INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Division of Disability and Rehabilitative Services

Home- and Community-Based Services Waivers

LIBRARY REFERENCE NUMBER: PRPR10014
PUBLISHED: SEPT. 21, 2022
POLICIES AND PROCEDURES AS OF JAN. 1, 2022
VERSION: 9.1

© Copyright 2022 Gainwell Technologies, All Right Reserved

Revision History

Version	Date	Reason for Revisions	Completed By
1.0	Policies and procedures as of Nov. 1, 2012 Published: June 10, 2013	Initial release	FSSA
1.1	Policies and procedures as of Dec. 1, 2013 Published: April 23, 2014	Scheduled review	FSSA and HP
2.0	Policies and procedures as of June 1, 2014 Published: Nov. 6, 2014	Scheduled review	FSSA and HP
2.1	Policies and procedures as of Dec. 1, 2014 Published: Feb. 24, 2015	Scheduled review	FSSA and HP
2.2	Policies and procedures as of Dec. 1, 2014 Published: May 12, 2015	Updates to Section 6, including updated tables	FSSA and HP
3.0	Policies and procedures as of June 1, 2015 Published: Sept. 8, 2015	Scheduled review	FSSA and HP
3.1	Policies and procedures as of Oct. 1, 2015 Published: Feb. 25, 2016	Conversion to modular format, scheduled review	FSSA and HPE
4.0	Policies and procedures as of April 1, 2016 Published: June 21, 2016	Scheduled review	FSSA and HPE
4.1	Policies and procedures as of April 1, 2016 *Core*MMIS updates as of: Feb. 13, 2017 Published: April 13, 2017	*Core*MMIS updates	FSSA and HPE
5.0	Policies and procedures as of April 1, 2017 *Core*MMIS updates as of Feb. 13, 2017 Published: Aug. 24, 2017	Scheduled review	FSSA and DXC
6.0	Policies and procedures as of Aug. 1, 2018 Published: Jan. 3, 2019	Scheduled review	FSSA and DXC
6.0	Policies and Procedures as of Aug. 1, 2018 Published: Aug. 22, 2019	Correction	FSSA and DXC
7.0	Policies and procedures as of July 1, 2019 Published: Dec. 19, 2019	Scheduled review	FSSA and DXC

Version	Date	Reason for Revisions	Completed By
8.0	Policies and procedures as of July 16, 2020 Published: Dec. 8, 2020	Scheduled review	FSSA and Gainwell
9.0	Policies and procedures as of Jan. 1, 2022 Published: June 24, 2022	Scheduled review: • Changed CMCO references to CMO throughout • Updated the annual cap for FSW • Updated *Section 1.7: Waiver Service Providers, Including Selected Contracting Case Management Organizations* • Updated *Section 1.8: Office of Administrative Law Proceedings (OALP)* • Updated the *Participating in Risk Plan Development and Implementation* section • Added *Section 1.10: FSSA BDDS Documentation Requests* • Updated *Section 2: Provider Information* • Updated the *Services Available* subsections and removed the *Terminated Services* subsections in the *Section 4.5: Family Supports Waiver (FSW)* and *Section 4.6: Community Integration and Habilitation (CIH) Waiver* • Updated *Section 5.1: Request for Application* section • Updated *Section 5.3: Initial Level of Care Evaluation* • Updated *Section 5.5: Targeting Process for the Family Supports Waiver (FSW)* • Updated the *Responsibilities of Individuals Applying for a CIH Waiver Priority Slot* section • Updated *Section 6.4: Translating Algo Level Into a Budget Allocation* • Added information about appeals in *Section 6.5: Budget Review Questionnaire and Budget Modification Request* subsections • Updated *Section 6.7: Personal Allocation Review (PAR) and the Appeal Process* • Updated *Section 8: Appeal Process* • Updated *Section 9.6: Case Record Reviews*	FSSA and Gainwell

Version	Date	Reason for Revisions	Completed By
		• Added *Section 9.7: Quality On-Site Provider Review* • Updated *Table 3 – Medicaid Waiver Services, Codes and Rates for FSW and CIH Waivers, Effective July 01, 2021, or as noted* • Removed *Section 10.5: Community-Based Habilitation - Group* (Effective 7/16/2020-7/31/2020, Terminated effective 8/1/2020) and *Section 10.6: Community-Based Habilitation – Individual* (Effective 7/16/2020-7/31/2020, Terminated effective 8/1/2020) • Updated *Section 10.8: Remote Supports* • Removed *Section 10.10: Facility-Based Habilitation – Group* (Effective 7/16/2020-7/31/2020, Terminated effective 8/1/2020) and *Section 10.11: Facility-Based Habilitation – Individual (Effective 7/16/2020-7/31/2020*, Terminated effective 8/1/2020) • Updated *Section 10.25: Specialized Medical Equipment and Supplies* • Updated *Section 10.27: Transportation* • Updated *Section 10.29: Case Management* • Updated *Section 10.30: Participant Assistance and Care* • Updated *Section 10.31: Structured Family Caregiving* • Added *Section 10.36: Vehicle Modifications* • Added item in the *Modifications/ Items – Noncovered* section • Updated *Section 11.2: Specialized Medical Equipment and Supplies* • Updated *Section 11.3: Vehicle Modification*	
9.1	Policies and procedures as of Jan. 1, 2022 Published: Sept. 21, 2022	Updated formatting	FSSA and Gainwell

Table of Contents

Section 1: Roles and Responsibilities **1**
Section 1.1: The Centers for Medicare & Medicaid Services (CMS) 1
Section 1.2: FSSA Division of Disability and Rehabilitative Services (DDRS) 1
Section 1.3: The Bureau of Developmental Disabilities Services (BDDS) 2
Section 1.4: The Bureau of Quality Improvement Services (BQIS) 2
Section 1.5: FSSA Office of Medicaid Policy and Planning (OMPP) 3
Section 1.6: FSSA Division of Family Resources 3
Section 1.7: Waiver Service Providers, Including Selected Contracting Case Management Organizations 4
Section 1.8: Office of Administrative Law Proceedings (OALP) 4
Section 1.9: Individuals and Guardians 5
Section 1.10: FSSA BDDS Documentation Requests 10

Section 2: Provider Information **13**
Section 2.1: Provider Application Process 13
Section 2.2: Provider Reverification 14
Section 2.3: Claims and Billing 15
Section 2.4: Financial Oversight – Waiver Audits 18

Section 3: Additional Medicaid Information **19**
Section 3.1: Other Program Information 19
Section 3.2: Medicaid Prior Authorization and Funding Streams 19

Section 4: Intellectual/Developmental Disabilities Services Waivers **21**
Section 4.1: Medicaid Waiver Overview 21
Section 4.2: State Definition of Intellectual/Developmental Disability 22
Section 4.3: Cost Neutrality 22
Section 4.4: Coordination With Medicaid State Plan Services 22
Section 4.5: Family Supports Waiver (FSW) 23
Section 4.6: Community Integration and Habilitation (CIH) Waiver 24

Section 5: Application and Start of Waiver Services **27**
Section 5.1: Request for Application 27
Section 5.2: Medicaid Eligibility 27
Section 5.3: Initial Level of Care Evaluation 28
Section 5.4: Waiting List for the Family Supports Waiver (FSW) 29
Section 5.5: Targeting Process for the Family Supports Waiver (FSW) 30
Section 5.6: Entrance into the Community Integration and Habilitation Waiver Program 32
Section 5.7: Initial Plan of Care/Cost Comparison Budget (POC/CCB) Development 34
Section 5.8: State Authorization of the Initial POC/CCB 35
Section 5.9: Initial Service Plan Implementation 36

Section 6: Objective-Based Allocation **39**
Section 6.1: OBA Development 39
Section 6.2: ICAP Assessment and Algo Level Development 39
Section 6.3: Algo Level Descriptors 40
Section 6.4: Translating Algo Level Into a Budget Allocation 41
Section 6.5: Budget Review Questionnaire and Budget Modification Request 44
Section 6.6: Implementation of Objective-Based Allocations 47
Section 6.7: Personal Allocation Review (PAR) and the Appeal Process 48

Section 7: Monitoring and Continuation of Waiver Services **49**
Section 7.1: Level of Care Reevaluation 49
Section 7.2: Medicaid Eligibility Redetermination 49

Section 7.3: Annual Plan of Care/Cost Comparison Budget (POC/CCB) Development.....49
Section 7.4: Plan of Care/Cost Comparison Budget (POC/CCB) Updates and Revisions.....51
Section 7.5: State Authorization of the Annual/Update Cost Comparison Budget (POC/CCB) 51
Section 7.6: Service Plan Implementation and Monitoring.....51
Section 7.7: Interruption/Termination of Waiver Services 53
Section 7.8: Waiver Slot Retention After Termination and Reentry.....54
Section 7.9: Parents, Guardians and Relatives Providing Waiver Services 55

Section 8: Appeal Process.....57

Section 8.1: Appeal Request 57
Section 8.2: Group Appeals 58
Section 8.3: Time Limits for Requesting Appeals 59
Section 8.4: The Hearing Notice.....59
Section 8.5: Request for Continuance from the Appellant.....60
Section 8.6: Review of Action 60
Section 8.7: Disposal of Appeal Without a Fair Hearing.....61
Section 8.8: The Fair Hearing 61
Section 8.9: Preparation for Hearing by Appellant 61
Section 8.10: Preparation for Hearing by the BDDS Service Coordinator or District Representative, BDDS Waiver Unit, or the DDRS Central Office.....62
Section 8.11: Conduct of the Hearing 63
Section 8.12: Continuance of Hearing 64
Section 8.13: The Hearing Record 64
Section 8.14: The Fair Hearing Decision 64
Section 8.15: Actions of the Administrative Law Judge's Decision.....64
Section 8.16: Agency Review 64
Section 8.17: Judicial Review 65
Section 8.18: Lawsuit.....65

Section 9: Bureau of Quality Improvement Services 67

Section 9.1: Overview.....67
Section 9.2: Incident Reports 67
Section 9.3: Complaints 68
Section 9.4: Mortality Reviews.....69
Section 9.5: National Core Indicator (NCI) Project 69
Section 9.6: Case Record Reviews.....70
Section 9.7: Quality On-Site Provider Review 70
Section 9.8: Statewide Waiver Ombudsman.....71

Section 10: Service Definitions and Requirements.....73

Section 10.1: Service Definition Overview.....73
Section 10.2: Medicaid Waiver Services, Codes and Rates.....73
Section 10.3: Adult Day Services 77
Section 10.4: Behavioral Support Services 80
Section 10.7: Community Transition 83
Section 10.8: Remote Supports.....85
Section 10.9: Environmental Modifications.....92
Section 10.12: Facility-Based Support.....94
Section 10.13: Family and Caregiver Training 97
Section 10.14: Intensive Behavioral Intervention 98
Section 10.15: Music Therapy 102
Section 10.16: Occupational Therapy 104
Section 10.17: Personal Emergency Response System.....106
Section 10.18: Physical Therapy.....108
Section 10.19: Prevocational Services 110
Section 10.20: Psychological Therapy.....112

Section 10.21: Recreational Therapy 115
Section 10.22: Rent and Food for Unrelated Live-in Caregiver 117
Section 10.23: Residential Habilitation and Support – (Hourly) 118
Section 10.24: Respite Care 124
Section 10.25: Specialized Medical Equipment and Supplies 127
Section 10.26: Speech/Language Therapy 129
Section 10.27: Transportation 132
Section 10.28: Workplace Assistance 134
Section 10.29: Case Management 137
Section 10.30: Participant Assistance and Care 143
Section 10.31: Structured Family Caregiving 146
Section 10.32: Wellness Coordination 149
Section 10.33: Extended Services 151
Section 10.34: Residential Habilitation and Support – Daily (RHS Daily) 155
Section 10.35: Day Habilitation (Effective 8/1/2020) 161
Section 10.36: Vehicle Modifications 165

Section 11: RFA Policies 169

Section 11.1: Environmental Modification Policy 169
Section 11.2: Specialized Medical Equipment and Supplies 174
Section 11.3: Vehicle Modification 179

Section 1: Roles and Responsibilities

This section presents the entities involved in the Division of Disability and Rehabilitative Services (DDRS) Home- and Community-Based Services (HCBS) waivers and their roles and responsibilities for providing these services. The roles and responsibilities of the individuals and guardians are included as well. Providers can give helpful hints to individuals or guardians to help them in selecting a waiver provider.

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

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

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

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

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

Additional information about the CMS is available on the CMS website at cms.gov.

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

As a division of the Indiana Family and Social Services Administration (FSSA), the DDRS has two overarching responsibilities for children and adults with physical and cognitive disabilities:

- Facilitate partnerships that enhance the quality of life
- Provide continuous, life-long support

The Bureau of Developmental Disabilities Services (BDDS) and the Bureau of Quality Improvement Services (BQIS) are under the DDRS.

Additional information about the DDRS is available at the *DDRS section* of the FSSA website at in.gov/fssa.

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

Within the DDRS, the BDDS operates a variety of services for individuals with intellectual/developmental disabilities, including two HCBS waiver programs for persons who meet the level of care (LOC) requirements for admission to an intermediate care facility for individuals with intellectual disabilities (ICF/IID):

- Family Supports Waiver (FSW)
- Community Integration and Habilitation (CIH) Waiver

The FSW and CIH Waiver programs provide services to individuals in a range of community settings, as an alternative to care in an ICF/IID.

Eight BDDS district offices serve specific counties in Indiana. The BDDS service coordinators determine initial eligibility for intellectual/developmental disability services, determining LOC for ICF/IID services. BDDS service coordinators also determine a new "initial" LOC for individuals who have been terminated from the HCBS waiver program, but desire to return to waiver services within the same waiver year.

The BDDS has statutory authority over the state's programs for individuals with intellectual/developmental disabilities. The BDDS is also the placement authority for persons with intellectual/developmental disabilities and helps develop policies and procedures for Indiana Medicaid waivers that serve persons with intellectual/developmental disabilities.

Additional information about the BDDS is available on the *DDRS Bureau of Developmental Disabilities Services* page at in.gov/fssa/ddrs.

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

Within the DDRS, the BQIS is responsible for developing and implementing quality improvement and quality assurance systems to assure the health and welfare of individuals receiving Medicaid HCBS waiver services, specifically the FSW or CIH Waivers. The oversight activities include the following:

- Developing policy
- Conducting case record reviews
- Investigating complaints
- Reviewing mortality
- Managing the state's automated system for reporting incidents of abuse, neglect and exploitation
- Assuring compliance with Indiana waiver regulations
- Researching best practices
- Analyzing quality data
- Managing provider reverification
- Monitoring provider accreditation

Additional information about the BQIS is available on the *DDRS Bureau of Quality Improvement Services* page at in.gov/fssa/ddrs.

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

The FSSA is the single state Medicaid agency for Indiana. A division of the FSSA, the Office of Medicaid Policy and Planning (OMPP), has been appointed by the Secretary to serve as the administrative authority for Medicaid HCBS programs and is responsible for monitoring the DDRS operation of the HCBS programs for compliance with CMS requirements. The OMPP is responsible for oversight of all HCBS program activities, including the following:

- LOC determinations
- Plan of care reviews
- Identification of trends and outcomes
- Initiating action to achieve desired outcomes
- Retaining final authority for approval of LOC and plans of care

The OMPP develops Medicaid policy for the state of Indiana and, on an ongoing and as-needed basis, works collaboratively with the DDRS to formulate policies specific to the HCBS program or that have a substantial impact on HCBS program individuals. The OMPP seeks and reviews comment from the DDRS before the adoption of rules or standards that may affect the services, programs or providers of medical assistance services for individuals with intellectual disabilities who receive Medicaid services. The OMPP and DDRS collaborate to revise and develop the application of the HCBS program to reflect current FSSA goals and policy programs. The OMPP reviews and approves all HCBS program documents, bulletins, communications regarding HCBS program policy and quality assurance/improvement plans prior to implementation or release to providers, individuals, families or any other entity.

Additional information about the OMPP is available on the *Office of Medicaid Policy & Planning* page at in.gov/fssa. For Medicaid eligibility requirements, see the *Eligibility Guide* on the member website at in.gov/medicaid/members.

Section 1.6: FSSA Division of Family Resources

As a division of the FSSA, the Division of Family Resources (DFR) is responsible for establishing eligibility and managing the timely and accurate delivery of benefits, including:

- Medicaid – health coverage plans
- Supplemental Nutrition Assistance Program (SNAP) – food assistance
- Temporary Assistance for Needy Families (TANF) – cash assistance
- Refugee assistance

The DFR Indiana Manpower and Comprehensive Training (IMPACT) program helps SNAP and TANF recipients to achieve economic self-sufficiency through education, training, job search and job placement activities.

The division's overarching focus is the support and preservation of families by emphasizing self-sufficiency and personal responsibility. Information about the DFR and DFR programs is available online on the *DFR section* of the FSSA website at in.gov/fssa or by telephone at 800-403-0864.

Section 1.7: Waiver Service Providers, Including Selected Contracting Case Management Organizations

HCBS waiver provider applicants are agencies, companies and individuals that have applied to provide waiver services and have been found to have the qualifications and business structures in place to seek enrollment as a Medicaid provider. After DDRS approval, the providers must then enroll in Medicaid as Indiana Health Coverage Programs (IHCP) providers.

For IHCP enrollment, the provider type for HCBS waiver providers is type 32 – Waiver. There are specialties under this waiver provider type including:

- 359 – Community Integration and Habilitation Waiver
- 360 – Family Supports Waiver
- 363 – Money Follows the Person (MFP) Demonstration Grant

For more information on how to enroll in Medicaid, see the *Provider Enrollment* provider reference module. After enrolling in Medicaid, the providers are paid by the IHCP to provide direct services to Medicaid HCBS Waiver program individuals.

The DDRS-approved selected contracting case management organizations are waiver service providers that provide only case management services to waiver individuals. These services include the following:

- Implementing the recently enhanced person-centered planning process
- Helping the individual identify members of the individualized support team (IST)
- Developing and submitting to the state the service plan known as the plan of care/cost comparison budget (POC/CCB, or just CCB)
- Developing a person-centered individualized support plan (PCISP) Case management providers often refer to themselves as *case management organizations*, using the acronym CMOs. Specific responsibilities of the case management provider, including monitoring activities, are described in *Section 10.29: Case Management*.

All waiver individuals must have case management services. Waiver individuals are provided a choice from among all CMOs that have been selected as contractors through a request for services, approved by the DDRS and enrolled by IHCP. After waiver individuals choose a CMO, they choose a case manager. The waiver individual's chosen case manager provides a list of available service providers at any time that the individual requests to select or change service providers, which includes changing providers of case management services. Case management is the only mandatory HCBS waiver service for individuals who chose the Medicaid HCBS waiver service programs administered by DDRS.

Section 1.8: Office of Administrative Law Proceedings (OALP)

Replacing the former FSSA Office of Hearings and Appeals (OHA), the Office of Administrative Law Proceeding (OALP) receives and processes appeals from people receiving services within FSSA programs and many other programs. Administrative hearings are held throughout the state of Indiana, usually at county DFR locations, at which time all parties have the opportunity to present their cases to an administrative law judge (ALJ) in OALP. The ALJs are no longer employees of the FSSA. See *Section 8: Appeal Process* for additional information about the hearing and appeal process. Interested parties may also review the new *OALP website* at in.gov/oalp. The new physical location of the OALP is:

Office of Administrative Law Proceedings
402 W. Washington St., Room W161
Indianapolis, IN 46204

Section 1.9: Individuals and Guardians

Note: Individual guidance is included in this section for provider reference.

It is the policy of the BDDS that individuals (or their legal representatives when indicated) participate actively and responsibly in the administration and management of their Medicaid-waiver-funded services.

The BDDS supports and encourages individual choice in selecting the individual's case management service provider, developing a PCISP and selecting all other service providers. Successful service delivery is dependent on the collaboration of the IST and entities with oversight responsibilities, including the BQIS. The individuals receiving services are the most prominent members of the IST, making their participation and cooperation in waiver service planning and administration essential.

For additional information, see *Individual/Guardian Responsibilities While Receiving Waiver Funded Services*, available on the *Current DDRS Policies* page at in.gov/fssa/ddrs.

Information Sharing

The individual (or the individual's legal representative, when indicated) must, on request from the BDDS, the BQIS or any DDRS-contracted vendor, provide information for the purpose of administration and management of waiver services.

Selecting or Changing Providers

When selecting a case management organization/provider, the individual (or the individual's legal representative, when indicated) must participate in the following:

- Choosing a CMO (provider agency/organization) from a provider choice list of DDRS-approved and IHCP-enrolled CMOs
  - For newly approved applicants preparing to enter into waiver services, the case management list is generated by the BDDS.
  - For individuals already active on the waiver, the case management choice list may be generated by the BDDS or by the current provider of case management services.
- Interviewing and choosing a case manager
- Completing the service-planning process

The individual (or the individual's legal representative, when indicated) must complete all actions as requested by the BDDS to secure replacement of any other type of provider within one of the following time frames:

- Sixty calendar days of the date the change is requested
- Sixty calendar days of when the provider gives notice of terminating services to the individual

If a new provider is not in place after 60 calendar days, the current provider shall continue to provide services to an individual.

See the *Helpful Hints for Individuals and Guardians Selecting Waiver Providers* section.

Participating in Risk Plan Development and Implementation

The individual (or the individual's legal representative, when indicated) and the individual's IST must work together to identify risk(s) for the individual. This includes recognizing the possibility of adverse consequences by participating in, or lack thereof, a given situation. Dignity of risk is having the right to choose and either succeed or fail.

> *In the words of Michael Smull, "Managing any risk begins with learning what is "important to" the person as well as what is "important for" and helping to find a good balance between them. Often risk is significantly diminished when our understanding of what the person wants deepens and we find reasonably safe ways for the person to get it. In other instances, understanding how important something is leads to better ways to support the person."*

- Development of risk plans for individuals will follow current BDDS and BQIS procedures and be clearly reflected in the PCISP
- Potential risks should be identified by category, including:
  - Health
  - Personal Safety
  - Behavior
- Once categorized, the IST can further identify:
  - The nature of the risk
  - The likelihood of occurrence
  - The severity of consequences from the risk
  - If a risk mitigation plan is warranted
- Key points include:
  - One plan for each identified risk should be developed
  - The IST should determine who will write the plan
  - All providers must implement the plan
  - If a team member disagrees with the components of the plan, it should be discussed with the entire IST
- Implementation of the risk mitigation plan requires:
  - All support staff must be trained on the plan
  - Adjustment to the plan are made as needed
  - At least annually, the team will discuss the continued need for the plan
- The goal is not to remove all risks that may exist in everyday life but to support the individual in navigating risks to reduce the negative outcomes and potential likelihood of the risk.

Risk assessment and planning tools and additional guidance is available on the *DDRS Bureau of Quality Improvement Services* page at in.gov/fssa/ddrs and includes the following:

- Person-centered risk management webinar recording (6/30/2021)
- Person-centered risk management PowerPoint (6/30/2021)
- Risk assessment and planning FAQ
- Risk issues identification tool (Word document) – Teams may utilize this tool to identify and plan to mitigate risks for an individual. The tool can be edited to suit the individual's circumstances.

- Risk issues identification tool example – A completed example of how a team may utilize the tool to identify and plan to mitigate risks for an individual.
- Risk matrix – A tool for teams to assess potential risks for an individual.

Allowing Representatives of the State Into the Individual's Home

The individual (or the individual's legal representative, when indicated) must allow representatives from the BDDS, the BQIS, the selected case management organization and any DDRS-contracted vendor into the individual's home for visits scheduled at least 72 hours prior.

Consequences for Nonparticipation

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

Should a termination occur, the individual (or the individual's legal representative, when indicated) has a right to appeal the state's decision. See *Section 8: Appeal Process* for further information regarding appeals.

Helpful Hints for Individuals and Guardians Selecting Waiver Providers

Waiver individuals and their guardians may find the following tips useful when selecting a provider:

- Selecting good providers is critical. It is helpful to think about the issues that are important to you and your family member before you begin the process. A list of certified waiver providers for each county is available through your case manager. If you are new to waiver services, or your current agency has terminated your service, you need to prioritize the providers and try to schedule interviews and visits within a short time frame, so the process does not become extended. Individuals who are new to the waiver program are asked to select a provider within 14 calendar days of receiving the provider choice list. Individuals who have been terminated by the current provider must select and transition to a new provider within 60 calendar days of termination.
- You will be able to make an informed choice by reading information, such as the BDDS Fact Sheets found on the *DDRS Bureau of Developmental Disabilities Services* page at in.gov/fssa/ddrs, or by discussing alternatives with the case manager or an advocate. You may want to visit an individual who is currently receiving waiver services or meet with various service providers. Case managers can assist in setting up visits or meeting with service providers.
- Sometimes a provider can arrange for you to visit people who are receiving services from the provider. Remember, when you visit a house or apartment where waiver services are being provided, you are visiting someone's home.
- When meeting with providers or case managers, it is important to take notes because it is easy to forget details later. Ask for copies of any written materials and write down information, such as names, titles, telephone numbers, email addresses and the date of the meeting. It's important to maintain accurate information. See the *Questions to Ask Prospective Service Providers* section for questions to consider when selecting waiver providers. The questions you ask depend on what kind of service it is and whether you will be served in your family home or in your own home or apartment, with or without housemates. Many of the questions are applicable to any setting, and others can be skipped or modified as needed.

General Topics to Discuss with Service Providers

Waiver individuals and their guardians may want to consider and discuss the following with potential service providers during the selection process:

- What areas of service are absolute requirements for you and your family member, such as medications being administered on time, direct supervision, sign-language training and so on?
- What makes you and your family member happy? What causes pain? How can the provider maximize opportunities for the former, and minimize or eliminate instances of the latter?
- What do you and your family member want to happen? To find a job? To attend or become a member of a church? To live within a half-hour drive of family? How many housemates would you or your family member like? Anything else? Are these wishes or requirements?
- What are the risks for you or your family member? Examples include daily seizures, a lack of street-safety skills, the inability to talk or use sign language, forgetfulness, a tendency to hit others when angry and so on. How will the provider deal with those risks?
- What is the provider's experience working with children and adults with disabilities, or adults who are elderly?
- How would the provider ensure the implementation of the PCISP?
- What connections has the provider established in the community? How would the provider assist in building a support system in the community?

Questions to Ask Prospective Service Providers

The following are good questions for an individual or guardian to ask a prospective service provider:

- What is the provider's mission? (Does it match the intent you are seeking?)
- Is the provider certified, accredited or licensed? What are the standards of service?
- What kind of safety measures does the provider have in place to protect the individual and assure effective treatment?
- How does the provider assure compliance with the person's rights? Did you (and family members and advocates) receive copies of your rights as a consumer of services, as well as have these rights explained?
- Is the provider interested in what you and your family member want or are hopeful about?
- Is the provider connected to other programs that you may need, such as day support, local school and education services, or work programs? How is the provider connected? Ask for specific contacts.
- If you are to live in a home shared with other people, can families drop in whenever they wish?
- How are birthdays, vacations and special events handled?
- How would family money issues be handled? What is the policy on personal and client finances?
- How would minor illnesses and injuries be handled? What about major illnesses and injuries?
- What information is routinely reported to families?
- Can you get a copy of the provider's complaint policies and procedures? Is there someone else whom family members can talk to if there is a disagreement?
- How are behavior problems handled? Are staff allowed to contact a behavioral support provider? How are new staff trained on the behavior support plan? Are they trained before working with waiver individuals? What is the relationship between residential provider and behavioral provider?

- How is medication handled? What happens if medication is refused?
- What is the smoking policy?
- How are planning meetings scheduled and conducted, and who attends? Can a family member call a meeting? How does the provider assure that what is agreed on in the meeting is actually provided?
- Who would be the provider's contact person, how will that contact occur, and how often? Is someone available 24 hours a day in case of emergencies?
- How many people with disabilities have the agency terminated or discontinued from services? Why? What happened to them?
- Has the agency received any abuse or neglect allegations? Who made these allegations? What were the outcomes? What is the process for addressing allegations of abuse or neglect?
- What challenges does the provider think the waiver individual will create for him or her?
- As a provider of waiver services, what are the provider's strengths and weaknesses?
- What is the process for hiring staff? Are background checks conducted and training given? Who provides services to the waiver individual while a new staff person is hired and trained?
- How is direct staff supervised? What training does the staff receive? What is the average experience or education of staff?
- How is staffing covered if someone on regular staff is ill? What happens if staff does not show up for the scheduled time? How often does that happen?
- What is the staff turnover rate? How are the staffs' needs for respite handled?
- What kind of support does staff have? Who can staff call if a problem develops?

What to Look for and Ask during Visits to Supported Living Settings

Members should consider these issues when looking for a supported living setting:

- How do the staff and housemates interact? Do they seem to respect and like each other?
- Does the environment look comfortable? Is there enough to do? Are there concerns about behaviors or support in the home?
- What kind of food is available and who selects it? Are choices encouraged and available? Are diets supervised?
- Do people have access to banks, shops, restaurants and so on? How is transportation handled? Are trips to access these resources planned or do they occur as needed?
- Is there a telephone available to housemates (with privacy)? Is the telephone accessible (equipped with large buttons, volume control other access features) if needed?
- Does each person have their own bedroom? Is each person allowed to individually decorate the bedroom?
- Do housemates seem to get along well? What happens when they don't?
- Are there restrictions on personal belongings? What are the procedures for lost personal items? Are personal items labeled? Are lost items replaced?
- Are pets allowed? What are the rules regarding pets?
- How much time is spent in active learning (neighborhood, home or community) and leisure activities? Is there a good balance with unstructured time?

- Is there evidence that personal hygiene and good grooming (hair, teeth, nails and so on) are encouraged?
- How are personal need items, clothing and so on, paid for?
- Does each person have privacy when they want to be alone or with a special friend?
- Does each person have the opportunity to belong to a church, club, community group and so on?
- Do staff knock on doors and wait for a response before entering a private room?
- What kind of rules are there within the living situation? What are the consequences for breaking rules?
- Does each housemate have opportunities to pursue their own individual interests, or do they travel in a group with everyone doing the same thing, attending the same movie and so on?

Section 1.10: FSSA BDDS Documentation Requests

Documentation Requests

Each individual's BDDS documentation is housed within the state's case management system/document library and is the property of the state of Indiana. This information may not be shared with external entities without proper consent. All entities that receive requests for an individual's BDDS records must submit requests directly to the BDDSdocumentationrequests@fssa.in.gov mailbox.

Proper consent is required prior to the release of BDDS records.

Guidance for Selected Contracting Case Management Organizations

With the exception of documentation, case managers are specifically required to disseminate to individuals and parent(s) of minor children or legal representatives, as applicable (such as PCISPs and Notices of Action) as outlined in the Case Management Waiver Service Definition, documentation may not be shared by case managers.

If selected contracting case management organizations or their case managers receive requests from external entities for BDDS records, the requesting entity should be referred to the FSSA BDDS Documentation Requests mailbox.

Additional information for case managers is available in the *Quality Guide for Case Managers and Case Management Organizations*, found under the Resources tab of the BDDS Portal. However, the following is offered for reference:

- ***Eligibility Determination Requests -*** If the case management organization does receive requests for documentation from Vocational Rehabilitation (VR), the Disability Determination Bureau (DDB), Social Security Administration (SSA) or attorneys representing individuals in SSA cases, the case manager shall:
  - Review the BDDS Portal to ensure all profile information, including legal status, is correct and up to date.
  - Submit the original request for documentation, including a signed release, to FSSA BDDS Documentation Requests BDDSdocumentationrequests@fssa.in.gov.

- ***Subpoenas -*** If the case management organization receives a subpoena, the case manager shall:
  - Review the BDDS Portal to ensure all profile information, including legal status, is correct and up to date.

    Submit the original request for documentation, including the subpoena, to FSSA BDDS Documentation Requests BDDSdocumentationrequests@fssa.in.gov.

Section 2: Provider Information

This section presents how providers apply to become HCBS waiver providers, the reverification process, claims and billing, and audit responsibilities.

Section 2.1: Provider Application Process

Applications to provide Indiana's Home- and Community-Based Services (HCBS) waiver services through the Bureau of Developmental Disabilities Services (BDDS) may be submitted twice yearly. Case management organization (CMO) providers must still be approved by the Family and Social Services Administration (FSSA) Division of Disability and Rehabilitative Services (DDRS) Provider Services Department, but case management is now provided through a selective contracting waiver approved by the Centers for Medicare & Medicaid Services (CMS) to operate concurrently with the Medicaid HCBS waivers operated by DDRS, the Community Integration and Habilitation (CIH) Waiver and the Family Supports Waiver (FSW).

For all other HCBS provider types, the first step for potential providers is submittal of a Letter of Intent and References as outlined in the Sept. 14, 2020, policy at New Provider Approval Process. The Letter of Intent must include the following information and be reviewed and approved by BDDS:

- Contact information (include email and phone number)
- Background and experience supporting individuals with intellectual and developmental disabilities
- Education
- Motivation for becoming an HCBS waiver services provider:
  - How do you intend to support individuals with intellectual and developmental disabilities to:
    - Direct their own lives
    - Make well-informed decisions
    - Access and explore new experiences and opportunities
    - Explore ways to make meaningful connections within their communities
- References:
  - Two professional references:
    - One of the professional references must speak to experience in the intellectual and developmental disabilities community
    - One personal reference.

Letters of Intent and references are to be emailed to BDDSProviderServices@fssa.in.gov.

Letters of Intent will be reviewed by BDDS. Applications are accepted only if the Letter of Intent is approved by BDDS. Potential providers whose Letter of Intent is approved will then receive the full Provider Instructions and Application, including all necessary forms, documents and requirements. A single application is used for all BDDS HCBS Waiver services except case management services.

All components of the provider application packet must be completed as instructed. When a completed application is received, the information submitted is reviewed by the FSSA/DDRS Provider Services Department. Provider applicants may receive a written Request for Information if the application components are not clear or questions exist. If the provider applicant meets the requirements of *Indiana Administrative Code 460 IAC 6* and DDRS policies, the application will be moved forward as authorized to start the process of applying for enrollment with Indiana Health Coverage Programs (IHCP). Initial approval by BDDS is issued for 12 months. If the application packet is not completed in its entirety (with all documentation provided in full, labeled correctly, and in the order requested per the application

instructions), or the applicant does not meet the requirements outlined for the services, the application will be denied by FSSA/DDRS Provider Services.

Completed applications may be submitted to:

MS18
Director of Provider Services
DDRS − Division of Disability and Rehabilitative Services
402 W. Washington St., Room 453
Indianapolis, IN 46207

Section 2.2: Provider Reverification

The DDRS Bureau of Quality Improvement Services (BQIS) reviews the performance of Medicaid HCBS waiver service providers and makes a reverification determination at least once every four years. Reverification terms are two or four years.

The BQIS initiates the reverification process and evaluates the following information submitted by each provider:

- BDDS waiver provider information
- Indiana Secretary of State documentation
- Financial information
- Annual individual satisfaction survey and results

The BQIS also evaluates the provider's data from monitoring activities such as:

- Complaint investigations BQIS has conducted about the provider and number of substantiated allegations
- Numbers of and types of incidents
- Numbers of mortalities and related findings
- Staff training
- Criminal background checks
- Any other information the DDRS deems necessary to assess a provider's performance

Note: A provider may select from approved national accreditation organizations set forth in Indiana Code IC 12-11-1(i))

Although case management organizations are not permitted to provide any other waiver services, residential and day program providers may choose to obtain accreditation (specific to Indiana programs) for other waiver services that they are approved to provide. However, this accreditation is not required. Some accreditation entities accredit the organization, whereas others allow providers to select the services they wish to accredit.

The process for reverifying providers is outlined in the following DDRS policies:

- *Provider Reverification for Accredited Waiver Services* (Revised Oct. 4, 2021)
- *Provider Reverification for Non-Accredited Waiver Services*

Further information about the reverification process and related tools is available on the *DDRS Bureau of Quality Improvement Services* page at in.gov/fssa/ddrs.

The director of the BQIS issues providers notices of 24- or 48-month terms. This notice also specifies that the reverification term is contingent on the provider submitting a signed Provider Agreement within 30 calendar days. The provider's reverification term begins when the document is received by the BQIS.

If a provider fails to return a Provider Agreement within the 30 calendar days, the provider will have been deemed to have failed to meet the requirements for reverification and will receive a letter indicating that it is under a six-month approval and may be referred to the DDRS Sanctions Committee for civil sanctions or a potential moratorium on new admissions.

At the end of the six-month period, the provider must repeat the DDRS provider reverification process and submit all the required information to assure that the quality of services meets or exceeds the required standards.

Administrative Review

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

- States facts demonstrating that the provider is:
  - A provider to whom the action is specifically directed
  - Aggrieved or adversely affected by the action
  - Entitled to review under any law filed with the director of the DDRS within 15 calendar days after the provider receives notice of the sanctioning order. Per the Administrative Orders and Appeals Act (AOPA), the petition must also be filed with the Office of Administrative Law Proceedings (OALP) at the following email or fax number:

    Office of Administrative Law Proceedings
    Fax: (317) 232-4412
    Email: fssa.appeals@oalp.in.gov
  - Conducted in accordance with *IC 4-21.5-3-7*

* *Order as defined in IC 4-21.5-1-9 means an agency action of particular applicability that determines the legal rights, duties, privileges, immunities or other legal interests of one (1) or more specific persons. The term includes: (1) a license; or (2) a determination under IC 4-21.5-3-6(a)(3) or IC 4-21.5-3-6(a)(4). As added by P.L.18-1986, SEC.1. Amended by P.L.42-1995, SEC.1.*

If a provider has complied with the renewal timelines, and if the BDDS does not act on a provider's request for renewal of approved status before expiration of the provider's approved status, the provider continues in approved status until the BDDS acts on the provider's request for renewal of approved services.

Section 2.3: Claims and Billing

Waiver Authorization – Service Definitions and Requirements

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

- The IHCP does not reimburse time spent by office staff billing claims.
- Providers may bill only for those services authorized on an approved Notice of Action (NOA).
- A claim may include dates of service within the same month. Claims may not be submitted with dates that span more than one month on the same claim.

- The units of service as billed to the IHCP must be substantiated by documentation in accordance with the appropriate *Indiana Administrative Code* (IAC) regulations and the waiver documentation standards issued by the FSSA Office of Medicaid Policy and Planning (OMPP) and the DDRS.
- Services billed to the IHCP must meet the service definitions and parameters as published in the aforementioned rules and standards.

Updated information is disseminated through IHCP provider bulletins posted on in.gov/medicaid/providers and announcements on the DDRS website at in.gov/fssa. Each provider is responsible for obtaining the information and implementing new or revised policies and procedures as outlined in these notices. IHCP provider reference materials include numerous valuable documents such as the *Home- and Community-Based Services Billing Guidelines* provider reference module.

> *Note: The timely filing limit on claims for services rendered through the fee-for-service (FFS) delivery system is 180 days from the date of service (DOS).*

Reimbursement During Hospitalization

The following guidance pertains to the delivery of HCBS in acute care hospital stays:

In accordance with the recent amendment to *Section 1902(h)* of the *Social Security Act (42 U.S.C. 1396a(h))*, states' Medicaid programs are permitted to provide Home- and Community-Based Services (HCBS) to individuals in acute care hospitals. The Bureau of Developmental Disabilities Services (BDDS) has developed the following guidance for the delivery of HCBS (that is, Family Support Waiver and the Community Integration Habilitation Waiver) in acute care hospitals.

This guidance is only applicable for individuals receiving BDDS waiver services who are seeking or receiving treatment in an acute care hospital setting for inpatient medical care or other related services for surgery, acute medical conditions or injuries. This guidance does not pertain to individuals who require long term care in a facility-based setting including, but not limited, to nursing homes, rehabilitation centers and/or treatment facilities.

Individuals may receive HCBS from their direct support professional or other support staff, like a behavior management or music therapy provider, while receiving medical care and treatment in an acute care hospital, so long as all the following conditions exist:

- The waiver service is accurately documented in the person-centered individualized support plan (PCISP).
- The waiver service provided meets the need(s) of the individual that are not met through the provision of hospital services.
- The waiver service is being provided to ensure a smooth transition between the acute care setting and home- and community-based setting, and preserve the individual's functional abilities.

The HCBS provided by the direct support professional or other support staff may not be utilized as a substitute for services that the hospital is obligated to provide through its conditions, requirements and expectations under any participation, licensing and/or professional partnership agreement(s), as well as local, state and/or federal laws.

Case managers are required to document in the case notes when an individual receives acute medical care. The case manager must ensure the waiver service is identified in the PCISP and all the following must be included in the case note:

- Which waiver service(s) will be provided during the acute hospital stay
- Description of how the waiver service(s) will assist in returning to the community and preserve the individual's functional abilities

- Coordination and communication activities among individualized support team members
- Anticipated length of acute hospital stay
- Anticipated frequency and duration of the waiver service(s)

Case managers may not interrupt or terminate an individual's waiver due to an acute hospital admission or stay. Case managers must update the individual's plan within waiver rules and service limitations as needed to accommodate for acute hospital stays.

Parent(s) and legal guardian(s) of adults who are employed as the individual's direct support professionals may continue to provide the waiver service while the individual is receiving care and treatment in the acute care hospital setting, up to and including the current approved number of hours that exists with the current service plan at the time of hospitalization.

Individuals receiving services on the Community Integration and Habilitation (CIH) Waiver who may need additional supports while receiving care in an acute care hospital setting may submit a budget modification request that documents the need for increased supports, the anticipated length of temporary supports needed, and the availability of staff to provide the support.

All Family Supports Waiver (FSW) and CIH Waiver rules and service limitations still apply (for example, 40-hour rule, incident reporting guidelines and so on).

Third-Party Liability Exempt

The IHCP will not bill private insurance carriers through the third-party liability (TPL) or reclamation processes for claims containing any HCBS benefit modifier codes. This billing practice includes modifiers specific to claims for the following benefit plans:

- Community Integration and Habilitation (CIH) Waiver
- Family Supports Waiver (FSW)

Electronic Visit Verification System Required for Personal Care Services

The 21st Century Cures Act directs state Medicaid programs to require providers of personal care services and home health services to use an electronic visit verification (EVV) system to document services rendered. Federal law requires that providers use the EVV system to document the following information:

- Date of service
- Location of service
- Individual providing service
- Type of service
- Individual receiving service
- Time the service begins and ends

In accordance with federal requirements, the Indiana Health Coverage Programs (IHCP) required providers to use an EVV system to document personal care services rendered on or after Jan. 1, 2021. Additional information and resources on EVV, system specifications, services requiring EVV, and training are available on the *IHCP Electronic Visit Verification* page at in.gov/medicaid/providers.

Section 2.4: Financial Oversight – Waiver Audits

The state of Indiana employs a hybrid program integrity approach to overseeing waiver programs, incorporating oversight and coordination by the Surveillance and Utilization Review (SUR) Unit, as well as engaging the full array of technology and analytic tools available through the Fraud and Abuse Detection System (FADS) contractor arrangements. The FSSA has expanded its program integrity activities using a multifaceted approach to SUR activity that includes provider self-audits, desk audits and on-site audits. SUR is required to complete an initial assessment of each provider type annually. Then, based on the assessment information and referrals, audits are completed as needed. The FADS team analyzes claims data, allowing them to identify providers and claims that indicate aberrant billing patterns and other risk factors.

The program integrity audit process uses data mining, research, identification of outliers, problematic billing patterns, aberrant providers and issues that are referred by other divisions and state agencies. The State Benefit Integrity Team composed of key stakeholders meets biweekly to review and approve audit plans and provider communications, and make policy and system recommendations to affected program areas. The SUR Unit also meets with all waiver divisions on a quarterly basis, at a minimum, and receives referrals on an ongoing basis to maintain open lines of communication and understanding in specific areas of concern, such as policy clarification.

The SUR waiver specialist is a subject-matter expert (SME) responsible for directly coordinating with the waiver divisions. This specialist also analyzes data to identify potential areas of risk and identify providers that appear to be outliers warranting review. The SME may also perform desk or on-site audits and be directly involved in reviewing waiver providers and programs.

Throughout the entire program integrity process, the FSSA maintains oversight. Although the FADS contractor may be incorporated in the audit process, no audit is performed without the authorization of the FSSA. The FSSA's oversight of the contractor's aggregate data is used to identify common problems to be audited, determine benchmarks and offer data to peer providers for educational purposes, when appropriate.

The SUR Unit offers education regarding key program initiatives and audit issues at waiver provider meetings to promote ongoing compliance with federal and state guidelines, including all IHCP and waiver requirements.

FSSA Audit Oversight

To ensure program integrity, Indiana FSSA Audit Services, the IHCP Finance team and contractors employ various methods, standards, processes and procedures to perform the required audit tasks to bring the Indiana Medicaid Program Integrity Program into full compliance with Centers for Medicare & Medicaid Services (CMS) regulations.

Medicaid Fraud Control Audit Overview

The Indiana Medicaid Fraud Control Unit (MFCU) is an investigative branch of the Attorney General's Office. The MFCU conducts investigations in the following areas:

- Medicaid provider fraud
- Misuse of Medicaid members' funds
- Patient abuse or neglect in Medicaid facilities

When the MFCU identifies a provider that has violated regulations in one of these areas, the provider's case is presented to the state or federal prosecutors for appropriate action. Providers can access information about the *MFCU* at in.gov/attorneygeneral.

Section 3: Additional Medicaid Information

This section gives providers additional information about Indiana Health Coverage Programs (IHCP) programs, member eligibility and benefit coverage. Also presented in this section are the prior authorization (PA) and funding streams for Home- and Community-Based Services (HCBS) waiver services.

Section 3.1: Other Program Information

Information about the variety of healthcare programs offered through the IHCP – including the Healthy Indiana Plan (HIP), Hoosier Care Connect, Hoosier Healthwise and Traditional Medicaid – is available on the *IHCP Programs and Services* page at in.gov/medicaid/providers.

See the *Member Eligibility and Benefit Coverage* provider reference module for detailed information about member eligibility and services.

Section 3.2: Medicaid Prior Authorization and Funding Streams

The Centers for Medicare & Medicaid Services (CMS) requires that an HCBS waiver member exhaust all services regardless of funding stream, including those on the Indiana Medicaid State Plan, before utilizing HCBS waiver services. HCBS waiver programs are considered funding of last resort and have a closed funding stream. The following list shows the hierarchy of funding streams for HCBS waiver programs:

1. Private insurance, Medicare, Department of Education/school funding
2. Medicaid State Plan services
3. Natural/unpaid supports
4. HCBS waiver programs
    a. Because HCBS waiver programs are a funding stream of last resort, waiver teams must ensure that all other revenue streams are exhausted before utilizing HCBS waiver services.
    b. Medicaid home health PA requests must specify whether there are other caregiving services received by the member, including but not limited to services provided by Medicare, Medicaid waiver programs, Community and Home Option to Institutional Care for the Elderly (CHOICE), vocational rehabilitation, and private insurance programs. The number of hours per day and days per week for each service must be listed.

Indiana Medicaid State Plan services that must be accessed prior to the use of waiver-funded services include but are not limited to:

- Home health
- Medical transportation
- Occupational therapy
- Physical therapy
- Speech/language therapy
- Medicaid Rehabilitation Option (MRO)

> *Note: For additional information regarding PA, see the Prior Authorization page at in.gov/medicaid/providers.*

Section 4: Intellectual/Developmental Disabilities Services Waivers

This section presents an overview of the Medicaid waiver program, as well as the state's definition of intellectual/developmental disability as it applies to waiver service eligibility, cost neutrality of the waivers and coordinating Home- and Community-Based Services (HCBS) waiver services with other Indiana Health Coverage Programs (IHCP) services. This section also provides information about the two waiver programs that the Division of Disability and Rehabilitative Services (DDRS) oversees:

- Family Supports Waiver (FSW)
- Community Integration and Habilitation (CIH) Waiver

Both waivers can be found on the *DDRS Bureau of Developmental Disabilities Services* page at in.gov/fssa/ddrs.

Section 4.1: Medicaid Waiver Overview

The Medicaid HCBS waiver program began in 1981 in response to the national trend toward providing home- and community-based services. In the past, Medicaid paid only for institutionally based long-term care services, such as nursing facilities and group homes.

The Medicaid HCBS waiver program is authorized in *Section 1915(c)* of the *Social Security Act*. The program permits a state to furnish an array of home- and community-based services that help Medicaid beneficiaries live in the community and avoid institutionalization. The states have broad discretion to design their waiver programs to address the needs of the waivers' target populations.

HCBS waiver services complement and supplement the services available to individuals through the Medicaid State Plan and other federal, state and local public programs, as well as the support that families and communities provide.

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

Indiana applies to CMS for permission to offer Medicaid waivers. The Medicaid waivers use federal Medicaid funds (plus state matching funds) for HCBS as an alternative to institutional care, under the condition that the overall cost of supporting people in the home or community is no more than the institutional cost for supporting that same group of people.

The goals of waiver services are to provide the individual with meaningful and necessary services and supports, to respect the individual's personal beliefs and customs, and to ensure that services are cost-effective. Specifically, waivers for individuals with an intellectual/developmental disability assist an individual to:

- Become integrated into the community where they live and work
- Develop social relationships within the person's home and work communities
- Develop skills to make decisions about how and where the individual wants to live
- Be as independent as possible

Section 4.2: State Definition of Intellectual/Developmental Disability

Individuals meeting the state criteria for an intellectual/developmental disability and meeting the criteria of an intermediate care facility for individuals with intellectual disabilities (ICF/IID) level of care (LOC) determination are eligible to receive waiver services when approved by the state. Per *Indiana Code IC 12-7-2-61*, "developmental disability" means a severe, chronic disability of an individual that meets all the following conditions:

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

An individual with an intellectual/developmental disability must also be found to meet the federal LOC requirements for admission into an ICF/IID and be approved for entrance into the waiver program before receiving waiver-funded services through an Indiana Medicaid HCBS waiver program operated by the DDRS. See *Section 5.3: Initial Level of Care Evaluation* for details.

Section 4.3: Cost Neutrality

Indiana must demonstrate that average per capita expenditure for the FSW and CIH Waiver program individuals is equal to or less than the average per capita expenditures of institutionalization for the same population. Indiana must demonstrate this cost neutrality for each waiver separately.

Section 4.4: Coordination With Medicaid State Plan Services

The CMS requires that an HCBS waiver member exhaust all services on the State Plan before utilizing HCBS waiver services. HCBS waiver programs are considered funding of last resort and have a closed funding stream. See *Section 3.2: Medicaid Prior Authorization and Funding Streams* for more specific information.

Section 4.5: Family Supports Waiver (FSW)

Purpose

The FSW program provides Medicaid HCBS to individuals residing in a range of community settings as an alternative to care in an intermediate care facility for individuals with intellectual/developmental disabilities (known as an ICF/IID) or related conditions. The FSW serves persons with intellectual/developmental disabilities or autism, who have substantial functional limitations, as defined in *Code of Federal Regulations 42 CFR 435.1010*. Individuals may choose to live in their own home, family home or community setting appropriate to their needs. Individuals develop a person-centered individualized support plan (PCISP) using a person-centered planning process guided by an individualized support team (IST). The IST consists of the individual, the individual's case manager and anyone else of the individual's choosing, but typically family and friends. The individual, with the IST, selects services, identifies service providers of the individual's choice and develops a plan of care/cost comparison budget (POC/CCB).

See *Section 5.4: Waiting List for the Family Supports Waiver (FSW)* and *Section 5.5: Targeting Process for the Family Supports Waiver (FSW)* for information about entrance to the FSW.

Note: The POC/CCB is subject to an annual waiver services cost cap of $19,614.

Goals and Objectives

The FSW accomplishes the following:

- Provides access to meaningful and necessary home- and community-based services and supports
- Implements services and supports in a manner that respects the individual's personal beliefs and customs
- Ensures that services are cost-effective
- Facilitates the individual's involvement in the community where they live and work
- Facilitates the individual's development of social relationships in their home and work communities
- Facilitates the individual's independent living

Services Available

The following services are available through the FSW:

- Adult Day Services
- Behavioral Support Services
- Case Management (the only mandatory service)
- Day Habilitation (effective Aug. 1, 2020)
- Environmental Modifications
- Extended Services
- Facility-Based Support Services
- Family and Caregiver Training
- Intensive Behavioral Intervention
- Music Therapy

- Occupational Therapy
- Participant Assistance and Care
- Personal Emergency Response System
- Physical Therapy
- Prevocational Services
- Psychological Therapy
- Recreational Therapy
- Remote Supports
- Respite
- Specialized Medical Equipment and Supplies
- Speech/Language Therapy
- Transportation
- Vehicle Modifications
- Workplace Assistance

Section 4.6: Community Integration and Habilitation (CIH) Waiver

Purpose

The CIH Waiver program provides Medicaid HCBS to individuals residing in a range of community settings as an alternative to care in an ICF/IID. The CIH Waiver serves individuals with an intellectual/developmental disability, autism spectrum disorder or related conditions, who have substantial functional limitations, as defined in *42 CFR 435.1010*. However, entrance into services under the CIH Waiver occurs only when an applicant has been determined by the DDRS to meet priority criteria of one or more federally approved *reserved waiver capacity* categories, a funded slot is available, and the DDRS determines that other placement options are neither appropriate nor available.

When priority access has been deemed appropriate and a priority waiver slot in the specific reserved waiver capacity category met by the applicant remains open, individuals may choose to live in their own home, family home or community setting appropriate to their needs. Individuals develop a PCISP using a person-centered planning process guided by an IST. The IST is composed of the individual, their case manager, and anyone else of the individual's choosing but typically family and/or friends. The individual, along with the IST, selects services, identifies service providers of the individual's choice and develops a POC/CCB.

Goals and Objectives

The CIH Waiver accomplishes the following:

- Provides access to meaningful and necessary home- and community-based services and supports
- Seeks to implement services and supports in a manner that respects the individual's personal beliefs and customs
- Ensures that services are cost-effective
- Facilitates the individual's involvement in the community where they live and work

- Facilitates the individual's development of social relationships in their home and work communities
- Facilitates the individual's independent living

Services Available

The following services are available:

- Adult Day Services
- Behavioral Support Services
- Case Management (the only mandatory service)
- Community Transition
- Day Habilitation (effective Aug. 1, 2020)
- Environmental Modifications
- Extended Services
- Facility-Based Support Services
- Family and Caregiver Training
- Intensive Behavioral Intervention
- Music Therapy
- Occupational Therapy
- Personal Emergency Response System
- Physical Therapy
- Prevocational Services
- Psychological Therapy
- Recreational Therapy
- Remote Supports (previously Electronic Monitoring)
- Rent and Food for Unrelated Live-in Caregiver
- Residential Habilitation and Support (hourly)
- Residential Habilitation and Support – Daily (RHS Daily)
- Respite
- Specialized Medical Equipment and Supplies
- Speech/Language Therapy
- Structured Family Caregiving
- Transportation
- Vehicle Modifications
- Wellness Coordination
- Workplace Assistance

Section 5: Application and Start of Waiver Services

The section explains the application process for the Family Supports Waiver (FSW) and Community Integration and Habilitation (CIH) Waiver program. Also presented are the activities that take place after an individual is approved for one of the waiver programs.

Section 5.1: Request for Application

An individual or the individual's guardian may apply for the FSW or the CIH Waiver program through the local Division of Disability and Rehabilitative Services (DDRS) Bureau of Developmental Disabilities Services (BDDS) office. An individual or the individual's guardian has the right to apply without questions or delay.

To apply for BDDS services, including the FSW or CIH Waiver, the individual or guardian now has two options available.

- The first option is to use the BDDS Gateway, an online application available 24/7 where individuals and families seeking may submit an application for services. The BDDS Gateway may be accessed at: Bddsgateway.fssa.in.gov.

The second option is to complete, sign and date an *Application for Developmental Disability Services (State Form 55068 [8-12])*, which is available on the DDRS *Forms* page at in.gov/fssa/ddrs. The form may be completed as a fillable PDF or handwritten. The form must be printed, signed and returned to the local BDDS office via fax, mail or in-person delivery. Other individuals or agency representatives may help the individual or guardian complete the application and forward it to the BDDS office serving the county in which the individual currently resides. Upon receiving the waiver application, the BDDS staff must contact the individual and the individual's guardian and discuss the process for determining eligibility for the waiver (documentation of an intellectual/developmental disability, Medicaid eligibility and initial level of care [LOC]). If the applicant is not a Medicaid member, they are referred to the local Division of Family Resources (DFR) office to apply for Medicaid.

Applicants requesting, meeting and approved for specific reserved waiver capacity (priority) criteria for entrance into the CIH Waiver program are advised of those services and the availability of a funded priority slot. See *Section 5.6: Entrance into the Community Integration and Habilitation Waiver Program* for details.

Section 5.2: Medicaid Eligibility

Note: Member guidance is included in this section for provider reference.

Applicants under the age of 18 should submit the plan of care/cost comparison budget (POC/CCB) approval letter (see *Section 5.8: State Authorization of the Initial POC/CCB)* to the Family and Social Services Administration (FSSA) Division of Family Resources (DFR) when submitting an application for Medicaid benefits or when requesting a change of Medicaid Aid Category to qualify for waiver eligibility.

Note: Medicaid eligibility is required before starting waiver services. See the Apply for Coverage page at in.gov/medicaid/members for instructions on how to apply for Medicaid.

Section 5.3: Initial Level of Care Evaluation

An individual targeted for the FSW or who meets reserved waiver capacity (priority) criteria and is approved for entrance into the FSW or CIH Waiver program, must meet the level of care (LOC) required for placement in an intermediate care facility for individuals with intellectual disabilities (ICF/IID). All LOC determinations require secondary review to ensure accuracy.

- Initial LOC determinations are made by a BDDS service coordinator, including a new "initial" LOC for individuals who have been terminated from the Home- and Community-Based Services (HCBS) waiver program but desire to return to waiver services within the same waiver year.
- Reevaluations are performed by the selected provider of case management services.
- For those applicants whose initial LOC evaluation was unfavorable, the information is submitted to the BDDS Central Office for a tertiary review. The FSSA Office of Medicaid Policy and Planning (OMPP) retains final authority for determination of eligibility.
- Only individuals (state employees) who are Qualified Intellectual Disability Professionals (QIDP), as specified by the standard in *Code of Federal Regulations 42 CFR 483.430(a*), may perform initial LOC determinations.
- If collateral records are not available or are not valid reflections of the individual, additional assessments may be obtained from contracted psychologists, physicians, nurses and licensed social workers. Following review of the collateral records, the LOC assessment tool applicable to individuals with intellectual/developmental disabilities and other related conditions is completed to ascertain if the individual meets ICF/IID LOC.
- The LOC assessment tool is used for:
  - Reviewing and referencing documentation related to the intellectual/developmental disabilities of the applicant or individual, as well as any psychiatric diagnosis and results of the individual's intellectual assessment
  - Recording age of onset
  - Identifying areas of major life activity in which the individual may exhibit a substantial functional limitation, including the areas of mobility, understanding and use of language, self-care, capacity for independent living, learning, self-direction, economic self-sufficiency, and the state definition of developmental disability found in *Indiana Code IC 12-7-2-61*
- The BDDS service coordinator (initial LOC) or selected provider of case management (reevaluations) reviews the LOC assessment tool and collateral material applicable to individuals with intellectual/developmental disabilities and other related conditions to ascertain whether the individual meets ICF/IID LOC requirements. An applicant or individual must meet requirements for three of six substantial functional limitations and each of four basic conditions (lists follow) to meet LOC criteria.
  - The basic conditions are:
    - Intellectual disability, cerebral palsy, epilepsy, autism or other condition (other than a sole diagnosis of mental illness) similar to intellectual disability
    - The intellectual disability or other related condition is expected to continue indefinitely.
    - The intellectual disability or other related condition had an age of onset prior to age 22.
    - The intellectual disability or other related condition results in substantial functional limitations in at least three major life activities.
  - The substantial functional limitation categories, as defined in *42 CFR 435.1010*, are:
    - Self-care
    - Learning
    - Self-direction
    - Capacity for independent living

    - Understanding and use of language
    - Mobility
  - After the evaluation is complete, a LOC decision letter is sent to the individual or legal guardian. Each LOC decision letter provides a Right to Appeal Notice explaining the individual's right to appeal the decision as well as how to file an appeal. For more on appeals, see *Section 8: Appeals Process* in this module.

Section 5.4: Waiting List for the Family Supports Waiver (FSW)

The BDDS policy states individuals may be placed on a single statewide waiting list after applying for waiver services and meeting specified criteria. Individuals are responsible for maintaining current collateral and contact information with their local BDDS office.

Initial Placement on a Single, Statewide Home- and Community-Based Services Waiver Waiting List

For initial placement on a single, statewide HCBS waiver waiting list, the following requirements must be met:

- An individual or their legal representative must complete an application and submit the application to their local BDDS office to apply for HCBS waiver services.
- The individual or their legal representative is expected to participate in the completion of the following:
  - Application
  - Collateral information, including the following:
    - LOC assessment tool
    - Supporting documents:
      - Diagnostic evaluations
      - Functional evaluations
      - Psychological reports
      - Individualized Education Program from schools
      - School records
      - Physician's diagnosis and remarks
      - Existing evaluation done by Supplemental Security Income (SSI) or Vocational Rehabilitation
    - Intelligence Quotient (IQ) testing done at any time
      - Medicaid application for individuals more than 18 years of age
      - SSI application, if applicable
- LOC must be assessed for all individuals
- An individual must meet these requirements:
  - The state definition of a developmental disability found in *IC 12-7-2-61(a)*
  - ICF/IID LOC with substantial functional limitations as defined in *42 CFR 435.1010*
- If an individual completes the application and meets the LOC criteria listed in *Section 5.3: Initial Level of Care Evaluation*, they are placed on a waiting list using the individual's application date

Waiting List Targeting for a Family Supports Waiver Slot

For an individual to be targeted for an FSW, the following requirements must be met:

- Individuals are targeted for an FSW waiver slot from a single statewide waiting list using the individual's application date
- Individuals are targeted in the order they applied for services, from the oldest date of application to newest
- Individuals ages 18 through 24 who have aged out of, graduated from, or permanently separated from their school setting may be able to enter waiver services under the FSW upon that separation if funded slots are available

> *Note: Entrance into services under the CIH Waiver now occurs only by meeting and being approved for certain priority criteria known as reserved waiver capacity.*

Responsibilities of Individuals on a Waiting List

Individuals on a waiting list have the following responsibilities:

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

Section 5.5: Targeting Process for the Family Supports Waiver (FSW)

When a slot becomes available under the FSW, an individual on a single statewide waiting list will receive a letter from the BDDS Central Office, asking the individual to do the following:

- Accept or decline the waiver slot within 30 calendar days
- Apply for Medicaid if they haven't already done so
- Provide or obtain confirmation of their diagnosis from a physician on the *Confirmation of Diagnosis (State Form 54727),* available from the DDRS *Forms* page at in.gov/fssa/ddrs
- A response accepting or declining the waiver slot must be received by the state within 30 days.
- Individuals may be eligible to enter into FSW waiver services by meeting one of the specific priority criteria of the following reserved waiver capacity categories:
- Individuals ages 18 through 24 who have aged out of, graduated from, or permanently separated from their school setting may be eligible to enter waiver services under the FSW on that separation, if funded slots are available
- Eligible children who are either:
  - A child of an active member/veteran of the armed forces of the United States, defined in *IC 5-9-4-2*
  - A child of an active member/veteran of the National Guard

If an individual declines the offer for an FSW slot, their name is removed from a single statewide waiting list.

If an individual accepts the offer for an FSW slot:

- An "intake" meeting with a service coordinator from the local BDDS District Office is scheduled for the BDDS to complete the following:
  - Collateral information, provided by the individual, is reviewed.
  - LOC is again established.
- The individual and/or any legal guardian must obtain confirmation of the individual's diagnosis on a *Confirmation of Diagnosis (State Form 54727),* signed by the individual's physician within 21 calendar days from date of the letter.
- The individual and/or any legal guardian has 60 calendar days to apply for and obtain Medicaid if the individual does not yet have Medicaid coverage.
- If the individual already has Medicaid coverage, but the aid category to which the individual's Medicaid eligibility has been assigned is not compatible with waiver program requirements, they have 30 calendar days from the date on the contact letter from the BDDS to request that the DFR process the needed change in Medicaid aid category.
- The individual or guardian must cooperate fully with requests related to the application for Medicaid eligibility and any change needed in the Medicaid aid category.

After all assessments have been made, applicants under the age of 18 and their legal guardians are given a provider choice list by the BDDS containing providers of selective contracting case management services that are approved by the DDRS.

Because parental income is not factored into a minor receiving waiver services, proof of an approved POC/CCB may be required before some minors can obtain Medicaid eligibility. For that reason, the BDDS service coordinator creates an initial POC/CCB, although selection of a case management organization is still required. The case management organization is cited on the initial POC/CCB if the selection has been finalized but may also be added at a later date if necessary.

For adults, generating the case management choice list and choosing a selective contracting case management organization does not occur until after all eligibility criteria are met, including establishing Medicaid eligibility in a waiver-compatible aid category. Thereafter, the applicant or guardian (if applicable) completes the service planning process and chooses service providers for any other selected services, and the case manager submits a POC/CCB for waiver service.

BDDS issued the following interim guidance for the timely completion of requirements for the PCISP and CCB, which will be in place until implementation of the BDDS Portal 2.0 in 2022:

- Initial PCISPs are due 45 calendar days following the confirmation date of the Initial CCB at a minimum.
- Annual PCISPs are due on or before the start date of the plan year.
- Revisions to PCISPs are due within seven calendar days of the individualized support team (IST) meeting, face-to-face visit or conversation in which the desire or need for revision is identified. Updated PCISPs are required in any of the following situations:
  - When the needs or circumstances of the individual changes
  - When services are added or removed
  - When requested by the individual and/or legal representative
  - For nonannual team meetings to record team discussion on outcomes and any related plan changes
- Annual CCBs, also known as service plans, are due 45 calendar days prior to the end of the current plan year.

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

> *Note: Entrance into services under the CIH Waiver program now occurs only by meeting and being approved for certain priority criteria known as reserved waiver capacity.*

Section 5.6: Entrance into the Community Integration and Habilitation Waiver Program

Entrance into the HCBS CIH Waiver program requires the following:

- Individuals must meet and be approved for the specific priority criteria of at least one of the following reserved waiver capacity categories:
  - Eligible individuals transitioning to the community from a nursing facility (NF), Extensive Support Needs Home (ESN) or a State Psychiatric Hospital (SPH)
  - Eligible individuals determined to no longer need/receive active treatment in Supervised Group Living (SGL)
  - Eligible individuals transitioning from 100% state-funded services
  - Eligible individuals aging out of Indiana department of education facility/residential placement; the Indiana department of child services foster care; facility, residential or group home placement; or Indiana Medicaid Supervised Group Living
  - Eligible individuals choosing to leave an ICF/IID
  - Eligible individuals meeting one of the following emergency placement criteria:
    - Death of a primary caregiver when there is no other caregiver available
    - Caregiver over 80 years of age when there is no other caregiver available
    - Evidence of abuse or neglect in the current institutional or home placement
    - Extraordinary health and safety risk as reviewed and approved by the division director
- Individual, their legal representatives or other persons acting on the individual's behalf must request and apply for a priority waiver slot when it appears that the individual meets the specific criteria of one or more reserved waiver capacity categories.
- It is necessary to complete an application and submit the application to the local BDDS office to apply for HCBS waiver services.
- The individual and any legal guardian are expected to participate in completing the following:
  - Application
  - Collateral information, including the following:
    - LOC assessment tool
    - Supporting documents:
      - Diagnostic evaluations
      - Functional evaluations
      - Psychological reports
      - Individualized Education Programs from schools
      - School records
      - Physician's diagnosis and remarks
      - Existing evaluation done by Supplemental Security Income or vocational rehabilitation
      - IQ testing done at any time
    - Medicaid application for individuals over 18 years of age
    - Supplemental Security Income application, if applicable
- LOC must be assessed for all individuals.
- An individual must meet the following:

- The state definition of a developmental disability in *IC 12-7-2-61(a)*
- ICF/IID LOC with substantial functional limitations, as defined in *42 CFR 435.1010*
  - Additionally, if an individual meets the LOC criteria listed in *Section 5.3: Initial Level of Care Evaluation*, and a funded priority slot is available in the reserved waiver capacity category met by the individual, the BDDS office first determines whether other potential placement options have been exhausted before offering the slot to the individual.
  - Individuals are responsible for maintaining current collateral and contact information with their local BDDS office.

Application for a CIH Waiver Priority Slot

When application for a CIH Waiver priority slot is made, priority access by reserved waiver capacity category is made available only as long as available capacity exists for the current waiver year.

Responsibilities of Individuals Applying for a CIH Waiver Priority Slot

The responsibilities of an individual applying for a CIH Waiver priority slot are as follows:

- An individual or an individual's legal representative is expected to maintain current contact information with the individual's local BDDS office, including changes in address or telephone number
- If the BDDS attempts to contact an individual or the individual's legal guardian or the identified secondary contact person, and is unable to make contact by mail or telephone, the individual will forfeit the current opportunity for a CIH Waiver priority slot, but may reapply at any time

If an individual or their legal representative declines placement offered through a funded CIH Waiver priority slot, the individual's application for the CIH Waiver is denied.

If an individual or an individual's legal representative accepts placement through the offer of a funded CIH Waiver priority slot, an intake meeting with a service coordinator from the BDDS must occur. During the intake meeting, collateral information provided by the individual is reviewed and LOC is again established:

- A LOC assessment tool is completed.
- The allocation is recorded in the state's electronic case management system.

The individual or guardian must obtain confirmation of the individual's diagnosis on a *Confirmation of Diagnosis (State Form 54727)* signed by the individual's physician within 21 calendar days from the date on the BDDS letter offering a CIH Waiver priority slot.

The individual or guardian has 60 calendar days from the date on the BDDS letter to apply for and obtain Medicaid when the individual does not yet have Medicaid coverage.

If the individual already has Medicaid coverage, but the aid category to which the individual's Medicaid eligibility has been assigned is not compatible with waiver program requirements, they have 30 calendar days from the date on the contact letter from the BDDS to request that the DFR process the needed change in Medicaid aid category, if the applicant is eligible.

The individual or guardian must cooperate fully with requests related to the application for Medicaid eligibility and any needed change in Medicaid aid category.

After all assessments have been made, the BDDS gives applicants younger than the age of 18 and their legal guardians a choice list of case management providers that are approved by the DDRS and enrolled through the IHCP to provide selected contracting case management services. Due to the disregard of parental income for minors receiving waiver services, proof of a POC/CCB may be required before some minors can obtain

Medicaid eligibility. In those situations, the BDDS creates the POC/CCB, enabling the minor to obtain Medicaid. Otherwise, selection of a DDRS-approved provider of contracted case management services is required before the POC/CCB can be created. For adults, generating the BDDS case management organization choice list and selecting a case management organization does not occur until after all eligibility criteria are met, including establishing Medicaid eligibility in a waiver-compatible aid category. Thereafter, the applicant or guardian (if applicable) completes the service planning process and chooses service providers for any other selected services, and the case management provider submits a POC/CCB for waiver service.

BDDS issued the following interim guidance for the timely completion of requirements for the PCISP and CCB, which will place until implementation of the BDDS Portal 2.0 in 2022:

- Initial PCISPs are due 45 calendar days following the confirmation date of the Initial CCB at a minimum.
- Annual PCISPs are due on or before the start date of the plan year.
- Revisions to PCISPs are due within seven calendar days of the IST meeting, face-to-face visit, or conversation in which the desire or need for revision is identified. Updated PCISPs are required in any of the following situations:
  - When the needs or circumstances of the individual changes
  - When services are added or removed
  - When requested by the individual and/or legal representative
  - For nonannual team meetings to record team discussion on outcomes and any related plan changes
- Annual CCBs, also known as service plans, are due 45 calendar days prior to the end of the current plan year.

If the individual is unable to start CIH Waiver services within the given time frames, the individual may be removed from the process, resulting in the available CIH Waiver priority slot being offered to another individual in need of services.

The individual must work with the local BDDS office if additional time is needed to complete any required steps in the process.

Section 5.7: Initial Plan of Care/Cost Comparison Budget (POC/CCB) Development

The state monitors and recently enhanced its person-centered planning (PCP) process to ensure compliance with *CMS 2249-F* and *CMS 2296-F*. The new person-centered individualized support plan (PCISP) approach enhances the way in which supports and services are explained to individuals and families so that their needs, aspirations and opportunities for the achievement of self-determination, interdependence, productivity, integration and inclusion in all facets of community life can be identified and explored. Additionally, the PCISP drives the development of the POC/CCB. The PCISP is the new plan that identifies the array of services and supports, paid and unpaid from all sources that will be utilized to implement desired outcomes and ensure the individual's health and welfare while the POC/CCB identifies those supports and services which are funded by the waiver. The individual, case manager, selected providers and other persons chosen by the individual form the IST. The individual has the right and power to command and direct the entire PCISP process with focus on their preferences, aspirations and needs. The process empowers individuals to create life plans and direct the planning and allocation of resources to meet their self-directed life goals. The POC/CCB is developed by the individual-chosen case manager a minimum of six weeks prior to the initial start date of services and then six weeks prior to the end date of each annual service plan. The POC/CCB is routinely developed to cover a time frame of 12 consecutive months.

While the FSW is capped at $19,614 annually for each individual, budgeted amounts for POC/CCBs developed under the CIH Waiver use the objective-based allocation process described in *Section 6: Objective-Based Allocation*.

- Coordination of waiver services and other services is completed by the case manager. Within 30 days of implementation of the plan, the case manager is responsible for ensuring that all identified services and supports have been implemented as identified in the PCISP and the POC/CCB. The case manager is responsible for monitoring and coordinating services on an ongoing basis and is required to record a case note for each encounter with, or on behalf of, the individual. A formal 90-day review is also completed by the case manager using information received from the individual, family or guardian as applicable, and other IST members before, during and after the face-to-face visit or IST meeting. The IST is advised of any concerns or needs for updates that may require scheduling of additional team meetings by the case manager.
- Most waiver service providers are required to submit a quarterly report summarizing the level of support provided to the individual, based on the identified supports and services in the PCISP and the POC/CCB. As part of the 90-day review process, the case manager reviews these reports for consistency with the PCISP and POC/CCB and works with providers as needed to address findings from this review.

Section 5.8: State Authorization of the Initial POC/CCB

The case manager transmits the POC/CCB electronically to the state's waiver specialist, who reviews the POC/CCB and confirms that the individual is a current Medicaid member in one of the following categories:

- Aged (MA A)
- Blind (MA B)
- Low-income families (MA GF)
- Disabled (MA D)
- Disabled worker (MADW, MADI)
- Children receiving adoption assistance or children receiving federal foster care payments under *Title IV E – Sec 1902(a)(10)(A)(i)(I) of the Act* (MA 4, MA 8)
- Children receiving adoption assistance under a state adoption agreement – *Sec 1902(a)(10)(A)(ii)(VIII)* (MA 8)
- Independent foster care adolescents – *Sec 1902(a)(10)(A)(ii)(XVII)* (MA 14)
- Children under age 1 – *Sec 1902(a)(10)(A)(i)(IV)* (MA Y)
- Children age 1 to 5 – *Sec 1902(a)(10)(A)(i)(VI)* (MA Z)
- Children age 1 through 18 – *Sec 1902(a)(10)(A)(i)(VII)* (MA 9, MA 2)
- Transitional medical assistance – *Sec 1925 of the Act* (MA F)

Note that for the aged, blind or disabled in *Sec 1634* states such as Indiana:

- Supplemental Security Income (SSI)-eligible individuals will be automatically enrolled in the Indiana Health Coverage Programs (IHCP) and will not need to file a separate *Indiana Application for Health Coverage*. Members with SSI will be assigned to the new Modified Adjusted Gross Income (MAGI) eligibility aid category. Individuals deemed disabled by the Social Security Administration and who are receiving SSI based on that determination will not be required to undergo a separate determination of disability from Indiana's Medical Review Team (MRT).

- Individuals who receive Social Security Disability Income (SSDI) will not be required to undergo a separate determination of disability from Indiana's MRT. A financial eligibility review will still be required, so these individuals will need to complete the *Indiana Application for Health Coverage*.

The waiver specialist also confirms the following:

- The individual has a current ICF/IID LOC approval.
- The individual has been targeted for an available waiver slot.
- The individual's identified needs are addressed with a plan to assure their health, safety and welfare.
- The individual or guardian has signed, indicating acceptance of the POC/CCB, that they have been offered choice of DDRS-approved waiver service providers and that they have chosen waiver services over services in an institution.

The waiver specialist may request additional information from the case manager to assist in reviewing the POC/CCB.

If the waiver specialist approves the initial POC/CCB, the initial approval letter and signed Notice of Action (NOA) (*HCBS Form 5*) are electronically transmitted to the case manager, BDDS (for initial POC/CCBs only) and service providers. Within three calendar days of receiving the initial POC/CCB approval letter and NOA, the case manager must provide copies of the approval letter, signed NOA and addendum (containing information from the POC/CCB) to the individual or guardian. The individual's chosen waiver service providers are required to register so that they receive the NOA and the addendums electronically.

The Notice of Action (NOA)

The NOA serves as the official authorization for service delivery and reimbursement:

- If the waiver specialist approves the POC/CCB pending Medicaid eligibility or change of aid category (for minors only), disenrollment of a child from Hoosier Healthwise, facility discharge or other reasons, the pending approval letter is to be transmitted to the case manager, the BDDS and the service providers. The case manager must notify the individual or guardian within their calendar days of receipt of the pending approval and provide a copy of the initial approval letter naming the pending conditions. No NOA is generated until all pending issues are resolved and a final approval letter is released.
- If the waiver specialist denies the initial POC/CCB, a denial letter must be transmitted to the case manager, the BDDS (for initial and annual POC/CCBs only) and service providers. Within three calendar days of receipt of the denial, the case manager must provide a copy of the NOA (*HCBS Form 5*), the appeal rights as an HCBS waiver services recipient, and an explanation of the decision to deny to the individual or guardian. The case manager discusses other service options with the individual and guardian, unless the individual or guardian files an appeal.

> *Note: After waiver services begin, waiver individuals are sometimes referred to as "beneficiaries" or "members" for Medicaid purposes.*

Section 5.9: Initial Service Plan Implementation

An individual cannot begin waiver services under the FSW program or the CIH Waiver program before the approval of the initial POC/CCB by the state's waiver specialist. The initial POC/CCB represents the service plan identified for the individual resulting from the PCISP development process. If the waiver specialist issues an initial approval letter pending certain conditions being met, those conditions must be resolved before the start of the individual's waiver services. For applicants under the age of 18, if the individual's Medicaid eligibility is approved pending waiver approval, the case manager notifies the local DFR caseworker when the waiver has been approved. The DFR caseworker and waiver case manager coordinate

the Medicaid eligibility date and waiver start date. If Medicaid eligibility depends on eligibility for the waiver, the Medicaid start date is usually the first day of the month following approval of the POC/CCB.

If an individual is in a Hoosier Healthwise, Hoosier Care Connect or Medicaid managed care program, the case manager must contact the local DFR caseworker to coordinate the managed care program stop date and waiver services start date. Individuals receiving the IHCP hospice benefit do not have to disenroll from the hospice benefit to receive waiver services that are not related to the terminal condition and are not duplicative of hospice care. If applicable, the case manager and managed care benefit advocate must inform the individual and individual's parent or guardian of their options to ensure they make an informed choice.

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

Following discharge from the facility and within three calendar days after the individual begins waiver services, the case manager must complete the *Confirmation of Waiver Start* form in the Insite database and electronically transmit it to the state through the DDRS Insite database.

For all waiver starts, when the case manager completes the *Confirmation of Waiver Start* form in the Insite database and electronically transmits it to the DDRS database, the FSSA is also electronically notified to enter the individual's waiver start information in the Core Medicaid Management Information System (*Core*MMIS) database.

When the *Confirmation of Waiver Start* form is received electronically by the DDRS, the form is reviewed and, if accepted, an approval letter is automatically transmitted back to the case manager. The period covered by the initial POC/CCB is from the effective date of the confirmation form through the end date of the initial POC/CCB that was previously approved by the waiver specialist.

Within three calendar days of receiving the initial POC/CCB approval letter and signed NOA (*HCBS Form 5*), the case manager must provide copies of the approval letter, signed NOA and addendum (containing information from the POC/CCB) to the individual or guardian. The individual's chosen waiver service providers are required to register so they receive the NOA form and the Addendums electronically.

There is no reimbursement for services delivered before receipt of the NOA.

Section 6: Objective-Based Allocation

This section presents the objective-based allocation (OBA) methodology that the Family and Social Security Administration (FSSA) Division of Disability and Rehabilitative Services (DDRS) uses to determine the level of supports an individual needs to live in a community setting while receiving services under the Community Integration and Habilitation (CIH) Waiver.

Section 6.1: OBA Development

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

The development included baseline research, provider cost reporting, modeling, assessment validation, pilots and best practices. Modeling was used to determine the parameters for Algorithm development (Algo). As is further explained in *the following section*, the OBA is determined by combining the overall Algo (determined by the Inventory for Client and Agency Planning [ICAP] and the ICAP addendum), age, employment and living arrangement.

> *Note: The OBA methodology is not used with the already-capped Family Supports Waiver (FSW).*

Section 6.2: ICAP Assessment and Algo Level Development

The nationally recognized ICAP was selected to be the primary tool for individual assessment.

The ICAP assessment determines an individual's level of functioning for broad independence and general maladaptive factors. The ICAP addendum, commonly referred to as the behavior and health factors, determines an individual's level of functioning on behavior and health factors.

These two assessments determine an individual's overall Algo level, which can range from 0-6. Algos 0 and 6 are considered outliers, representing those who are the lowest and the highest on both ends of the functioning spectrum. Upon review, the state may manually adjust the designation of an individual from an Algo 5 to an Algo 6. Although this individual continues receiving the Algo 5 budget, the Algo 6 designation indicates a need for additional oversight of the individual.

The stakeholder group designed a building-block grid to build the allocations. The building-block grid was developed with the following tenets playing key roles:

- Focus on daytime programming
- Employment
- Community integration
- Housemates

The OBA's total allocation is then determined by combining the overall Algo (determined by the ICAP and ICAP addendum), age, employment and living arrangement.

It should be noted that for any individual who is living alone, the OBA is based on a shared living model. *Section 6.5: Budget Review Questionnaire and Budget Modification Request* addresses potential adjustments to the allocation amount.

Section 6.3: Algo Level Descriptors

Table 1 presents the Algo level descriptors as found in *Indiana Administrative Code 460 IAC 13*.

Table 1 – Algo Level Descriptors

Level	Descriptor
0 (Low)	Algo level zero (0): (A) high level of independence with few supports needed; (B) no significant behavioral issues; and (C) requires minimal residential habilitation services.
1 (Basic)	Algo level one (1): (A) moderately high level of independence with few supports needed; (B) behavioral needs, if any, can be met with medication or informal direction by caregivers through the Medicaid State Plan services; and (C) likely a need for day programming and light residential habilitation services to assist with certain tasks, but the individual can be unsupervised for much of the day and night.
2 (Regular)	Algo level two (2): (A) moderate level of independence with frequent supports needed; (B) behavioral needs, if any, can be met with medication or light therapy, or both, every one (1) to two (2) weeks; (C) does not require twenty-four (24) hours a day supervision; and (D) generally able to sleep unsupervised, but needs structure and routine throughout the day.
3 (Moderate)	Algo level three (3): (A) requires access to full-time supervision for medical or behavioral, or both, needs; (B) twenty-four (24) hours a day, seven (7) days a week staff availability; (C) behavioral and medical supports are not generally intense; and (D) behavioral and medical supports can be provided in a shared staff setting.
4 (High)	Algo level four (4): (A) requires access to full-time supervision for medical or behavioral, or both, needs: (i) twenty-four (24) hours a day, seven (7) days a week frequent staff interaction; and (ii) requires line of sight support; and (B) has moderately intense needs that can generally be provided in a shared staff setting.
5 (Intensive)	Algo level five (5): (A) requires access to full-time supervision with twenty-four (24) hours a day, seven (7) days a week absolute line of sight support; (B) needs areintense; (C) needs require the full attention of a caregiver with a one-to-one staff to individual ratio; and (D) typically only needed by those with intense behavioral needs, not medical needs alone.
6 (High Intensive)	Algo level six (6): (A) requires access to full-time supervision: (i) twenty-four (24) hours a day, seven (7) days a week; and (ii) more than a one-to-one staff to individual ratio; (B) needs are exceptional; (C) needs require more than one (1) caregiver exclusively devoted to the individual for at least part of each day; and (D) imminent risk of individual harming self or others, or both, without vigilant supervision.

Section 6.4: Translating Algo Level Into a Budget Allocation

Based on the Algo level, age and living arrangement, overall/total budget allocations have been established by taking a predetermined baseline from that Algo level group to calculate a dollar amount for each of three categories of funds:

- Other/Residential Habilitation and Support (RHS)*
- Behavioral Support Services (BMAN)
- Day services (DAYS)

While the calculation for the overall budget is calculated using the three categories, the way in which the allocation is spent is not dedicated to the buckets/categories. Individuals may use their total allocation with flexibility to support their community integration needs identified through the person-centered planning process.

After the ICAP and ICAP addendum assessments (described in *Section 6.2: ICAP Assessment and Algo Level Development*) are completed and the information is received by the state. Individuals in the CIH Waiver program and their support teams are required to review the information and ensure that it accurately reflects them. Upon completion of their review, individuals and their support teams are notified of their OBA through their case managers.

Individual teams may request a formal review of their allocations through their case managers. Teams are asked to review the ICAP and ICAP addendum and provide supporting documentation to substantiate an individual's need for placement in a different Algo level. The supporting documentation is reviewed, as are the PCISPs, behavior-support plans, risk plans and any other collateral documentation needed to analyze the individual's Algo level.

> **Note: RHS funding amounts come from the budget category referred to as "Other," because that category must also cover all other (non-BMAN and non-DAYS) services, such as environmental modifications, vehicle modifications, specialized medical equipment and supplies, personal emergency response systems, family and caregiver training, electronic monitoring, and so on, when and if these other services are selected by the individual and the individual support team (IST). While the total allocation is still established by using the three categories, these funds are no longer dedicated within specific categories.*

Table 2 shows an example of how the total budget allocation was derived for the categories of individuals 19-24 years of age not attending school and individuals over the age of 25, using the service hours defined in *460 IAC 13-5-2* and the rates that were in effect as of October 2017. The example below indicates the components of the allocation amounts, but the combination of an individual's living arrangement and Algo level determines which budget amount (Total Allocation) the individuals may use when selecting the services required to meet their needs. As explained in the additional information box above, the total allocation may now be used outside of the established categories.

Table 2 – Algo to Budget – Example

Annual OBA for Adults Ages 25 and Older (Using Rates Effective October 2017)
and for Young Adults Ages 19-24 NOT Attending School

Living With Family Example

Living Arrangement	Overall Algo	Overall Algo 1	Overall Algo 2	Overall Algo 3	Overall Algo 4	Overall Algo 5	Overall Algo 6**
BMAN Component	$ -	$2,620.80	$5,241.60	$7,862.40	$10,483.20	$ -	$10,483.20
DAYS Component	$11,025.00	$11,025.00	$11,025.00	$11,025.00	$18,900.00	$11,025.00	$18,900.00
Other/ RHS Services	$19,089.50	$28,634.25	$47,723.75	$56,133.35	$64,152.40	$1,908.95	$64,152.40
Total Allocation	$30,114.50	$42,280.05	$63,990.35	$75,020.75	$93,535.60	$12,933.95	$93,535.60

Living Alone Example

Living Arrangement	Overall Algo	Overall Algo 1	Overall Algo 2	Overall Algo 3	Overall Algo 4	Overall Algo 5	Overall Algo 6**
BMAN Component	$ -	$2,620.80	$5,241.60	$7,862.40	$10,483.20	$ -	$10,483.20
DAYS Component	$11,025.00	$11,025.00	$11,025.00	$11,025.00	$18,900.00	$11,025.00	$18,900.00
Other/ RHS Services	$24,816.35	$43,905.85	$62,548.59	$80,992.41	$88,209.55	$1,908.95	$88,209.55
Total Allocation	$35,841.35	$57,551.65	$78,815.19	$99,879.81	$117,592.75	$12,933.95	$117,592.75

Living With One Other or Sharing RHS Staff With One Other Example

Living Arrangement	Overall Algo	Overall Algo 1	Overall Algo 2	Overall Algo 3	Overall Algo 4	Overall Algo 5	Overall Algo 6**
BMAN Component	$ -	$2,620.80	$5,241.60	$7,862.40	$10,483.20	$ -	$10,483.20
DAYS Component	$11,025.00	$11,025.00	$11,025.00	$11,025.00	$18,900.00	$11,025.00	$18,900.00
Other/ RHS Services	$24,816.35	$42,500.97	$62,548.59	$88,209.55	$96,228.60	$1,908.95	$96,228.60
Total Allocation	$35,841.35	$56,146.77	$78,815.19	$107,096.95	$125,611.80	$12,933.95	$125,611.80

Living With Two Others or Sharing RHS Staff With Two Others Example

Living Arrangement	Overall Algo	Overall Algo 1	Overall Algo 2	Overall Algo 3	Overall Algo 4	Overall Algo 5	Overall Algo 6**
BMAN Component	$ -	$2,620.80	$5,241.60	$7,862.40	$10,483.20	$ -	$10,483.20
DAYS Component	$11,025.00	$11,025.00	$11,025.00	$11,025.00	$18,900.00	$11,025.00	$18,900.00
Other/ RHS Services	$24,816.35	$43,905.85	$62,548.59	$80,992.41	$88,209.55	$1,908.95	$88,209.55
Total Allocation	$35,841.35	$57,551.65	$78,815.19	$99,879.81	$117,592.75	$12,933.95	$117,592.75

Living With Three or More Others or Sharing RHS Staff With Three or More Others Example

Living Arrangement	Overall Algo	Overall Algo 1	Overall Algo 2	Overall Algo 3	Overall Algo 4	Overall Algo 5	Overall Algo 6**
BMAN Component	$ -	$2,620.80	$5,241.60	$7,862.40	$10,483.20	$ -	$10,483.20
DAYS Component	$11,025.00	$11,025.00	$11,025.00	$11,025.00	$18,900.00	$11,025.00	$18,900.00
Other/ RHS Services	$22,907.40	$41,042.43	$58,539.07	$75,379.07	$80,190.50	$1,908.95	$80,190.50
Total Allocation	$33,932.40	$54,688.23	$74,805.67	$94,266.47	$109,573.70	$12,933.95	$109,573.70

Structured Family Caregiving (SFC) Example

Living Arrangement	Overall Algo	Overall Algo 1	Overall Algo 2	Overall Algo 3	Overall Algo 4	Overall Algo 5	Overall Algo 6**
BMAN Component	$ -	$2,620.80	$5,241.60	$7,862.40	$10,483.20	$ -	$10,483.20
DAYS Component	$11,025.00	$11,025.00	$11,025.00	$11,025.00	$11,025.00	$11,025.00	$11,025.00
Other/ SFC Services	$18,932.55	$27,619.55	$37,547.55	$37,547.55	$37,547.55	$18,932.55	$37,547.55
Total Allocation	$29,957.55	$41,265.35	$53,814.15	$56,434.95	$59,055.75	$29,957.55	$59,055.75

*Note: The BMAN Component is reduced to $0.00 and the Total Allocation is reduced by the corresponding BMAN Component amount when the ICAP Addendum indicates there are **no** behavioral challenges.*

***Algo 6

Individuals who receive an Algo 6 are calculated at an Algo 5 base allocation. Algo 6 indicates a significant behavior, high-risk event or health need that requires additional oversight and support with frequent interaction by agents of the state. Algo 6 individuals will receive monthly face-to-face interaction with their case managers.

Section 6.5: Budget Review Questionnaire and Budget Modification Request

This section describes the Budget Review Questionnaire (BRQ) and the Budget Modification Request (BMR).

The BRQ

Applicable only to the CIH Waiver program, a BRQ is a set of qualifying questions, responses and supporting documentation used to determine why a budget review is necessary. The BRQ and responses are submitted by the individual's case manager based on information provided by the IST.

Adjustments to the allocation amount may also occur when the individual has a change in needs. The IST may request reviews of the assigned allocation through their case managers via a BRQ. The IST must first evaluate the needs of the individual who is receiving services and experiences a qualifying event.

A qualifying event is defined as one or more of the following events:

- The IST identifies that the individual's needs are not being met through shared staffing
- The individual completes their education
- The IST believes the Algo level is incorrect
- A health or medical condition prevents the individual from attending day programs
- The IST believes that the Wellness Coordination Health score is inaccurate and needs to be reviewed
- An individual's behavioral conditions change
- The IST believes the ICAP assessment has significant errors
- The IST believes the ICAP addenda (behavioral and health factors) are incorrect

Next, the IST must review the functional assessment findings and, if it finds that the individual needs increased support, provide the individual's case manager with supporting documentation to justify a review of the individual's budget allocation.

The waiver case manager must submit the BRQ to the Bureau of Developmental Disabilities Services (BDDS) with the following documentation based on the specific qualifying event:

- The IST identifies that the individual's needs are not being met through shared staffing.
  - An explanation of why it is not feasible for the individual to share staffing or live with housemates
- The individual completes their education.
  - A copy of certificate of completion or other documentation from school noting the final date for attendance
- The IST believes the Algo level is incorrect.
  - The IST's review of the ICAP assessment with detailed notes on areas needing reviewed
  - The medical and behavioral documentation needed to update the addendum
- Health or medical condition prevents the individual from attending day programs.
  - Documentation from a medical professional outlining why the condition negates a day program, the duration of the condition and risk factors to consider

- The IST believes that the Wellness Coordination Health score is inaccurate and needs to be reviewed.
  - Documentation from a medical professional outlining the change in condition or diagnosis, with an anticipated duration of the condition, risk factors to consider and any other special considerations
- An individual's behavioral conditions change.
  - A copy of the behavioral support plan
  - Monthly documentation supporting the change in condition(s)
  - Incident reports
- The IST believes the ICAP assessment has significant errors.
  - The IST's review of the ICAP assessment with detailed notes on areas needing reviewed
  - The medical and behavior documentation needed to update the addendum
- The IST believes the ICAP addenda (behavioral and health factors) are incorrect.
  - Documentation from a medical professional outlining the change in condition or diagnosis, with an anticipated duration of the condition, risk factors to consider and any other special considerations:
    - A copy of the behavioral support plan
    - Monthly documentation supporting the change in condition(s)
    - Incident reports

When requested, the BRQ and supporting documentation and information are reviewed by the Personal Allocation Review (PAR) Unit within the DDRS. The PAR Unit may request additional information from the case manager to support the BRQ and may allocate funding above the OBA determination for a period of up to 90 days while waiting for the additional documentation that is needed. If, after 90 days, the case manager fails to provide the requested additional information for the PAR Unit, the request to modify the individual's budget may be denied. However, when all needed supporting documentation is provided, the PAR Unit determines the individual's Algo score based on that information. If the individual's Algo level has changed, a new Algo and corresponding budget allocation is entered into the state's case management system. The PAR Unit will notify the waiver case manager of any changes in the Algo or allocation. An individual who is dissatisfied with the PAR Unit's determination may appeal the NOA within 33 days of the date of the notice. During an appeal, the BDDS maintains the budget from the last agreed-upon budget allocation. An individual or the individual's legal representative may appeal the Algo if they feel the Algo level is inaccurate. Refer to *Section 8: Appeal Process* in this module for additional information on appeals.

Refer to the *BDDS Procedure Budget Review Questionnaire (BRQ)* (#2015-002-DDRS) found on the *Current DDRS Policies* page at in.gov/fssa/ddrs for further guidance.

The BMR

The BMR allows individuals on the CIH Waiver to obtain additional funds for a short-term when the individual experiences an unanticipated event that requires a higher budget to meet their needs.

If the IST identifies one or more of the unanticipated events listed below that it believes increases the short-term needs of the individual, it shall contact the individual's waiver case manager to request a BMR. The individual's case manager is responsible for submitting the initial BMR. Upon receipt of a request from the IST, the waiver case manager should complete the BMR and attach all required documentation in the BDDS case management system. If approved, the increased budget shall not exceed 180 days.

BMRs must be filed within 45 calendar days of the event or status change

The following timeline for filing a BMR appears in the Budget Modification Request Timeline policy, effective April 3, 2017. Although providers, individuals and support teams do not have to follow this exact timeline, the process must be completed within 45 calendar days of the qualifying event:

- An event or status lasting longer than 14 consecutive days is eligible for BMR review by the PAR Unit.
- The provider notifies the individual's case manager of the identified status change within seven days of identification of a 14-consecutive-day event or status, resulting in a potential need for budget modification.
- The case manager coordinates and documents with the individual's IST of the proposed modification within 14 days of receipt of the notice from the identifying provider.
- The case manager collects and submits BMR information and request within 10 days of the meeting with the individual's team via the format and required documentation noted in the current BDDS data entry system.
- The individual's BDDS district office must provide an initial response to the team's BMR within seven days of receipt.
- The BDDS central office must provide an initial response within seven days of the district office's approval of the request.

Unanticipated events defined in the BMR policy include:

- Loss of a housemate due to:
  - Death
  - Extended hospitalization of 14 or more days
  - Nursing facility respite stay of 14 or more days
  - Incarceration of 14 or more days
  - Substantiated abuse, neglect or exploitation
  - Needed intervention for behavioral needs
  - Needed intervention for health or medical needs
  - Inability to share staffing
- Loss of employment
- State substantiated abuse, neglect or exploitation
- Behavioral needs requiring intervention
- Extraordinary health or medical needs requiring intervention

Documentation requirements for BMRs include, but are not limited to, the following:

- For BMRs resulting from needed intervention for behavioral needs, documentation should include the following:
  - Documentation of behavior data for past 30 to 90 days
  - Documentation regarding changes to the individual's behavior plan that have already occurred prior to the submission of the BMR

> *Note: If the IST anticipates that the behaviors will last longer than 90 days, the waiver case manager should complete a BRQ instead of the BMR.*

- For BMRs resulting from a loss of a housemate, the IST should provide documentation that includes the following:
  - A schedule identifying when each service is being used, including non-RHS services activities
  - A plan with strategies that the IST will use to find a new housemate

- The documentation must demonstrate the alternative support options the IST considered before making the submission. The following is a non-exhaustive list of potential alternative support options:
  - Shared staffing with housemates
  - Electronic monitoring services
  - Medicaid prior authorization (PA) services
  - Family and community supports

The waiver case manager may submit an additional BMR with supporting documentation and ongoing status reports on a month-to-month basis, not to exceed a period of 180 days from the initial unanticipated event if a short-term budget is required after 90 days.

An email notification is sent to providers when new BMRs are submitted by case managers. The notification is sent to the NOA email address of record for the provider and contains the *Health Insurance Portability and Accountability Act* (HIPAA) name of the individual, the service the provider is currently authorized to provide, the month and year the BMR is intended to cover, and the associated Cost Comparison Budget.

The BDDS responds to new BMRs within seven business days of submission. Final decisions on BMRs are not made until case managers respond to all inquiries from the BDDS.

The individual or legal guardian has the right to appeal any waiver-related decision of the state within 33 calendar days of NOA. An NOA is issued with the release of each state decision pertaining to a plan of care/cost comparison budget (POC/CCB). Each NOA contains the individual's appeal rights, as well as instructions for filing an appeal. Refer to *Section 8: Appeal Process* in this module for additional information on appeals.

For further guidance, see the following BDDS policies and procedures found on the *Current DDRS Policies* page at in.gov/fssa/ddrs:

- *Budget Modification Request (BMR)* (#2015-001-DDRS)
- *Budget Modification Request Timeline* (#2017-03-B-001)
- *Retroactive Budget Modification Requests* (#2017-03-B-002)

Note: The BRQ and BMR processes are not used with the already capped FSW.

Section 6.6: Implementation of Objective-Based Allocations

The case manager for each individual participating in the CIH Waiver program receives the new OBA three months before the individual's annual renewal date. The case manager must review the OBA with the individual and the individual's IST prior to the development of a new annual service plan. If there has been a significant change in the life of the individual, with agreement of the IST, the case manager is responsible for requesting a BRQ (see *Section 6.5: Budget Review Questionnaire and Budget Modification Request*).

Note: The OBA is not used with the FSW.

Section 6.7: Personal Allocation Review (PAR) and the Appeal Process

Applicable only to individuals in the CIH Waiver program, an IST may request a PAR through the case manager via a BRQ. The BRQ states the reason for allocation review. The full list of acceptable reasons for allocation review is found in *Section 6.5: Budget Review Questionnaire and Budget Modification Request*, and examples include:

- The IST believes the Algo level is incorrect
- The IST believes the ICAP assessment has significant errors
- The IST believes the ICAP addenda (behavioral and health factors) are incorrect

The BRQ is submitted by the case manager to the BDDS. The BRQ, supporting documentation and information are reviewed by the PAR Unit within the DDRS. The PAR Unit determines whether an individual's Algo score is supported based on the provided information. The BDDS reviews the BRQ within seven business days of submission.

If additional documentation is needed, the PAR Unit may request that the individual's case manager submit additional information to support the BRQ. If, after 90 days, the case manager fails to provide the requested additional information, the PAR Unit shall deny the request to modify the individual's budget allocation.

If the documentation provided with the BRQ is complete, the PAR Unit shall determine an individual's budget allocation and the duration of the budget allocation increase, and, if appropriate, determine a new Algo and budget allocation if it finds that the individual's Algo changed.

The PAR Unit will notify the waiver case manager of any changes in the Algo or allocation. If a change in the Algo score is appropriate, an Update POC/CCB must be submitted at the correct allocation level so that an NOA with appeal rights may be generated by the BDDS and distributed to the individual through the waiver case manager. If you question the indicated decision, you may discuss it with your case manager.

An individual who is dissatisfied with the PAR Unit's determination may appeal the NOA within 33 days of the date of the notice. During the appeal, the BDDS shall maintain the budget from the last agreed-upon budget allocation.

Note: PAR reviews are not available under the FSW.

The appeal process is located on the back pages of the NOA and is also described in *Section 8: Appeals Process* in this module.

Section 7: Monitoring and Continuation of Waiver Services

This section describes the different processes that occur to monitor and continue waiver services.

Section 7.1: Level of Care Reevaluation

The process for reevaluation of level of care (LOC) is the same as the initial evaluation process, except that a new confirmation of diagnosis form is no longer required for each reevaluation. The reevaluation is typically performed by the waiver case management organization (CMO), as opposed to being performed by Division of Disability and Rehabilitative Services (DDRS) Bureau of Developmental Disabilities Services (BDDS) staff. However, under specific circumstances, such as potential denials of LOC, tertiary reevaluations may be completed by BDDS staff or by the DDRS Central Office. Reevaluation is required at least annually, or as needed.

Family Supports Waiver (FSW) and Community Integration and Habilitation (CIH) Waiver program individuals must be reevaluated each year to meet the LOC for intermediate care facilities for individuals with intellectual disabilities (ICF/IID).

Only individuals who are Qualified Intellectual Disability Professionals (QIDP) as specified by the federal standard within *Code of Federal Regulations 42 CFR 483.430(a)*, may perform LOC determinations.

Section 7.2: Medicaid Eligibility Redetermination

The Family and Social Services Administration (FSSA) Division of Family Resources (DFR) is the group that determines eligibility for all Indiana social services programs. The DFR helps individuals determine which programs are right for them and their families. Individuals can learn more about the application process on the *Apply for Coverage* page at in.gov/medicaid/members.

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

As ongoing Medicaid eligibility is required for participation in the FSW and CIH Waiver programs, Home- and Community-Based Services (HCBS) providers must ensure the individuals served obtain/maintain Medicaid eligibility.

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

All individuals (also known as members) receiving waiver services must have a new plan of care/cost comparison budget (POC/CCB) approved at least annually. The new person-centered individualized support plan (PCISP) planning approach enhances the way in which supports and services are explained to individuals and families, so that their needs, aspirations and opportunities to achieve self-determination, interdependence, productivity, integration and inclusion in all facets of community life, can be identified and explored.

Additionally, the PCISP drives the development of the POC/CCB. The PCISP is the new plan that identifies the array of services and supports, paid and unpaid from all sources that will be utilized to implement desired outcomes and ensure the individual's health and welfare while the POC/CCB identifies those supports and services which are funded by the waiver. The individual, case manager and others of the individual's choosing form the individualized support team (IST). The individual has the right and power to

command and direct the entire PCISP process, with focus on their preferences, aspirations and needs. The process empowers individuals to create life plans and allows the individual to direct the planning and allocation of resources to meet their self-directed life goals. The annual POC/CCB is developed by the individual-chosen case manager a minimum of six weeks prior to the end date of each annual service plan. The POC/CCB is routinely developed to cover 12 consecutive months. The following apply to this process:

- Although the FSW is already capped at $19,614 annually, budgeted amounts for POC/CCBs developed under the CIH Waiver use the objective-based allocation process described in *Section 6: Objective-Based Allocation*.
- Coordination of waiver services and other services is completed by the case manager. Within 30 days of implementation of the plan, the case manager is responsible for ensuring that all identified services and supports have been implemented as identified in the PCISP and the POC/CCB. The case manager is responsible for monitoring and coordinating services on an ongoing basis and is required to record a case note for each encounter with the individual. A formal 90-day review is also completed by the case manager with the individual. The IST is advised of any concerns or needs for updates that may require scheduling of additional team meetings by the case manager.
- Most waiver service providers are required to submit a quarterly report summarizing the level of support provided to the individual based on the identified supports and services in the PCISP and the POC/CCB. As part of the 90-day review process, the case manager reviews these reports for consistency with the PCISP and POC/CCB, and works with providers as needed to address findings from this review.
- If an annual POC/CCB is not submitted or cannot be approved in a timely manner, the most recently approved POC/CCB is automatically converted to a new annual POC/CCB. The total cost and amount of services on the "auto-converted" or "default" POC/CCB is determined by the cost of services and supports appearing on the most recently approved but expiring POC/CCB. The auto-converted or default POC/CCB ensures that there is no loss of services for the member. The case manager is subsequently contacted and required to complete the annual person-centered planning process to update the PCISP and POC/CCB as needed.
- Risks are assessed during the PCISP process to help identify risks related to health*, behavior, safety and support needs for waiver individuals.

> **Note: For the CIH Waiver, when individuals have state-assessed health scores of 5 or higher and opt to utilize the waiver's Wellness Coordination services, healthcare needs and associated risks are separately assessed and monitored by a registered nurse (RN) or licensed practical nurse (LPN) employed by the individuals chosen Wellness Coordination provider agency. The RN/LPN, who must be actively involved in all IST meetings, develops a Wellness Coordination Plan specific to the assessed healthcare needs and risks, sharing the plan with the IST. As described in the service definition for Wellness Coordination services in Appendix C-1/C-3 of the CIH Waiver, the Wellness Coordinator's healthcare-related coordination and monitoring responsibilities vary according to the specified tier of Wellness Coordination services. However, as is true of all other waiver funded services, it is ultimately the responsibility of the waiver case manager to monitor and ensure that the Wellness Coordination activities occur as specified within the PCISP and POC/CCB.*

- The POC/CCB identifies the name of the waiver service, the name of the individual-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 POC/CCB.

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

The PCISP and POC/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 individual can request a change to the POC/CCB at any point, whether a new service provider or a change in the type or amount of service. If a change to the PCISP and/or the POC/CCB is determined necessary during that time, the individual and/or family or legal representative and IST will meet to discuss the change. The actual updating of the POC/CCB is completed by the case manager based on the individual and the IST discussion and determination.

Section 7.5: State Authorization of the Annual/Update Cost Comparison Budget (POC/CCB)

The case manager will transmit the POC/CCB electronically to the state's waiver specialist, who will review the POC/CCB and confirm the following:

- The individual is a current Medicaid member within one of the approved Medicaid Eligibility groups.
- The individual has a current ICF/IID LOC approval.
- The individual's identified needs will be met, and health and safety will be assured.
- The costs are consistent with identified needs of the individual and the services to be provided.
- Signatures indicate that the individual and/or guardian accepts the POC/CCB; has been offered choice of certified waiver service providers; and has chosen waiver services over services in an institution.

The waiver specialist may request additional information from the case manager to assist in reviewing the POC/CCB:

- If the waiver specialist denies the POC/CCB, a denial letter must be transmitted to the case manager and service providers. Within three calendar days of receipt of the denial, the case manager must provide a copy of a Notice of Action (NOA) (*HCBS Form 5*), the appeal rights as an HCBS waiver services recipient, and an explanation of the decision to deny to the individual or guardian.
- If the waiver specialist approves the POC/CCB, an approval letter and signed NOA are transmitted to the case manager, BDDS (for initial and annual POC/CCBs only) and service providers. The case manager notifies the individual or guardian within three calendar days of receipt of the approval and provides a copy of the approval letter, signed NOA and addendum (containing information from the POC/CCB).

Section 7.6: Service Plan Implementation and Monitoring

Case managers are responsible for the implementation and monitoring of the service plan (inclusive of the PCISP, POC/CCB, and often, other nonfunded services) and the individual's health and welfare.

- A minimum of one face-to-face contact between the case manager and the individual is required at least every 90 calendar days or as frequently as needed to support the individual. The case manager reviews current concerns, progress and implementation of the POC in addition to any risk assessment(s) incorporated in the PCISP to ensure the individual's needs are being met. Meetings may occur in the home of the individual or another location convenient to the individual. For

individuals living in a home owned or controlled by the waiver provider, there must be at least one unannounced visit in the home each year. IST meetings are now required at least semiannually, 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 remain at least every 90 days or more often as determined by the IST.

- A monitoring checklist is used by the case manager and IST to systematically review the status of the POC/CCB, the PCISP, any behavioral support program, the individual's choice and rights, medical needs, medications (including psychotropic medications if applicable), seizure management (if applicable), nutritional/dining needs, incident review, staffing issues, fiscal issues, risk plans and any other issues that may be identified in regard to the satisfaction and health and welfare of the individual. The checklist is also used to verify that emergency contact information is in place in the home, including the telephone numbers for Adult Protective Services or Child Protective Services and the Bureau of Quality Improvement Services (BQIS). Case managers educate the individual by offering examples of when the emergency contact numbers should be called.
- The case manager is required to enter a case note for each encounter (at least one per month) with the individual indicating the progress and implementation of the service plan. The case manager also maintains regular contact with the individual, family/guardian and the providers of services through home and community visits or by phone to coordinate care, monitor progress and address any immediate needs. During each of these contacts, the case manager assesses the service plan implementation and monitors the individual's needs.
- The monitoring and follow-up methods used by the case manager include conversations with the individual, the parent/guardian and providers to monitor the frequency and effectiveness of the services through team meetings and regular face-to-face and telephone contacts. The case manager asks:
  - Are the services being rendered in accordance with the POC?
  - Are the service needs of the individual being met?
  - Do individuals exercise freedom of choice of providers?
  - What is the effectiveness of the crisis and backup plans?
  - Is the individual's health and welfare being ensured?
  - Does the individual have access to nonwaiver services identified in the POC, including access to health services?
- At all times, full, immediate and unrestricted access to the individual data is available to the state, including the DDRS case management liaison position as well as other members of the DDRS executive management team and the FSSA Office of Medicaid Policy and Planning (OMPP).

Service Problems

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

- Case managers conduct a face-to-face visit with each individual at least every 90 calendar days to review and update the monitoring checklist, obtaining agreement of the IST for any needed updates
- Case managers investigate the quality of individual services and indicate whether there are any problems related to individual services not being in place. This information is recorded on the monitoring checklist. For each identified problem, the case manager identifies the time frame and person responsible for corrective action, communicates this information to the IST, and monitors to ensure that corrective action takes place by the designated deadline
- Case manager supervisors, directors or other identified executive management staff within each case management provider agency 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 every 90 calendar days, in conjunction with the monitoring checklist, case managers update the individual's PCISP progress notes to indicate whether all providers and other team members are current and accurate in their implementation of plan activities on behalf of the individual
- Any lack of compliance on the part of provider entities or other team members is noted within individual-specific case notes, flagged for follow up, and communicated to the noncompliant entity for resolution

Section 7.7: Interruption/Termination of Waiver Services

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

- Voluntarily withdrawals
- Chooses institutional placement
- Remains in a Medicaid-funded long-term care facility for more than 30 days
- Dies
- Needs services so substantial that the total cost of Medicaid services for the individual would jeopardize the waiver program's cost-effectiveness
- No longer meets ICF/IID LOC criteria
- Is no longer eligible for Medicaid services
- No longer requires home- and community-based services
- Is no longer intellectually or developmentally disabled

Other examples of circumstances appropriate for termination may include when the:

- Individual is convicted, sentenced and incarcerated for more than 30 days

Other examples of circumstances appropriate for interruption may include when the individual:

- Enters a Medicaid-funded long-term care facility for 30 days or less
- Engages in out of state travel that does not meet the standards for reimbursement of out of state home- and community-based waiver services as defined in BDDS policy
- Is arrested and remains in jail awaiting trial

Waivers may not be interrupted or terminated due to individual/family/guardian non-responsiveness without prior approval from BDDS.

For waiver terminations due to institutionalization or death, the termination Data Entry Worksheet (DEW) entered by the case manager and accepted by the state autogenerates the NOA.

Within three calendar days of a processed termination, the case manager must provide the individual or guardian with a copy of the NOA, the *Appeal Rights as an HCBS Waiver Services Recipient* instructions and an explanation of the termination. As appropriate, other service options are to be discussed with the individual and guardian.

Section 7.8: Waiver Slot Retention After Termination and Reentry

The following situations related to waiver slot retention after termination are contingent upon review and approval by the state:

- Upon review and approval of the state, if an individual who has been terminated from the waiver wishes to return to the program, they may do so within the same waiver year of their termination, if otherwise eligible. The individual shall return to the waiver without going on a waiting list.
  - "Within the same waiver year" means from July 16 through July 15 of the following year for both the FSW and CIH Waiver
- An individual who has been interrupted from the waiver program within the past 30 calendar days may resume the waiver with the same LOC approval date and the POC/CCB if the individual's condition has not significantly changed, and the POC/CCB continues to meet their needs. The following must occur:
  - The case manager must certify that the individual continues to meet LOC criteria
  - The case manager must complete a "Re-Start" DEW in the Insite database and submit it electronically into the DDRS case management database. The information will be reviewed by a waiver specialist and automatically transmitted to the OMPP to enter into the Core Medicaid Management Information System (*Core*MMIS) database.
- If an individual who has been terminated from the waiver program longer than 30 calendar days, wishes to return to the program, and is otherwise eligible, the following must occur:
  - The BDDS service coordinator determines a new "initial" LOC for the individual
  - The case manager is responsible for developing the POC/CCB following the same processes described in *Section 5.7: Initial Plan of Care/Cost Comparison Budget Development* minus the need for a new confirmation of diagnosis form. The case manager is to indicate a "Re-Entry" POC/CCB when electronically submitting the POC/CCB to the state waiver specialist via the DDRS case management database.
  - When the individual "re-enters" waiver services, the case manager must enter a Confirmation of Waiver Start form in the INsite database and electronically transmit it to the DDRS case management database. The information will be automatically transmitted to the OMPP to enter in the *Core*MMIS database.
  - When the Confirmation of Waiver Start form is received electronically by the DDRS, it is reviewed. After the form is received, reviewed and accepted, an NOA form will be automatically transmitted to the case manager and all the individual's waiver service providers.
  - Within three calendar days of receiving the Re-Entry POC/CCB approval letter, the case manager must provide copies of the approval letter, signed NOA and addendum (containing information from the POC/CCB) to the individual or guardian
- When an individual "reenters" waiver services:
  - If within 30 calendar days of terminating waiver services, the annual LOC and the POC/CCB dates remain the same dates as they were prior to the termination of waiver services
  - If more than 30 calendar days since terminating waiver services, the new LOC and the POC/CCB dates are used for determining when future annual LOC determinations and the POC/CCBs are due

If an individual interrupts or terminates waiver services within 30 calendar days of the end of the waiver year with the intention of returning to waiver services early in the next waiver year, the anticipated return to the waiver must occur within 60 calendar days of the next waiver year or the individual may lose their waiver slot and be required to reapply for services.

Section 7.9: Parents, Guardians and Relatives Providing Waiver Services

Parents, stepparents and legal guardians of waiver individuals who are minors (under the age of 18) may **not** receive payment for the delivery of any waiver funded service to the minor waiver individuals. Per *Section 4442.3.B.1* of the *State Medicaid Manual,* the Version 3.6 Instructions, Technical Guide and Review Criteria and *42 CFR 440.167*, all of which are published by the Centers for Medicare & Medicaid Services (CMS), this prohibition is based on the presumption that legally responsible individuals may not be paid for supports that they are ordinarily obligated to provide.

Other relatives (defined as follows and excluding spouses) may provide waiver services to waiver individuals when that relative is employed by or a contractor of a DDRS-approved provider.

Reimbursable waiver-funded residential habilitation services furnished to an adult waiver individual by a paid relative and/or legal guardian may not exceed a total of 40 hours a week per paid relative and/or legal guardian caregiver.

For all purposes pertaining to waiver-funded programs operated by the DDRS, "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:

- Aunt (natural, step, adopted)
- Brother (natural, step, half, adopted, in-law)
- Child (natural, step, adopted)
- First cousin (natural, step, adopted)
- Grandchild (natural, step, adopted)
- Grandparent (natural, step, adopted)
- Nephew (natural, step, adopted)
- Niece (natural, step, adopted)
- Parent (natural, step, adopted, in-law)
- Sister (natural, step, half, adopted, in-law)
- Spouse (husband or wife)
- Uncle (natural, step, adopted)

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

- The relative must be at least 18 years of age.
- The relative is employed by or a contractor of an agency that is approved by the DDRS to provide care under the waiver.
- The relative meets the appropriate provider standards (per *Indiana Administrative Code 460 IAC 6*) for the services being provided.
- The decision for the relative to provide services to a waiver individual is part of the PCISP planning process, which indicates that the relative (defined previously) is the best choice of persons to provide services from the DDRS-approved provider agency, and this decision is recorded and explained in the PCISP.
- There is detailed justification as to why the relative is providing service.

- The decision for a relative to provide services is evaluated periodically (for example, at least annually) to determine whether it continues to be in the best interest of the waiver individual.
- Payment is made only to the DDRS-approved Medicaid enrolled waiver provider agency in return for specific services rendered.
- The services must be rendered one-on-one with the individual or in shared settings with group sizes allowable per specified waiver service definitions and documented as acceptable by all relevant ISTs.
- Authorization for shared or group services must be documented in the approved NOA for each group individual. With the exception of groups of waiver individuals as noted previously, the relative (defined above) may not be responsible for others (including their other children or family members) nor engaged in other activities while providing services.

Note: Regarding participant assistance and care (PAC) under the FSW and residential habilitation and support (RHS) under the CIH Waiver, reimbursable waiver funded residential habilitation services furnished to an adult waiver individual by a paid relative and/or legal guardian may not exceed a total of 40 hours a week per paid relative and/or legal guardian caregiver.

Section 8: Appeal Process

This section presents information about the appeal process and all that is involved, from beginning to end of the process. Note that changes were implemented within the appeals process, moving administrative law judge (ALJ) offices from the Family and Social Services Administration (FSSA) to a new Office of Administrative Law Proceedings (OALP). The ALJs are no longer employees of the FSSA. Appeals are now submitted and processed as outlined in Sections 8.1 through 8.18 below. Interested parties may review the new *OALP website* at in.gov/oalp. The new physical location of the OALP is:

Office of Administrative Law Proceedings
402 W. Washington St., Room W161
Indianapolis, IN 46204

Section 8.1: Appeal Request

The following pertain to requests for appeal:

- An appeal is a request for a hearing before an ALJ with the OALP. The purpose of an appeal is to determine whether a decision made by a service coordinator, waiver specialist, the Division of Disability and Rehabilitative Services (DDRS) Central Office, or other entities affecting the waiver applicant, waiver individual or provider was correct. An appeal request must be in writing and forwarded to the hearing authority.
- Notice of Action (NOA) (*HCBS Form 5*) is used to notify each Medicaid Home- and Community-Based Services (HCBS) applicant, waiver individual or prospective waiver individual of any action that affects their HCBS services, including:
  - Choice of HCBS as an alternative to institutional care
  - HCBS waiver service actions, including reduction, termination or denial of a service
  - Authorized services and service providers
  - NOAs generated for other reason such as the initial approval/denial of a service plan, updates to service plan, changes in allocation or objective-based allocation (OBA), eligibility/level of care (LOC) changes and/or other issues decisions impacting waiver participation, contain appeal rights.
    - Data Entry Worksheets (DEWs) related to the interruption, termination or withdrawal from HCBS waiver services may be appealed. Waivers may not be interrupted or terminated due to individual/family/guardian non-responsiveness without prior approval from BDDS. However, for waiver terminations due to institutionalization or death, the termination DEW entered by the case manager and accepted by the state autogenerates the NOA.
- Medicaid benefits related to HCBS waivers, including determinations regarding LOC may be appealed. The LOC Decision Letter contains a Right to Appeal Notice instructing the individual how to file an appeal when desired.
- Providers can find an explanation regarding an appellant's appeal rights and the opportunity for a fair hearing on the back of the NOA. *"Your Right to Appeal and Have a Fair Hearing"* advises the appellant (the petitioner) who may be an applicant, waiver individual, prospective waiver individual or provider, of their right to appeal and the timeliness requirements associated with the right to appeal. *"How to Request an Appeal"* provides instructions regarding the procedures that are necessary in the appeal process, including the right of the appellant to authorize representation by an attorney, relative or other spokesperson on behalf of the appellant.
- The case manager provides each individual and eligible prospective individual (as well as the individual's guardian or advocate, as appropriate) with a copy of the NOA along with an explanation of the right to appeal and to request a fair hearing.

- When the case manager generates the plan of care/cost comparison budget (POC/CCB) and the POC/CCB is authorized by the Bureau of Developmental Disabilities Services (BDDS), an NOA is generated and sent to the individual receiving HCBS waiver supports and/or the individual's legal representative. The NOA specifies any adverse determination (when the individual is denied the services or the providers of their choice, or when actions are taken to deny, suspend, reduce or terminate services). The NOA informs the individual (and the individual's guardian or advocate, as appropriate) of their right to appeal the determination and also advises the individual that services will be continued if they file the appeal in a timely manner. Appeals must be received by the FSSA within 33 calendar days of the decision date noted on the NOA.
- When a request for entrance into the Community Integration and Habilitation (CIH) Waiver or the Family Support Waiver (FSW) program is denied, the denial letter advises the applicant of their right to file an appeal with the OALP.
- Additionally, individuals of the CIH Waiver have the right to appeal the assessment used to determine the OBA amount. Individuals of the CIH Waiver have the right to appeal decisions of the Personal Allocation Review (PAR) unit, including decisions related to the budget review questionnaire (BRQ) and the budget modification request (BMR) described under *Sections 6.5: Budget Review Questionnaire and Budget Modification Request* and *6.7: Personal Allocation Review (PAR) and the Appeal Process* in this module.

Note: The FSW has a capped allocation that is not subject to appeal.

- Upon request, the case manager may inform the individual on how to prepare the written request for appeal and fair hearing, including assisting the individual in preparing the written request for an appeal. The case manager may inform the individual of the required time frames and the address for submission of the appeal, The case manager can also provide an opportunity to discuss the issue being appealed. However, due to conflict-free case management requirements, the case manager may not file an appeal or appear at an appeal hearing on behalf of a waiver individual or service provider unless the case manager is the Medicaid authorized representative noted on the waiver individual or service provider's record with the Division of Family Resources (DFR), as doing so could result in a conflict of interest.
- The request for an appeal and a fair hearing should be recorded in a case note by the case manager, as well as recorded at the OALP.

Section 8.2: Group Appeals

The following pertain to group appeals:

- The OALP may respond to a series of requests for hearings by providing group hearings, on similar questions or changes in federal or state law or regulation. Similarly, a group of individuals that wishes to appeal some aspect of policy may request to be heard as a group. If there is disagreement as to whether the issue is one of federal or state law, regulation, or the facts of an appellant's personal situation, OALP makes the decision as to whether the appeal may be included in a group hearing.
- The ALJ may limit the discussion in a group hearing to the sole issue under appeal. When an appellant's request for a hearing adds issues to the (sole) issue serving as the basis for the group hearing, the appeal is handled as an individual hearing. An appellant scheduled for a group hearing may choose to withdraw and be granted an individual hearing, even if the matter under appeal is limited to the sole issue involved in the group hearing.
- Policies governing the conduct of individual hearings are pertinent to group hearings. Each appellant (or authorized representative) is given full opportunity to present the case (or have an authorized representative present the case).

Section 8.3: Time Limits for Requesting Appeals

The following are time limits for requesting appeals:

- POC/CCB: The applicant for HCBS waiver supports, waiver individual or their legal guardian/authorized representative has the right to appeal any waiver-related decision of the state. An NOA is issued with the release of each state decision pertaining to a POC/CCB. Each NOA contains the appeal rights of the applicant/individual, as well as instructions for filing an appeal. The appeal must be received by the OALP within 33 calendar days of the NOA.
- OBA: The individual, or their legal guardian/authorized representative, has the right to appeal the OBA within 30 calendar days of the NOA. Each NOA contains the appeal rights of the individual, as well as instructions for filing an appeal.
- Developmentally Disabled (DD) eligibility: The applicant, individual or their legal guardian/authorized representative has the right to appeal DD eligibility within 15 calendar days of the decision. The decision letter will contain the appeal rights of the applicant/individual, as well as instructions for filing an appeal. Per *Indiana Code IC 12-11-1.1-1*, an individual must be found to have a developmental disability to qualify for BDDS services.
- Individuals with Intellectual Disabilities (IID) LOC: The applicant, individual or their legal guardian/authorized representative has the right to appeal LOC within 15 calendar days of the decision. The decision letter contains the appeal rights of the applicant/individual, as well as instructions for filing an appeal. Per *Code of Federal Regulations 42 CFR §441.301(b)(6)*, to quality for HCBS waiver services under the CIH Waiver or FSW administered by DDRS, an individual must be found to require the same state-defined level of care specified for admission/entrance to an intermediate care facility for individuals with intellectual disabilities (ICF/IID).
- Reserved Waiver Capacity (priority criteria): The applicant, individual or their legal guardian/authorized representative has the right to appeal a denial for entrance to the waiver via priority criteria within 18 calendar days of the decision. The decision letter will contain the appeal rights of the applicant/individual, as well as instructions for filing an appeal.

Section 8.4: The Hearing Notice

The OALP sends a notice acknowledging the appeal to the individual filing the appeal.

The Notice of Scheduled Hearing is then sent to all parties, which includes the individual (or the authorized representative, if applicable), and the service coordinator. The DDRS Central Office also receives a notice if the central office was involved in the decision.

The Notice of Scheduled Hearing

The Notice of Scheduled Hearing contains the following:

- Includes a statement of the date, time, place and nature of the hearing. In most cases, both budget-related and eligibility/LOC related hearings are conducted telephonically unless otherwise directed by the ALJ.
- Advises the appellant of the name, address and telephone number of the person to notify in the event it is not possible for them to attend
- Specifies that the hearing request may be dismissed if the appellant fails to appear for the hearing without good cause
- Specifies that the appellant may request a continuance of the hearing if good cause is shown
  - Request for a continuance must be submitted in writing

- Includes the appellant's rights, information and procedures to provide the appellant or authorized representative with an understanding of the hearing process
- Explains that the appellant may examine the case record prior to the hearing

The notice of scheduled hearing is sent so that it reaches both parties at least 10 calendar days before the hearing.

> *Note: Please contact the ALJ from OALP for all questions and issues related to scheduling a hearing. The DDRS and the BDDS cannot schedule hearings. Neither party is permitted to contact the ALJ prior to the scheduled hearing date to discuss specific information without the other party being included/notified.*

Section 8.5: Request for Continuance from the Appellant

A written request for a continuance is to be directed to the OALP. Good cause must exist for a continuance to be granted. "Good cause" is defined as a valid reason as determined by the ALJ for the appellant's inability to be present at the scheduled hearing.

Reasons a continuance may be granted under "good cause" include but are not limited to the following:

- Serious physical or mental condition
- Incapacitating injury
- Desire to obtain legal counsel
- Submission of additional exhibits for consideration
- A death in the family
- Severe weather conditions impacting hearing participation
- Schedule conflicts impacting availability of witnesses whose attendance is essential and unable to be obtained in any other way
- Other similar circumstances

An ALJ is not obligated to grant a continuance and will consider each case according to legal and case standards. If the ALJ determines there is good cause to grant a continuance, the hearing will be rescheduled at an agreed upon date between all involved parties. Only in rare cases will additional continuances be granted.

> *Note: Contact the OALP for all questions or issues related to scheduling a hearing; contact the OALP ALJ regarding continuances. The DDRS and BDDS cannot reschedule hearings. Neither party is permitted to contact the ALJ prior to the scheduled hearing date to discuss specific information without the other party being included/notified.*

Section 8.6: Review of Action

When an appeal request is received, a designated state staff within the appropriate units (BDDS service coordinator, DDRS Central Office or BDDS waiver unit) should review the proposed action to determine whether the proposed action is appropriate.

Upon request, the designated state staff is available and will hold an informal pre-hearing conference with the individual (or authorized representative) including an opportunity to review the evidence prior to the hearing. Individuals should be advised that an informal pre-hearing conference prior to the hearing is optional and in no way delays or replaces the administrative hearing. The conference may lead to an informal resolution of

the dispute. An administrative hearing must still be held unless the individual (or authorized representative) in writing withdraws the request for a hearing.

Section 8.7: Disposal of Appeal Without a Fair Hearing

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

- If, after review of the appellant's situation, the BDDS service coordinator and/or the case manager or the DDRS Central Office realizes that the proposed action or action taken is incorrect, adjusting action may be taken. The appeal process continues unless/until the appellant formally withdraws in writing.
- If the appellant wishes to withdraw the appeal, they are to be assisted by the BDDS service coordinator and/or the case manager or the DDRS Central Office in promptly notifying the OALP ALJ in writing of the decision. No pressure is to be exerted on the appellant to withdraw the appeal. The withdrawal must be acknowledged in writing and it is only with the receipt of a signed voluntary withdrawal statement from the appellant that the appeal is to be dismissed by the ALJ.
- An appeal may be dismissed when the appellant (or authorized representative), without good cause, does not appear at a scheduled hearing. Both parties will be notified of the appeal being dismissed by the OALP.

Section 8.8: The Fair Hearing

Regarding HCBS waiver services, an administrative hearing is a review of actions of a service coordinator, case manager, DDRS Central Office or BDDS waiver unit regarding issues relating to the FSW or the CIH Waiver. An ALJ, who is not an employee of the OALP is designated to hold the hearing and to issue findings of fact, conclusions of law, and a decision related to the appeal request.

A hearing allows the dissatisfied appellant an opportunity to present their issue and to describe the circumstance and needs in their own words. An attorney or another individual of his choice may represent the individual. A designated state staff within the appropriate units (BDDS service coordinator, DDRS Central Office or BDDS waiver unit) will attend the hearing and present evidence supporting the action under appeal.

Section 8.9: Preparation for Hearing by Appellant

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

- Upon request, have an informal pre-hearing conference to discuss the issue being appealed with the BDDS District representative, BDDS waiver unit (or authorized representative) or the DDRS Central Office representative.
- Upon request, examine the entire case file and all documents and records that will be used by the BDDS District representative, BDDS waiver unit representative or the DDRS Central Office representative at the hearing, noting that the state's appeal-related evidence is sent by the state to the appellant and their authorized representative, if applicable, prior to the hearing.
  - The state's appeal-related evidence is sent by the state to the appellant free of charge prior to the hearing. BDDS reserves the right to charge a nominal fee for additional records requests involving printing and mailing for records larger than 100 pages.
- The appeal notice informs the appellant of their right be represented by legal counsel at the appeal hearing.

Note: The state provides its exhibits to the individual or legal guardian prior to the hearing. Any other requests for copies of these exhibits must be submitted to the state at the time the appeal is requested and must include a signed release from the individual/appellant or legal guardian authorizing release of the exhibits to another party.

Additionally, the appellant is directed to submit their own exhibits to the state and the ALJ prior to the hearing within the time frame provided by the ALJ and using the format described by the ALJ. Failure to submit exhibits within 10 calendar days of the hearing may lead to a continuance of the scheduled hearing to allow all parties sufficient time to review all relevant documents. A decision for a continuance is at the sole discretion of the presiding ALJ, though both parties may request such consideration. It is expected that appellants who are submitting exhibits will bring copies of their own exhibits to the hearing for the ALJ and for the state.

*The appellant submits their exhibits as outlined in the Notice of Hearing. To submit exhibits, please follow instructions on the notice of hearing you have received by mailing, emailing or faxing your evidence to **OALP**.*

OALP
402 W. Washington St., E34
Indianapolis, IN 46204
Fax: (317) 232-4412
Email: fssa.appeals@oalp.in.gov

The appeal must be received by FSSA within 33 calendar days of the NOA decision date. For eligibility-related appeals, appellants submit their exhibits to:

Office of Administrative Law Proceedings
100 N. Senate Ave. Ste. N802
Indianapolis, IN 46204

The appeal must be received by FSSA within 15 calendar days of the eligibility decision date.

Section 8.10: Preparation for Hearing by the BDDS Service Coordinator or District Representative, BDDS Waiver Unit, or the DDRS Central Office

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

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

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

- Review all factors and issues that led to the action being appealed.
- Discuss the issue being appealed with the appellant (or representative) if at all possible, and definitely if a discussion is requested by the appellant. If requested, allow the appellant (or representative) to examine the entire case record.
- Identify and label all documents that are pertinent to the issue under appeal. The exhibits should be labeled in the lower right-hand corner, with the state's Exhibit beginning with Exhibit A. If more

than one page is in an exhibit, the pages are labeled (for the first page) *State's Exhibit A, page 1 of 2*; and (for page 2) *State's Exhibit A, page 2 of 2*. The next numbers continue for each page in the exhibit being presented. The subsequent exhibit would be labeled Exhibit B and the pages according to the number of pages. For example, if three pages are in an exhibit, the third page would be labeled:

State's Exhibit A, page 3 of 3

- Make one copy of labeled exhibits for the ALJ and one copy for the appellant (unless already given to the appellant). A duplicate copy of the notice sent to the appellant advising of the proposed action should be included as part of the documentation.
- Prepare a written outline that can be used as a tool in presenting the testimony at the hearing. Bear in mind when preparing the outline that the ALJ knows nothing about the situation. The outline or testimony should include:
  1) Identification of relevant statutes (state or federal) along with policies/procedures supporting the decision.
  2) Brief background of staff person presenting case including name, position and expertise when needed.
  3) Brief summary of the specific issue being appealed along with more expanded testimony regarding the state's decision, how it was reached, why it complies with statute/policy, and why it should be upheld.
  4) Staff should be prepared to answer questions related to the case proposed by both the ALJ and the appellant.
- Include the labeled exhibits at the appropriate point in the presentation outline.

Section 8.11: Conduct of the Hearing

The ALJ conducts the hearing. The appellant and the appropriate state representative have the opportunity to:

- Present the case or have it presented by legal counsel or another person
- Present testimony of witnesses
- Introduce relevant documentary evidence
- Establish all pertinent facts and circumstances
- Present any arguments without interference
- Question or refute any testimony or evidence presented by the other party, including the opportunity to confront and cross-examine any adverse witnesses
- Examine the appellant's entire case record and all documents and records used by the BDDS service coordinator or other District representative, the DDRS Central Office, or the BDDS waiver unit at the hearing

The parties are advised at the close of the hearing that they will be informed in writing of the ALJ's decision. They are also informed of any subsequent appeal rights

> *Note: See Section 8.9: Preparation for Hearing by Appellant and Section 8.10: Preparation for Hearing by the BDDS Service Coordinator or District Representative, BDDS Waiver Unit, or the DDRS Central Office in this module. The state shall ensure that the appellant receives the state's exhibits and the appellant shall ensure that the state receives any exhibits submitted by the appellant prior to the day of the hearing. As directed in the hearing notice and in most cases, exhibits should be submitted at least 10 calendar days prior to the scheduled hearing.*

Section 8.12: Continuance of Hearing

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

Section 8.13: The Hearing Record

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

Section 8.14: The Fair Hearing Decision

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

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

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

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

Unless an Agency Review is requested, the decision of the ALJ shall be binding upon the DDRS or the Office of Medicaid Policy and Planning (OMPP) and is to be enacted.

Section 8.16: Agency Review

Any party may request an Agency Review if dissatisfied with the decision made by the ALJ. The Agency Review request must be made in writing to the FSSA's OALP or the ultimate agency authority, within 10 calendar days following receipt of the hearing decision.

- After an Agency Review is requested, the OALP or the ultimate agency authority will write to all parties to acknowledge receipt of the request and to provide information concerning the review.

- No new evidence will be considered during the Agency Review; however, any party may submit a written Memorandum of Law, citing evidence in the record, for consideration.
- The Secretary of the FSSA or the Secretary's designee shall complete the agency review. The decision made at the Agency Review will be sent to all appropriate parties.

Section 8.17: Judicial Review

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

Section 8.18: Lawsuit

If a lawsuit is filed, all inquiries should be directed to the FSSA OGC or the Attorney General's Office.

Section 9: Bureau of Quality Improvement Services

Section 9.1: Overview

Within the Family and Social Services Administration (FSSA) Division of Disability and Rehabilitative Services (DDRS), the Bureau of Quality Improvement Services (BQIS) is responsible for developing and implementing quality improvement and quality assurance systems to assure the health and welfare of individuals receiving Medicaid Home- and Community-Based Services (HCBS) waiver services. The BQIS activities include developing policy, conducting provider compliance reviews, investigating complaints, reviewing mortality, and managing the state's automated system for reporting incidents of abuse, neglect and exploitation. Information about the BQIS can be found on the *DDRS Bureau of Quality Improvement Services* page at in.gov/fssa/ddrs, under Programs & Services.

Section 9.2: Incident Reports

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

- Alleged, suspected or actual abuse, neglect or exploitation of an individual
  - This event includes physical, sexual, emotional/verbal and domestic abuse. An incident in this category must also be reported to Adult Protective Services (APS) or Child Protection Services (CPS), as applicable. The provider will suspend staff involved in an incident from duty, pending investigation by the provider.
- Peer-to-peer aggression that results in significant injury
- Death of an individual
  - A death shall also be reported to APS or CPS, as applicable. If death is a result of alleged criminal activity, the death must be reported to law enforcement
- Structural or environmental issues with a service delivery site that compromise the health and safety of an individual; fire that jeopardizes or compromises the health or welfare of an individual
- Elopement of an individual that results in evasion of required supervision as described in the PCISP, as necessary for the individual's health and welfare
- Missing person, when an individual wanders away and no one knows where they are
- Alleged, suspected or actual criminal activity by a staff member, employee, agent of a provider or an individual receiving services
- An emergency intervention for an individual resulting from a physical symptom, a medical or psychiatric condition, or any other event
- Injury to an individual when the origin or cause of the injury is unknown, and the injury requires medical evaluation or treatment
- A significant injury to an individual, including but not limited to:
  - A fracture
  - A burn greater than first degree
  - Choking that requires intervention

  - Bruises or contusions larger than three inches or lacerations requiring more than basic first aid
  - Any puncture wound penetrating the skin
  - Any pica ingestion requiring more than first aid
- A fall resulting in injury, regardless of severity of the injury
- A medication error, except for refusal to take medications, including the following:
  - Medication given that was not prescribed or ordered for the individual, or wrong medication
  - Failure to administer medication as prescribed, including an incorrect dosage, missed medication, wrong route, and failure to give medication at the appropriate time
  - Medication error that jeopardizes an individual's health and welfare and requires medical attention
- Use of any aversive technique, including but not limited to:
  - Seclusion
  - Painful or noxious stimuli
  - Denial of a health-related necessity
  - Other aversive technique identified by the DDRS policy
- Use of any PRN (as needed/when necessary) medication related to an individual's behavior
- Use of any physical or mechanical restraint, regardless of whether it was planned, was approved by a human rights committee (HRC) or there was informed consent

View the full *Policy on Incident Reporting and Management* at in.gov/fssa. Additional information about incident reporting is available on the *BQIS Incident Reporting* at in.gov/fssa/ddrs.

Section 9.3: Complaints

Any individual, guardian, family member, service provider or community member has the right to file a complaint on the behalf of an individual receiving supports or services through the FSW or CIH Waiver:

- The BQIS quality vendor is responsible for operating the BQIS Complaint System for individuals receiving Supportive Living Services from the FSW or CIH Waiver.
- By definition, complaints are broad in type and scope and can be specific to either one individual, a group of individuals or a provider. The DDRS does not intend for complaints to replace any of the waivers' primary systems established to routinely monitor and assure individuals' health and welfare, specifically the state's case management and incident reporting systems. Instead, the complaint system is meant to provide individuals, their families/guardians, providers and community members an additional venue for identifying and addressing issues when day-to-day monitoring activities have been, or appear to be, ineffective in assuring an individual's health and safety.
- To give the system an opportunity to work, the BQIS encourages complainants with individual-specific issues, who have not already done so, to approach their case managers to try and resolve the issue first. If this has not produced the desired outcome, the complainant can contact the BQIS again to file a complaint. When requested, complainants can choose to be anonymous.
- The BQIS quality vendor reviews and categorizes all initial complaints as *urgent or critical*, and assigns a complaint investigator to investigate the case within specified time parameters. Certain circumstances may require the BQIS to contact APS, DCS, local law enforcement and/or the provider to take immediate measures to assure the individual's health and welfare.
- It should be noted that the BQIS quality vendor conducts most activities related to complaint investigations on an unannounced basis. Some activities, such as interviews with individuals who may have information regarding the issue but are not directly employed by the entity the complaint

is against, sometimes require advanced scheduling to ensure those individuals are available. Depending on the nature of the complaint, investigation activities may include:

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

When complaint allegations are found to be in violation of IAC, the BQIS quality vendor sends the provider a corrective action plan (CAP) to remedy the situation. In rare cases in which the issue was already discovered and corrected by the provider prior to any investigation by the quality vendor, a CAP may not be required. In these cases, the quality vendor would verify the implementation of the corrective action the provider implemented to ensure that the issue is appropriately resolved. To obtain specific information related to the investigation process, providers may refer to the *Policy on BQIS Complaints Supported Living Services & Supports* at in.gov/fssa.

Currently, complaints can be filed via email at *BQIS.Help@fssa.in.gov* or through the BQIS toll-free telephone number at 866-296-8322.

Section 9.4: Mortality Reviews

The BQIS is responsible for conducting mortality reviews for all deaths of individuals that received the Bureau of Developmental Disabilities Services (BDDS) services, regardless of service setting. Providers are required to report all deaths through the Incident Reporting System:

- The BQIS quality vendor is responsible for conducting the mortality review process, which begins when the BQIS Mortality Review Triage Team (MRTT) requests and reviews medical history and other related documentation for all deceased individuals. Reviews involve discussion of events prior to the death, supports/services in place at the time of death, documentation received, whether additional documentation is needed for review, and whether the death should be presented to the Mortality Review Committee (MRC) as a focus case for further review and discussion. Any death can be brought before the MRC for discussion at the request of the members, the BQIS director or other DDRS staff that has a concern.
- The MRC is facilitated by the BQIS quality vendor. Committee members include representatives from APS, the Indiana State Department of Health (ISDH), Indiana Disability Rights, the Office of Medicaid Policy and Planning (OMPP), the statewide waiver ombudsman, BDDS field service staff and community advocates.
- Based on their discussion, the MRC makes recommendations for systemic improvements, such as developing new DDRS policy, revising policy, training, or the development and sharing of critical service area fact sheets and posting to the BQIS webpage. The MRC also makes provider-specific recommendations that are included in the closure letter from the MRC.
- The MRTT and/or the MRC can refer a case to BQIS for a mortality investigation to review key areas of a provider's system that appear to have not been in place or to have been ineffective at the time of an individual's death. Providers may be required to develop CAPs to address identified issues and to prevent other individuals from experiencing negative outcomes.
- See the *Policy on Mortality Review* at in.gov/fssa for further information regarding mortality reviews and the MRC.

Section 9.5: National Core Indicator (NCI) Project

The DDRS participates in the National Core Indicator (NCI) Project. This national research project, administered through the Human Services Research Institute and the National Association of State Developmental Disabilities Directors (NASDDDS), was developed to obtain a standardized set of

consumer outcome measures for community-based services. NCI Project information is designed to be captured through face-to-face consumer satisfaction interviews. The BQIS quality vendor conducts these interviews across the state with individuals selected based on representative random samples from each DDRS waiver. Participation in this project allows the DDRS to make comparisons with other states providing waiver services across the country.

Section 9.6: Case Record Reviews

The BQIS is responsible for conducting case record reviews (CRRs) on files for individuals who receive HCBS waiver services to ascertain case manager compliance with *460 IAC 7* and the FSW and CIH Waiver. Based on the requirement that the service plan is centered around the individual's needs and preferences using person-centered services that support them and their families in living their defined best life, Case record reviews include:

- Review of the person-centered individualized support plan (PCISP) to ensure it reflects what is important to and for the individual in each completed Life Domain
- Risk assessment (embedded in PCISP) is demonstrated by information included in the appropriate Life Domain
- Identified risk plans are attached to PCISP and have been reviewed/updated during the service plan year
- Nonwaiver services or choice to not receive intermediate care facility for individuals with intellectual disabilities (ICF/IID) Medicaid services is documented on the BDDS Signature Page/Freedom of Choice Section
- Signed pick lists (provider choice lists) for each service is documented
- An updated PCISP was completed when an individual's conditions or circumstances changed

Reviews are conducted on a monthly basis using a waiver-specific valid random sampling methodology.

Section 9.7: Quality On-Site Provider Review

To evaluate services, BQIS has created the Quality On-Site Provider Review, or QOPR. This process includes an on-site review and evaluation of the quality of services being delivered to individuals receiving waivers. While BQIS will continue to review compliance with Medicaid rules (e.g., qualified provider, employee background checks and training), the state will also talk directly to individuals to make sure they are receiving person-centered quality services. Detailed information related to the QOPR, including an overview video, individual and organizational indicators, and information sheets can be found on the *DDRS Bureau of Quality Improvement Services* page at in.gov/fssa/ddrs.

For ease of reference, the *Provider Information Sheet* contains the following:

> **What is the Quality On-Site Provider Review?**
> The Bureau of Quality Improvement Services is using the Quality On-Site Provider Review to ensure the quality of the home and community-based (waiver) services individuals receive. These person-centered services should empower the individual to live, love, learn, work, play and pursue their dreams.
>
> **What is the Quality On-Site Provider Tool?**
>
> The tool is organized around the Charting the LifeCourse domains and includes indicators which will support BQIS in determining if individual outcomes are being achieved as well as provider compliance with the HCBS Settings Rule. The Quality On-Site Provider Review has two sets of indicators. One set is used to assess a provider's systems to support people to have their best life. The second set of

indicators is used in conversations with individuals supported by the provider. Each indicator is given a rating: disagree, met, strongly agree, not observed.

What can we expect of the process?
To assess service delivery, the Quality On-Site Provider Review process will include a two-day, on-site review conducted by a quality reviewer. They will have conversations with individuals, support staff, supervisors and management. They'll also review key documents to ensure provider standards are being met.

How will I know the result of the Quality On-Site Provider Review?
The review will include a wrap-up meeting to discuss the results and an opportunity for the provider to request technical assistance and training regarding any of the review. BQIS want to ensure that you have the tools you need to be successful. A final report will summarize the review.

What if I have questions about the Quality On-Site Provider Review?
You are welcome to contact BQIS:
BQIS.Help@fssa.IN.gov
800-545-7763

Section 9.8: Statewide Waiver Ombudsman

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

- Complaints may be received via the toll-free number 800-622-4484, via email, in hard-copy format or by referral.
- Types of complaints received include complaints initiated by families and/or individuals involving rights or issues of individual choice, and complaints requiring coordination between legal services, administrating agency services and provider services.
- The ombudsman is expected to initiate contact with the complainant as soon as possible after the complaint is received. However, precise timelines for the final resolution of each complaint are not established. Although it is expected that the ombudsman will diligently and persistently pursue the resolution of each complaint determined to require investigation, it is recognized that circumstances surrounding each investigation vary.
- Time frames 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. Although the statewide waiver ombudsman is considered "independent" by statute, the DDRS director is responsible for oversight of the ombudsman.
- With the consent of the waiver individual, the ombudsman must be provided access to the individual records, including records held by the entity providing services to the individual. When it has been determined the individual is not capable of giving consent, the statewide waiver ombudsman must be provided access to the name, address and telephone number of the individual'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 their activities among the programs that provide legal services for individuals with an intellectual/developmental disability, the

administrative agency, providers of waiver services and providers of other necessary or appropriate services, and ensures that the identity of the individual will not be disclosed without either the individual's written consent or a court order.

- At the conclusion of an investigation of a complaint, the ombudsman reports the ombudsman's findings to the complainant. If the ombudsman does not investigate a complaint, the ombudsman notifies the complainant of the decision not to investigate and the reasons for the decision.
- The statewide waiver ombudsman prepares a report at least annually (or upon request), describing the operations of the program. A copy of the report is provided to the governor, the legislative council and the director of the DDRS. Trends are identified so that recommendations for needed changes in the service delivery system can be implemented.
- The administrative agency is required to maintain a statewide toll-free telephone line continuously open to receive complaints regarding waiver individuals with intellectual/developmental disabilities. All complaints received from the toll-free line must be forwarded to the statewide waiver ombudsman, who will advise the individual that the complaint process is not a prerequisite or a substitute for a Medicaid fair hearing when the problem falls under the scope of the Medicaid fair hearing process.
- A person who does any of the following commits a Class B misdemeanor:
  - 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
  - Knowingly or intentionally retaliates against an individual, a client, an employee or another person who files a complaint or provides information to the ombudsman

Section 10: Service Definitions and Requirements

Section 10.1: Service Definition Overview

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

- A description of the service
- A list of reimbursable (allowable) activities for the service
- Service standards
- Documentation standards
- Limitations
- A list of activities not allowed
- Provider qualifications
- In some cases, additional information or clarifications that are unique to the service

By March 17, 2023, all services will be compliant with the HCBS Final Rule settings requirements as outlined in *Indiana Statewide Transition Plan* at in.gov/fssa/ddrs.

> *Note: Indiana Health Coverage Programs (IHCP) members can incur a transfer of property penalty while receiving services, including from nursing facilities, other medical institutions where members receive equivalent nursing facility services, HCBS and the following waiver programs:*
>
> *• Aged and Disabled (A&D)*
>
> *• Community Integration and Habilitation (CIH)*
>
> *• Family Supports Waiver (FSW)*
>
> *• Traumatic Brain Injury (TBI)*
>
> *Claims submitted for these services during a member's transfer of property penalty period will be denied.*
>
> *The transfer of property penalty is a period during which a member who is transferring assets will be ineligible for Medicaid services, as required by federal guidelines.*
>
> *Providers can determine whether a member is in the transfer of property penalty period using either the IHCP Provider Healthcare Portal (Portal) or electronic data interchange (EDI). For more information, refer to IHCP Banner Page BR201931.*

Section 10.2: Medicaid Waiver Services, Codes and Rates

Table 3 contains Healthcare Common Procedure Coding System (HCPCS) procedure (billing) codes and modifiers, as well as unit rates.

Table 3 – Medicaid Waiver Services, Codes and Rates for FSW and CIH Waiver, Effective July 1, 2021, or as Noted

FSW	CIH	INsite Code	Service Description	HCPCS Code	Modifiers	Rate	Unit/ Size	Unit/$ Limit
Yes	Yes	ADS1	Adult Day Services, Level 1	S5101	U7 U5 U1	$26.28	0.50/Day	2 Units/Day
Yes	Yes	ADS2	Adult Day Services, Level 2	S5101	U7 U5 U2	$34.47	0.50/Day	2 Units/Day
Yes	Yes	ADS3	Adult Day Services, Level 3	S5101	U7 U5 U3	$41.04	0.50/Day	2 Units/Day
Yes	Yes	AS14	Adult Day Services, 1/4 Hour, Level 1	S5100	U7 U5 U1	$1.65	0.25/Hour	16 Units/Day
Yes	Yes	AS24	Adult Day Services, 1/4 Hour, Level 2	S5100	U7 U5 U2	$2.15	0.25/Hour	16 Units/Day
Yes	Yes	AS34	Adult Day Services, 1/4 Hour, Level 3	S5100	U7 U5 U3	$2.57	0.25/Hour	16 Units/Day
Yes	Yes	BMGO	Behavior Management, Basic	H0004	U7 U5 U2	$18.20	0.25/Hour	---
Yes	Yes	BG1O	Behavior Management, Level 1	H0004	U7 U5 U1	$18.20	0.25/Hour	---
Yes	Yes	CMGT	Case Management	T2022	U7 U5	$143.75	1/Month	1 Unit/Month
No	Yes	TRCM	Transitional Case Management Activities	T2038	U7 U5 UA	$131.25	1/Month for up to 6 months based on successful transition to Waiver Services	1 Unit per month for up to 6 Units/ Successful Transition
No	Yes	CT	Community Transition	T2038	U7 U5	Individual	1/Unit	$2,500 Lifetime
Yes	Yes	DHI	Day Habilitation, Individual	T2020	U7 U5	$28.33	1/Hour	Effective 8/1/2020
Yes	Yes	DHGS	Day Habilitation, Group-Small (2:1 to 4:1)	T2020	U7 U5 U2	$10.15	1/Hour	Effective 8/1/2020
Yes	Yes	DHGM	Day Habilitation, Group-Medium (5:1 to 10:1)	T2020	U7 U5 UA	$5.65	1/Hour	Effective 8/1/2020
Yes	Yes	DHGL	Day Habilitation, Group-Large (11:1 to 16:1)	T2020	U7 U5 UB	$3.59	1/Hour	Effective 8/1/2020
Yes	Yes	EMOI	Environmental Modification, Install	S5165	U7 U5 NU	Individual	1/Unit	$15,000 Lifetime
Yes	Yes	EMOM	Environmental Modification, Maintain	S5165	U7 U5 U8	Individual	1/Unit	$500/Year
Yes	Yes	INSP	Equipment – Assess/Inspect/Train	T1028	U7 U5	$17.99	0.25/Hour	---
Yes	Yes	EXTS	Extended Services	T2025	U7 U5 UA	$42.13	1/Hour	---
Yes	Yes	FBS	Facility Based Support	T1020	U7 U5 UA	$2.21	1/Hour	---
Yes	Yes	FCAR	Family & Caregiver Training, Family	S5111	U7 U5	Individual	1/Unit	$5,000/Year
Yes	Yes	FCNF	Family & Caregiver Training, Non-Family	S5116	U7 U5	Individual	1/Unit	$5,000/Year

FSW	CIH	INsite Code	Service Description	HCPCS Code	Modifiers	Rate	Unit/ Size	Unit/$ Limit
Yes	Yes	IBI1	Intensive Behavioral Intervention, Level 1	H2020	U7 U5 U1	$104.60	1/Hour	---
Yes	Yes	IBI2	Intensive Behavioral Intervention, Level 2	H2020	U7 U5 U2	$25.00	1/Hour	---
Yes	Yes	MUTH	Music Therapy	H2032	U7 U5 U1	$10.78	0.25/Hour	---
Yes	Yes	OCTH	Occupational Therapy	G0152	U7 U5 UA	$17.99	0.25/Hour	---
Yes	No	PAC	Participant Assistance and Care	T2033	U7 U5	$27.82	1/Hour	---
Yes	Yes	PRSI	Personal Response System, Install	S5160	U7 U5	$52.07	1/Unit	1 Unit/ POC/CCB
Yes	Yes	PRSM	Personal Response System, Maintain	S5161	U7 U5	$52.07	1/Unit	1 Unit/Month
Yes	Yes	PHTH	Physical Therapy	G0151	U7 U5 UA	$18.12	0.25/Hour	---
Yes	Yes	PV02	Prevocational (2:1)	T2015	U7 U5 U2	$10.15	1/Hour	---
Yes	Yes	PV04	Prevocational (4:1)	T2015	U7 U5 U4	$10.15	1/Hour	---
Yes	Yes	PV06	Prevocational (6:1)	T2015	U7 U5 U6	$5.65	1/Hour	---
Yes	Yes	PVO8	Prevocational (8:1)	T2015	U7 U5 U8	$5.65	1/Hour	---
Yes	Yes	PV10	Prevocational (10:1)	T2015	U7 U5 UB	$5.65	1/Hour	---
Yes	Yes	PV12	Prevocational (12:1)	T2015	U7 U5 UC	$3.59	1/Hour	---
Yes	Yes	PV14	Prevocational (14:1)	T2015	U7 U5 UD	$3.59	1/Hour	---
Yes	Yes	PV16	Prevocational (16:1)	T2015	U7 U5 U9	$3.59	1/Hour	---
Yes	Yes	PSTF	Psychological Therapy, Family	90846	U7 U5	$17.27	0.25/Hour	---
Yes	Yes	PSTG	Psychological Therapy, Group	90853	U7 U5	$4.81	0.25/Hour	---
Yes	Yes	PSTI	Psychological Therapy, Individual	H0004	U7 U5 U3	$15.45	0.25/Hour	---
Yes	Yes	RETH	Recreational Therapy	H2032	U7 U5 U2	$10.78	0.25/Hour	---
Yes	No	RSE	Remote Supports, Equipment/Install	A9279	U7 U5 NU	Individual	1/Unit	$500/year
Yes	Yes	RS1	Remote Supports, 1 Individual	A9279	U7 U5 UA	$13.62	1/Hour	---
Yes	Yes	RS2	Remote Supports, 2 Individuals	A9279	U7 U5 U2	$6.81	1/Hour	---
Yes	Yes	RS3	Remote Supports, 3 Individuals	A9279	U7 U5 U3	$4.54	1/Hour	---
Yes	Yes	RS4	Remote Supports, 4 Individuals	A9279	U7 U5 U4	$3.41	1/Hour	---
No	Yes	R&F	Rent & Food for Unrelated Live-In Caregiver	T2025	U7 U5	$545.00	1/Month	---
No	Yes	RH1O	Residential Habilitation Services, Level 1 (35 or Less Hrs/Week)	T2016	U7 U5 UA	$29.81	1/Hour	---

FSW	CIH	INsite Code	Service Description	HCPCS Code	Modifiers	Rate	Unit/ Size	Unit/$ Limit
No	Yes	RH2O	Residential Habilitation Services, Level 2 (Over 35 Hrs/Week)	T2016	U7 U5	$25.05	1/Hour	---
No	Yes	RD1	RHS Daily Level 1 (2-Person Setting, Algo Level 3)	T2016	U7 U5 UN UA	$195.32	1/Day	1 Unit/Day
No	Yes	RD2	RHS Daily Level 2 (2-Person Setting, Algo Level 4)	T2016	U7 U5 UN UB	$275.46	1/Day	1 Unit/Day
No	Yes	RD3	RHS Daily Level 3 (2-Person Setting, Algo Level 5)	T2016	U7 U5 UN UC	$300.49	1/Day	1 Unit/Day
No	Yes	RD4	RHS Daily Level 4 (3-Person Setting, Algo Level 3)	T2016	U7 U5 UP UA	$195.32	1/Day	1 Unit/Day
No	Yes	RD5	RHS Daily Level 5 (3-Person Setting, Algo Level 4)	T2016	U7 U5 UP UB	$252.91	1/Day	1 Unit/Day
No	Yes	RD6	RHS Daily Level 6 (3-Person Setting, Algo Level 5)	T2016	U7 U5 UP UC	$275.46	1/Day	1 Unit/Day
No	Yes	RD7	RHS Daily Level 7 (4-Person Setting, Algo Level 3)	T2016	U7 U5 UQ UA	$182.80	1/Day	1 Unit/Day
No	Yes	RD8	RHS Daily Level 8 (4-Person Setting, Algo Level 4)	T2016	U7 U5 UQ UB	$235.38	1/Day	1 Unit/Day
No	Yes	RD9	RHS Daily Level 9 (4-Person Setting, Algo Level 5)	T2016	U7 U5 UQ UC	$250.41	1/Day	1 Unit/Day
Yes	Yes	RNUR	Respite Nursing Care, RN	T1005	U7 U5 TD	$8.88	0.25/Hour	---
Yes	Yes	RNUR	Respite Nursing Care, LPN	T1005	U7 U5 TE	$6.74	0.25/Hour	---
Yes	Yes	RSPO	Respite Care Services	S5151	U7 U5	$29.81	1/Hour	---
No	Yes	ATCH	Specialized Medical Equip/Supply, Install	T2029	U7 U5 NU	Individual	1/Unit	---
Yes	No	ATCH	Specialized Medical Equip/Supply, Install	T2029	U7 U5 NU	Individual	1/Unit	$7,500 Lifetime under FSW
Yes	Yes	ATCM	Specialized Medical Equip/Supply, Maintain	T2029	U7 U5 U8	Individual	1/Unit	$500/Year
Yes	Yes	SPTH	Speech/Language Therapy	92507	U7 U5 UA	$18.12	0.25/Hour	---
No	Yes	AF01	Structured Family Caregiving, Level 1	T2033	U7 U5 U1	$51.87	1/Day	1 Unit/Day
No	Yes	AF02	Structured Family Caregiving, Level 2	T2033	U7 U5 U2	$75.67	1/Day	1 Unit/Day
No	Yes	AF03	Structured Family Caregiving, Level 3	T2033	U7 U5 U3	$102.87	1/Day	1 Unit/Day
No	Yes	TRNO	Transportation, Level 1	T2002	U7 U5	$5.99	1/Trip	2 Trips/Day, $2,625/Year

FSW	CIH	INsite Code	Service Description	HCPCS Code	Modifiers	Rate	Unit/ Size	Unit/$ Limit
No	Yes	TRN2	Transportation, Level 2	T2002	U7 U5 U2	$23.94	1/Trip	2 Trips/Day, $5,250/Year
No	Yes	TRN3	Transportation, Level 3	T2002	U7 U5 U3	$47.88	1/Trip	2 Trips/Day, $7,875/Year
Yes	No	TRNO	Transportation, Level 1	T2002	U7 U5	$5.99	1/Trip	2 Trips/Day, $2,995/Year
Yes	No	TRN2	Transportation, Level 2	T2002	U7 U5 U2	$23.94	1/Trip	2 Trips/Day, $5,985/Year
Yes	No	TRN3	Transportation, Level 3	T2002	U7 U5 U3	$47.88	1/Trip	2 Trips/Day, $8,977.50/Year
No	Yes	VMOD	Vehicle Modification, Install	T2039	U7 U5	Individual	1/Unit	$15,000 for one vehicle every 10 years
Yes	No	VMOD	Vehicle Modification, Install	T2039	U7 U5	Individual	1/Unit	$15,000 for one vehicle every 10 years
Yes	Yes	VMOM	Vehicle Modification, Maintain	T2039	U7 U5 U8	Individual	1/Unit	$1,000/Year
No	Yes	WEL1	Wellness Coordination Tier 1	T2022	U7 U5 U1	$52.77	1/Month	1 Unit/Month
No	Yes	WEL2	Wellness Coordination Tier 2	T2022	U7 U5 U2	$111.96	1/Month	1 Unit/Month
No	Yes	WEL3	Wellness Coordination Tier 3	T2022	U7 U5 U3	$223.92	1/Month	1 Unit/Month
Yes	Yes	WPA	Workplace Assistance	T1020	U7 U5	$31.57	1/Hour	---

Section 10.3: Adult Day Services

Service Definition

Adult day services (ADS) are community-based group programs designed to support individuals as specified through the person-centered individualized support plan (PCISP). These programs encompass both the health and social service needs to ensure the optimal functioning of the individual. Meals and/or nutritious snacks are required. The meals provided as part of these services do not constitute a full non-institutional, nutritional regimen (that is, three meals per day). The meals need not constitute the full daily nutritional regimen (that is, three meals per day).

However, each meal must meet one-third 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.

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

A half-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 per day. A maximum of two half-day units per day is allowed.

A quarter-hour unit is defined as 15 minutes. It is 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 quarter-hour units per day are allowed.

Additional Information:

- ADS are available under the Family Supports Waiver (FSW) and the Community Integration and Habilitation (CIH) waiver.

Reimbursable Activities

ADS may be used in conjunction with Transportation services.

- 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 individuals
- Enhanced ADS (Level 2) includes the Level 1 service requirements and the following additional services:
  - 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 supervising the dispensing of medication
  - Psychological needs assessed and addressed, including counseling as needed for individuals and caregivers
  - Therapeutic structure, support and intervention for those with mild to moderate cognitive impairments
  - Minimum staff ratio: One staff for each six individuals
- Intensive ADS (Level 3) includes the Level 1 and Level 2 service requirements and the following additional services:
  - Hands-on assistance or supervision with all ADLs and personal care
  - One or more direct health interventions required
  - Rehabilitation and restorative services, including physical therapy, speech therapy and occupational therapy coordinated or available
  - Therapeutic intervention to address dynamic psychosocial needs such as depression or family issues affecting care
  - Therapeutic interventions for those with moderate to severe cognitive impairments
  - Minimum staff ratio: One staff for each four individuals

Service Standards

ADS must follow a written plan of care addressing specific needs determined by the individual's *Adult Day Service Level of Service Evaluation Form*. The case manager completes this form in the INsite case management system and gives it to the provider.

Documentation Standards

The following are required documentation for ADS:

- Services must be outlined in the PCISP
- Evidence that level of service provided is required by the individual
- Attendance record documenting the date of service and the number of units of service delivered that day
- Completed *Adult Day Service Level of Service Evaluation Form*
  - The case manager should give the completed *Adult Day Service Level of Service Evaluation Form* to the provider

As applicable, monthly/quarterly reports must be uploaded to the document library of the state's case management system by the chosen service provider on or before the 15th day of the following month.

Limitations

Therapies provided through ADS will not duplicate therapies provided under any other service.

Activities Not Allowed

Any activity that is not described under *Reimbursable Activities* is not included in ADS.

Provider Qualifications

ADS providers must meet the following criteria:

- Enrolled as an active Medicaid provider
- 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 comply with any applicable FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS BDDS policies, written agreements and the *FSSA/DDRS HCBS Waivers* module accessible from the *IHCP Provider Reference Materials* page at in.gov/medicaid/providers
- Obtain/maintain accreditation (specific to Indiana programs) by at least one 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 (CQL) 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 quality assurance (QA) system
  - An independent national accreditation organization approved by the secretary
  - The Council on Accreditation or its successor

Section 10.4: Behavioral Support Services

Service Definition

Behavioral supports are an array of services designed to support 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.

Additional Information:

- Behavioral Support Services are available under the FSW and CIH Waiver.

Reimbursable Activities

Reimbursable activities of behavioral support services include:

- 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 behavior support plan (BSP)
- Developing a comprehensive behavioral support plan and subsequent revisions: this includes devising proactive and reactive strategies designed to support the individual. Any restrictive techniques employed as part of the behavioral support plan must be approved by a human rights committee (HRC), 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 individualized support team (IST) that the behavioral support plan is feasible for implementation and uses the least restrictive methods possible
- Supporting the individual 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
- Training staff, family members, housemates or other IST members on the implementation of the behavioral support plan
- 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:
  - 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.
  - 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.

Service Standards

Behavioral support services must be reflected in the PCISP:

- Services must address needs identified in the person-centered planning process and be outlined in the PCISP.
- The behavior supports specialist will observe the individual in their own milieu and develop a specific plan to address identified issues.
- The behavior supports specialist must assure that residential habilitation and support (RHS) direct service staff are aware of and are active individuals in the development and implementation of the behavioral support plan. The behavior plan will meet the requirements stated in the DDRS *Behavioral Support Plan Policy (2011)* at in.gov/fssa/ddrs.
- The behavior supports provider will comply with all specific standards in *460 IAC 6*.
- Any behavior supports techniques that limit the individual's human or civil rights must be approved by the IST and the provider's HRC. No aversive techniques may be used. Chemical restraints and medications prescribed for use as needed (PRN) meant to retrain the individual shall be used with caution. The use of these medications must be approved by the IST and the appropriate HRC.
- The efficacy of the plan must be reviewed not less than quarterly and adjusted as necessary.
- The behavior specialist will provide a written report to pertinent parties at least quarterly. Pertinent parties include the individual, guardian, BDDS service coordinator, waiver case manager, all service providers and other involved entities.

The PCISP must identify the behavioral support services needed by the individual to pursue their desired outcomes as identified during the person-centered planning process. The need for service continuation is to be evaluated annually by the individualized support team (IST) and reflected in the PCISP. Each outcome within the PCISP has at least one associated proposed strategy/action step designed to address potential barriers or maintenance needs in relation to the desired outcomes and the support and services needed to facilitate the outcomes. The proposed strategy/action step also identifies all paid and unpaid responsible parties and includes the name(s) of each responsible party including the provider, the service, and the staffing positions within the agency that are responsible for the strategy/action step. The individual may be the responsible party for a strategy/action step initiative, if they so determine. In addition, each proposed strategy/activity has a specific time frame identified, including a minimum time frame for review. The plan of care/cost comparison budget (POC/CCB) identifies the name of the waiver-funded service, the name of the individual-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 POC/CCB.

Documentation must include any progress toward outcomes in addition to any changes or modifications within the PCISP.

While the behavior support plan (BSP) is an integral part of the PCISP, the dates of the BSP are not required to be the same as the annual PCISP. However, the BSP must have been updated within the individual's plan year.

Documentation Standards

Documentation shall include:

- Services outlined in the PCISP
- A functional behavior assessment
- A behavioral support plan (BSP), which must be attached to the PCISP

- The POC/CCB identifies the name of the waiver-funded service, the name of the individual-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 POC/CCB
- Documentation must include progress toward outcomes and any changes or modifications within the PCISP
- Documentation in compliance with *460 IAC 6-18-4*

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

- Name of individual served
- IHCP Member ID (also known as RID) of the individual
- Name of provider
- Date of service including the year
- Time frame of service (include a.m. or p.m.)
- Duration of service
- Summary of the specific, person-centered behavioral support activities conducted
- Summary of the behavior support progress made towards outcomes
- Signature of the person providing the behavioral support services (Electronic signatures are permissible when in compliance with the *Uniform Electronic Transactions Act* [*IC 26-2-8*])
- For instance, if a consultation occurred, the note should state the date it took place, the length of time, individual involved, a summary of the discussion, a summary of the progress towards outcomes, and the behavior clinician's signature

A quarterly report specific to behavioral support services must be created by the chosen service provider. The quarterly report should summarize the level of support provided to the individual, based on the identified supports and services in the PCISP and the POC/CCB. The quarterly report must be shared with the individual, guardian (as applicable) and entire IST. The service provider must upload the quarterly report to the document library of the individual in the state's case management system on or before the 15th day of the month following the end of the quarter. The quarterly report shall be based on the quarters of the individual's POC/CCB date range.

The quarterly report shall contain the following elements:

- Name of individual served
- IHCP Member ID (also known as RID) of the individual
- Name of provider
- Date range of services
- Service rendered
- Brief summary of progress towards PCISP outcomes
- Data obtained during the quarter to track BSP related outcomes
- Data obtained during the quarter on targeted behaviors identified in the BSP
- Challenges hindering progress towards PCISP outcomes, if applicable
- A positive event that occurred during the quarter that contributed to the individual's good life

Upon request, all data elements must be made available to auditors, quality monitors, case managers and any other government entity. The documentation may reside in multiple locations but must be clearly and easily linked to the individual or the standard will not be met.

Limitations

See *Activities Not Allowed*.

Activities Not Allowed

The following activities are not allowed under behavioral support services:

- Restrictive techniques – any techniques not approved by the IST and the human rights committee
- Therapy services provided to the individual within the educational/school setting or as a component of the individual's school day
- Services provided to a minor by parent(s), stepparent(s) or legal guardian
- Services provided to an individual by the individual's spouse
- In the event that a Level 1 clinician performs Level 2 clinician activities, billing for Level 1 services
- 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

Provider Qualifications

BSS providers must meet the following criteria:

- Enrolled as an active Medicaid provider
- Be FSSA/DDRS-approved
- 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 accessible from the *IHCP Provider Reference Materials* page at in.gov/medicaid/providers

Section 10.7: Community Transition

Service Definition

Community transition services are specified in the PCISP and include reasonable, one-time, setup expenses for individuals who make the transition from an institution to their own home in the community and will not be reimbursable on any subsequent move.

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

Items purchased through community transition services are the property of the individual receiving the service, and the individual should take the property with him or her in the event of a move to another residence, even if the residence from which they are moving is owned by a provider agency. Nursing facilities are not reimbursed for community transition services because those services are part of the per diem.

Reimbursable Activities

Reimbursable activities include the following:

- Security deposits that are required to obtain a lease on an apartment or home
- Essential furnishings and moving expenses required to occupy and use a community domicile including a bed, table or chairs, window coverings, eating utensils, food preparation items, and bed or bath linens
- Set-up fees or deposits for utility or service access including telephone, electricity, heating and water
- Health and safety assurances including pest eradication, allergen control or one-time cleaning prior to occupancy

When the individual is receiving residential habilitation and support, structured family caregiving (SFC) services or day habilitation services under the Community Integration and Habilitation (CIH) waiver, the community transition service is included in the POC/CCB.

Requests for community transition funds should precede and coincide with the individual's transition from an institution to their own home. However, as a potential exception, DDRS/BDDS may approve the one-time use of community transition funds subsequent to the emergency transition of an individual.

Service Standards

Community transition services must be reflected in the PCISP. Services must address needs identified in the person-centered planning process and be outlined in the PCISP.

Services must address needs identified in the PCISP and the POC/CCB.

Documentation Standards

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

Limitations

Community transition services are limited to one-time setup expenses, up to $2,500.

Activities Not Allowed

The following activities are not allowed under community transition services:

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

Provider Qualifications

Providers must meet the following criteria:

- Enrolled as an active Medicaid provider
- Be FSSA/DDRS-approved
- 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 6-5-34* Community Transition Supports Provider Qualifications
  - *460 IAC 6-14-4* Staff Training 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 accessible from the *IHCP Provider Reference Materials* page at in.gov/medicaid/providers

Additional Information:

- Community transition services are available only under the CIH Waiver.

Section 10.8: Remote Supports

Service Definition

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 from a remote location in place of on-site 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 *Health Insurance Portability and Accountability Act* (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 and so on.

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 support services foster independence and security by combining technology and service to allow for direct contact with trained staff when the individual needs. Remote supports provide a realistic, non-invasive way for individuals to build life skills and familiarity in their level of independence with a sense of security. Remote supports can assist individuals to live more independently or support a safe transition to independent living while enhancing their self-advocacy skills and increase opportunities for participating in the community.

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 residential habilitation and support (CIH Waiver) or participant assistance and care (Family Supports Waiver, or FSW) that is both the primary point of contact for the remote supports 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.

The person-centered individualized support plan (PCISP) will reflect how the remote supports are being used to meet the individual's needs, vision for their good life, and health and welfare needs.

Additional Information:

- Remote supports are available under the FSW and CIH Waiver.

Reimbursable Activities

Reimbursable activities include the following:

- Monitoring, oversight and support by the RSP.
- 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 on-site 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 individuals present in the home during any portion of the hour for which reimbursement is requested.

Dividing the unit rate by and among waiver individuals applies only to individuals for whom remote supports are included on the plan.

Service Standards

- The remote supports system must be designed and implemented to ensure the individual's independence, health and safety in their own home/apartment

> *Note: The case manager and/or the BDDS service coordinator will review the use of the system at seven calendar days, and again at 14 calendar days post-installation.*

Assessment and Informed Consent

The following are key points regarding assessment and informed consent:

- Informed consent: Informed consent by the individual using the service, their guardian and other individuals and their guardians residing in the home must be obtained and clearly state the parameters in which the remote support service would be used.
- Each individual, guardian and IST must be made aware of both the benefits and risks of the operating parameters and limitations. Through an assessment by the remote support provider with input from the individual and their IST the location of the devices or monitors will be determined to best meet the individual's needs.
- The PCISP will reflect the individual's control and use of the equipment. The individual must be informed by the remote support provider on the operation and use of the equipment.
- 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, they 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 individuals, 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.
- Withdrawing consent: If the individual desires to withdraw consent, they 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 alternative supports. All residing adult and youth individuals, 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.
- Use of the system may be restricted to certain hours through the PCISPs of the individuals involved.
- 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.

System Design

The following are requirements of a remote supports system design when utilized to replace in-person direct support service delivery:

- The provider must have safeguards and/or backup system such as battery and generator for the electronic devices in place at the remote supports monitoring base and the individual's residential living sites in the event of electrical outages.
- The provider must have backup procedures for system failure (for example, prolonged power outage), fire or weather emergency, individual medical issue or personal emergency in place and detailed in writing for each site utilizing the system as well as in each individual's PCISP. This plan should specify the staff person or persons to be contacted by remote support monitoring base staff who will be responsible for responding to these situations and traveling to the individual's living sites, including any previously identified paid or unpaid backup support responder.

- The remote supports system must receive notification of smoke/heat alarm activation at each individual's residential living site.
- The remote supports system must have two-way (at minimum, full duplex) audio communication capabilities to allow monitoring base staff to effectively interact with and address the needs of individuals in each living site, including emergency situations when the individual may not be able to use the telephone.
- The remote supports system must allow the monitoring base staff to have visual (video) oversight of areas in individual's residential living sites as deemed necessary by the IST.
- A remote supports monitoring base may not be located in an individual's residential living site.
- A secure (compliant with the HIPAA) network system requiring authentication, authorization and encryption of data must be in place to ensure access to computer vision, audio, sensor or written information is limited to authorized staff including the parent/guardian, provider agency, FSSA, the DDRS, the BDDS, the BQIS, the QIDP, case manager and individual.
- The equipment must include a visual indicator to the individual that the system is on and operating.
- For situations involving remote supports of individuals needing 24-hour support, if an individual indicates that they want the remote supports system to be turned off and wants in-person supports, the following protocol will be implemented:
  - The electronic caregiver will notify the provider to request an on-site staff or other previously identified paid or unpaid backup support responder
  - The system would be left operating until the on-site staff or other previously identified paid or unpaid backup support responder arrives
  - The electronic caregiver would turn off the system at that site after it has been relieved by an on-site staff or other previously identified paid or unpaid backup support responder
  - A visible light on the control box would signal when the system is on and when it is off

Remote Support Monitoring Base Staff

The following are requirements for remote supports monitoring base staff when remote supports are used in place of in-person direct support service delivery:

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

Backup Support (Applicable to RHS Hourly and RHS Daily Services Under the CIH Waiver and PAC under the FSW)

The following are requirements for stand-by intervention staff/backup support utilized with residential habilitation and support (RHS) hourly, RHS daily services (for CIH Waiver) and participant assistance and care (PAC) (for FSW):

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

Documentation Standards

Documentation must include the following:

- A remote supports care plan must be developed/updated at least annually outlining how remote supports will be utilized. The care plan must be attached to the PCISP.
- Every 90 days a report must be submitted within the DDRS system outlining the past quarters remote support activities including any suggested modifications or area of concern. These reports should be discussed, at minimum, during semi-annual and annual team meetings.
- Services outlined in the PCISP:
  - To be reimbursed, the provider must prepare and be able to produce the following:
    - Status as a BDDS-approved provider
    - Case notes regarding the assessment and approval by both the IST of each individual, documented within both the DDRS system and the PCISP
    - Informed consent documents written, signed and dated by the individual, guardian, case manager and provider agency representative, as appropriate. Copies of consent documents maintained by the local BDDS office, the case manager, the guardian (if applicable) and in the home file
    - Proof of utilization of the remote support device outlined in the PCISPs, and budgets of each individual in a setting, including typical hours of remote supports utilization
  - Each remote site where remote supports are used in place of in-person direct support service delivery will have a written policy and procedure approved by the DDRS (and available to the OMPP for all providers serving waiver individuals) that defines emergency situations and details how remote and backup staff will respond to each. Examples include:
    - Fire, medical crises, stranger in the home, violence between individuals and any other situation that appears to threaten the health or welfare of the individual.
    - Emergency response drills must be carried out once per quarter per shift in each home equipped with and capable of utilizing the remote supports monitoring service. Documentation of the drills must be available for review upon request.
    - When used to replace in-person direct support service delivery, the remote monitoring base staff shall generate a written report on each individual served in each individual's residential living site on a daily basis. This report will follow documentation standards of the RHS or PAC service. This report must be transmitted to the primary RHS or PAC provider daily.

- Each time an emergency response is generated, an incident report must be submitted to the state per the BDDS and BQIS procedures.

As applicable, monthly/quarterly reports must be uploaded to the document library of the state's case management system by the chosen service provider on or before the 15th day of the following month.

Limitations and Reimbursement Parameters

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

Remote supports provides a realistic, non-invasive way for many individuals and families to find the supports they need to build life skills and familiarity in their level of independence with a sense of security. Individuals and families who are utilizing the Family Supports Waiver (FSW) may want to try the service to see if it works for them. With this in mind, the first $500 of remote supports added to their annual service plan year will be outside of the $19,614 budget cap.

The budget will be completed for each individual based upon the total number of individuals residing within the residence. However, lower tiers may also appear on the service plans to reflect reimbursement rates for situations where one or more individual is away from the home during service utilization. Reimbursement will then be the hourly rate of $13.62 divided by and among the number of individuals who are at home during the hours of utilization (see Table 4). If only one individual from a four-individual setting is at home during service utilization, the solitary individual pays the full hourly rate of $13.62. If only two of the four individuals are home, each pays $6.81 per hour of utilization, and if three of the four are home, each pays $4.54 per hour of utilization.

Table 4 – Reimbursement Rates by Tier

Tier	Number of Individuals	Reimbursement
Tier 1	One individual in a home	$13.62
Tier 2	Two individuals in a home	$6.81
Tier 3	Three individuals in a home	$4.54
Tier 4	Four individuals in a home	$3.41

Billing clarification: 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 individuals present in the home during any portion of the hour for which reimbursement is requested.

Reimbursement for paid on-site backup responders would be billed as RHS (hourly) for CIH Waiver or as PAC for FSW. Therefore, it may be necessary for the remote supports provider to contract with an RHS or PAC provider.

Activities Not Allowed

The following activities are not allowed under remote supports:

- Remote supports may not be used concurrently with structured family caregiving (SFC) services in the structured family caregiving home

Note: SFC is available only under the CIH Waiver.

- Remote supports systems intended to monitor direct care staff
- Remote supports service in intermediate care facilities for individuals with intellectual disabilities (ICFs/IID) licensed under *IC 16-28* and *410 IAC 16.2*

- Remote supports systems used in place of in-home staff when in-person staff has been deemed necessary by IST.
- Cameras are not permitted in bathrooms or bedrooms.
- Installation costs related to video and/or audio equipment for any purpose other than the provision of remote support services in place of on-site staffing.
- Services furnished to a minor by parent(s), stepparent(s) or legal guardian
- Services furnished to an individual by the individual's spouse

Remote support services may serve as a potential replacement for PAC services under the FSW, or as a replacement for RHS services Level 1 and Level 2; therefore, remote supports and PAC, or remote supports and RHS services are not billable during the same time period. However, remote supports are an allowable component of the RHS daily service but may not be billed in addition to the daily rate of the RHS daily service.

Note: RHS is available only under the CIH Waiver.

Provider Qualifications

Providers must meet the following criteria:

- Be enrolled as an active Medicaid provider
- 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* page at in.gov/medicaid/providers
- 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 their 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.

Section 10.9: Environmental Modifications

Service Definition

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

DDRS' waiver services staff must approve all environmental modifications prior to service being rendered.

Additional Information:

- Environmental modifications are available under the FSW and CIH Waiver.
- The costs for environmental modifications are outside the $19,614 cap of the FSW.
- Photographs of the proposed areas to be modified must be provided.
- The environmental modification policy appears in *Section 11: RFA Policies* and *Section 11.1: Environmental Modification Policy. Policy updates are in process*.

  As a reminder, HCBS waiver funding covers only basic modifications determined to be medically necessary for the waiver individual and is not available for items that exceed basic medical need. Requests to upgrade products or to use materials exceeding the individual's basic need will not be approved. For example, if a bathroom modification is necessary but the individual or family requests tiled flooring when basic vinyl flooring could be installed, the individual or family must decide whether to access waiver funds for completion of the basic modification or to assume financial responsibility for the entire modification inclusive of desired upgrade(s).

  Due to the state's responsibility to ensure each modification is the most cost effective or conservative means to meet the individual's need(s) for accessibility within the home, it is not acceptable to submit bids attempting to combine waiver funding for basic modifications with private funding to cover the higher costs of the desired upgrade(s).

Reimbursable Activities

Reimbursable activities include the following:

- 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 that are necessary for the welfare of the individual, including anti-scald devices
- Maintenance and repair of the items and modifications installed during the initial request
- Assessment and inspection

For the FSW, environmental modifications are outside the $19,614 cap.

Service Standards

The following service standards apply to environmental modifications:

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

Documentation Standards

Documentation standards for environmental modifications include the following:

- Documentation of the identified direct medical benefit for the individual
- Documented prior authorization (PA) denial from Medicaid, if applicable
- Receipts for purchases
- Identified need in PCISP
- Documentation in compliance with *460 IAC 6*, Supported Living Services and Supports requirements

Limitations

The following limitations apply to environmental modifications:

- Reimbursement for environmental modification services 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

The following activities are not allowed under environmental modifications:

- Adaptations to the home that are of general utility
- Adaptations that are not of direct medical or remedial benefit to the individual (such as carpeting, roof repair or central air conditioning)
- Adaptations that 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* form

- Adaptations to service provider-owned and -leased housing.
- Compensation for the costs of life safety code modifications and other accessibility modifications made with individual waiver funds to provider-owned housing

Provider Qualifications

Providers must meet the following criteria:

- Enrolled as an active Medicaid provider
- Be FSSA/DDRS-approved
- 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* Insurance,
  - *460 IAC 6-11* Financial Status of Providers,
  - *460 IAC 6-5-11* Environmental Modification Supports Provider Qualifications
- 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 accessible from the *IHCP Provider Reference Materials* page at in.gov/medicaid/providers
- Where licensure or certification is required, providers rendering waiver funded services must obtain/maintain Indiana-specific licensure/certification. Examples include but are not limited to:
  - Home Inspector *IC 25-20.2*
  - Plumber IC 25-28.5
  - Physical Therapist *IC 25-27-1*
  - Occupational Therapist *IC 25-23.5*
  - Speech/Language Therapist *IC 25-35.6*
  - Architect *IC 25-4-1*

Section 10.12: Facility-Based Support

Service Definition

Facility-based support services are structured, comprehensive, non-residential programs that provide health, social, recreational and therapeutic activities, as well as educational and life skill opportunities as described in the PCISP. Individuals attend on a planned basis.

These services must be provided in a congregate-setting in groups not to exceed 16:1.

Facility settings are defined as nonresidential, nonintegrated settings that take place within the same buildings for the duration of the service rather than being out in the community.

Additional Information:

- Facility-based support services are available under the FSW and CIH Waiver.

Reimbursable Activities

Reimbursable activities include the following:

- Monitoring and/or supervision of 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 individuals
- 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, and so on) may be offered and pursued

Service Standards

The following service standards apply to facility-based support:

- Facility-based support services must be reflected in the PCISP.
- Facility-based support services must follow a written plan of care addressing specific needs as identified in the PCISP.

Documentation Standards

Documentation standards for facility-based support services include the following:

- Services outlined in the PCISP
- In addition to compliance with documentation requirements outlined in *460 IAC 6*, the following data elements are required for each service rendered:
  - Name of individual served
  - IHCP Member ID (also known as RID) of the individual
  - Name of provider
  - Service rendered
  - Time frame of service (include a.m. or p.m.)
  - Date of service including the year
  - Notation of the primary location of service delivery
  - A brief activity summary of service rendered
  - In addition to the brief activity summary of service rendered, a description by direct care staff of any issue or circumstance concerning the individual including, but not limited to, significant medical or behavioral incidents or any other situation that may be uncommon for the individual
  - Signature that includes at least the last name and first initial of the direct care staff person making the entry (Electronic signatures are permissible when in compliance with the *Uniform Electronic Transactions Act* [*IC 26-2-8*])

Upon request, all data elements must be made available to auditors, quality monitors, case managers and any other government entity. The documentation may reside in multiple locations but must be clearly and easily linked to the individual, or the standard will not be met.

As applicable, monthly/quarterly reports must be uploaded to the document library of the state's case management system by the chosen service provider on or before the 15th day of the following month.

For Group Services

Providers must be able to indicate, in concise format, that the ratio for each claimed time frame of the service did not exceed (group or individual) the maximum allowable ratio for individuals utilizing waiver funding.

Limitations

The following are limitations on facility-based support:

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

Activities Not Allowed

The following activities are not allowed under facility-based support:

- Any activity that is not described in reimbursable activities is not included in this service
- Services furnished to a minor by parent(s), stepparent(s) or legal guardian
- Services furnished to an individual by the individual's spouse
- Prevocational services

Provider Qualifications

Providers must meet the following criteria:

- Enrolled as an active Medicaid provider
- Be FSSA/DDRS-approved
- 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* Staff Training and *460 IAC 6-14-4* Training
  - *460 IAC 6-5-14* Health Care Coordination Services Provider Qualifications
  - *460 IAC 6-5-30* Transportation Services Provider Qualifications
- 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 accessible from the *IHCP Provider Reference Materials* page at in.gov/medicaid/providers

Section 10.13: Family and Caregiver Training

Service Definition

Family and caregiver training services provides education and support directly to the family caregiver of an individual in order to increase the confidence and stamina of the caregivers to support the individual. Education and training activities are based on the family/caregiver's unique needs and must be specifically identified in the PCISP.

The services under family and caregiver training are limited to additional services not otherwise covered under the state plan, including Early and Periodic Screening, Diagnosis and Treatment (EPSDT), but consistent with waiver objectives of avoiding institutionalization.

Additional Information:

- Family and caregiver training services cannot be used to provide behavioral programs or supports, or other direct services covered under other available Medicaid state plan or waiver services.
- Family and caregiver training services are available under the FSW and CIH Waiver.

Reimbursable Activities

Reimbursable activities include the following:

- Educational materials or training programs, workshops, and conferences for caregivers that are directly related to the caregiver's role in supporting the individual in areas specified in the PCISP that relate to:
  - Understanding the disability of the individual
  - Achieving greater competence and confidence in providing supports
  - Developing and accessing community other resources and supports
  - Developing or enhancing key parenting strategies
  - Developing advocacy skills
  - Supporting the individual in developing self-advocacy skills
- Education, training or counseling must be aimed at assisting caregivers who support the individual to understand and address individual needs as specified in the PCISP.

Service Standards

The following service standards apply to family and caregiver training:

- Family and caregiver training services must be included in the PCISP.
- The PCISP shall be based on the person-centered planning process for that individual.

Documentation Standards

Documentation standards for Family and Caregiver Training services include the following:

- Services outlined in the PCISP
- Receipt of payment for activity

- Proof of participation in activity if payment is made directly to individual/family
- Documentation in compliance with *460 IAC 6* Supported Living Services and Supports requirements

As applicable, monthly/quarterly reports must be uploaded to the document library of the state's case management system by the chosen service provider on or before the 15th day of the following month.

Limitations

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

Activities Not Allowed

The following activities are not allowed under family and caregiver training:

- 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 to train providers, even when those providers will subsequently train caregivers.
- Training provided to caregivers who receive training reimbursement within their Medicaid or state line item reimbursement rates.
- Cost of travel, meals and overnight lodging while attending the training program, workshop or conference.

Provider Qualifications

Providers must meet the following criteria:

- Enrolled as an active Medicaid provider
- Be FSSA/DDRS-approved
- 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, and *460 IAC 6-23-1* Requirements for Provision of Services
  - *460 IAC 6-14-4* Staff Training and *460 IAC 6-14-4* Training
- 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 accessible from the *IHCP Provider Reference Materials* page at in.gov/medicaid/providers

Section 10.14: Intensive Behavioral Intervention

Service Definition

Intensive behavioral intervention (IBI) services focus on developing effective behavior management strategies for individuals whose challenging behavioral issues put them at risk of placement in a more restrictive residential setting. IBI services teach the individual, families and other caregivers how to

respond to and deal with intense and challenging behaviors. IBI services are designed to reduce an individual's behaviors and improve independence and inclusion in the community. The need for IBI services is determined by a functional, behavioral needs assessment of the individual. 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 with other people
  - Training of caregivers, IBI direct care staff and providers of other waiver services
  - Breaking down targeted skills into small, manageable and attainable steps for behavior change
  - Utilizing systematic instruction, comprehensible structure and high consistency in all areas of programming
  - Provision for one-on-one structured therapy
  - Treatment approach tailored to address the specific needs of the individual
- Skills training under IBI must include:
  - Measurable goals and objectives (specific targets may include appropriate social interaction, communication skills and/or language skills)
  - Heavy emphasis on skills that are prerequisites to language (attention, cooperation, imitation)

Additional Information:

- IBI services are available under the FSW and CIH Waiver.
- If individuals under age 21 choose to utilize IBI-type services they should access equivalent service such as applied behavior analysis (ABA) under EPSDT.

Reimbursable Activities

Reimbursable activities include the following:

- Preparation of an IBI support plan in accordance with the DDRS *Behavioral Support Plan Policy (2011) at in.gov/fssa/ddrs*
- Application of a combination of the following empirically based, multimodal and multidisciplinary comprehensive treatment approaches:
  - Intensive Teaching Trials (ITT), also called Discrete Trial Training, is a highly specific and structured teaching approach that uses empirically validated behavior change procedures. This type of learning is instructor-driven and may use error-correction procedures or reinforcement to maintain motivation and attention to task. ITT consists of the following:
    - Antecedent: A directive or request for the individual to perform an action
    - Behavior: A response from the individual, including anything from successful performance, non-compliance, to no response
    - Consequence: A reaction from the therapist, including a range of responses from strong positive reinforcement, faint praise or a negative (not aversive) reaction
    - 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 that have been found to be effective in the treatment of individual with intellectual/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" (that is, critical for learning other behaviors). The therapist focuses on these behaviors to change other behaviors that depend on them.
  - Errorless teaching or other prompting procedures that have been found to support successful intervention. These procedures focus on the prevention of errors or incorrect responses while also monitoring when to fade the prompts to allow the learner to demonstrate ongoing and successful completion of the desired activity.
  - Additional methods that occur and are empirically based.
- Specific and ongoing objective measurement of progress, with success closely monitored via detailed data collection.

Service Standards

The following service standards apply to intensive behavioral intervention:

- An appropriate range of hours per week is generally between 20–30 hours of direct service. It is recommended that IBI services be delivered a minimum of 20 hours per week. When fewer than 20 hours per week will be delivered, justification must be submitted explaining why the IST feels a number fewer than the recommended minimum is acceptable.
- A detailed IBI support plan is required.
- At least quarterly, the IST must meet to review the IBI, consider the need for change, develop a new plan or set new goals.
- IBI services must be reflected in the PCISP.
- Services must address needs identified in the person-centered planning process and be outlined in the PCISP.
- Services must be detailed in the IBI support plan.
- Services are usually direct and one-to-one, with the exception of time spent in training the caregivers and the family, performing ongoing data collection and analysis, and revising goals and plans.
- The IBI case supervisor will provide a narrative and graphical report to pertinent parties at least monthly. Pertinent parties include the individual, IBI director, guardian, BDDS service coordinator, waiver case manager, all service providers and other entities.
- The IBI director will provide a narrative and graphical report to pertinent parties at least quarterly. Pertinent parties include the individual, IBI case supervisor, guardian, BDDS service coordinator, waiver case manager, all service providers and other entities.
- The services under IBI are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Documentation Standards

Documentation standards for intensive behavioral intervention services include the following:

- Services outlined in the PCISP
- Documentation in compliance with *460 IAC 6*
- The IBI case supervisor will provide a narrative and graphical report to pertinent parties at least monthly. Pertinent parties include the individual, IBI director, guardian, BDDS service coordinator, waiver case manager, all service providers and other entities.
- The IBI director will provide a narrative and graphical report to pertinent parties at least quarterly. Pertinent parties include the individual, IBI case supervisor, guardian, BDDS service coordinator, waiver case manager, all service providers and other entities.

As applicable, monthly/quarterly reports must be uploaded to the document library of the state's case management system by the chosen service provider on or before the 15th day of the following month.

Limitations

If individuals under age 21 choose to utilize IBI-type services, they should access equivalent services, such as applied behavioral analysis (ABA), under Early and Periodic Screening, Diagnosis and Treatment (EPSDT).

See *Activities Not Allowed*.

Activities Not Allowed

The following activities are not allowed under intensive behavioral intervention:

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

Provider Qualifications

Providers must meet the following criteria:

- Enrolled as an active Medicaid provider
- Be FSSA/DDRS-approved
- 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* Staff Training and *460 IAC 6-14-4* Training

- 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 accessible from the *IHCP Provider Reference Materials* page at in.gov/medicaid/providers
- Where licensure/certification is required, providers rendering waiver funded services must obtain/maintain Indiana-specific licensure/certification:
  - For IBI director: Psychologist licensed under *IC 25-33*, or psychiatrist licensed under *IC-25-22.5*
  - For IBI case supervisor: IBI case supervisor must be Board Certified Behavior Analyst (BCBA)-certified or Board Certified Assistant Behavior Analyst (BCaBA)-certified

Section 10.15: Music Therapy

Service Definition

Music therapy services are services provided for the systematic application of music in the treatment of the physiological and psychosocial aspects of an individual's disability, and focus on the acquisition of nonmusical skills and behaviors.

Additional Information:

- The focus of this service must be therapeutic in nature rather than on the acquisition of musical skills obtained as the result of music lessons, such as piano lessons, guitar lessons and so forth.
- Music therapy services are available under the FSW and CIH Waiver.

Reimbursable Activities

Reimbursable activities include the following:

- 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 an individual'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 individual

- Individual music therapy
- Group services in group sizes no greater than four individuals to one music therapist (unit rate divided by number of individuals)

Service Standards

The following service standards apply to music therapy:

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

Documentation Standards

Documentation standards for music therapy services include the following:

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

As applicable, monthly/quarterly reports must be uploaded to the document library of the state's case management system by the chosen service provider on or before the 15th day of the following month.

Limitations

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.

One hour of billed therapy service must include a minimum of 45 minutes of direct individual care/therapy, with the balance of the hour spent in related-patient services.

Activities Not Allowed

The following activities are not allowed under music therapy:

- Any services that are reimbursable through the Medicaid state plan
- Therapy services furnished to the individual within the educational/school setting or as a component of the individual's school day
- Specialized equipment (Specialized equipment needed for the provision of Music Therapy services should be purchased under the specialized medical equipment and supplies service; see *Section 11.2: Specialized Medical Equipment and Supplies*)
- Activities delivered in a nursing facility
- Group sizes greater than four individuals to one music therapist or group sizes exceeding the maximum allowable group size determined by the IST for each group individual

Provider Qualifications

Providers must meet the following criteria:

- Enrolled as an active Medicaid provider
- Be FSSA/DDRS-approved
- 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
- 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 accessible from the *IHCP Provider Reference Materials* page at in.gov/medicaid/providers
- Certified Music Therapist by a Certification Board for Music Therapists, that is Accredited by a National Commission for Certifying Agencies
- Where licensure/certification is required, providers rendering waiver funded services must obtain/maintain Indiana-specific licensure/certification

Section 10.16: Occupational Therapy

Service Definition

Occupational therapy services are services provided by a licensed/certified occupational therapist.

These services cannot be provided as a substitute for services offered under the Medicaid state plan.

Reimbursable Activities

Reimbursable activities include the following:

- 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 individual
- 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 hour of billed therapy service must include a minimum of 45 minutes of direct patient care with the balance of the hour spent in related patient services.

Service Standards

The following service standards apply to occupational therapy:

- Individual occupational therapy services must be reflected in the PCISP regardless of the funding source.
- The need for such services must be documented by an appropriate assessment and authorized in the PCISP.
- Documentation of this service being requested on Medicaid State Plan shall be included in the PCISP.

Documentation Standards

Documentation standards for occupational therapy services include the following:

- Documentation by appropriate assessment by a qualified therapist
- Services provided under both the Medicaid state plan and the waiver must be outlined in the PCISP
- Appropriate credentials for service provider
- Attendance record, therapist logs and/or chart detailing services provided, dates and times
- Documentation in compliance with *460 IAC 6* Supported Living Services and Supports requirements

As applicable, monthly/quarterly reports must be uploaded to the document library of the state's case management system by the chosen service provider on or before the 15th day of the following month.

Limitations

If individuals under the age of 21 choose to utilize occupational therapy, they should access occupational therapy services through EPSDT.

One hour of billed therapy service must include a minimum of 45 minutes of direct individual care/therapy with the balance of the hour spent in related individual services.

Activities Not Allowed

The following activities are not allowed under occupational therapy:

- Therapy services furnished to the individual within the educational/school setting or as a component of the individual's school day
- Activities delivered in a nursing facility
- Services that are available through the Medicaid State plan (a Medicaid State plan PA 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.*

Provider Qualifications

Providers must meet the following criteria:

- Enrolled as an active Medicaid provider
- Be FSSA/DDRS-approved
- 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
- 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 accessible from the *IHCP Provider Reference Materials* page at in.gov/medicaid/providers
- Where licensure/certification is required, providers rendering waiver funded services must obtain/maintain Indiana-specific licensure/certification
- For licensed occupational therapist, meet requirements set forth in *IC 25-23.5*

Additional Information:

- Occupational therapy services are available under the FSW and CIH Waiver.
- Physical therapy services are available under the FSW and CIH Waiver.

Section 10.17: Personal Emergency Response System

Service Definition

Personal Emergency Response System (PERS) is an electronic device that enables individuals to secure help in the event of an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center after a "help" button is activated. The response center is staffed by trained professionals.

Additional Information:

- The purpose of equipment or a device under PERS is to enable the individual to secure help in an emergency. If a device doesn't have the ability to initiate a call for help, it doesn't fit this service definition.
- PERS is limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive supervision.
- If the intent and purpose of equipment or a device is to either locate an individual who is lost or to enable the individual to periodically "check in," such as to report making it home safely from an outing, then remote supports would be the appropriate service.
- A human rights committee may need to determine the appropriateness of a device if it is to be worn by the individual as a tracking device.

Reimbursable Activities

Reimbursable activities include the following:

- Device installation service
- Ongoing monthly maintenance of the device

Service Standards

Service standards require that PERS must be included in the PCISP.

Documentation Standards

Documentation standards for a PERS include the following:

- An identified need in the PCISP
- Documentation of expense for installation
- Documentation of monthly rental fee

Limitations

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

Activities Not Allowed

Reimbursement is not available for PERS when the individual requires constant support to maintain health and safety.

Provider Qualifications

Providers must meet the following criteria:

- Be enrolled as an active Medicaid provider
- Be FSSA/DDRS-approved
- 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
- 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 accessible from the *IHCP Provider Reference Materials* page at in.gov/medicaid/providers

Section 10.18: Physical Therapy

Service Definition

Physical therapy services are services provided by a licensed physical therapist.

These services cannot be provided as a substitute for services offered under the Medicaid state plan.

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

Additional Information:

- Therapies provided through this service will not duplicate therapies provided under any other service.
- Physical therapy services are available under the FSW and CIH Waiver.

Reimbursable Activities

Reimbursable activities include the following:

- 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, and 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 individual
- Direct therapeutic intervention
- Training and assistance with adaptive aids and devices
- Consultation or demonstration of techniques with other service providers and family members

Service Standards

The following service standards apply to physical therapy:

- Individual physical therapy services must be reflected in the PCISP, regardless of the funding source.
- The need for such services must be documented by an appropriate assessment and authorized in the PCISP.

Documentation Standards

Physical therapy services documentation must include the following:

- Documentation by appropriate assessment
- Services provided under both the Medicaid state plan and the waiver must be outlined in the PCISP
- Appropriate credentials for service providers
- Attendance record, therapist logs and chart detailing services provided, dates and times

- Documentation in compliance with *460 IAC 6* Supported Living Services and Supports requirements
- Documentation of this service being requested on Medicaid state plan shall be included in the PCISP

As applicable, monthly/quarterly reports must be uploaded to the document library of the state's case management system by the chosen service provider on or before the 15th day of the following month.

Limitations

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.

One hour of billed therapy service must include a minimum of 45 minutes of direct individual care, with the balance of the hour spent in related individual services.

Activities Not Allowed

The following activities are not allowed under physical therapy:

- Therapy services furnished to the individual within the educational/school setting or as a component of the individual's school day
- Activities delivered in a nursing facility
- Services available through the Medicaid state plan (a Medicaid state plan PA 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.*

Provider Qualifications

Providers must meet the following criteria:

- Enrolled as an active Medicaid provider
- Be FSSA/DDRS-approved
- 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 accessible from the *IHCP Provider Reference Materials* page at in.gov/medicaid/providers
- Where licensure/certification is required, providers rendering waiver funded services must obtain/maintain Indiana-specific licensure/certification

Section 10.19: Prevocational Services

Service Definition

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

Individuals 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

Additional Information:

- Prevocational services are available under the FSW and CIH Waiver.
- Facility settings are defined as nonresidential, nonintegrated settings that take place within the same building(s) for the duration of the service rather than being out in the community.
- Community settings are defined as nonresidential, integrated settings that are primarily out in the community where services are not rendered within the same building(s) alongside other nonintegrated individuals.

Reimbursable Activities

Reimbursable activities under prevocational services include the following:

- 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 at less than 50% of the federal minimum wage
  - Generalized and transferrable employment skills acquisition
- These activities may be provided using offsite enclave or mobile community work crew models.

Service Standards

The following service standards apply to prevocational services:

- Prevocational services must be reflected in the PCISP.
- All prevocational services will be reflected in the individual's plan of care as directed to habilitative rather than explicit employment objectives.
- The individual is not expected to be able to join the general workforce or participate in sheltered employment within one year.

Documentation Standards

Prevocational services documentation must include the following:

- Services outlined in the PCISP
- In addition to compliance with documentation requirements outlined in *460 IAC 6*, the following data elements are required for each service rendered:
  - Name of individual served
  - IHCP Member ID (also known as RID) of the individual
  - Name of provider
  - Service rendered
  - Time frame of service (include a.m. or p.m.)
  - Date of service including the year
  - Notation of the primary location of service delivery
  - A brief activity summary of service rendered
  - In addition to the brief activity summary of service rendered, a description by direct care staff of any issue or circumstance concerning the individual including, but not limited to, significant medical or behavioral incidents or any other situation that may be uncommon for the individual
  - Signature that includes at least the last name and first initial of the direct care staff person making the entry (Electronic signatures are permissible when in compliance with the *Uniform Electronic Transactions Act [IC 26-2-8])*

Upon request, all data elements must be made available to auditors, quality monitors, case managers and any other government entity. The documentation may reside in multiple locations, but must be clearly and easily linked to the individual or the standard will not be met.

As applicable, monthly/quarterly reports must be uploaded to the document library of the state's case management system by the chosen service provider on or before the 15th day of the following month.

For Group Services

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

Limitations

The following are limitations on group sizes (individuals:staff) for prevocational services:

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

Monitoring of prevocational services occurs on a quarterly basis. The objectives of monitoring include assessment of the individual's progress toward achieving the outcomes identified on the individual'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.

Activities Not Allowed

The following activities are not allowed under prevocational services:

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

Provider Qualifications

Providers must meet the following criteria:

- Enrolled as an active Medicaid provider
- Be FSSA/DDRS-approved
- 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
- 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 accessible from the *IHCP Provider Reference Materials* page at in.gov/medicaid/providers
- 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

Section 10.20: Psychological Therapy

Service Definition

Psychological therapy services are services provided by a licensed psychologist with an endorsement as a health service provider in psychology (HSPP), a licensed marriage and family therapist, a licensed clinical social worker or a licensed mental health counselor.

These services cannot be provided as a substitute for services offered under the Medicaid state plan.

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.

Additional Information:

- Therapies provided through this service will not duplicate therapies provided under any other service.
- Psychological therapy services are available under the FSW and CIH Waiver.

Reimbursable Activities

Reimbursable activities under psychological therapy include the following:

- 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 individual

Service Standards

The following service standards apply to psychological therapy:

- Therapy services should be reflected in the PCISP of the individuals regardless of the funding source.
- Services must address needs identified in the person-centered planning process and be outlined in the PCISP.
- Services must complement other services the individuals receive and enhance increasing independence for the individual.

Documentation Standards

Psychological therapy services documentation must include the following:

- Documentation by appropriate assessment
- Services provided under both the Medicaid state plan and the waiver must be outlined in the PCISP
- Appropriate credentials for service provider
- Attendance record, therapist logs and/or charts detailing services provided, dates and times

- Documentation in compliance with *460 IAC 6* Supported Living Services and Supports requirements
- Documentation of this service being requested on Medicaid state plan shall be included in the PCISP

As applicable, monthly/quarterly reports must be uploaded to the document library of the state's case management system by the chosen service provider on or before the 15th day of the following month.

Limitations

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.

One hour of billed therapy service must include a minimum of 45 minutes of direct individual care with the balance of the hour spent in related patient services.

Activities Not Allowed

The following activities are not allowed under psychological therapy:

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

> *Note: Therapies provided through this service will not duplicate therapies provided under any other service.*

Provider Qualifications

Providers must meet the following criteria:

- Enrolled as an active Medicaid provider
- Be FSSA/DDRS-approved
- 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
- 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 accessible from the *IHCP Provider Reference Materials* page at in.gov/medicaid/providers
- Where licensure/certification is required, providers rendering waiver funded services must obtain/maintain Indiana-specific licensure/certification:
  - For a clinical social worker, meet requirements set forth in *IC 25-23.6*
  - For a licensed psychologist, meet requirements set forth in *IC 25-33-1-5.1*

  - For a marriage/family therapist, meet requirements set forth in *IC 25-23.6*
  - For a mental health counselor, meet requirements set forth in *IC 25-23.6*

Section 10.21: Recreational Therapy

Service Definition

Recreational therapy services are services provided under *460 IAC 6-3-43* and consisting of a medically approved recreational program to restore, remediate or rehabilitate an individual to:

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

Additional Information:

- Recreational Therapy services are available under the FSW and CIH Waiver.

Reimbursable Activities

Reimbursable activities under recreational therapy services include the following:

- 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 individual
- Individual services

Service Standards

The following service standards apply to recreational therapy:

- Recreational therapy services, regardless of funding source, should be reflected in the PCISP.
- Services must address needs identified in the person-centered planning process and be outlined in the PCISP.
- Services must complement other services the individual receives and enhance increasing independence for the individual.

Documentation Standards

Recreational therapy services documentation must include the following:

- Documentation by appropriate assessment
- Services provided under both the Medicaid state plan and the waiver must be outlined in PCISP
- Appropriate credentials for service provider
- Attendance record, therapist logs and/or charts detailing services provided, dates and times

- Documentation in compliance with *460 IAC 6* Supported Living Services and Supports requirements
- Documentation of this service being requested on Medicaid state plan shall be included in the PCISP

As applicable, monthly/quarterly reports must be uploaded to the document library of the state's case management system by the chosen service provider on or before the 15th day of the following month.

Limitations

- Services provided under the waiver cannot be used as a substitute for services that are provided under the Medicaid state plan.
- Group services in group sizes no greater than four individuals to one recreational therapist (unit rate divided by number of individuals served).
- One hour of billed therapy service must include a minimum of 45 minutes of direct individual care with the balance of the hour spent in related individual services.

Activities Not Allowed

The following activities are not allowed as part of recreational therapy:

- 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 individual within the educational/school setting or as a component of the individual's school day
- Group sizes greater than four individuals to one recreational therapist or group sizes exceeding the maximum allowable group size determined by the IST for each group individual
- Group services when group settings were not determined to be appropriate by the IST for each group individual

Provider Qualifications

Providers must meet the following criteria:

- Enrolled as an active Medicaid provider
- Be FSSA/DDRS-approved
- 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 Insurance *460 IAC 6-12-2*
  - *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
- 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 accessible from the *IHCP Provider Reference Materials* page at in.gov/medicaid/providers.

Section 10.22: Rent and Food for Unrelated Live-in Caregiver

Service Definition

Rent and food for unrelated live-in caregiver services are payment for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in caregiver who resides in the same household as the waiver individual. Payment will not be made when the individual lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

Additional Information:

- Paid caregivers are not eligible for the rent and food for unrelated live-in caregiver service.
- Rent and food for unrelated live-in caregiver services are available only under the CIH Waiver, and not under the FSW.

Reimbursable Activities

Reimbursable activities under rent and food for unrelated live-in caregiver include the following:

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

Service Standards

The following service standards apply to rent and food for unrelated live-in caregiver:

- Rent and food for unrelated live-in caregiver should be reflected in the PCISP.
- Services must address needs identified in the person-centered planning process and be outlined in the PCISP.
- Services must complement other services the individual receives and enhance increasing independence for the individual.
- The person-centered planning team will decide and assure that the individual who will serve as a live-in caregiver has the experience, skills, training and knowledge appropriate to the individual and the type of support needed.

Documentation Standards

Rent and food for unrelated live-in caregiver services documentation must include the following:

- Identified in the PCISP
- Documentation of how amount of rent and food was determined
- Receipt that funds were paid to the live-in caregiver
- Documentation in compliance with *460 IAC 6 Supported Living Services and Supports* requirements

As applicable, monthly/quarterly reports must be uploaded to the document library of the state's case management system by the chosen service provider on or before the 15th day of the following month.

Limitations

See *Activities Not Allowed*.

Activities Not Allowed

The following situations are not allowed under rent and food for unrelated live-in caregiver:

- The individual is not permitted to live in the home of the caregiver or in a residence that is owned or leased by the provider of other services, including Medicaid waiver services.
- The live-in caregiver cannot be related by blood or marriage (to any degree) to the individual and/or has any legal responsibility to support the individual.
- The individual cannot receive live-in caregiver services and structured family caregiving services concurrently.

Provider Qualifications

Providers must meet the following criteria:

- Enrolled as an active Medicaid provider
- Be FSSA/DDRS-approved
- Comply with *Indiana Administrative Code*, *460 IAC 6*, including but not limited to:
  - *460 IAC 6-5-24* Residential Habilitation and Support Services Provider Qualifications
  - *460 IAC 6-14-5* Requirements for Direct Care Staff
  - *460 IAC 6-14-4* Training
- 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 accessible from the *IHCP Provider Reference Materials* page at in.gov/medicaid/providers

Section 10.23: Residential Habilitation and Support – (Hourly)

Service Definition

Residential habilitation and support hourly (RHS hourly) services mean individually tailored supports that are specified in the PCISP that assist with the acquisition, retention or improvement in skills related to

living in the community. These supports include adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult educational supports, and social and leisure skill development that support the individual to live successfully in their own home.

A relative of the individual may be a provider of residential habilitation and support services. 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 individual's relative should continue to be the provider of residential habilitation and support services.

RHS Level 1 and Level 2 services provide up to a full day (24-hour basis) of services and/or supports for individuals assigned an Algo score of 0, 1 or 2*, or individuals assigned any Algo level not meeting criterion for RHS Daily Rate.

The service is billable as either of the following:

- RH1O − Level 1 - for intermittent use of RHS Level 1 at 35 or fewer hours per week; OR
- RH2O − Level 2 - for greater than 35 hours per week of RHS

Algo Score/Descriptors/ICAP/OBA

The following descriptors appear in *Indiana Administrative Code 460 IAC 13-5-1* Algo levels:

Level: 0 (Low)

Descriptor: Individuals with Algo score of zero (0):

(A) High level of independence with few supports needed;

(B) No significant behavioral issues; and

(C) Requires minimal residential habilitation services.

Level: 1 (Basic)

Descriptor: Individuals with Algo score of one (1):

(A) Moderately high level of independence with few supports needed;

(B) Behavioral needs, if any, can be met with medication or informal direction by caregivers through the Medicaid state plan services; and

(C) Likely a need for day programming and light residential habilitation services to assist with certain tasks, but the individual/participant can be unsupervised for much of the day and night.

Level: 2 (Regular)

Descriptor: Individuals with Algo score of two (2):

(A) Moderate level of independence with frequent supports needed;

(B) Behavioral needs, if any, can be met with medication or light therapy, or both, every one (1) to two (2) weeks;

(C) Does not require twenty-four (24) hours a day support; and

(D) Generally able to sleep unsupervised, but needs structure and routine throughout the day.

Level: 3 (Moderate)

Descriptor: Individuals with Algo score of three (3):

(A) Requires access to full-time support for medical or behavioral, or both, needs;

(B) Twenty-four (24) hours a day, seven (7) days a week staff availability;

(C) Behavioral and medical supports are not generally intense; and

(D) Behavioral and medical supports can be provided in a shared staff setting.

Level: 4 (High)

Descriptor: Individuals with Algo score of four (4):

(A) Requires access to full-time support for medical or behavioral, or both, needs:

(i) Twenty-four (24) hours a day, seven (7) days a week frequent staff interaction; and

(ii) Requires line of sight support; and

(B) Has moderately intense needs that can generally be provided in a shared staff setting.

Level: 5 (Intensive)

Descriptor: Individuals with Algo score of five (5):

(A) Requires access to full-time support with twenty-four (24) hours a day, seven (7) days a week absolute line of sight support;

(B) Needs are intense;

(C) Needs require the full attention of a caregiver with a one-to-one staff to individual ratio; and

(D) Typically, only needed by those with intense behavioral needs, not medical needs alone.

Level: 6 (High Intensive)

Descriptor: Individuals with Algo score of six (6):

(A) Requires access to full-time support:

(i) Twenty-four (24) hours a day, seven (7) days a week; and

(ii) More than a one-to-one staff to individual ratio;

(B) Needs are exceptional;

(C) Needs require more than one (1) caregiver exclusively devoted to the individual for at least part of each day; and

(D) Imminent risk of individual harming self or others, or both, without vigilant support.

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

The ICAP assessment determines an individual's level of functioning for broad independence and general maladaptive factors. The ICAP addendum, commonly referred to as the behavior and health factors, determines an individual's level of functioning on behavior and health factors.

These two assessments determine an individual's overall Algo score, which can range from 0-6. Individuals with Algo scores between 0 and 6 are considered outliers representing those who are the lowest and the highest on both ends of the functioning spectrum. On review, the state may manually adjust the designation of an individual from an Algo score of 5 to an Algo score of 6. Although this individual continues receiving the Algo 5 budget, their Algo score of 6 indicates a need for additional oversight of the individual.

The stakeholder group designed a grid to build the allocations. The grid was developed with the following tenets playing key roles:

- Focus on daytime programming
- Employment
- Community integration
- Housemates

The objective-based allocation (OBA) is then determined by combining the overall Algo score (determined by the ICAP and ICAP addendum), age, employment and living arrangement.

Note: Individuals designated as Algo 3, 4 or 5 and meeting criteria for RHS Daily services may choose to use RHS Daily.

Additional Information:

- RHS-hourly services are available only under the CIH Waiver, and not under the FSW.

Reimbursable Activities

RHS includes the following reimbursable activities:

- Direct support, monitoring and training to implement the PCISP outcomes for the individual through the following:
  - Assistance with personal care, meals, shopping, errands, chore and leisure activities, and transportation (excluding transportation that is covered under the Medicaid State Plan)
  - Assurance that direct service staff are aware and active individuals in the development and implementation of PCISP, behavior support plans and risk plans
  - Coordination and facilitation of medical and non-medical services to meet healthcare needs, including physician consults, medications, development and oversight of a health plan, utilization of available supports in a cost effective manner, and maintenance of each individual's health record when the individual receiving RHS does not also utilize wellness coordination Services. Collaboration and coordination with the wellness coordinator when the individual receiving RHS also utilizes wellness coordination services.

When wellness coordination services are utilized in addition to RHS-hourly services, the wellness coordinator is responsible for the development, oversight and maintenance of a wellness coordination plan as well the development, oversight and maintenance of the health-related risk plan, noting that a comprehensive medical risk plan may substitute for the wellness coordination plan or individual risk plans.

The registered nurse/licensed practical nurse (RN/LPN) determines the appropriate mode of training to be used for the direct support professional to ensure implementation of risk plans, noting that training may be by staff trained by the RN/LPN with the exception of nursing delegated tasks or other items the nurse feels that only a licensed nurse should train.

Additionally, the RN/LPN ensures completion of training of the direct support professional to ensure implementation of risk plans.

Group services/shared staffing is reimbursable at the unit rate divided by the number of individuals sharing RHS staffing. Group services/shared staffing is not billable at a 1:1 ratio.

Service Standards

The following service standards apply to RHS hourly:

- Services must address needs identified in the person-centered planning process and be outlined in the PCISP.
- RHS-hourly services should complement but not duplicate habilitation services being provided in other settings.
- Services provided must be consistent with the individual's service plan.

Documentation Standards

RHS-hourly documentation must include the following:

- Services must be outlined in the PCISP.
- Data record of staff-to-individual service must document the complete date and time entry (including a.m. or p.m.). All staff members who provide uninterrupted, continuous service in direct supervision or care of the individual must make one entry. If a staff member provides interrupted service (one hour in the morning and one hour in the evening), an entry for each unique encounter must be made. All entries should describe an issue or circumstance concerning the individual. The entry should include complete time and date of entry and at least the last name, first initial of the staff person making the entry.
- If the person providing the service is required to be professionally licensed, the title of that individual must also be included. For example, if a nurse is required, the nurse's title should be documented.
- Any significant issues involving the individual requiring intervention by a healthcare professional, case manager or BDDS staff member that involved the individual are also to be documented.
- Quarterly reporting summaries are required.
- Documentation must be in compliance with *460 IAC 6*.

As applicable, monthly/quarterly reports must be uploaded to the document library of the state's case management system by the chosen service provider on or before the 15th day of the following month.

Limitations

The following are limitations on RHS-hourly services:

- Reimbursable waiver funded services furnished to an adult waiver individual 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 relative follows the *Activities Not Allowed* section below.)

Additionally:

- Providers may not bill for RHS (hourly) reimbursement for time when staff/paid caregiver is asleep. Only awake, engaged staff can be counted in reimbursement. (A team may decide that a staff or contractor may sleep while with an individual, but this activity is not billable.)
- Providers may only bill for RHS reimbursement during the time when an individual receiving HCBS waiver services is admitted to an acute care hospital setting for inpatient medical care or other related services for surgery, acute medical condition or injuries if all conditions specified in guidance under *Section 2.3: Claims and Billing* in this module are met.
- Providers may not bill for RHS reimbursement during the time when an individual is admitted for an extended stay hospitalization, or when individuals require long-term care in a facility-based setting including but not limited to nursing homes, rehabilitation centers and/or treatment facilities. (As specified under guidance in *Section 2.3: Claims and Billing* in this module, the care and support of an individual who is admitted to a hospital or facility for long-term is a non-billable RHS activity.)
- RHS Level 1 and RHS Level 2 and remote support services are not billable concurrently/during the same time period.
- Intermittent use of RHS Level 1 may not exceed thirty-five (35) hours of service per week.

> *Note: Per Indiana Code [IC 12-11-1.1], supported living service arrangements providing residential services may not serve more than four (4) unrelated individuals in any one (1) setting. However, a program that was in existence on January 1, 2013, as a supervised group living program described within IC 12-11-1.1 and having more than four (4) individuals residing as part of that program, was allowed to convert to a supported living service arrangement and continue to provide services to up to the same number of individuals in the supported living setting.*

Activities Not Allowed

Reimbursement is not available through RHS-hourly in the following circumstances:

- Services furnished to a minor by the parent(s), stepparent(s) or legal guardian
- Services furnished to an individual by the individual's spouse
- Services to individuals in structured family caregiving (SFC) services or children's foster care services
- Services that are available under the Medicaid state plan

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:

- Aunt (natural, step, adopted)
- Brother (natural, step, half, adopted, in-law)
- Child (natural, step, adopted)
- First cousin (natural, step, adopted)
- Grandchild (natural, step, adopted)
- Grandparent (natural, step, adopted)
- Nephew (natural, step, adopted)
- Niece (natural, step, adopted)
- Parent (natural, step, adopted, in-law)
- Sister (natural, step, half, adopted, in-law)
- Spouse (husband or wife)
- Uncle (natural, step, adopted)

Provider Qualifications

Providers must meet the following criteria:

- Enrolled as an active Medicaid provider
- Be DDRS-approved
- Comply with *460 IAC 6*, including but not limited to:
  - *460 IAC 6-5-24* Residential Habilitation and Support Services Provider Qualifications
  - *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 6-5-14* Health Care Coordination Services Provider Qualifications
  - *460 IAC 6-14-4* Staff Training and *460 IAC 6-14-4* Training
  - *460 IAC 6-5-30* Transportation Services Provider Qualifications
  - *460 IAC 6-5-31* Transportation Supports Provider Qualifications
- 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 accessible from the *IHCP Provider Reference Materials* page at in.gov/medicaid/providers

In accordance with *Indiana Code 12-11-1.1-1*, RHS providers 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
- The Council on Accreditation, or its successor
- An independent national accreditation organization approved by the secretary

Section 10.24: Respite Care

Service Definition

Respite care services means services provided to individuals 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 individual. Respite care can be provided in the individual'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).

Additional Information:

- Respite care services are available under the FSW and CIH Waiver.
- Respite may be used intermittently to cover those hours normally covered by an unpaid caregiver.

Reimbursable Activities

Reimbursable activities under respite care include the following:

- 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 individuals served)

Service Standards

The following service standards apply to respite care:

- Respite care must be reflected in the PCISP.
- Respite nursing care (RN) or respite nursing care LPN) services may be delivered only when skilled care is required and documented in the PCISP.

Documentation Standards

A service note can include multiple discrete services, as long as discrete services are clearly identified. A service note must include:

- Individual name
- IHCP Member ID (also known as RID) of the individual
- Date of service
- Provider rendering service
- Primary location of services rendered

An activity summary for each block of time this service is rendered must exist and must include duration, service, a brief description of activities, significant medical or behavioral incidents requiring intervention, or any other situation that is uncommon for the individual. A staff signature must be present for each block of time claimed on a service note. A new entry is not required unless a different discrete service is provided (that is, one continuous note may exist even if the ratio changes).

As applicable, monthly/quarterly reports must be uploaded to the document library of the state's case management system by the chosen service provider on or before the 15th day of the following month.

For Group Services

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

Electronic signatures are acceptable if the provider has a log on file showing the staff member's electronic signature, actual signature and printed name.

Limitations

Waiver-funded respite services may not be rendered in a nursing facility.

Activities Not Allowed

The following activities are not allowed under respite care:

- Reimbursement for room and board
- Services provided to an individual 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 is being furnished to the individual or when the individual is in Children's Foster Care
- Other family members (such as siblings of the individual) may not receive care or support from the provider while respite care is being provided/billed for the waiver individual(s)
- Respite care used as day/child care
- Respite care 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 an individual while the individual is attending school
- Respite care shall 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 individual's PCISP
- Services furnished to a minor by a parent(s), stepparent(s) or legal guardian
- Services furnished to an individual by the individual's spouse

Provider Qualifications

Providers must meet the following criteria:

- Enrolled as an active Medicaid provider
- Be FSSA/DDRS-approved
- 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
- 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 accessible from the *IHCP Provider Reference Materials* page at in.gov/medicaid/providers
- Where licensure/certification is required, providers rendering waiver funded services must obtain/maintain Indiana-specific licensure/certification
  - For LPNs and RNs, meet requirements set forth in *IC 25-23*
  - For home health agencies, meet requirements set forth in *IC 16-27-1* for Home Health Agency, *IC 25-23-1* for RN and LPN; *IC 16-27-1.5* for Home Health Aide, Registered

Section 10.25: Specialized Medical Equipment and Supplies

Service Definition

Specialized medical equipment and supplies include:

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

DDRS's waiver services staff must approve all specialized medical equipment and supplies prior to service being rendered.

Additional Information:

- Specialized medical equipment and supplies services are available under the FSW and CIH Waiver.
- Sensory items, seizure detection devices, GPS tracking devices and other electronic devices not currently specified as items covered or reimbursable in the waiver or current Request for Approval to Authorize Services (RFA) policy may be electronically submitted for consideration under specialized medical equipment and supplies (SMES) via the request for approval to authorize services form as outlined in Section 11 of this module.

Reimbursable Activities

Reimbursable activities under specialized medical equipment and supplies services include the following:

- 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
  - It is the responsibility of the provider to offer interpreter services if needed by the individual. Per the *Introduction to the IHCP* provider reference module, the provider makes available free aids and services to people with disabilities to communicate effectively with the provider, including qualified interpreters, written information in other formats and free language services to people whose primary language is not English.

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.

Documentation Standards

Specialized medical equipment and supplies services documentation must include the following:

- Identified need in PCISP and the POC/CCB
- Identified direct medical benefit for the individual
- Documentation of the *request* for **Medicaid** state plan **PA**
- Documentation of the *reason of denial* of **Medicaid** state plan **PA**
- Signed and approved *Request for Approval to Authorize Services* (State Form 45750)
- Receipts for purchases

Limitations

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 under the Family Supports Waiver (FSW).
- Specialized medical equipment and supplies (SMES) has no lifetime cap under the Community Integration and Habilitation (CIH) Waiver

The services under the CIH Waiver and FSW are limited to additional services not otherwise covered under the state plan, including Early and Periodic Screening, Diagnosis and Treatment (EPSDT), but consistent with waiver objectives of avoiding institutionalization.

Activities Not Allowed

The following activities are not allowed under specialized medical equipment and supplies:

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

Provider Qualifications

Providers must meet the following criteria:

- Enrolled as an active Medicaid provider
- Be FSSA/DDRS-approved
- 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
- 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 accessible from the *IHCP Provider Reference Materials* page at in.gov/medicaid/providers.
- Where licensure/certification is required, providers rendering waiver funded services must obtain/maintain Indiana-specific licensure/certification. Examples include but are not limited to:
  - For licensed/certified occupational therapist, meet requirements set forth in *IC 25-23.5*
  - For licensed physical therapist, meet requirements set forth in *IC 25-27-1*
  - For DDRS-approved pharmacies (as applicable), meet requirement set forth in *IC 25-26-13-18*
  - For speech/language therapist, meet requirements set forth in *IC 25-35.6*
  - For home health agencies, meet requirements set forth in *IC 16-27-1*

Section 10.26: Speech/Language Therapy

Service Definition

Speech/language therapy services are services provided by a licensed speech pathologist under *460 IAC 6* Supported Living Services and Supports requirements.

These services cannot be provided as a substitute for services offered under the Medicaid state plan.

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.

Additional Information:

- Therapies provided through this service will not duplicate therapies provided under any other service.
- Speech/language therapy services are available under the FSW and CIH Waiver.

Reimbursable Activities

Reimbursable activities under speech/language therapy services include the following:

- 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 nonverbal 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 individual

Service Standards

The following service standards apply to speech/language therapy:

- Individual speech/language therapy services must be reflected in the PCISP regardless of funding sources.
- To be eligible for this service, the individual must have been examined by a certified audiologist and/or a certified speech therapist who has recommended a formal speech and audio logical program.
- The need for such services must be documented by an appropriate assessment and authorized in the individual's PCISP.

Documentation Standards

Speech/language therapy services documentation must include the following:

- Documentation of an appropriate assessment
- Services provided under both the Medicaid state plan and the waiver outlined in the PCISP
- BDDS-approved provider
- Appropriate credentials for service provider
- Attendance record, therapist logs and/or chart detailing services provided, dates and times
- Documentation in compliance with *460 IAC 6* Supported Living Services and Supports requirements
- Service being requested on Medicaid state plan included in the PCISP

As applicable, monthly/quarterly reports must be uploaded to the document library of the state's case management system by the chosen service provider on or before the 15th day of the following month.

Limitations

If individuals under age 21 choose to utilize speech/language therapy, they should access speech/language therapy services through EPSDT.

One hour of billed therapy service must include a minimum of 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.

Activities Not Allowed

The following activities are not allowed under speech/language therapy:

- Services available through the Medicaid state plan (a Medicaid state plan PA denial is required before reimbursement is available through the Medicaid waiver for this service)
- Therapy services furnished to the individual within the educational/school setting or as a component of the individual's school day
- Activities delivered in a nursing facility
- Therapies provided through this service will not duplicate therapies provided under any other service

Provider Qualifications

Providers must meet the following criteria:

- Enrolled as an active Medicaid provider
- Be DDRS-approved
- 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
- 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 accessible from the *IHCP Provider Reference Materials* page at in.gov/medicaid/providers
- Speech/Language Therapists rendering waiver funded services must obtain/maintain Indiana licensure.
- Where licensure/certification is required, providers rendering waiver funded services must obtain/maintain Indiana-specific licensure/certification
  - For speech/language therapist, meet requirements set forth in *IC 25-35.6*
  - For home health agencies, meet requirements set forth in *IC 16-27-1*

Section 10.27: Transportation

Service Definition

Transportation services are services to transfer individuals in a vehicle from the point of pick-up to a destination point. Transportation services enable individuals to access nonmedical 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 on the needs of the individual, 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 an individual who for medical reasons must remain prone during transportation (such as ambulette).

Additional Information:

- Available under the FSW and CIH Waiver.
- There is no prohibition against using transportation services to get to or from a place of employment providing this is reflected in the PCISP.
- Transportation may be used to reach any nonmedical destination or activity outlined within the PCISP.

Reimbursable Activities

Reimbursable activities under transportation services include the following:

- Two one-way trips per day to or from a nonmedical community service or resource or place of employment as specified on the PCISP and provided by an approved provider of RHS (a service currently available only under the CIH Waiver), day habilitation, adult day services or transportation services.
- Bus passes or alternate methods of transportation may be used 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 individual'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 that can provide transportation services without charge will be utilized.

Service Standards

The following service standards apply to transportation services:

- Transportation services are offered in addition to medical transportation required under *42 CFR 431.53* and transportation services under the Medicaid State Plan, defined at *42 CFR 440.170(a)* (if applicable), and shall not replace them.

- Transportation services under the waiver shall be offered in accordance with the PCISP, and when unpaid transportation is not available.
- Whenever possible, family, neighbors, friends or community agencies that can provide this service without charge will be utilized.

Documentation Standards

Documentation for transportation services must include the following:

- Service notes
  - A service note can include multiple discrete services as long as discrete services are clearly identified.
  - A service note entry for this service can be part of a comprehensive daily note with other services recorded, as long it is clearly separated from other services in the note.
  - A service note must include the following:
    - Individual/waiver individual name
    - IHCP Member ID (also known as RID) of the individual
    - Date of service
    - Provider rendering service
    - Pick-up point and destination
- If contract transportation is used, contractor must provide log and invoice support that includes dates of transportation provided.
- If bus passes or alternative methods of transportation are used, invoices and attendance logs must support days for which round trips are billed to the waiver.

Limitations

Note that no individual is excluded from participating in nonmedical waiver transportation services.

Annual limits are applied to the nonmedical waiver transportation services.

- For the CIH Waiver, the costs of nonmedical transportation services are paid for outside of and in addition to the individuals' annual allocation amount that is determined by their Algo score.
  - The annual limits for each level of nonmedical waiver transportation under the CIH Waiver are:
    - $2,625 for Level 1 Transportation
    - $5,250 for Level 2 Transportation
    - $7,875 for Level 3 Transportation
- For the FSW, the costs of nonmedical transportation services and are paid for within the waiver's $19,614 annual cap.
  - The annual limits for each level of nonmedical waiver transportation under the FSW are:
    - $2,995 for Level 1 Transportation
    - $5,985 for Level 2 Transportation
    - $8,977.50 for Level 3 Transportation

Activities Not Allowed

Reimbursement is not available under transportation services for the following activities:

- May not be used to meet medical transportation needs already available under the Indiana Medicaid State Plan.
- May not be used in conjunction with the structured family care services available under the CIH Waiver.

Provider Qualifications

Providers must meet the following criteria:

- Enrolled as an active Medicaid provider
- Be FSSA/DDRS-approved
- 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
  - *460 IAC 6-14-4* Staff Training
- 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 accessible from the *IHCP Provider Reference Materials* page at in.gov/medicaid/providers

Section 10.28: Workplace Assistance

Service Definition

Workplace assistance services provide a range of personal care services and/or supports during paid competitive community employment hours and in a competitive community employment setting to enable waiver individuals 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 individual) or prompting the individual to perform a personal care task. Workplace assistance services may be provided on an episodic or on a continuous basis.

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

Additional Information:

- Workplace Assistance services are available under the FSW and CIH Waiver.
- Workplace Assistance may be used in conjunction with extended services.
- Workplace Assistance may be used with each hour the individual is engaged in paid competitive community employment, including employment hours overlapping with extended services.

Reimbursable Activities

Reimbursable activities under workplace assistance include the following:

- Direct support, 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 and so forth)
- May have been used in conjunction with extended services
- May be used with each hour the individual is engaged in paid competitive community employment

Service Standards

The following service standards apply to workplace assistance:

- Workplace assistance services must be reflected in the PCISP.
- Workplace assistance services should complement but not duplicate day habilitation services being provided in other settings.
- Workplace assistance services may only be delivered in the employment setting.
- There is no requirement for a physician's prescription or authorization. The need for workplace assistance services is determined entirely by the IST.

Documentation Standards

Workplace assistance services documentation must include the following:

- Services must be outlined in the PCISP.
- In addition to compliance with documentation requirements outlined in *460 IAC 6*, the following data elements are required for each service rendered:
  - Name of individual served
  - IHCP Member ID (also known as RID) of the individual
  - Name of provider
  - Service rendered
  - Time frame of service (include a.m. or p.m.)
  - Date of service including the year
  - Notation of the primary location of service delivery
  - A brief activity summary of service rendered
  - In addition to the brief activity summary of service rendered, a description by direct care staff of any issue or circumstance concerning the individual including, but not limited to, significant medical or behavioral incidents or any other situation that may be uncommon for the individual
  - Signature that includes at least the last name and first initial of the direct care staff person making the entry (Electronic signatures are permissible when in compliance with the *Uniform Electronic Transactions Act [IC 26-2-8]*.)

Upon request, all data elements must be made available to auditors, quality monitors, case managers and any other government entity. The documentation may reside in multiple locations, but must be clearly and easily linked to the individual or the standard will not be met.

As applicable, monthly/quarterly reports must be uploaded to the document library of the state's case management system by the chosen service provider on or before the 15th day of the following month.

Limitations

The following are limitations on workplace assistance services:

- Allowed Ratio – Individual, one client to one staff.
- Reimbursement for workplace assistance services is available only during the individual's hours of paid, competitive community employment.

Activities Not Allowed

Reimbursement is not available through workplace assistance under the following circumstances:

- When services are furnished to a minor child by the parent(s), stepparent(s) or legal guardian
- When services are furnished to an individual by that individual'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 individual for the purpose of teaching job tasks or to ascertain the success of the job placement.
- Workplace assistance is ***not*** to be used for offsite monitoring when the monitoring directly relates to maintaining a job.
- Workplace assistance is ***not*** to be used for the provision of skilled job trainers who accompany the individual 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, individuals, parents, family members, guardians, advocates or authorized representatives of the individuals, or other appropriate professional or informed advisors, 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 individual.
- Workplace Assistance is ***not*** to be used for staff time in traveling to and from a work site.

Provider Qualifications

Providers must meet the following criteria:

- Enrolled as an active Medicaid provider
- Be FSSA/DDRS-approved
- 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* Staff Training and *460 IAC 6-14-4* Training
  - *460 IAC 6-5-30* Transportation Services Provider Qualifications
  - *460 IAC 6-5-31* Transportation Supports Provider Qualifications
- 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 accessible from the *IHCP Provider Reference Materials* page at in.gov/medicaid/providers

Section 10.29: Case Management

Service Definition

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 include annual planning and assessment and ongoing case management support.

Additional Information:

- Case management services are mandatory for all waiver individuals under both the FSW and CIH Waiver.
- Case management services are provided only by the DDRS-approved case management organizations/entities awarded contracts through the selected contracting process of the §1915(b)(4) waiver, which operates concurrently with the §1915(c) waivers.

Reimbursable Activities

Reimbursable activities under case management services include the following:

- Annual planning and assessment – initial and annual activities outlined by BDDS that support the individual in:
  - 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
  - Developing an annual budget in support of the PCISP
  - Determining continued eligibility for services
- Ongoing case management services are based on the principles of person-centered thinking and driven by the PCISP. Person-centered practices include:
  - Convening IST meetings at least semiannually:
    - 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.

- 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 semiannually and as needed:
  - At least one visit each year must be held in the home of the waiver individual.
  - 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.
  - Face-to-face visits must be intentional interactions and may not be held as drop-in visits at a day program.
  - IST meetings and face-to-face contacts are both required in a manner that ensures interaction at least every 90 days.
- Regularly reviewing and updating the PCISP including when:
  - The needs or circumstances of the individual have changed.
  - Services are added or changed.
  - At the request of the individual and guardian, if applicable.
  - For nonannual team meetings, to record team discussions on outcomes and any related plan changes.
- Identifying, assessing and addressing risks initially and as needed
- Updating service plans and timely submission of budget requests consistent with the individual's PCISP
- Monitoring service delivery and utilization to ensure that services are being delivered in accordance with the PCISP
- Monitoring individuals' health and safety
- Assessing individuals' satisfaction and service outcomes and sharing the results with BDDS at least annually
- Completing and processing the Monitoring Checklist within BDDS established timeline
- Completing, submitting and following up on incident reports as established by BQIS
- Completing case notes and necessary PCISP revisions documenting each encounter with or on behalf of the individual within seven calendar days at a minimum
  - Case managers must have at least one documented meaningful encounter monthly to support billing.
- Disseminating information including the PCISP, all Notices of Action and forms to the individual, guardian, if applicable, and the IST
- Maintaining files in accordance with state standards
- In the absence of a residential provider, conducting mortality reviews in accordance with *460 IAC 6* and BDDS/BQIS policy and guidance

For the CIH Waiver only:

- Case management services may be available during the last 180 consecutive days of a Medicaid eligible individual's institutional stay to allow case management activities to be performed specifically related to transitioning the individual from an institutional setting which include the following: nursing facility, comprehensive rehabilitative management needs facility, state psychiatric facility, ICF/IID to DDRS HCBS services.
  - The individual must be approved for Medicaid waiver services and fully transitioned into a DDRS HCBS waiver setting for case management to be billed. If the individual dies during the transition process, billing can still be an option.
  - The need for transitional service should be clearly documented in the PCISP.
  - Case management services may be available in adherence to specific MFP-related activities or requirements for individuals transitioning to the community from an institutional setting.

Note: The need for the transitional service should be clearly documented in the PCISP.

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:
  - Services delivered to persons who do not meet eligibility requirements established by DDRS/BDDS
  - 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*)
  - Case management conducted by a person related through blood or marriage to any degree to the waiver individual

Service Standards

The following service standards apply to case management by any organization/entity selected as a contractor of case management services:

- Perform the activities listed in the *Reimbursable Activities* section.
- Case managers must understand, maintain and assert that the Medicaid program functions as the payer of last resort. The role of the case manager includes care planning, service monitoring, working to cultivate and strengthen informal and natural supports for each individual, and identifying resources and negotiating the best solutions to meet identified needs. Toward these ends, case managers are required to:
  - Demonstrate a willingness and commitment to explore, pursue, access and maximize the full array of non-waiver-funded services, supports, resources and unique opportunities available within the individual's local community, thereby enabling the Medicaid program to complement other programs or resources.
  - Be a trained facilitator who has completed a training provided by a BDDS-approved training entity or person; observed a facilitation; and participated in a person-centered planning meeting prior to leading an IST.
- At minimum, the case management entity must provide a 60-day notice to the individual (and to their legal guardian, if applicable) prior to the termination of case management services.
- Upon request of the individual and/or their legal guardian, if applicable, the individual's most recently selected case management entity must provide a provider choice list of alternate DDRS-approved contractors of case management services and assist the individual in selecting a new provider of case management.

Noting the individuals' right to select and transition to a new provider of case management services at any time, only one selected contractor of case management services may bill for the authorized monthly unit of case management services during any given month. With the state's approval of the individual's POC/CCB, a single PA of the monthly case management service unit will be sent from the administrative

agency (DDRS) to the contractor of the Medicaid Management Information System (MMIS). Therefore, it is *recommended* that transitions from one case management entity/organization to another occur on the first day of the month. When transitions occur on other days of the month, the two providers of case management services must determine which contracting provider entity will bill and whether one entity owes the other a portion of the monthly fee. Providers will handle any such transactions and/or arrangements amongst themselves, with both (or all involved) contracting provider entities being held responsible for documenting these transactions in regard to future financial audits.

Documentation Standards

Case managers must perform and document one meaningful activity with or on behalf of the waiver individual each calendar month in case notes to support billing. The case note must include applicable information that informs the reader:

- Who the contact or activity was with
- What was the purpose of the contact or activity
- What was discussed and what decisions were reached
- What next steps will be taken
- What was the date of the contact or activity

Examples:

1. CM Smith contacted Sam and his mother to schedule the annual planning meeting due in September. An agenda for the meeting was discussed as well as who Sam and his mother would like invited to the meeting. Sam is enjoying camping with his family and would like to have the meeting in his backyard so he can show his team his new tent. The meeting will be held on September 20th at Sam's house. CM will share the time and location with the team and ask them to bring their own lawn chairs. Mom will contact Sam's aunt, as he would like her at his team meeting.
2. CM Smith called Mary to schedule a face-to-face meeting but there was no answer. As case noted, the CM has tried to reach Mary for a couple of months, but Mary hasn't returned the calls, texts or emails sent. An unannounced visit was attempted on July 5, 2020, but no one was home. CM Smith will contact Supervisor Jones to see if a certified letter should be sent or BDDS contacted for assistance in connecting with Mary.

Preferred practice calls for activity to be documented via case note within 48 hours of a Case Management activity or event. At a minimum, a case note must be completed within seven calendar days of an activity or event.

Provider Qualifications

Case management service by selected contracting organizations/entities must meet the following criteria:

- Enrolled as an active Medicaid provider
- Be FSSA/DDRS-approved
- Be eligible to provide case management services in every Indiana county
- 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 6-19-1* through *460 IAC 6-19-9* Case Management
  - *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:
  - 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
- 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 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.

> ** Note: Five of the six awarded selected contracting case management organizations (CMO) were already operating statewide at the time of the state's request for services. The one remaining CMO was given a six-month window as of the Oct.1, 2021, award announcement to become statewide for the concurrent operation of the* ***§1915(c) and §1915(b)(4) waivers.***

- 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.
  - Persons in this role may not carry a case load of more than 10 cases.
  - Persons in this role may not do quality and compliance reviews on their own caseload.
  - 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 organizations/agencies specifically agree to comply with the provisions of the Americans with Disabilities Act of 1990 (*U.S. Code 42 USC 12101* et seq. and *47 USC 225*).
- Case management entities must:
  - 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* module accessible from the *IHCP Provider Reference Materials* page at in.gov/medicaid/providers
  - 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

- Require initially and annually, that each case manager employed by the DDRS-approved case management organization/agency obtain proof of competency demonstrated through successful completion of the DDRS/BDDS case management training curriculum and certification exam
- Ensure case managers complete and demonstrate competency of the BDDS required training
- Ensure case managers complete the required hours of BDDS approved, case management entity provided, training
- 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
- 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
- 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.
  - 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.
  - 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 they serve.

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:
  - Case management organizations/agencies may not be an approved provider of any other waiver service.
  - The owners of one case management organization/agency may not own multiple case management organizations/agencies.
  - The owners of one case management organization/agency may not be a stakeholder of any other waiver service agency.
  - There may be no financial relationship between the referring case management organization/agency, its staff and the provider of other waiver services.
  - Case managers may not be financially influenced in the course of their service delivery.
- In addition, case managers must not be:
  - Related by blood or marriage to the individual
  - Related by blood or marriage to any paid caregiver of the individual

  - Financially responsible for the individual
  - Authorized to make financial or health-related decisions on behalf of the individual

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

Section 10.30: Participant Assistance and Care

Service Definition

Participant assistance and care (PAC) services are provided to allow individuals with intellectual/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 individual 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 individual.

A relative of the individual 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 individual's relative should continue to be the provider of PAC.

Additional Information:

- Individuals will use any appropriate services available under the Indiana Medicaid state plan.
- Utilization of PAC services does not prohibit the use of any other service available under the FSW that is outlined on the PCISP.
- PAC services are available only under the FSW. PAC is not available under the CIH Waiver.

Reimbursable Activities

Reimbursable activities under participant assistance and care services include the following:

- Activities may include any task or tasks of direct benefit to the individual that would generally be performed independently by persons without intellectual/developmental disabilities or by family members for or on behalf of persons with intellectual/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 individual to community activities and appointments
  - Support and person-centered monitoring of the individual
  - Reinforcement of behavioral support
  - Adherence to risk plans
  - Reinforcement of principle 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 to claim reimbursement)
  - PCA is available individually or as a shared service

Service Standards

The following service standards apply to participant assistance and care:

- PAC services must follow a written POC addressing the specific needs determined by the individual's assessment and identified in the PCISP
- Ability to consult with a nurse as needed (on staff or on call for the provider)

Documentation Standards

Participant assistance and care services documentation must include:

- Recorded completion of tasks on an individual-specific task list (created by the IST) that includes identification of paid staff members as well as the date and start/stop time of each waiver-funded shift
- Documentation in compliance with *460 IAC 6*

As applicable, monthly/quarterly reports must be uploaded to the document library of the state's case management system by the chosen service provider on or before the 15th day of the following month.

Limitations

The following are limitations on participant assistance and care services:

- Reimbursable waiver funded PAC services furnished to a waiver individual 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. (See *Activities Not Allowed* for definition of relative)
- Shared/group services in group sizes no greater than four individuals to one paid staff member of the PAC provider (unit rate divided by number of PAC individuals sharing service)

Activities Not Allowed

PAC services will not be provided to household members other than to the waiver individuals.

- Reimbursable waiver funded services furnished to an adult waiver individual relatives and/or legal guardian(s)may not exceed a total of 40 hours per week per relative.

Reimbursement is not available through PAC in the following circumstances:

- When services are furnished to a *minor* by the parent(s), step-parent(s) or legal guardian(s)
- When services are furnished to an individual by the individual'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 the *Individuals with Disabilities Education Act*
- For homeschooling, special education and related activities
- 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
- For transportation costs

- Group sizes greater than four individuals to one 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 individual
- 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.
- Regarding hospitalizations:
  - Providers may only bill for PAC reimbursement during the time when an individual receiving HCBS waiver services is admitted to an acute care hospital setting for inpatient medical care or other related services for surgery, acute medical condition, or injuries if all conditions specified in guidance under *Section 2.3: Claims and Billing* in this module are met
  - Providers may not bill for PAC reimbursement during the time when an individual is admitted for an extended stay hospitalization, or when individuals require long term care in a facility-based setting including but not limited to nursing homes, rehabilitation centers and/or treatment facilities. (As specified under guidance in *Section 2.3: Claims and Billing* in this module, the care and support of an individual who is admitted to a hospital or facility for long-term is a non-billable PAC activity)

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:

- Aunt (natural, step, adopted)
- Brother (natural, step, half, adopted, in-law)
- Child (natural, step, adopted)
- First cousin (natural, step, adopted)
- Grandchild (natural, step, adopted)
- Grandparent (natural, step, adopted)
- Nephew (natural, step, adopted)
- Niece (natural, step, adopted)
- Parent (natural, step, adopted, in-law)
- Sister (natural, step, half, adopted, in-law)
- Spouse (husband or wife)
- Uncle (natural, step, adopted)

Available individually or as a shared service:

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

Provider Qualifications

Providers must meet the following criteria:

- Enrolled as an active Medicaid provider
- Be FSSA/ DDRS-approved
- 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* Staff Training and *460 IAC 6-14-4* Training
  - *460 IAC 6-14-5* Requirements for Direct Care Staff
- Training in completion of Task List
- 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 accessible from the *IHCP Provider Reference Materials* page at in.gov/medicaid/providers

Section 10.31: Structured Family Caregiving

Service Definition

Structured family caregiving (SFC) means a living arrangement in which an individual lives in the private home of a principal caregiver who may be a non-family member (foster care) or a family member who is not the individual's spouse, the parent of the individual who is a minor, or the legal guardian of the minor individual. Guardians of adult individuals are allowed to provide structured family caregiving with agreement of the individualized support team (IST).

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

Additional Information:

- *Structured family caregiving services are available only under the CIH Waiver.*
- *Structured family caregiving is not available under the FSW.*

Service Levels and Rates

There are three service levels of structured family caregiving each with a unique rate. The Algo score assigned to the individual will determine the appropriate level of structured family caregiving service and reimbursement to be utilized in the person-centered individualized support plan (PCISP) at the individual's next annual anniversary date.

- Level 1 – Appropriate for individuals choosing structured family caregiving having an Algo score of 0 or 1
- Level 2 – Appropriate for individuals choosing structured family caregiving and having an Algo score of 2
- Level 3 – Appropriate for individuals choosing structured family caregiving and having an Algo score of 3, 4, 5 or 6

Reimbursable Activities

Reimbursable activities under structured family caregiving services include the following:

- Personal care and services
- Homemaker or chore services
- Attendant care and companion care services
- Medication oversight
- Respite services for the family caregiver must be offered and funding for respite service is included in the per diem paid to the service provider. The actual service of respite care may not be billed in addition to the per diem
- Transporting the participant when indicated in the PCISP
- Other appropriate supports as described in the PCISP

Service Standards

The following service standards apply to SFC:

- Structured family caregiving services must be reflected in the PCISP.
- Services must address the needs (for example, intellectual/developmental needs, vocational needs and so forth) identified in the person-centered planning process and must be outlined in the PCISP.
- Ten percent of the total per diem amount is intended for use by the provider for respite care as needed. It is the provider's responsibility to approve any providers of respite chosen by the family or the individual.
- The provider determines the total amount per month paid to the family caregiver.
- The agency's administrative/supervision fee comes from the remaining total amount and includes the following duties:
  - Publish written policies and procedures regarding SFC support services
  - Maintain financial and service records to document services provided to the individual
  - Establish a criteria for the acceptance of the family caregiver or foster parent; screen potential family caregivers/foster parents for qualities of stability, maturity and experiences so as to ensure the safety and well-being of the individual; and obtain a criminal background and reference check
  - Coordinate/provide adequate initial training and ongoing training, consultation, and supervision to the family caregiver/foster parent
  - Provide for the safety and well-being of the individual by inspection of environment for compliance with the DDRS policies and procedures, including, but not limited to, the provider and case management standards found in *460 IAC 6* Supported Living Services and Supports requirements
  - Reimburse the family caregiver/foster parent

Documentation Standards

SFC services documentation must include:

- Written policies and procedures, including for screening and accepting family caregivers/foster parents
- Maintaining financial and service records to document services provided to the individual

- Documenting provision of training to family caregivers according to agency policies/procedures
- Reimbursement of family caregiver/foster parent
- One entry per individual per week

As applicable, monthly/quarterly reports must be uploaded to the document library of the state's case management system by the chosen service provider on or before the 15th day of the following month.

Documentation by Families

Under SFC services, families must provide the following documentation:

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

Limitations

Separate payment will not be made for homemaker or chore services furnished to an individual receiving structured family caregiving, because these services are integral to and inherent in the provision of structured family caregiving services.

Activities Not Allowed

Structured family caregiving services will not be provided to household members other than to the waiver individuals. Reimbursement is not available through SFC in the following circumstances:

- Services provided by a caregiver who is the spouse of the individual or the parent of the minor individual.
- The service of residential habilitation and support (whether paid hourly or daily) is not available to individuals receiving structured family caregiving services.
- Transportation services through the waiver may not be separately billed in conjunction with structured family caregiving services.
- The limit is a maximum of four waiver individuals per structured family caregiving household.

Provider Qualifications

Providers must meet the following criteria:

- Enrolled as an active Medicaid provider
- Be FSSA/DDRS-approved

- 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
  - ~~*4*~~*60 IAC 6-5-3* Adult Foster Care Services Provider Qualifications
  - *460 IAC 6-14-5* Requirements for Direct Care Staff
  - *460 IAC 6-14-4* Staff Training and *460 IAC 6-14-4* Training
- 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 accessible from the *IHCP Provider Reference Materials* page at in.gov/medicaid/providers
- Where licensure is required, providers rendering waiver funded services must obtain/maintain Indiana-specific licensure

Section 10.32: Wellness Coordination

Service Definition

Wellness coordination services means the development, maintenance and routine monitoring of the individual's wellness coordination plan and the medical services required to manage their health care needs. A comprehensive medical risk plan may substitute for the wellness coordination plan or individual risk plans.

Wellness coordination services extend beyond those services provided through routine doctor/healthcare visits required under the Medicaid state plan and are specifically designed for individuals requiring the assistance of an RN or LPN to properly coordinate their medical needs. The following levels of support have these requirements:

- Tier I: Healthcare needs require a face-to-face visit once a month with an RN or LPN and consultations/reviews based on the individual's current healthcare needs.
- Tier II: Healthcare needs require a face-to-face visit twice a month with an RN or LPN and consultations/reviews based on the individual's current healthcare needs.
- Tier III: Healthcare needs require a face-to-face visit once a week with an RN or LPN and consultations/reviews based on the individual's current healthcare needs.

Conditions and Requirements

Necessity for wellness coordination services will typically be reserved for individuals assessed with health scores of 5 or higher through the state's objective-based allocation process. Individuals assessed with health scores of 0-4 would not require assistance of an RN or LPN to coordinate medical needs. As medical events occur and/or an individual's medical needs change, the IST is expected to obtain reassessment for potential revision to the health score and to ensure utilization of the appropriate tier of services.

Service Standards

Reimbursement is available for wellness coordination services only when the following circumstances are present:

- The individual requires assistance in coordinating medical needs beyond what can be provided through routine doctor/health care visits.
- Wellness coordination services are specifically included in the individual's PCISP.
- The member has a wellness coordination plan.

Reimbursable Activities

Coordination of wellness services by the wellness coordinator, who must be an RN or LPN, must include, but is not limited to the following:

- Completion of risk assessment information gathered by the IST and documented by the case manager in the PCISP
- Development, oversight and maintenance of a wellness coordination plan, while noting that a comprehensive medical risk plan may substitute for the wellness coordination plan or individual risk plans
- Development, oversight and maintenance of the medical risk plan, which includes:
  - Determination of the appropriate mode of training to be used for the direct support professional to ensure implementation of risk plans, noting that training may be by staff trained by the RN or LPN with the exception of nursing delegated tasks or other items the nurse feels that only a licensed nurse should train
  - Ensuring the completion of training of direct support professionals to ensure implementation of risk plans
  - Consultation with the individual's healthcare providers
  - Face-to-face consultations with the as described in the support plan based on tier level
  - Consultation with the individual's IST
  - Active involvement at annual team meetings (and any additional team meetings if an individual is having a medical concern or a health and safety issue that the IST needs to address), reporting on the wellness coordination plan as it relates to the individual's full array of services as listed in the PCISP

Limitations

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

Individuals assessed with health scores of 0-4 would not require assistance of an RN or LPN to coordinate medical needs.

Activities Not Allowed

Reimbursement for wellness coordination is not available under the following circumstances:

- The individual does not require wellness coordination services.
- Services are furnished to a minor by a parent(s), stepparent(s) or legal guardian.
- Services are furnished to an individual by the individual's spouse.

Documentation Standards

Wellness coordination services documentation standards are as follows:

- Wellness coordination services must be documented in agency files:
  - Weekly consultations/reviews
  - Face-to-face visits with the individual
  - Other activities, as appropriate

- Services must address needs identified in the person-centered planning process and be outlined in the PCISP.
- The provider of wellness coordination will provide a written report to pertinent parties at least quarterly. ("Pertinent parties" include the individual, guardian, BDDS service coordinator and waiver case manager.)
- As applicable, monthly/quarterly reports must be uploaded to the document library of the state's case management system by the chosen service provider on or before the 15th day of the following month.
- Within the wellness coordination plan, the provider must document what level of consultation/visits has been deemed necessary or appropriate for the individual.

Provider Qualifications

Providers must meet the following criteria:

- Enrolled as an active Medicaid provider
- Be FSSA/DDRS-approved
- 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 Provider Qualifications

Note: Wellness Coordination is referred to as Health Care Coordination within 460 IAC 6.

- 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 accessible from the *IHCP Provider Reference Materials* page at in.gov/medicaid/providers
- Nurses rendering waiver funded services must obtain/maintain Indiana licensure

Section 10.33: Extended Services

Service Definition

- Extended services are ongoing employment support services that enable an individual to maintain integrated competitive employment in a community setting. Individuals must be employed in a community-based, competitive job that pays at or above minimum wage to access this service.
- The initial job placement, training and stabilization may be provided through Indiana Vocational Rehabilitation Services. Extended services provide the additional work-related supports needed by the individual to continue to be as independent as possible in community employment. If an employed individual has obtained community-based competitive employment and stabilization without Vocational Rehabilitation's services, the individual is still eligible to receive Extended Services, as long as the individual meets the qualifications (see the *Provider Qualifications* section).
- Ongoing employment support services are identified in the individuals' PCISP and must be related to the individuals' limitations in functional areas (for example, self-care, understanding and use of

language, learning, mobility, self-direction, capacity for independent living, economic self-sufficiency), as 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 USC 1401 et seq.*). Federal financial participation is not claimed for incentive payments, subsidies or unrelated vocational training expenses such as the following:

- Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment; or
- Payments that are passed through to users of supported employment services.

Additional Information

- Individuals 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 nonresidential, integrated settings that are in the community. Services may not be rendered within the same building(s) alongside other nonintegrated individuals.
- 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.
- Individuals 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.
- Extended services are available under the FSW and CIH Waiver.

Reimbursable Activities

Reimbursable activities include the following:

- Ensuring that natural supports at the worksite are secured through interaction with supervisors and staff (A tangible outcome of this activity would be a decrease in the number of hours of extended services an individual accessed over time.)
- Training for the individual and/or the individual’s employer, supervisor or coworkers, to increase the individual’s inclusion at the worksite
- Regular observation or support of the individual 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 worksite 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 a waiver individual or to a group of individuals. 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 individuals have similar training needs.

Service Standards

Extended Services are provided in integrated community settings where persons without disabilities are also employed. Reimbursement will only be made for the employment support services required by the individual receiving services as a result of their disability.

Extended Services do not include sheltered work or other similar types of vocational services furnished in specialized facilities or volunteer endeavors.

An individuals' PCISP should be constructed in a manner that reflects individual informed choice and goals relating to employment and ensures provision of services in the most integrated setting possible. The Extended Services supports should be designed to support employment outcomes that lead to further independence and are consistent with the individual's goals.

Documentation Standards

Individual informed choices and goals related to employment and the justification/need for Extended Services must be outlined in the PCISP.

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

- Name of individual served
- IHCP Member ID (also known as RID) of the individual
- Name of provider
- Identified employment need
- Service rendered
- Expected outcome
- Date of service including the year
- Time frame of service (include a.m. or p.m.) (from/to)
- Notation of the primary location of service delivery
- A summary of services rendered to include the specific reimbursable activities that were performed and the outcomes realized from those activities

- A description of any issue or circumstance concerning the individual including, but not limited to, significant medical or behavioral incidents or any other situation that may be uncommon for the individual
- Signature that includes at least the last name and first initial of the staff person making the entry (Electronic signatures are permissible when in compliance with the *Uniform Electronic Transactions Act [IC 26-2-8]*)

Upon request, all data elements must be made available to auditors, quality monitors, case managers and any other government entity. The documentation may reside in multiple locations but must be clearly and easily linked to the individual or the standard will not be met.

As applicable, monthly/quarterly reports must be uploaded to the document library of the state's case management system by the chosen service provider on or before the 15th day of the following month.

Limitations

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 under *Documentation Standards* for extended services, demonstrating that the ratio for each claimed time frame of services did not exceed the maximum allowable ratio determined by the IST for each group individual, and provide documentation identifying other group individuals, by using the individuals' HIPAA naming convention.

Activities Not Allowed

Reimbursement is not available under extended services for the following activities:

- Any non-community-based setting where the majority (51% or more) of the individuals have an intellectual or developmental disability
- Sheltered work observation or participation
- Volunteer endeavors
- Any service that is otherwise available under the *Rehabilitation Act of 1973* or *Public Law 94-142*
- Public relations
- Incentive payments made to an employer to subsidize the employer's participation in extended services
- Payment for vocational training that is not directly related to the individual's extended service needs outlined in the 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), legal guardian or spouse
- The provision of transportation to an individual is not a reimbursable activity within extended services.
- Waiver funding 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 individuals who are using 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.)

> *Note: Supported Employment services continue to be available under the Rehabilitation Act of 1973 through the Vocational Rehabilitation Services (VRS) program within DDRS Bureau of Rehabilitation Services (BRS).*

Provider Qualifications

Providers must meet the following criteria:

- Enrolled as an active Medicaid provider
- Be FSSA/DDRS-approved
- Comply with *Indiana Administrative Code 460 IAC 6*, including but not limited to:
  - *460 IAC 6-12-1* and *460 IAC 6-12-2* Insurance
  - *460 IAC 6-10-5* Documentation of Criminal Histories
  - *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* Staff Training and *460 IAC 6-14-4* Training
- 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 accessible from the *IHCP Provider Reference Materials* page at in.gov/medicaid/providers
- Must obtain/maintain Indiana accreditation by at least one 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 Commission on Quality Assurance, or its successor
  - An independent national accreditation organization approved by the secretary
- 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*

Section 10.34: Residential Habilitation and Support – Daily (RHS Daily)

Service Definition

Residential habilitation and support – daily (RHS Daily) services provides individually tailored supports that are specified in the PCISP that assist with the acquisition, retention or improvement in skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult educational supports, and social and leisure skill development that support the individual to live successfully in their own home.

A relative of the individual may be a provider of residential habilitation and support services. 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 individual's relative should continue to be the provider of residential habilitation and support services.

> **Additional Information:**
>
> - Available only under the CIH Waiver.

Individuals Eligible for RHS Daily Services

Individuals who choose residential habilitation and support (RHS) and meet all the following criteria are eligible for and may choose to use RHS daily services:

- Individuals who have an Algo score of 3, 4 or 5 on their objective based allocation (OBA)
- Individuals who are living with housemates and are using a shared staffing model
- Individuals who are living outside their family home

Algo Score Descriptors

The following descriptors appear in *460 IAC 13-5-1* Algo level:

Level 0 (Low)

Descriptor: Individual with Algo score of zero:

(A) High level of independence with few supports needed;

(B) No significant behavioral issues; and

(C) Requires minimal residential habilitation services.

Level 1 (Basic)

Descriptor: Individual with Algo score of one:

(A) Moderately high level of independence with few supports needed;

(B) Behavioral needs, if any, can be met with medication or informal direction by caregivers through the Medicaid state plan services; and

(C) Likely a need for day programming and light residential habilitation services to assist with certain tasks, but the individual can be unsupervised for much of the day and night.

Level 2 (Regular)

Descriptor: Individual with Algo score of two:

(A) Moderate level of independence with frequent supports needed;

(B) Behavioral needs, if any, can be met with medication or light therapy, or both, every one to two weeks;

(C) Does not require twenty-four hours a day support and

(D) Generally able to sleep unsupervised, but needs structure and routine throughout the day.

Level 3 (Moderate)

Descriptor: Individual with Algo score of three:

(A) Requires access to full-time support for medical or behavioral, or both, needs;

(B) Twenty-four hours a day, seven days a week staff availability;

(C) Behavioral and medical supports are not generally intense; and

(D) Behavioral and medical supports can be provided in a shared staff setting.

Level 4 (High)

Descriptor: Individual with Algo score of four:

(A) Requires access to full-time supports for medical or behavioral, or both, needs:

(i) Twenty-four hours a day, seven days a week frequent staff interaction; and

(ii) Requires line of sight support; and

(B) Has moderately intense needs that can generally be provided in a shared staff setting.

Level 5 (Intensive)

Descriptor: Individual with Algo score of five:

(A) Requires access to full-time support with twenty-four hours a day, seven days a week absolute line of sight support;

(B) Needs are intense;

(C) Needs require the full attention of a caregiver with a one-to-one staff to individual ratio; and

(D) Typically only needed by those with intense behavioral needs, not medical needs alone.

Level 6 (High Intensive)

Descriptor: Individual with Algo score of six:

(A) Requires access to full-time support

(i) Twenty-four (24) hours a day, seven days a week; and

(ii) More than a one-to-one staff to individual ratio;

(B) Needs are exceptional;

(C) Needs require more than one caregiver exclusively devoted to the individual/participant for at least part of each day; and

(D) Imminent risk of individual harming self or others, or both, without vigilant support.

Refer to *Table 3 – Medicaid Waiver Services, Codes and Rates for FSW and CIH Waiver* under *Section 10.2: Medicaid Waiver Services, Codes and Rates* for applicable billing information.

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

The ICAP assessment determines an individual's level of functioning for broad independence and general maladaptive factors. The ICAP addendum, commonly referred to as the behavior and health factors, determines an individual's level of functioning on behavior and health factors.

These two assessments determine an individual's overall Algo level, which can range from 0-6. Algos 0 and 6 are considered outliers representing those who are the lowest and the highest on both ends of the functioning spectrum. On review, the state may manually adjust the budget of an individual from an Algo 5 to an Algo 6. Although this individual continues receiving the Algo 5 budget, the Algo 6 indicates a need for additional oversight of the individual.

The stakeholder group designed a grid to build the allocations. The grid was developed with the following tenets playing key roles:

- Focus on daytime programming
- Employment
- Community integration
- Housemates

The OBA is then determined by combining the overall Algo (determined by the ICAP and ICAP addendum), age, employment and living arrangement.

See *Section 6: Objective-Based Allocation* in this module for further details.

Reimbursable Activities

Reimbursable activities include the following:

- Assistance with acquiring, enhancing and building natural supports
  - For example, a measurable outcome would be increased hours of natural supports and a decrease in the number of hours needed for paid staff. Another measurable outcome would be the number of activities an individual participates in with nonpaid (natural support) supports versus paid staff.
- Working with the individual to meet the goals they have set for themselves on their PCISP
- Training the individual to enhance their homemaking skills, meal preparation, household chores, money management, shopping, communication skills, social skills and positive behavior
- Provision of transportation to fully participate in social and recreational activities in the community (such as transportation to church, the park, the library, the YMCA and classes)
- Provision of transportation to community employment and/or volunteer activities
- Coordination and facilitation of medical and wellness services to meet the healthcare and wellness needs, including physician consults, medications, implementation of risk plans, dining plans and wellness plans
- Maintenance of each individual's health record
- Remote support services are allowable only when billed as a component of RHS daily (Remote support services may not be billed concurrently with RHS daily.)
- When wellness coordination services are utilized in addition to RHS-daily services, the wellness coordinator is responsible for the development, oversight and maintenance of a wellness coordination plan as well the development, oversight and maintenance of the health-related risk plan, noting that a comprehensive medical risk plan may substitute for the wellness coordination plan or individual risk plans.
- The RN/LPN determines the appropriate mode of training to be used for the direct support professional to ensure implementation of risk plans, noting that training may be by staff trained by the RN/LPN with the exception of nursing delegated tasks or other items the nurse feels that only a licensed nurse should train.
- Additionally, the RN/LPN ensures completion of training of the direct support professional to ensure implementation of risk plans.

Service Standards

The following service standards apply to RHS daily:

- Services must address needs identified in the person-centered planning process and be outlined in the PCISP.
- RHS daily should complement but not duplicate habilitation services provided in other settings.
- The individual must be present and receive RHS daily services for at least a portion of any day the provider bills as a day of RHS daily service.

Documentation Standards

A minimum of one daily note for each day the individual is present and receiving RHS daily services, with appropriate elements, documenting one or more distinct actions or behaviors as outlined in the *Reimbursable Activities* section, per individual served is required to support the billing of RHS daily

services. The RHS daily service provider must able to demonstrate through relevant time keeping records or other similar documentation which staff members were working during the RHS daily service provided upon audit, or upon request by the state or its contracted agents.

RHS daily documentation standards are as follows:

- Documentation of services rendered as outlined in the PCISP
- Data record of service delivered documenting the complete date and time entry (including a.m. or p.m.)
  - If the person providing the service is required to be professionally licensed, the title of that individual must also be included. For example, if a nurse provides RHS daily services, the nurse's title should be included.
- Any significant issues involving the individual requiring intervention by a healthcare professional, case manager or BDDS staff member
- Documentation in compliance with *460 IAC 6*
- Quarterly summaries as specified by BDDS and monthly, quarterly and/or annual outcome data as specified by BDDS

As applicable, monthly/quarterly reports must be uploaded to the document library of the state's case management system by the chosen service provider on or before the 15th day of the following month.

Limitations

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

The individual must be present and receive RHS daily services for at least a portion of any day the provider bills as a day of RHS daily service.

Additionally, the following limitations apply:

- Providers will not be reimbursed separately for remote support services for individuals receiving RHS daily services. Remote support is built into the daily rate of RHS daily services. Providers must adhere to all remote support service standards as defined within the remote support service definition.
- Providers may not bill for RHS daily reimbursement for time when staff/paid caregiver is asleep. Only awake, engaged staff can be counted in reimbursement.
- Providers may only bill for RHS ***daily*** reimbursement during the time when an individual receiving HCBS waiver services is admitted to an acute care hospital setting for inpatient medical care or other related services for surgery, acute medical condition, or injuries if all conditions specified in guidance under Section 2.3: Claims and Billing of this module are met.
- Providers may not bill for RHS ***daily*** reimbursement during the time when an individual is admitted for an extended stay hospitalization, or when individuals require long term care in a facility based setting including but not limited to nursing homes, rehabilitation centers and/or treatment facilities. (As specified under guidance in *Section 2.3: Claims and Billing* in this module, the care and support of an individual who is admitted to a hospital or facility for long-term is a non-billable RHS activity.)

Per *IC 12-11-1.1*, supported living service arrangements providing residential services may not serve more than four unrelated individuals in any one setting. However, a program that was in existence on January 1, 2013, as a supervised group living program described within *IC 12-11-1.1* and having more than four individuals residing as part of that program, was allowed to convert to a supported living service

arrangement and continue to provide services to up to the same number of individuals in the supported living setting.

Activities Not Allowed

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

- Services furnished to a minor by the parent(s), step-parent(s), or legal guardian
- Services furnished to an individual by the individual's spouse
- Services to individuals in structured family caregiving services
- Services that are available under the Medicaid state plan

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:

- Aunt (natural, step, adopted)
- Brother (natural, step, half, adopted, in-law)
- Child (natural, step, adopted)
- First cousin (natural, step, adopted)
- Grandchild (natural, step, adopted)
- Grandparent (natural, step, adopted)
- Niece (natural, step, adopted)
- Nephew (natural, step, adopted)
- Parent (natural, step, adopted, in-law)
- Sister (natural, step, half, adopted, in-law)
- Spouse (husband or wife)
- Uncle (natural, step, adopted)

Provider Qualifications

Providers must meet the following criteria:

- Enrolled as an active Medicaid provider
- Be DDRS-approved
- Comply with *Indiana Administrative Code*, *460 IAC 6*, including but not limited to:
  - *460 IAC 6-5-24* Residential Habilitation and Support Services Provider Qualifications
  - *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 6-5-14* Heath Care Coordination Services Provider Qualifications
  - *460 IAC 6-14-5* Requirements for Direct Care Staff
  - *460 IAC 6-14-4* Training
  - *460 IAC 6-34* Transportation Services Requirements
- Comply with *Indiana Administrative Code*, *460 IAC 6*, including but not limited any applicable FSSA/BDDS service standards, guidelines, policies and/or manuals, including FSSA/DDRS BDDS

policies and the *FSSA/DDRS HCBS Waivers* module accessible from the *IHCP Provider Reference Materials* page at in.gov/medicaid/providers.

- In accordance with Indiana Code *12-11-1.1-1*, RHS providers 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
  - The Council on Accreditation, or its successor
  - An independent national accreditation organization approved by the secretary

Section 10.35: Day Habilitation (Effective 8/1/2020)

Service Definition

Day habilitation (effective Aug. 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 an individual's private residence or other residential living arrangements.

Additional Information:

- Day habilitation services are available under the FSW and CIH Waiver effective Aug. 1, 2020.

Reimbursable Activities

Reimbursable activities include the following:

- Person-centered 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 (that is, integrated camp settings)
  - Educational activities
  - Hobbies
  - Unpaid work experiences (for example, volunteer opportunities)
  - Maintaining contact with family and friends
- Training and education in self-direction designed to help individuals achieve one or more of the following outcomes:
  - Develop self-advocacy skills
  - Exercise civil rights
  - Acquire skills that enable self-control and responsibility for services and supports received or needed
  - Acquire skills that enable the individual to become more independent, integrated or productive in the community

Service Standards

Day habilitation services must be reflected in the PCISP. Services must address needs identified in the person-centered planning process and be outlined in the PCISP.

The PCISP must outline the day habilitation services needed by the individual to pursue their desired outcomes as identified during the person-centered planning process. The need for service continuation is to be evaluated annually by the individualized support team (IST) and reflected in the PCISP. As with any outcome within the PCISP, the day habilitation service has at least one associated proposed strategy/ activity step designed to address potential barriers or maintenance needs in relation to the desired outcomes and the support and services needed to facilitate the outcomes. The proposed strategy/action steps also identify all paid and unpaid responsible parties and includes the name(s) of each responsible party including the provider, the service and the staffing positions within the agency that are responsible for the strategy/activity. The individual may be the responsible party for a strategy/action steps initiative if they so determine. In addition, each proposed strategy/action step has a specific time frame identified, including a minimum time frame for review. The plan of care/cost comparison budget (POC/CCB) identifies the name of the waiver-funded service, the name of the individual-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 POC/CCB.

An allowable relative of the individual may be a direct support professional of day habilitation services. The relative must be employed by a BDDS approved waiver provider. The decision that a relative is the most appropriate option to provide supports must be part of the person-centered planning process and documented in the PCISP. When the direct support professional is a relative, an annual review by the IST is required to determine whether the individual's relative should continue to be the direct support professional of day habilitation services.

Services may be provided in a group setting. The decision that services should be provided in a group setting must be included as a part of the person-centered planning process and documented in the PCISP. The PCISP must also reflect the ratio appropriate for the individual during service delivery. Upon request, the provider must be able to verify in a concise format the ratio for each individual during the claimed time frame of service.

Documentation Standards

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

- Name of individual served
- IHCP Member ID (also known as RID) of the individual
- Name of provider
- Service rendered
- Time frame of service (include a.m. or p.m.)
- Date of service including the year
- Primary type of service: Community or Facility
- Notation of the primary location of service delivery
- Notation of the ratio for service delivery
- A brief activity summary of service rendered

- In addition to the brief activity summary of service rendered, provide a description by direct care staff of any issue or circumstance concerning the individual including, but not limited to, significant medical or behavioral incidents or any other situation that may be uncommon for the individual
- Signature that includes at least the last name and first initial of the direct care staff person making the entry (Electronic signatures are permissible when in compliance with the *Uniform Electronic Transactions Act* [*IC 26-2-8*])

A quarterly report specific to day habilitation services must be created by the chosen service provider. The quarterly report should summarize the level of support provided to the individual, based on the identified supports and services in the PCISP and the POC/CCB. The quarterly report must be shared with the individual, guardian (as applicable) and entire IST. The chosen service provider must upload the quarterly report to the document library of the individual in the state's case management system on or before the 15th day of the month following the end of the quarter. The quarterly report shall be based on the quarters of the individual's POC/CCB date range.

The quarterly report shall contain the following elements:

- Name of individual served
- IHCP Member ID (also known as RID) of the individual
- Name of provider
- Date range of services
- Service rendered Primary type of service: Community or Facility
- Notation of the ratio for service delivery
- Percent of time in community
- Percent of time in a facility
- Brief summary of progress towards PCISP outcomes
- Challenges hindering progress towards PCISP outcomes, if applicable
- A positive event that occurred during the quarter that contributed to the individual's good life

Upon request, all data elements must be made available to auditors, quality monitors, case managers and any other government entity. The documentation may reside in multiple locations, but must be clearly and easily linked to the individual or the standard will not be met.

For Group Services

Further guidance related to Day Habilitation, including group services, is posted on the *Current DDRS Policies* page at in.gov/fssa/ddrs and at the direct link for *Day Habilitation: Service Definition and Standards*.

Limitations

The following are limitations on group 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)

Day 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 or a camp.

Activities Not Allowed

The following activities are not allowed under day habilitation:

- 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's habilitation outcome
- Activities that do not foster the acquisition and retention of skills
- Activities that duplicate or replace supports provided through residential habilitation and support services.
- Services furnished to a minor by parent(s), stepparent(s) or legal guardian
- Services furnished to an individual by the individual's spouse

Provider Qualifications

Providers of day habilitation must meet the following criteria:

- Enrolled as an active Medicaid provider
- Be FSSA/DDRS-approved
- 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* Staff Training and *460 IAC 6-14-4* Training
  - *460 IAC 6-5-14* Health Care Coordination Services Provider Qualifications
  - *460 IAC 6-5-30* Transportation Services Provider Qualifications
- 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 accessible from the *IHCP Provider Reference Materials* page at in.gov/medicaid/providers
- 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

Section 10.36: Vehicle Modifications

Service Definition

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.

DDRS' waiver services staff must approve all environmental modifications prior to service being rendered.

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:

- Wheelchair lifts
- Wheelchair tie-downs (if not included with lift)
- Wheelchair/scooter hoist
- Wheelchair/scooter carrier for roof or back of vehicle
- Raised roof and raised door openings
- Power transfer seat base
- Lowered floor and lowered door openings
- Wheelchair ramp for vehicle

Maintenance is limited to $1,000 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 $1,0000, 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 nonwaiver funding source.

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

The vehicle to be modified must meet all of the following:

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

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.

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

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
- Two bids if the cost exceeds $1,000: 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 for documentation include the following:

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

Limitations

A cap of $15,000 is available for one vehicle per every 10-year period for an individual's household. In addition to the applicable cap, $1,000 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

The following activities are not allowed under vehicle modifications:

- Modifications/adaptations that have not been approved on a Request for Approval to Authorize Services (RFA) form.
- Examples/descriptions of modifications/items not covered include but are not limited to the following:
  - Repair or replacement of modified equipment damaged or destroyed in an accident
  - Alarm systems
  - Auto loan payments
  - Insurance coverage
  - Driver's license, title registration or license plates
  - Emergency road service
  - Routine maintenance and repairs related to the vehicle itself
  - Specialized Medical Equipment or Home Modification items are not allowed.
  - Leased vehicles

Provider Qualifications

Providers of vehicle modifications must meet the following criteria:

- 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 accessible from the *IHCP Provider Reference Materials* page at in.gov/medicaid/providers
- Where licensure is required, providers rendering waiver funded services must obtain/maintain Indiana licensure.

Section 11: RFA Policies

The following policies address use of the required *Request for Approval to Authorize Services* (RFA) form for authorization of the environmental modification, specialized medical equipment and supplies, and vehicle modification services.

Section 11.1: Environmental Modification Policy

Waiver Policy Notification

Authority: *Code of Federal Regulations 42 CFR 441.302*

Policy Topic: Environmental Modification Policy Clarification

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

- Community Integration and Habilitation (CIH) Waiver
- Family Supports Waiver (FSW) Effective July 16, 2020, environmental modifications are now a covered service under both the Community Integration and Habilitation (CIH) and the Family Supports Waiver (FSW)

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

Description

Environmental modifications are minor physical adaptations to the home, as required by the individual's plan of care/cost comparison budget (POC/CCB), which are necessary to ensure the health, welfare, and safety of the individual, which enable the individual to function with greater independence in the home, and without which the individual would require institutionalization.

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

For the FSW, environmental modifications are outside the $19,614 cap.

Additional Information:

As a reminder, HCBS waiver funding covers only basic modifications determined to be medically necessary for the waiver individual and is not available for items that exceed basic medical need. Requests to upgrade products or to use materials exceeding the individual's basic need will not be approved. For example, if a bathroom modification is necessary but the individual or family requests tiled flooring when basic vinyl flooring could be installed, the individual or family must decide whether to access waiver funds for completion of the basic modification or to assume financial responsibility for the entire modification inclusive of desired upgrade(s).

Due to the state's responsibility to ensure each modification is the most cost effective or conservative means to meet the individual's need(s) for accessibility within the home, it is ***not*** *acceptable to submit bids attempting to combine waiver funding for basic modifications with private funding to cover the higher costs of the desired upgrade(s).*

Home Ownership

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

Choice of Provider

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

Requirements

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

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

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

- The modification is the most cost effective or conservative means to meet the individual's need(s) for accessibility within the home.
- The environmental modification is individualized, specific and consistent with, but not in excess of, the individual's need(s).
- Three home modification bids must be obtained for all modifications over $1,000.
- If three bids cannot be obtained, it must be documented to show what efforts were made to secure the three bids and explain why fewer than three bids were obtained (including provider name, dates of contact, response received).
- For modifications under $1,000, one bid is required, and pricing must be consistent with the fair market price for such modification(s).
- Bids must be itemized to include information shown in the example in Table 5.

Table 5 – Bid Itemization Example – Environmental Modifications

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

- Requests for modifications at two or more locations may only be approved at the discretion of the state division director or state agency designee.
- Requests for modifications may be denied if the state division director or state agency designee determines the documentation does not support residential stability and/or the service requested.

Service Standards

- Environmental Modification must be of direct medical or remedial benefit to the individual.
- To ensure that environmental modifications meet the needs of the individual and abide by established federal, state, local, and Family and Social Services Administration (FSSA) standards, as well as ADA requirements. When applicable, approved environmental modifications will include:
  - Assessment of the individual's specific needs, conducted by an approved, qualified individual who is independent of the entity providing the environmental modifications
  - Independent inspections during, as well as at the completion of, the modification process, prior to authorization for reimbursement
- Modifications must meet applicable standards of manufacture, design and installation.
- Modifications must be compliant with applicable building codes.

Documentation Standards

- The identified direct benefit or need must be documented within the following:
  - POC/CCB
  - Physician prescription and/or clinical evaluation as deemed appropriate
  - Person-centered individualized support plan (PCISP)
- Documentation/explanation of the service within the *Request for Approval to Authorize Services* (RFA) including the following:
  - Property owner of the residence where the requested modification is proposed
  - Property owner's relationship to the individual
  - What, if any, relationship the property owner has to the waiver program
  - Length of time the individual has lived at this residence
  - If a rental property - length of lease
  - Written agreement of landlord for modification
  - Verification of individual's intent to remain in the setting
  - Land survey if required when exterior modification(s) approach property line
  - Signed and approved RFA
  - Signed and approved POC/CCB
  - Receipts for all incurred expenses by service provider related to the modification
  - Anything needed to be in compliance with FSSA and division-specific guidelines and/or policies

Reimbursement

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

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

Modifications/Items – Covered

Justification and documentation are required to demonstrate that the modification is necessary to meet the individual's identified needs:

- Adaptive door openers and locks – Limited to one per individual primary residence for an individual living alone or who is alone without a caregiver for substantial periods of time but has a need to open, close or lock the doors and cannot do so without special adaptation.
- Bathroom modification – Limited to one existing bathroom per individual primary residence when no other accessible bathroom is available. The bathroom modification may include:
  - Removal of existing bathtub, toilet and/or sink
  - Installation of roll-in shower, grab bars, ADA toilet and wall-mounted sink
  - Installation of replacement flooring, if necessary due to bath modification
- Environmental control units – Adaptive switches and buttons to operate medical equipment, communication devices, heat and air conditioning, and lights for an individual living alone or who is alone without a caregiver for a substantial portion of the day.
- Environmental safety devices limited to:
  - Door alarms
  - Anti-scald devices
  - Hand-held shower head
  - Grab bars for the bathroom
- Fence – Limited to 200 linear feet (individual must have a documented history of elopement).
- Ramp – Limited to one per individual primary residence, and only when no other accessible ramp exists:
  - In accordance with the ADA or ADAAG, unless this is not in the best interest of the client
  - Portable – Considered for rental property only
  - Permanent
  - Vertical lift – May be considered in lieu of a ramp if there is photographic and written documentation that shows it is not possible for a ramp to be used
- Stair lift – If required for access to areas of the home necessary to meet the direct medical or remedial benefit of the individual per POC/CCB (and PCISP under CIH Waiver).

- Single-room air conditioners/single- room air purifiers – If required for access to areas of the home necessary to meet the direct medical or remedial benefit of the individual per POC/CCB (and PCISP under CIH Waiver):
  - There is a documented medical reason for the individual's need to maintain a constant external temperature. The documentation necessary for this equipment includes a prescription from the primary care physician.
  - The room air conditioner size is consistent with the room size (square feet) capacity to be cooled.
- Widen doorway – To allow safe egress:
  - Exterior – Modification limited to one per individual primary residence when no other accessible door exists.
  - Interior – Modification of bedroom, bathroom and/or kitchen door/doorway as needed to allow for access. (A pocket door may be appropriate when there is insufficient room to allow for the door swing).
- Windows – Replacement of glass with plexiglass or other shatterproof material when there is a documented medical/behavioral reason(s).
- Upon the completion of the modification, painting, wall coverings, doors, trim, flooring and so forth will be matched (to the degree possible) to the previous color/style/design.
- Maintenance – Limited to $500 annually for the repair and service of environmental modifications that have been provided through a HCBS waiver:
  - Requests for service must detail parts cost and labor cost.
  - If the need for maintenance exceeds $500, the case manager will work with other available funding streams and community agencies to fulfill the need. If service costs exceed the annual limit, those parts and labor costs funded through the waiver must be itemized clearly to differentiate the waiver service provision from those parts and labor funded through a nonwaiver funding source.
- Items requested which are not listed above, must be reviewed and decision rendered by the state division director or state agency designee.

Modifications/Items – Noncovered

Examples/descriptions of modifications/items not covered include, but are not limited to the following:

- Adaptations or improvements that are not of direct medical or remedial benefit to the individual
  - Central heating and air conditioning
  - Routine home maintenance
  - Installation of standard (non-ADA or ADAAG) home fixtures (for example, sinks, commodes, tub, wall, window and door coverings, and so forth) which replace existing standard (non-ADA or ADAAG) home fixtures
  - Roof repair
  - Structural repair
  - Garage doors
  - Elevators
  - Ceiling track lift systems
  - Driveways, decks, patios, sidewalks, household furnishings
  - Replacement of carpeting and other floor coverings
  - Storage (for example, cabinets, shelving, closets), sheds
  - Swimming pools, spas or hot tubs
  - Video monitoring system

  - Adaptive switches or buttons to control devices intended for entertainment, employment or education
  - Home security systems
- Modifications that create living space or facilities where they did not previously exist (for example, installation of a bathroom in a garage/basement and so forth)
- Modifications that duplicate existing accessibility (for example, second accessible bathroom, a second means of egress from home and so forth)
- Modifications that will add square footage to the home
- Completion of, or modifications to, new construction or significant remodeling/reconstruction unless there is documented evidence of a significant change in the individual's medical or remedial needs that now require the requested modification
- Adaptations that have not been approved on a *Request for Approval to Authorize Services* form
- Individuals living in foster homes, group homes, assisted living facilities or homes for special services (any licensed residential facility)

> *Note: The responsibility for environmental modifications rests with the facility owner or operator.*

- Individuals living in a provider owned residence

> *Note: The responsibility for environmental modifications rests with the facility owner or operator.*

Decision-Making Authority

Each division, with approval from the FSSA Office of the Secretary, shall identify designees to render decisions based on the articles in this policy. The designees are responsible for preparing and presenting testimony for all fair hearings – see *Section 8: Appeal Process*. The case management entity, working as an agent of the state, shall not attend fair hearings in opposition of the state, unless requested by the individual when there is no other advocate to represent the individual at the hearing. If the case manager does attend the hearing, working as an agent of the state, they must also uphold the established federal, state, local and FSSA standards and division specific guidelines and/or policies. Additionally, the case manager must submit a letter, in writing to the administrative law judge at the fair hearing, explaining their role at the hearing.

Each division shall implement a quality assurance plan. In the event of inappropriate authorizations being granted, any or all of the following actions may be required:

- A corrective action plan
- Reimbursement to Medicaid
- Loss of decision-making authority

Section 11.2: Specialized Medical Equipment and Supplies

Waiver Policy Notification

Authority: *42 CFR 441.302*

Policy Topic: Specialized Medical Equipment and Supplies Policy Clarification

Impacts the following HCBS waivers:

- Community Integration and Habilitation (CIH) Waiver
- Family Supports Waiver (FSW)
- Effective Date: Dec. 1, 2007, and replaces all previous policies related to the authorization of specialized medical equipment and supplies (SMES)

Additional Information

Sensory items, seizure detection devices, GPS tracking devices and other electronic devices not currently specified as items covered or reimbursable in the waiver or current RFA policy may be electronically submitted for consideration under SMES via the request for approval to authorize services form as outlined in Section 11 of this module.

Description

Specialized medical equipment and supplies are medically prescribed items required by the individual's PCISP and POC/CCB, which are necessary to assure the health, welfare and safety of the individual, which enable the individual to function with greater independence in the home, and without which the individual would require institutionalization.

Under the FSW, a lifetime cap of $7,500 is available for specialized medical equipment and supplies. There is no lifetime cap for specialized medical equipment and supplies under the CIH Waiver.

Choice of Provider

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

Requirements

- All specialized medical equipment and supplies must be approved by the waiver program prior to the service being rendered.
- Individuals requesting authorization for this service through utilization of HCBS waivers must first exhaust eligibility for the desired equipment or supplies through Indiana Medicaid State Plan, which may require prior authorization (PA):
  - There should be no duplication of services between HCBS waiver and Medicaid State Plan.
  - The refusal of a Medicaid vendor to accept the Medicaid reimbursement through the Medicaid State Plan is not a justification for waiver purchase.
  - Preference for a specific brand name is not a medically necessary justification for waiver purchase. Medicaid State Plan often covers like equipment but may not cover the specific brand requested. When this occurs, the individual is limited to the Medicaid State Plan covered service/brand.
  - Reimbursement is limited to the Medicaid State Plan fee schedule, if the requested item is covered under Medicaid State Plan.
  - See *Indiana Administrative Code 405 IAC 5-19* for additional information regarding Medicaid State Plan coverage. All requests for items to be purchased through a Medicaid waiver must be accompanied by documentation of Medicaid State Plan PA request and decision, if the requested item is covered under the State Plan.

- Specialized medical equipment and supplies shall be authorized only when it is determined to be medically necessary and shall have direct medical or remedial benefit for the waiver individual. This determination includes the following considerations:
  - The request is the most cost effective or conservative means to meet the individual's specific needs.
  - The request is individualized, specific and consistent with, but not in excess of, the individual's needs.
  - Three bids must be obtained for items over $1,000.
  - If three bids cannot be obtained, it must be documented to show what efforts were made to secure the three bids and explain why fewer than three bids were obtained (including provider name, dates of contact, response received).
  - For requested items under $1,000, one bid is required, and pricing must be consistent with the fair market price.
  - Bids must be itemized to include a picture of the product and detailed product information, including make/model number of the item as shown in the example in Table 6.

Table 6 – Bid Itemization Example – Specialized Medical Equipment and Supplies

Scope	Make/Model Number	Material
Adapted plates/bowls		$$
Interpreter service		$$
Wheelchair		$$
Portable generator		$$
Total Cost:		$$

- Requests will be denied if the state division director or state agency designee determines the documentation does not support the service requested.

Service Standards

- Specialized medical equipment and supplies must be of direct medical or remedial benefit to the individual.
- All items shall meet applicable standards of manufacture, design and service specifications.
- Under the FSW and CIH Waiver, requests for items over $500 require that the individual first be evaluated by a qualified professional such as a physician, nurse, occupational therapist, physical therapist, speech and language therapist or rehabilitation engineer as required per the approved waiver.

Documentation Standards

Documentation standards include the following:

- The identified direct benefit or need must be documented within all the following:
  - POC/CCB
  - Physician prescription and/or clinical evaluation as deemed appropriate
  - PCISP under the FSW and CIH Waiver
- Medicaid State Plan prior authorization request and the decision rendered, if applicable
- Signed and approved *Request for Approval to Authorize Services* (RFA)
- Signed and approved POC/CCB

- Provider of services must maintain receipts for all incurred expenses related to this service
- Must be in compliance with FSSA and division-specific guidelines and/or policies

Reimbursement

Reimbursement is available for specialized medical equipment and supplies that satisfy each of the following:

- Service and documentation standards outlined within this policy
- Allowable under current Medicaid waiver guidelines
- Not available under the *Rehabilitation Act of 1973*, as amended
- Included in the individual's approved POC/CCB
- Authorized on the RFA and linked to the POC/CCB
- Included on a state-approved and signed Notice of Action (NOA)
- Completed by an approved Medicaid waiver service provider (that is approved to perform this service)

Items – Covered

Justification and documentation are required to demonstrate that the request is necessary to meet the individual's identified needs.

- Communication Devices – Computer adaptations for keyboard, picture boards and so forth.
- The RFA must be accompanied by documentation of Medicaid State Plan PA request and decision rendered under Medicaid State Plan.
- Generators (portable) – When either ventilator, daily use of oxygen via a concentrator, continuous infusion of nutrition (tube feeding), or medication through an electric pump are medical requirements of the individual. The generator is limited to the kilo-wattage necessary to provide power to the essential life-sustaining equipment and is limited to one generator per individual per 10-year period.
- Interpreter service – Provided in circumstances where the interpreter assists the individual in communication during specified scheduled meetings for service planning (for example, waiver case conferences, team meetings) and is not available to facilitate communication for other service provision.
- Self-help devices – Including over the bed tables, reachers, adaptive plates, bowls, cups, drinking glasses and eating utensils that are prescribed by a physical therapist or occupational therapist.
- Strollers – When needed because individual's primary mobility device does not fit into the individual's vehicle/mode of transportation, or when the individual does not require the full time use of a mobility device, but a stroller is needed to meet the mobility needs of the individual outside of the home setting. The RFA must be accompanied by documentation of Medicaid State Plan PA request and decision rendered under Medicaid State Plan.
- Manual wheelchairs – When required to facilitate safe mobility. The RFA must be accompanied by documentation of Medicaid State Plan PA request and decision rendered under Medicaid State Plan.
- Maintenance – Limited to $500 annually for the repair and service of items that have been provided through a HCBS waiver:
  - Requests for service must detail parts cost and labor cost.

- If the need for maintenance exceeds $500, the case manager will work with other available funding streams and community agencies to fulfill the need. If service costs exceed the annual limit, those parts and labor costs funded through the waiver must be itemized clearly to differentiate the waiver service provision from those parts and labor provided through a nonwaiver funding source.

Posture chairs and feeding chairs – As prescribed by physician, occupational therapist or physical therapist. The RFA must be accompanied by documentation of Medicaid State Plan PA request and decision rendered under Medicaid State Plan.

Note: While not currently listed as covered items - Sensory items, seizure detection devices, GPS tracking devices and other electronic devices not currently specified as items covered or reimbursable in the waiver or current RFA policy may be electronically submitted for consideration under SMES via the request for approval to authorize services form as outlined in Section 11 of this module. As an interim step toward RFA policy updates, BDDS will develop a SMES fact sheet citing things individuals and families may wish to consider prior to submitting a request.

Items – Noncovered

The following items and equipment are not covered:

- Hospital beds, air fluidized suspension mattresses/beds
- Therapy mats
- Parallel bars
- Scale
- Activity streamers
- Paraffin machines or baths
- Therapy balls
- Books, games, toys
- Electronics – such as CD players, radios, cassette players, tape recorders, televisions, VCRs and DVDs, cameras or film, videotapes, and other similar items
- Computers and software
- Adaptive switches and buttons
- Exercise equipment such as treadmills or exercise bikes
- Furniture
- Appliances – such as refrigerator, stove, hot water heater
- Indoor and outdoor play equipment such as swing sets, swings, slides, bicycles adaptive tricycles, trampolines, playhouses, merry-go-rounds
- Swimming pools, spas, hot tubs, portable whirlpool pumps
- Tempur-Pedic mattresses, positioning devices, pillows
- Bathtub lifts
- Motorized scooters
- Barrier creams, lotions, personal cleaning cloths

- Totally enclosed cribs and barred enclosures used for restraint purposes
- Medication dispensers
- Any equipment or items that can be authorized through Medicaid State Plan
- Any equipment or items purchased or obtained by the individual, the individual's family members or other nonwaiver providers

Note: In rare circumstances, a new or unanticipated item may be presented for consideration as a covered item under this service. Prior to submission of an RFA for this item, a written proposal justifying the need for this item must be sent to the FSSA OMPP for submission to the FSSA Policy Governance Board for consideration and determination of appropriateness as a covered item. The written proposal should be directed to:

Director of Agency Coordination and Integration
Office of Medicaid Policy and Planning
402 W. Washington St., Room W374
Indianapolis, IN 46204-2739

These requests should be extremely rare and should not include items on the noncovered list, which have been previously vetted at the state, and determined to be noncovered items.

Decision-Making Authority

- Each division, with approval from the FSSA Office of the Secretary, shall identify a designee(s) to render decisions based upon the articles within this policy.
- The designee(s) is responsible for preparing and presenting testimony for all fair hearings.
- The case management entity, working as an agent of the state, shall not attend fair hearings in opposition of the state, unless requested by the individual when there is no other advocate to represent the individual at the Hearing. If the case manager does attend the hearing, working as an agent of the state, the case manager must also uphold the established federal, state, local and FSSA standards and the division-specific guidelines and/or policies. Additionally, the case manager must submit a letter in writing to the administrative law judge at the fair hearing, as to what their role is at the hearing.
- Each division shall implement a Quality Assurance Plan. In the event of inappropriate authorizations being granted, any or all of the following actions may be required:
  - A corrective action plan
  - Reimbursement to Medicaid
  - Loss of decision-making authority

Section 11.3: Vehicle Modification

Waiver Policy Notification

Authority: *42 CFR 441.302*

Policy Topic: Vehicle Modification Policy Clarification

Impacts the following HCBS waivers:

- Community Integration and Habilitation (CIH) Waiver
- Family Supports Waiver (FSW)
- Effective Date: Dec. 1, 2007, and replaces all previous policies related to the authorization of Vehicle Modifications.

Description

Vehicle modifications (VMOD) are the addition of adaptive equipment or structural changes to a motor vehicle that permit an individual with a disability to safely transport in a motor vehicle. Vehicle modifications, as specified in the person-centered individualized support plan (PCISP) and POC/CCB, may be authorized when necessary to increase an individual's ability to function in a home- and community-based setting to ensure accessibility of the individual with mobility impairments. These services must be necessary to prevent or delay institutionalization. The necessity of such items must be documented in the plan of care by a physician's order. Vehicles necessary for an individual to attend post-secondary education or job-related services should be referred to Vocational Rehabilitation Services.

A cap of $15,000 is available for one vehicle per every 10-year period for an individual's household. In addition to the applicable cap, $1,000 will be allowable annually for repair, replacement, or an adjustment to an existing modification that was funded by an HCBS waiver.

Vehicle Ownership

The vehicle to be modified must meet all of the following:

- The individual or primary caregiver is the titled owner.
- The vehicle is registered and/or licensed under state law.
- The vehicle has appropriate insurance as required by state law.
- The vehicle is the individual's sole or primary means of transportation.
- The vehicle is less than 10 years old and has less than 100,000 miles on the odometer.
- The vehicle is not registered to or titled by an FSSA-approved provider agency.
- Only one vehicle per an individual may be modified.

Choice of Provider

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

Requirements

- All vehicle modifications must be approved by the HCBS waiver program prior to services being rendered.
- Vehicle modification requests must meet and abide by the following:
  - The vehicle modification is based on, and designed to meet, the individual's specific need(s):
    - Only one vehicle per an individual's household may be modified.
    - The vehicle is less than 10 years old and has less than 100,000 miles on the odometer.

- All vehicle modification shall be authorized only when it is determined to be medically necessary and/or shall have direct medical or remedial benefit for the waiver individual. This determination includes the following considerations:
  - The modification is the most cost effective or conservative means to meet the individual's specific need(s).
  - The modification is individualized, specific and consistent with, but not in excess of, the individual's need(s).
  - 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 three bids and explain why fewer than three bids were obtained (for example, provider name, dates of contact, response received).
  - For modifications under $1,000, one bid is required, and pricing must be consistent with the fair market price for such modification (s).
  - All bids must be itemized to include the items as shown in the example in Table 7.

Table 7 – Bid Itemization Example – Vehicle Modification

Make: _____Model: _____Mileage: _____Year: _____		
Scope of Work	**Materials Cost**	**Related Labor**
Lift	$$	$$
Tie down	$$	$$
Total Cost:	$$$$$	

- 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.
- Requests for modifications may be denied if the state division director or state agency designee determines the documentation does not support the service requested.

Service Standards

- Vehicle modification must be of direct medical or remedial benefit to the individual.
- All items must meet applicable manufacturer, design and service standards.

Documentation Standards

- The identified direct benefit or need must be documented within all the following:
  - POC/CCB
  - Physician prescription and/or clinical evaluation as deemed appropriate
  - PCISP if under the FSW and CIH Waiver
- Documentation/explanation of service within the *Request for Approval to Authorize Services* (RFA) must include:
  - Ownership of vehicle to be modified or vehicle owner's relationship to the individual and the following information:
    - Make, model, mileage and year of vehicle to be modified
    - Signed and approved RFA
    - Signed and approved POC/CCB
    - Receipts for all incurred expenses related to the modification
    - Any documentation needed to be in compliance with FSSA and division-specific guidelines and/or policies

Reimbursement

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

- Service and documentation standards outlined within this policy
- Allowable under current Medicaid waiver guideline
- Not available under the *Rehabilitation Act of 1973*, as amended
- Included in the individual's approved POC/CCB
- Authorized on the RFA and linked to the POC/CCB
- Included on a state-approved and signed NOA
- Completed by an approved Medicaid waiver service provider (that is approved to perform this service)

Modifications/Items – Covered

Justification and documentation are required to demonstrate that the modification is necessary to meet the individual's identified need(s) for the following:

- Wheelchair lifts
- Wheelchair tie-downs (if not included with lift)
- Wheelchair/scooter hoist
- Wheelchair/scooter carrier for roof or back of vehicle
- Raised roof and raised door openings
- Lowered floor van conversions
- Wheelchair ramp for vehicle
- Power transfer seat base (excludes mobility base)
- Maintenance is limited to $1,000 annually for repair and service of items that have been funded through a HCBS waiver:
  - Requests for service must differentiate between parts and labor costs.
  - If the need for maintenance exceeds $1,000, the case manager will work with other available funding streams and community agencies to fulfill the need. If service costs exceed the annual limit, those parts and labor costs funded through the waiver must be itemized clearly to differentiate the waiver service provision from those parts and labor provided through a nonwaiver funding source.

Items requested that are not listed above must be reviewed and decision rendered by the state division director or state agency designee.

Modifications/Items – Noncovered*

Examples/descriptions of modifications/items not covered include, but are not limited to, the following:

- Purchase, installation or maintenance of CB radios, cellular phones, global positioning/tracking devices or other mobile communication devices
- Repair or replacement of modified equipment damaged or destroyed in an accident
- Alarm systems

- Auto loan payments
- Insurance coverage
- Driver's license, title registration or license plates
- Emergency road service
- Routine maintenance and repairs related to the vehicle itself

> **Note: Until policy is updated - Sensory items, seizure detection devices, GPS tracking devices and other electronic devices not currently specified as items covered or reimbursable in the waiver or current RFA policy may be electronically submitted for consideration under SMES via the request for approval to authorize services form as outlined in Section 11 of this module. As an interim step toward RFA policy updates, BDDS will develop a SMES fact sheet citing things individuals and families may wish to consider prior to submitting a request.*

Decision-Making Authority

- Each division, with approval from the FSSA Office of the Secretary, shall identify a designee(s) to render decisions based upon the articles within this policy.
- The designee(s) is responsible for preparing and presenting testimony for all fair hearings – see *Section 8: Appeal Process*.
- The case management entity, working as an agent of the state, shall not attend fair hearings in opposition of the state.
- Each division shall implement a Quality Assurance Plan. In the event of inappropriate authorizations being granted, any or all of the following actions may be required:
  - A corrective action plan
  - Reimbursement to Medicaid
  - Loss of decision-making authority