMIS. The CCB data is utilized by the MMIS as the basis to create or modify Prior Authorization fields for billing of services against Medicaid waiver participants.

Providers submit electronic (or paper) claims directly to the MMIS. Claims are submitted with date(s) of service, service code, and billing amount. Reimbursements are only authorized and made in accordance with the Prior Authorization data. The MMIS also confirms that the waiver participant had the necessary Level of Care and Medicaid eligibility for all dates of service being claimed against.

c) Documentation and verification of service delivery consistent with paid claims is reviewed during the look behind efforts of the Bureau of Quality Improvement Services as well as by the Office of Medicaid Policy and Planning when executing Surveillance & Utilization (SUR) activities.

In summary, the participant's eligibility for Medicaid and eligibility for approved dates of service are controlled through the electronic case management database system which is linked to Medicaid's claims system. All services are approved within these systems by the operating agency. As part of the 90 day review, the case manager verifies with participant the appropriateness of services and monitors for delivery of service as prescribed in the plan of care.

Modifications to the plan of care are made as necessary.

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

- (●) ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***
- ( ) ***Payments for some, but not all, waiver services are made through an approved MMIS.***

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are not made through an approved MMIS.***

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☒ ***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.

- (●) ***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.***
- ( ) ***This waiver is a part of a concurrent ?1115/?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 ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ( ) ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

  In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver 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.

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:

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	8973.95	7917.53	16891.48	82308.11	6247.56	88555.67	71664.19
2	9075.54	11056.45	20131.99	86711.98	6589.87	93301.85	73169.86
3	9292.80	11343.91	20636.71	88532.93	6761.21	95294.14	74657.43
4	9533.35	11638.86	21172.21	90392.12	6937.00	97329.12	76156.91
5	9732.60	11941.47	21674.07	92290.36	7117.36	99407.72	77733.65

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	*24173*	*24173*
Year 2	*26231*	*26231*
Year 3	*28181*	*28181*
Year 4	*30028*	*30028*
Year 5	*31777*	*31777*

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.*

Projected average length of stay has been updated to reflect actual experience through November 2018 in WY 4 of the third renewal. It also reflects new entrant projections of 270 per month.

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 and methodology for these estimates is as follows:*

Base Year data reflects experience from Waiver Year 5 of the third renewal: April 1, 2019 – March 31, 2020.

The base year data was projected to WY 1 through WY 5 of the fourth renewal in the following manner:
• Number of users of each service was adjusted based on projected slots.
• Average units per user were projected to vary with average length of stay.
• Person-centered planning was integrated into the Case Management service effective June 1, 2020 and data was adjusted to reflect the impact of this change. The new rate for Case Management is $143.75 per month.
• Community Habilitation services and Facility Habilitation services were terminated effective July 31, 2020 and replaced by Day Habilitation effective 8/1/2020. The rates for each level of service remained unchanged. The number of users was projected based on WY5 number of users and projected slots and in addition was adjusted for any overlap between prior services. Average cost per unit is based on the weighted average cost per unit of prior services for each level of service. Expenditures were adjusted to reflect the change in slots and average units per user for each level of service were calculated by dividing adjusted expenditures by number of users and average cost per unit.
• Reimbursement for the following services was projected to increase by 14% effective July 1, 2021, as mandated by HEA 1001 legislation:
o Adult Day Services
o Day Habilitation
o Prevocational services
o Respite
o Extended Services
o Facility Based Support Services
o Participant Assistance and Care
o Transportation
o Workplace Assistance
• SME will be split into two services
• SME will be split into two services effective January 1, 2022 with the following changes to the service limitations to better align with the Division of Aging waivers:
o SME installation cap is currently set at $7,500 and includes to both SME and Vehicle Mod installation. There will no longer be a cap applied to SME installation, while Vehicle Mod will be limited to $15,000 for every 10 years. This change is estimated to increase installation costs by approximately 14.1%.
o The maintenance/repair cap that currently includes both SME maintenance and Vehicle Mod repair services will increase from $500 to $1,000 for SME maintenance. Vehicle Mod repair will have a separate cap of $500 per year. The impact of this change is a 23.2% increase.
o Vehicle Mod installation will be subject to a cap of $15,000 for every 10 years, which is assumed to increase
costs by approximately 14.1%.

Cost per unit trend of 2.1% was estimated using the average of Medical CPI-U and CPI-U as waiver costs tend to trend midway between medical and non-medical costs over the recent 5 years (rounded). Estimates of Factor D for each waiver year are illustrated in the cost neutrality summary in Figure 1.

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 reflects experience from Waiver Year 5 of the third renewal: April 1, 2019 – March 31, 2020. Base year data was trended at 2.6% per year to reflect Medical CPI-U over the recent 5 years (rounded).

Estimates of Factor D' for each waiver year are illustrated in the cost neutrality summary in Figure 1.

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 reflects experience Waiver Year 5 of the third renewal: April 1, 2019 – March 31, 2020.
Base year data was trended at 2.1% per year estimated using the average of Medical CPI-U and CPI-U.
Factor G reflects average institutional cost for beneficiaries with an ICF/IID level of care.

Estimates of Factor G for each waiver year are illustrated in the cost neutrality summary in Figure 1.

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 reflects experience from Waiver Year 5 of the third renewal: April 1, 2019 – March 31, 2020.
Base year data was trended at 2.6% per year to reflect Medical CPI-U over the recent 5 years (rounded).

Estimates of Factor G' for each waiver year are illustrated in the cost neutrality summary in Figure 1.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Adult Day Services	
Case Management	
Prevocational Services	
Respite	
Occupational Therapy	
Physical Therapy	
Psychological Therapy	
Speech/Language Therapy	
Behavioral Support Services	
Community-Based Habilitation-Group (Terminated Eff. 7/31/2020)	
Community-Based Habilitation-Individual (Terminated Eff. 7/31/2020)	
Day Habilitation	
Environmental Modifications	
Extended Services	
Facility Based Habilitation-Group (Terminated Eff. 7/31/2020)	
Facility Based Support Services	
Facility-Based Habilitation-Individual (Terminated Eff. 7/31/2020)	
Family and Caregiver Training	
Intensive Behavioral Intervention	
Music Therapy	
Participant Assistance and Care	
Personal Emergency Response System	
Recreational Therapy	
Remote Supports	
Specialized Medical Equipment and Supplies	
Transportation	
Vehicle Modifications	
Workplace Assistance	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). *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. If applicable, check the capitation box next to that service. 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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services Total:							1419431.62
Adult Day Services - 1/4 hour - Level 3	☐	1/4 hour	1	1.00	2.34	2.34	
Adult Day Services - 1/4 hour - Level 2	☐	1/4 hour	3	142.00	1.97	839.22	
Adult Day Services - half day - Level 1	☐	half day	117	232.00	23.95	650098.80	
Adult Day Services - half day - Level 2	☐	half day	88	217.00	31.21	595986.16	
Adult Day Services - half day - Level 3	☐	half day	23	204.00	36.76	172477.92	
Adult Day Services - 1/4 hour - Level 1	☐	1/4 hour	3	6.00	1.51	27.18	
Case Management Total:							39459872.10
Case Management	☐	Month	23963	11.00	149.70	39459872.10	
Prevocational Services Total:							9272819.34
Prevocational Services - Large Group	☐	hour	1581	182.00	3.10	892000.20	
Prevocational Services - Small Group	☐	hour	1626	67.00	9.07	988103.94	
Prevocational Services - Medium Group	☐	hour	2392	606.00	5.10	7392715.20	
Respite Total:							32685260.66
Respite Nursing Care (RN)	☐	1/4 hour	61	811.00	7.46	369053.66	
Respite	☐	hour	5710	209.00	27.06	32293133.40	
Respite Nursing Care (LPN)	☐	1/4 hour	32	115.00	6.27	23073.60	

GRAND TOTAL:	216927242.60
Total: Services included in capitation:	
Total: Services not included in capitation:	216927242.60
Total Estimated Unduplicated Participants:	24173
Factor D (Divide total by number of participants):	8973.95
Services included in capitation:	
Services not included in capitation:	8973.95
Average Length of Stay on the Waiver:	333

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Occupational Therapy Total:							1469.93
Occupational Therapy	☐	1/4 hour	1	77.00	19.09	1469.93	
Physical Therapy Total:							8749.65
Physical Therapy	☐	1/4 hour	1	455.00	19.23	8749.65	
Psychological Therapy Total:							39.83
Psychological Therapy - Individual	☐	1/4 hour	1	1.00	16.40	16.40	
Psychological Therapy - Group	☐	1/4 hour	1	1.00	5.10	5.10	
Psychological Therapy - Family	☐	1/4 hour	1	1.00	18.33	18.33	
Speech/Language Therapy Total:							13230.24
Speech/Language Therapy	☐	1/4 hour	4	172.00	19.23	13230.24	
Behavioral Support Services Total:							35935171.80
Behaviorial Support Services - Level 1	☐	1/4 hour	6024	8.00	19.30	930105.60	
Behaviorial Support Services - Level 2	☐	hour	7751	234.00	19.30	35005066.20	
Community-Based Habilitation-Group (Terminated Eff. 7/31/2020) Total:							182451.39
Community Based Habilitation: Small	☐	hour	2380	8.00	9.12	173644.80	
Community Based Habilitation: Medium	☐	hour	579	3.00	5.07	8806.59	
Community-Based Habilitation-Individual (Terminated Eff. 7/31/2020) Total:							581103.82
Community-Based Habilitation-Individual (Terminated Eff. 7/31/2020)	☐	hour	2066	11.00	25.57	581103.82	
Day Habilitation Total:							21613859.56
Day Habilitation - Individual	☐	hour	3344	101.00	25.28	8538168.32	
Day Habilitation - Small	☐	hour	5864	157.00	9.16	8433135.68	
Day Habilitation - Medium	☐	hour	3291	275.00	5.00	4525125.00	
Day Habilitation - Large	☐	hour				117430.56	

GRAND TOTAL:	216927242.60
Total: Services included in capitation:	
Total: Services not included in capitation:	216927242.60
Total Estimated Unduplicated Participants:	24173
Factor D (Divide total by number of participants):	8973.95
Services included in capitation:	
Services not included in capitation:	8973.95
Average Length of Stay on the Waiver:	333

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
			1053	34.00	3.28		
Environmental Modifications Total:							**1434385.18**
Environmental Modifications - Install	☐	unit	230	1.00	6028.49	**1386552.70**	
Environmental Modifications - Equipment/Assessment/Inspection	☐	unit	4	1.00	18.72	**74.88**	
Environmental Modifications - Maintain	☐	unit	99	1.00	482.40	**47757.60**	
Extended Services Total:							**2015524.50**
Extended Services	☐	hour	1130	47.00	37.95	**2015524.50**	
Facility Based Habilitation-Group (Terminated Eff. 7/31/2020) Total:							**1020795.77**
Facility Based Habilitation: Small	☐	hour	3485	19.00	9.19	**608515.85**	
Facility Based Habilitation: Medium	☐	hour	2712	30.00	4.94	**401918.40**	
Facility Based Habilitation: Large	☐	hour	1053	3.00	3.28	**10361.52**	
Facility Based Support Services Total:							**2.02**
Facility Based Support Services	☐	hour	1	1.00	2.02	**2.02**	
Facility-Based Habilitation-Individual (Terminated Eff. 7/31/2020) Total:							**191396.76**
Facility-Based Habilitation-Individual (Terminated Eff. 7/31/2020)	☐	hour	1277	6.00	24.98	**191396.76**	
Family and Caregiver Training Total:							**56958.56**
Family and Caregiver Training - Family	☐	unit	73	2.00	375.59	**54836.14**	
Family and Caregiver Training - Non-Family	☐	unit	1	1.00	2122.42	**2122.42**	
Intensive Behavioral Intervention Total:							**137.53**
Intensive Behavioral Intervention - Level 2	☐	hour	1	1.00	26.53	**26.53**	
Intensive Behavioral Intervention - Level 1	☐	hour	1	1.00	111.00	**111.00**	
Music Therapy Total:							**8125294.32**
Music Therapy	☐	1/4 hour	4467	159.00	11.44	**8125294.32**	

GRAND TOTAL:	**216927242.60**
Total: Services included in capitation:	
Total: Services not included in capitation:	216927242.60
Total Estimated Unduplicated Participants:	**24173**
Factor D (Divide total by number of participants):	**8973.95**
Services included in capitation:	
Services not included in capitation:	8973.95
Average Length of Stay on the Waiver:	333

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Participant Assistance and Care Total:							50139609.40
Participant Assistance and Care	☐	hour	7426	269.00	25.10	50139609.40	
Personal Emergency Response System Total:							59392.98
Personal Emergency Response System - Installation	☐	unit	4	3.00	37.69	452.28	
Personal Emergency Response System - Maintenance	☐	unit	127	10.00	46.41	58940.70	
Recreational Therapy Total:							5234950.84
Recreational Therapy	☐	1/4 hour	1918	239.00	11.42	5234950.84	
Remote Supports Total:							2672942.67
Remote Supports	☐	hour	291	669.00	13.73	2672942.67	
Specialized Medical Equipment and Supplies Total:							89268.70
Specialized Medical Equipment and Supplies - Maintainence	☐	unit	8	1.00	245.80	1966.40	
Specialized Medical Equipment and Supplies - Installation	☐	unit	59	1.00	1479.70	87302.30	
Specialized Medical Equipment and Supplies	☐	unit	0	0.00	0.01	0.00	
Transportation Total:							4713094.62
Transportation	☐	trip	3723	234.00	5.41	4713094.62	
Vehicle Modifications Total:							0.00
Vehicle Modifications	☐	unit	0	0.00	0.01	0.00	
Workplace Assistance Total:							28.81
Workplace Assistance	☐	hour	1	1.00	28.81	28.81	

GRAND TOTAL:	216927242.60
Total: Services included in capitation:	
Total: Services not included in capitation:	216927242.60
Total Estimated Unduplicated Participants:	24173
Factor D (Divide total by number of participants):	8973.95
Services included in capitation:	
Services not included in capitation:	8973.95
Average Length of Stay on the Waiver:	333

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *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. If applicable, check the capitation box next to that*

service. 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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services Total:							1776912.35
Adult Day Services - 1/4 hour - Level 3	☐	1/4 hour	1	1.00	2.57	2.57	
Adult Day Services - 1/4 hour - Level 2	☐	1/4 hour	7	75.00	1.98	1039.50	
Adult Day Services - half day - Level 1	☐	half day	95	227.00	26.23	565649.95	
Adult Day Services - half day - Level 2	☐	half day	123	209.00	34.39	884063.73	
Adult Day Services - half day - Level 3	☐	half day	44	181.00	40.90	325727.60	
Adult Day Services - 1/4 hour - Level 1	☐	1/4 hour	5	52.00	1.65	429.00	
Case Management Total:							41397125.00
Case Management	☐	Month	26180	11.00	143.75	41397125.00	
Prevocational Services Total:							6831700.56
Prevocational Services - Large Group	☐	hour	1002	191.00	3.58	685147.56	
Prevocational Services - Small Group	☐	hour	1113	73.00	9.92	805990.08	
Prevocational Services - Medium Group	☐	hour	1619	588.00	5.61	5340562.92	
Respite Total:							31204787.61
Respite Nursing Care (RN)	☐	1/4 hour	69	757.00	8.36	436667.88	
Respite	☐	hour	4979	207.00	29.79	30703152.87	
Respite Nursing Care (LPN)	☐	1/4 hour	51	189.00	6.74	64966.86	
Occupational Therapy Total:							17.99
Occupational Therapy	☐	1/4 hour	1	1.00	17.99	17.99	
Physical Therapy Total:							18.12
Physical Therapy	☐	1/4 hour	1	1.00	18.12	18.12	

GRAND TOTAL:	238060413.25
Total: Services included in capitation:	
Total: Services not included in capitation:	238060413.25
Total Estimated Unduplicated Participants:	26231
Factor D (Divide total by number of participants):	9075.54
Services included in capitation:	
Services not included in capitation:	9075.54
Average Length of Stay on the Waiver:	335

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Psychological Therapy Total:							37.53
Psychological Therapy - Individual	☐	1/4 hour	1	1.00	15.45	15.45	
Psychological Therapy - Group	☐	1/4 hour	1	1.00	4.81	4.81	
Psychological Therapy - Family	☐	1/4 hour	1	1.00	17.27	17.27	
Speech/Language Therapy Total:							15873.12
Speech/Language Therapy	☐	1/4 hour	4	219.00	18.12	15873.12	
Behavioral Support Services Total:							44280055.84
Behaviorial Support Services - Level 1	☐	1/4 hour	7664	9.00	18.19	1254673.44	
Behaviorial Support Services - Level 2	☐	1/4 hour	9344	253.00	18.20	43025382.40	
Community-Based Habilitation-Group (Terminated Eff. 7/31/2020) Total:							0.00
Community Based Habilitation: Small	☐	hour	0	0.00	0.01	0.00	
Community Based Habilitation: Medium	☐	hour	0	0.00	0.01	0.00	
Community-Based Habilitation-Individual (Terminated Eff. 7/31/2020) Total:							0.00
Community-Based Habilitation-Individual (Terminated Eff. 7/31/2020)	☐	hour	0	0.00	0.01	0.00	
Day Habilitation Total:							22310645.62
Day Habilitation - Individual	☐	hour	2240	118.00	27.05	7149856.00	
Day Habilitation - Small	☐	hour	3627	264.00	10.05	9623156.40	
Day Habilitation - Medium	☐	hour	2705	353.00	5.59	5337695.35	
Day Habilitation - Large	☐	hour	913	61.00	3.59	199937.87	
Environmental Modifications Total:							684777.08
Environmental Modifications - Install	☐	unit	100	1.00	6619.64	661964.00	
Environmental Modifications - Equipment/Assessment/Inspection	☐	unit	2	1.00	17.99	35.98	
Environmental Modifications -	☐					22777.10	

GRAND TOTAL:	238060413.25
Total: Services included in capitation:	
Total: Services not included in capitation:	238060413.25
Total Estimated Unduplicated Participants:	26231
Factor D (Divide total by number of participants):	9075.54
Services included in capitation:	
Services not included in capitation:	9075.54
Average Length of Stay on the Waiver:	335

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Maintain		unit	43	1.00	529.70		
Extended Services Total:							1983736.62
Extended Services	☐	hour	1167	41.00	41.46	1983736.62	
Facility Based Habilitation-Group (Terminated Eff. 7/31/2020) Total:							0.00
Facility Based Habilitation: Small	☐	hour	0	0.00	0.01	0.00	
Facility Based Habilitation: Medium	☐	hour	0	0.00	0.01	0.00	
Facility Based Habilitation: Large	☐	hour	0	0.00	0.01	0.00	
Facility Based Support Services Total:							2.21
Facility Based Support Services	☐	hour	1	1.00	2.21	2.21	
Facility-Based Habilitation-Individual (Terminated Eff. 7/31/2020) Total:							0.00
Facility-Based Habilitation-Individual (Terminated Eff. 7/31/2020)	☐	hour	0	0.00	0.01	0.00	
Family and Caregiver Training Total:							47728.40
Family and Caregiver Training - Family	☐	unit	60	3.00	237.38	42728.40	
Family and Caregiver Training - Non-Family	☐	unit	1	1.00	5000.00	5000.00	
Intensive Behavioral Intervention Total:							129.60
Intensive Behavioral Intervention - Level 2	☐	hour	1	1.00	25.00	25.00	
Intensive Behavioral Intervention - Level 1	☐	hour	1	1.00	104.60	104.60	
Music Therapy Total:							8795746.96
Music Therapy	☐	1/4 hour	4828	169.00	10.78	8795746.96	
Participant Assistance and Care Total:							67310342.40
Participant Assistance and Care	☐	hour	8582	285.00	27.52	67310342.40	
Personal Emergency Response System Total:							54634.64
Personal Emergency Response System - Installation	☐	unit	4	3.00	31.77	381.24	

GRAND TOTAL:	238060413.25
Total: Services included in capitation:	
Total: Services not included in capitation:	238060413.25
Total Estimated Unduplicated Participants:	26231
Factor D (Divide total by number of participants):	9075.54
Services included in capitation:	
Services not included in capitation:	9075.54
Average Length of Stay on the Waiver:	335

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Emergency Response System - Maintenance	☐	unit	122	10.00	44.47	54253.40	
Recreational Therapy Total:							6668143.80
Recreational Therapy	☐	1/4 hour	2642	235.00	10.74	6668143.80	
Remote Supports Total:							37155.36
Remote Supports	☐	hour	4	682.00	13.62	37155.36	
Specialized Medical Equipment and Supplies Total:							216236.76
Specialized Medical Equipment and Supplies - Maintainence	☐	unit	3	1.00	310.99	932.97	
Specialized Medical Equipment and Supplies - Installation	☐	unit	123	1.00	797.45	98086.35	
Specialized Medical Equipment and Supplies	☐	unit	144	1.00	814.01	117217.44	
Transportation Total:							4422621.06
Transportation	☐	trip	3369	221.00	5.94	4422621.06	
Vehicle Modifications Total:							20121.99
Vehicle Modifications	☐	unit	7	1.00	2874.57	20121.99	
Workplace Assistance Total:							1862.63
Workplace Assistance	☐	hour	1	59.00	31.57	1862.63	

GRAND TOTAL:	238060413.25
Total: Services included in capitation:	
Total: Services not included in capitation:	238060413.25
Total Estimated Unduplicated Participants:	26231
Factor D (Divide total by number of participants):	9075.54
Services included in capitation:	
Services not included in capitation:	9075.54
Average Length of Stay on the Waiver:	335

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *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. If applicable, check the capitation box next to that service. 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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services Total:							1950577.54
Adult Day Services - 1/4 hour - Level 3	☐	1/4 hour	1	1.00	2.62	2.62	
Adult Day Services - 1/4 hour - Level 2	☐	1/4 hour	8	76.00	2.03	1234.24	
Adult Day Services - half day - Level 1	☐	half day	102	228.00	26.78	622795.68	
Adult Day Services - half day - Level 2	☐	half day	132	209.00	35.12	968890.56	
Adult Day Services - half day - Level 3	☐	half day	47	182.00	41.76	357215.04	
Adult Day Services - 1/4 hour - Level 1	☐	1/4 hour	5	52.00	1.69	439.40	
Case Management Total:							45408583.22
Case Management	☐	Month	28126	11.00	146.77	45408583.22	
Prevocational Services Total:							7530344.42
Prevocational Services - Large Group	☐	hour	1077	192.00	3.65	754761.60	
Prevocational Services - Small Group	☐	hour	1196	74.00	10.13	896545.52	
Prevocational Services - Medium Group	☐	hour	1739	590.00	5.73	5879037.30	
Respite Total:							34228725.88
Respite Nursing Care (RN)	☐	1/4 hour	75	759.00	8.53	485570.25	
Respite	☐	hour	5349	207.00	30.41	33671259.63	
Respite Nursing Care (LPN)	☐	1/4 hour	55	190.00	6.88	71896.00	
Occupational Therapy Total:							18.37
Occupational Therapy	☐	1/4 hour	1	1.00	18.37	18.37	
Physical Therapy Total:							18.50
Physical Therapy	☐	1/4 hour	1	1.00	18.50	18.50	
Psychological Therapy Total:							38.31
Psychological Therapy - Individual	☐	1/4 hour	1	1.00	15.77	15.77	
Psychological Therapy - Group	☐					4.91	

GRAND TOTAL:	261880460.24
Total: Services included in capitation:	
Total: Services not included in capitation:	261880460.24
Total Estimated Unduplicated Participants:	28181
Factor D (Divide total by number of participants):	9292.80
Services included in capitation:	
Services not included in capitation:	9292.80
Average Length of Stay on the Waiver:	336

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		1/4 hour	1	1.00	4.91		
Psychological Therapy - Family	☐	1/4 hour	1	1.00	17.63	17.63	
Speech/Language Therapy Total:							16206.00
Speech/Language Therapy	☐	1/4 hour	4	219.00	18.50	16206.00	
Behavioral Support Services Total:							48753401.90
Behaviorial Support Services - Level 1	☐	1/4 hour	8234	9.00	18.57	1376148.42	
Behaviorial Support Services - Level 2	☐	1/4 hour	10039	254.00	18.58	47377253.48	
Community-Based Habilitation-Group (Terminated Eff. 7/31/2020) Total:							0.00
Community Based Habilitation: Small	☐	hour	0	0.00	0.01	0.00	
Community Based Habilitation: Medium	☐	hour	0	0.00	0.01	0.00	
Community-Based Habilitation-Individual (Terminated Eff. 7/31/2020) Total:							0.00
Community-Based Habilitation-Individual (Terminated Eff. 7/31/2020)	☐	hour	0	0.00	0.01	0.00	
Day Habilitation Total:							24602798.10
Day Habilitation - Individual	☐	hour	2406	119.00	27.62	7907992.68	
Day Habilitation - Small	☐	hour	3897	265.00	10.26	10595553.30	
Day Habilitation - Medium	☐	hour	2907	354.00	5.71	5876035.38	
Day Habilitation - Large	☐	hour	981	62.00	3.67	223216.74	
Environmental Modifications Total:							754849.12
Environmental Modifications - Install	☐	unit	108	1.00	6758.65	729934.20	
Environmental Modifications - Equipment/Assessment/Inspection	☐	unit	2	1.00	18.37	36.74	
Environmental Modifications - Maintain	☐	unit	46	1.00	540.83	24878.18	
Extended Services Total:							2176354.62
Extended Services	☐	hour				2176354.62	

GRAND TOTAL:	261880460.24
Total: Services included in capitation:	
Total: Services not included in capitation:	261880460.24
Total Estimated Unduplicated Participants:	28181
Factor D (Divide total by number of participants):	9292.80
Services included in capitation:	
Services not included in capitation:	9292.80
Average Length of Stay on the Waiver:	336

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
			1254	41.00	42.33		
Facility Based Habilitation-Group (Terminated Eff. 7/31/2020) Total:							0.00
Facility Based Habilitation: Small	☐	hour	0	0.00	0.01	0.00	
Facility Based Habilitation: Medium	☐	hour	0	0.00	0.01	0.00	
Facility Based Habilitation: Large	☐	hour	0	0.00	0.01	0.00	
Facility Based Support Services Total:							2.26
Facility Based Support Services	☐	hour	1	1.00	2.26	2.26	
Facility-Based Habilitation-Individual (Terminated Eff. 7/31/2020) Total:							0.00
Facility-Based Habilitation-Individual (Terminated Eff. 7/31/2020)	☐	hour	0	0.00	0.01	0.00	
Family and Caregiver Training Total:							51638.12
Family and Caregiver Training - Family	☐	unit	64	3.00	242.36	46533.12	
Family and Caregiver Training - Non-Family	☐	unit	1	1.00	5105.00	5105.00	
Intensive Behavioral Intervention Total:							132.33
Intensive Behavioral Intervention - Level 2	☐	hour	1	1.00	25.53	25.53	
Intensive Behavioral Intervention - Level 1	☐	hour	1	1.00	106.80	106.80	
Music Therapy Total:							9708507.90
Music Therapy	☐	1/4 hour	5187	170.00	11.01	9708507.90	
Participant Assistance and Care Total:							74097452.00
Participant Assistance and Care	☐	hour	9220	286.00	28.10	74097452.00	
Personal Emergency Response System Total:							59863.28
Personal Emergency Response System - Installation	☐	unit	4	3.00	32.44	389.28	
Personal Emergency Response System - Maintenance	☐	unit	131	10.00	45.40	59474.00	
Recreational Therapy Total:							7347354.96

GRAND TOTAL:	261880460.24
Total: Services included in capitation:	
Total: Services not included in capitation:	261880460.24
Total Estimated Unduplicated Participants:	28181
Factor D (Divide total by number of participants):	9292.80
Services included in capitation:	
Services not included in capitation:	9292.80
Average Length of Stay on the Waiver:	336

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Recreational Therapy	☐	1/4 hour	2838	236.00	10.97	7347354.96	
Remote Supports Total:							47572.20
Remote Supports	☐	hour	5	684.00	13.91	47572.20	
Specialized Medical Equipment and Supplies Total:							237265.60
Specialized Medical Equipment and Supplies - Maintainence	☐	unit	0	0.00	0.01	0.00	
Specialized Medical Equipment and Supplies - Installation	☐	unit	0	0.00	0.01	0.00	
Specialized Medical Equipment and Supplies	☐	unit	286	1.00	829.60	237265.60	
Transportation Total:							4868713.08
Transportation	☐	trip	3619	222.00	6.06	4868713.08	
Vehicle Modifications Total:							38140.96
Vehicle Modifications	☐	unit	13	1.00	2933.92	38140.96	
Workplace Assistance Total:							1901.57
Workplace Assistance	☐	hour	1	59.00	32.23	1901.57	

GRAND TOTAL:	261880460.24
Total: Services included in capitation:	
Total: Services not included in capitation:	261880460.24
Total Estimated Unduplicated Participants:	28181
Factor D (Divide total by number of participants):	9292.80
Services included in capitation:	
Services not included in capitation:	9292.80
Average Length of Stay on the Waiver:	336

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *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. If applicable, check the capitation box next to that service. 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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services Total:							2140960.96
Adult Day Services - 1/4 hour - Level 3	☐	1/4 hour	1	1.00	2.67	2.67	
Adult Day Services - 1/4 hour - Level 2	☐	1/4 hour	8	76.00	2.07	1258.56	
Adult Day Services - half day - Level 1	☐	half day	109	229.00	27.34	682433.74	
Adult Day Services - half day - Level 2	☐	half day	141	211.00	35.85	1066573.35	
Adult Day Services - half day - Level 3	☐	half day	50	183.00	42.64	390156.00	
Adult Day Services - 1/4 hour - Level 1	☐	1/4 hour	6	52.00	1.72	536.64	
Case Management Total:							49399401.15
Case Management	☐	Month	29969	11.00	149.85	49399401.15	
Prevocational Services Total:							8228677.32
Prevocational Services - Large Group	☐	hour	1147	193.00	3.73	825713.83	
Prevocational Services - Small Group	☐	hour	1274	74.00	10.34	974813.84	
Prevocational Services - Medium Group	☐	hour	1853	593.00	5.85	6428149.65	
Respite Total:							37601328.58
Respite Nursing Care (RN)	☐	1/4 hour	80	764.00	8.71	532355.20	
Respite	☐	hour	5700	209.00	31.05	36989865.00	
Respite Nursing Care (LPN)	☐	1/4 hour	59	191.00	7.02	79108.38	
Occupational Therapy Total:							18.75
Occupational Therapy	☐	1/4 hour	1	1.00	18.75	18.75	
Physical Therapy Total:							18.89
Physical Therapy	☐	1/4 hour	1	1.00	18.89	18.89	
Psychological Therapy Total:							39.12
Psychological Therapy - Individual	☐	1/4 hour	1	1.00	16.11	16.11	
Psychological Therapy - Group	☐					5.01	

GRAND TOTAL:	286267491.10
Total: Services included in capitation:	
Total: Services not included in capitation:	286267491.10
Total Estimated Unduplicated Participants:	30028
Factor D (Divide total by number of participants):	9533.35
Services included in capitation:	
Services not included in capitation:	9533.35
Average Length of Stay on the Waiver:	338

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		1/4 hour	1	1.00	5.01		
Psychological Therapy - Family	☐	1/4 hour	1	1.00	18.00	18.00	
Speech/Language Therapy Total:							16698.76
Speech/Language Therapy	☐	1/4 hour	4	221.00	18.89	16698.76	
Behavioral Support Services Total:							53440223.44
Behaviorial Support Services - Level 1	☐	1/4 hour	8773	9.00	18.96	1497024.72	
Behaviorial Support Services - Level 2	☐	1/4 hour	10696	256.00	18.97	51943198.72	
Community-Based Habilitation-Group (Terminated Eff. 7/31/2020) Total:							0.00
Community Based Habilitation: Small	☐	hour	0	0.00	0.01	0.00	
Community Based Habilitation: Medium	☐	hour	0	0.00	0.01	0.00	
Community-Based Habilitation-Individual (Terminated Eff. 7/31/2020) Total:							0.00
Community-Based Habilitation-Individual (Terminated Eff. 7/31/2020)	☐	hour	0	0.00	0.01	0.00	
Day Habilitation Total:							26910363.19
Day Habilitation - Individual	☐	hour	2564	119.00	28.20	8604271.20	
Day Habilitation - Small	☐	hour	4152	267.00	10.48	11617960.32	
Day Habilitation - Medium	☐	hour	3097	357.00	5.83	6445817.07	
Day Habilitation - Large	☐	hour	1045	62.00	3.74	242314.60	
Environmental Modifications Total:							820661.51
Environmental Modifications - Install	☐	unit	115	1.00	6900.58	793566.70	
Environmental Modifications - Equipment/Assessment/Inspection	☐	unit	2	1.00	18.75	37.50	
Environmental Modifications - Maintain	☐	unit	49	1.00	552.19	27057.31	
Extended Services Total:							2367418.72
Extended Services	☐	hour				2367418.72	

GRAND TOTAL:	286267491.10
Total: Services included in capitation:	
Total: Services not included in capitation:	286267491.10
Total Estimated Unduplicated Participants:	30028
Factor D (Divide total by number of participants):	9533.35
Services included in capitation:	
Services not included in capitation:	9533.35
Average Length of Stay on the Waiver:	338

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
			1336	41.00	43.22		
Facility Based Habilitation-Group (Terminated Eff. 7/31/2020) Total:							0.00
Facility Based Habilitation: Small	☐	hour	0	0.00	0.01	0.00	
Facility Based Habilitation: Medium	☐	hour	0	0.00	0.01	0.00	
Facility Based Habilitation: Large	☐	hour	0	0.00	0.01	0.00	
Facility Based Support Services Total:							2.31
Facility Based Support Services	☐	hour	1	1.00	2.31	2.31	
Facility-Based Habilitation-Individual (Terminated Eff. 7/31/2020) Total:							0.00
Facility-Based Habilitation-Individual (Terminated Eff. 7/31/2020)	☐	hour	0	0.00	0.01	0.00	
Family and Caregiver Training Total:							55692.01
Family and Caregiver Training - Family	☐	unit	68	3.00	247.45	50479.80	
Family and Caregiver Training - Non-Family	☐	unit	1	1.00	5212.21	5212.21	
Intensive Behavioral Intervention Total:							135.10
Intensive Behavioral Intervention - Level 2	☐	hour	1	1.00	26.06	26.06	
Intensive Behavioral Intervention - Level 1	☐	hour	1	1.00	109.04	109.04	
Music Therapy Total:							10623115.08
Music Therapy	☐	1/4 hour	5527	171.00	11.24	10623115.08	
Participant Assistance and Care Total:							80891110.72
Participant Assistance and Care	☐	hour	9824	287.00	28.69	80891110.72	
Personal Emergency Response System Total:							71791.84
Personal Emergency Response System - Installation	☐	unit	4	3.00	33.12	397.44	
Personal Emergency Response System - Maintenance	☐	unit	140	11.00	46.36	71394.40	
Recreational Therapy Total:							8026905.60

GRAND TOTAL:	286267491.10
Total: Services included in capitation:	
Total: Services not included in capitation:	286267491.10
Total Estimated Unduplicated Participants:	30028
Factor D (Divide total by number of participants):	9533.35
Services included in capitation:	
Services not included in capitation:	9533.35
Average Length of Stay on the Waiver:	338

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Recreational Therapy	☐	1/4 hour	3024	237.00	11.20	8026905.60	
Remote Supports Total:							48848.00
Remote Supports	☐	hour	5	688.00	14.20	48848.00	
Specialized Medical Equipment and Supplies Total:							257494.08
Specialized Medical Equipment and Supplies - Maintainence	☐	unit	0	0.00	0.01	0.00	
Specialized Medical Equipment and Supplies - Installation	☐	unit	0	0.00	0.01	0.00	
Specialized Medical Equipment and Supplies	☐	unit	304	1.00	847.02	257494.08	
Transportation Total:							5322706.72
Transportation	☐	trip	3856	223.00	6.19	5322706.72	
Vehicle Modifications Total:							41937.56
Vehicle Modifications	☐	unit	14	1.00	2995.54	41937.56	
Workplace Assistance Total:							1941.69
Workplace Assistance	☐	hour	1	59.00	32.91	1941.69	

GRAND TOTAL:	286267491.10
Total: Services included in capitation:	
Total: Services not included in capitation:	286267491.10
Total Estimated Unduplicated Participants:	30028
Factor D (Divide total by number of participants):	9533.35
Services included in capitation:	
Services not included in capitation:	9533.35
Average Length of Stay on the Waiver:	338

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *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. If applicable, check the capitation box next to that service. 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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services Total:							2310447.55
Adult Day Services - 1/4 hour - Level 3	☐	1/4 hour	1	1.00	2.73	2.73	
Adult Day Services - 1/4 hour - Level 2	☐	1/4 hour	9	76.00	2.11	1443.24	
Adult Day Services - half day - Level 1	☐	half day	115	229.00	27.92	735273.20	
Adult Day Services - half day - Level 2	☐	half day	149	211.00	36.61	1150981.79	
Adult Day Services - half day - Level 3	☐	half day	53	183.00	43.53	422197.47	
Adult Day Services - 1/4 hour - Level 1	☐	1/4 hour	6	52.00	1.76	549.12	
Case Management Total:							53376345.00
Case Management	☐	Month	31715	11.00	153.00	53376345.00	
Prevocational Services Total:							8888423.55
Prevocational Services - Large Group	☐	hour	1214	193.00	3.81	892690.62	
Prevocational Services - Small Group	☐	hour	1348	74.00	10.56	1053381.12	
Prevocational Services - Medium Group	☐	hour	1961	593.00	5.97	6942351.81	
Respite Total:							40619241.38
Respite Nursing Care (RN)	☐	1/4 hour	84	764.00	8.89	570524.64	
Respite	☐	hour	6032	209.00	31.70	39963809.60	
Respite Nursing Care (LPN)	☐	1/4 hour	62	191.00	7.17	84907.14	
Occupational Therapy Total:							19.15
Occupational Therapy	☐	1/4 hour	1	1.00	19.15	19.15	
Physical Therapy Total:							19.29
Physical Therapy	☐	1/4 hour	1	1.00	19.29	19.29	
Psychological Therapy Total:							39.94
Psychological Therapy - Individual	☐	1/4 hour	1	1.00	16.44	16.44	
Psychological Therapy - Group	☐					5.12	

GRAND TOTAL:	309272981.94
Total: Services included in capitation:	
Total: Services not included in capitation:	309272981.94
Total Estimated Unduplicated Participants:	31777
Factor D (Divide total by number of participants):	9732.60
Services included in capitation:	
Services not included in capitation:	9732.60
Average Length of Stay on the Waiver:	338

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		1/4 hour	1	1.00	5.12		
Psychological Therapy - Family	☐	1/4 hour	1	1.00	18.38	18.38	
Speech/Language Therapy Total:							17052.36
Speech/Language Therapy	☐	1/4 hour	4	221.00	19.29	17052.36	
Behavioral Support Services Total:							57745395.84
Behaviorial Support Services - Level 1	☐	1/4 hour	9284	9.00	19.36	1617644.16	
Behaviorial Support Services - Level 2	☐	1/4 hour	11319	256.00	19.37	56127751.68	
Community-Based Habilitation-Group (Terminated Eff. 7/31/2020) Total:							0.00
Community Based Habilitation: Small	☐	hour	0	0.00	0.01	0.00	
Community Based Habilitation: Medium	☐	hour	0	0.00	0.01	0.00	
Community-Based Habilitation-Individual (Terminated Eff. 7/31/2020) Total:							0.00
Community-Based Habilitation-Individual (Terminated Eff. 7/31/2020)	☐	hour	0	0.00	0.01	0.00	
Day Habilitation Total:							29070768.32
Day Habilitation - Individual	☐	hour	2713	119.00	28.79	9294765.13	
Day Habilitation - Small	☐	hour	4394	267.00	10.70	12553218.60	
Day Habilitation - Medium	☐	hour	3277	357.00	5.95	6960839.55	
Day Habilitation - Large	☐	hour	1106	62.00	3.82	261945.04	
Environmental Modifications Total:							888905.86
Environmental Modifications - Install	☐	unit	122	1.00	7045.50	859551.00	
Environmental Modifications - Equipment/Assessment/Inspection	☐	unit	2	1.00	19.15	38.30	
Environmental Modifications - Maintain	☐	unit	52	1.00	563.78	29316.56	
Extended Services Total:							2556583.29
Extended Services	☐	hour				2556583.29	

GRAND TOTAL:	309272981.94
Total: Services included in capitation:	
Total: Services not included in capitation:	309272981.94
Total Estimated Unduplicated Participants:	31777
Factor D (Divide total by number of participants):	9732.60
Services included in capitation:	
Services not included in capitation:	9732.60
Average Length of Stay on the Waiver:	338

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
			1413	41.00	44.13		
Facility Based Habilitation-Group (Terminated Eff. 7/31/2020) Total:							0.00
Facility Based Habilitation: Small	☐	hour	0	0.00	0.01	0.00	
Facility Based Habilitation: Medium	☐	hour	0	0.00	0.01	0.00	
Facility Based Habilitation: Large	☐	hour	0	0.00	0.01	0.00	
Facility Based Support Services Total:							2.35
Facility Based Support Services	☐	hour	1	1.00	2.35	2.35	
Facility-Based Habilitation-Individual (Terminated Eff. 7/31/2020) Total:							0.00
Facility-Based Habilitation-Individual (Terminated Eff. 7/31/2020)	☐	hour	0	0.00	0.01	0.00	
Family and Caregiver Training Total:							59894.06
Family and Caregiver Training - Family	☐	unit	72	3.00	252.65	54572.40	
Family and Caregiver Training - Non-Family	☐	unit	1	1.00	5321.66	5321.66	
Intensive Behavioral Intervention Total:							137.94
Intensive Behavioral Intervention - Level 2	☐	hour	1	1.00	26.61	26.61	
Intensive Behavioral Intervention - Level 1	☐	hour	1	1.00	111.33	111.33	
Music Therapy Total:							11472053.13
Music Therapy	☐	1/4 hour	5849	171.00	11.47	11472053.13	
Participant Assistance and Care Total:							87391167.08
Participant Assistance and Care	☐	hour	10396	287.00	29.29	87391167.08	
Personal Emergency Response System Total:							77458.96
Personal Emergency Response System - Installation	☐	unit	4	3.00	33.81	405.72	
Personal Emergency Response System - Maintenance	☐	unit	148	11.00	47.33	77053.24	
Recreational Therapy Total:							8671220.91

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Total Estimated Unduplicated Participants:	31777
Factor D (Divide total by number of participants):	9732.60
Services included in capitation:	
Services not included in capitation:	9732.60
Average Length of Stay on the Waiver:	338

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Recreational Therapy	☐	1/4 hour	3201	237.00	11.43	8671220.91	
Remote Supports Total:							49880.00
Remote Supports	☐	hour	5	688.00	14.50	49880.00	
Specialized Medical Equipment and Supplies Total:							278468.82
Specialized Medical Equipment and Supplies - Maintainence	☐	unit	0	0.00	0.01	0.00	
Specialized Medical Equipment and Supplies - Installation	☐	unit	0	0.00	0.01	0.00	
Specialized Medical Equipment and Supplies	☐	unit	322	1.00	864.81	278468.82	
Transportation Total:							5751598.16
Transportation	☐	trip	4081	223.00	6.32	5751598.16	
Vehicle Modifications Total:							45876.60
Vehicle Modifications	☐	unit	15	1.00	3058.44	45876.60	
Workplace Assistance Total:							1982.40
Workplace Assistance	☐	hour	1	59.00	33.60	1982.40	

GRAND TOTAL:	309272981.94
Total: Services included in capitation:	
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Total Estimated Unduplicated Participants:	31777
Factor D (Divide total by number of participants):	9732.60
Services included in capitation:	
Services not included in capitation:	9732.60
Average Length of Stay on the Waiver:	338