

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

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in section 1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The state has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid state plan and other federal, state and local public programs as well as the supports that families and communities provide.

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

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

1. Request Information

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

B. Program Title:

Community Integration and Habilitation Waiver

C. Waiver Number: IN.0378

Original Base Waiver Number: IN.0378.

D. Amendment Number: IN.0378.R05.02

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

08/01/26

Approved Effective Date of Waiver being Amended: 07/16/25

2. Purpose(s) of Amendment

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

The purpose of this amendment is to effectuate the following changes:

- Remove reserved waiver capacity for eligible individuals transitioning from 100% state funded services (App B-3-c)
- Add reserved waiver capacity for Money Follows the Person (MFP) and remove reserved waiver capacity for individuals choosing to leave an ICF/IID (the category previously used for MFP) (App B-3-c)
- Update waiver waiting list procedures (App B-3-f)
- Implement new limit for Benefits Counseling service of 6 hours per year (App C-1/C-3)
- Update Case Management service definition to align with state's 1915(b)(4) waiver for case management services (App C-1/C-3)
- Update the definition of "own home" in the Community Transition service definition to align with revised "own home" definition in RHS (App C-1/C-3)
- Revise the Day Habilitation service definition and limitations (App C-1/C-3)
- Revise the Home Modifications and Assessments service definition and limitations (App C-1/C-3)
- Revise the Music Therapy service definition and limitations (App C-1/C-3)
- Revise the Recreational Therapy service definition and limitations (App C-1/C-3)
- Revise the Remote Supports service definition and limitations (App C-1/C-3)
- Revise the RHS (Hourly) and RHS (Daily) service definitions and limitations (App C-1/C-3)
- Revise the Specialized Medical Equipment and Supplies service definition and limitations (App C-1/C-3)
- Revise the Wellness Coordination service definition and limitations (App C-1/C-3)
- Revise documentation standards in service definitions (App C-1/C-3)
- Remove obsolete "individual" provider types (App C-1/C-3)
- Update quality improvement performance measures (App B, C, D and G)
- Revise payment policies for relatives and legal guardians (App C-2-e and related service limitations)
- Revise short-term budget requests (STBR) criteria (App C-4)
- Update description of grievance/complaint system to align statewide Bureau of Disabilities Services ombudsman provisions with revised Indiana Code and update additional ombudsman references throughout (App F-3)
- Update incident reporting requirements (App G-1-b)
- Update human rights committee safeguards and related service definitions (App G-2-a and G-2-b)
- Update cost neutrality demonstration information related to changes made in this amendment (App J)
- Revise Division of Disability and Rehabilitative Services (DDRS) references to Division of Disability Aging and Rehabilitative Services (DDARS) (throughout)
- Make technical changes to revise or delete obsolete language/provisions throughout

3. Nature of the Amendment

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

Component of the Approved Waiver	Subsection(s)
☒ Waiver Application	1-G, 2, 6-I, Attachment #1
☒ Appendix A - Waiver Administration and Operation	A-1, A-2, A-QIS
☒ Appendix B - Participant Access and Eligibility	B-3-c, B-3-f, B-QIS, B-8
☒ Appendix C - Participant Services	C-1/C-3, C-2-a, C-2-e, C-2-f, C-QIS, C-4
☒ Appendix D - Participant Centered Service Planning and	D-1-c, D-1-f, D-1-g, D-2-a, D-QIS

Component of the Approved Waiver	Subsection(s)
Delivery	
☒ Appendix E - Participant Direction of Services	E-1-a, E-1-i
☒ Appendix F - Participant Rights	F-2-b, F-3-b, F-3-c
☒ Appendix G - Participant Safeguards	G-1-b, G-1-c, G-1-d, G-2-a, G-2-b, G-2-c, G-QIS
☒ Appendix H	H-1-a, H-1-b
☒ Appendix I - Financial Accountability	I-2-a, I-2-d
☒ Appendix J - Cost-Neutrality Demonstration	J-1, J-2-d

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

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

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

1. Request Information (1 of 3)

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

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

Community Integration and Habilitation Waiver

C. Type of Request: amendment

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

☐ 3 years
☒ 5 years

Original Base Waiver Number: IN.0378

Waiver Number:IN.0378.R05.02

Draft ID: IN.006.05.02

D. Type of Waiver (select only one):

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/16/25

Approved Effective Date of Waiver being Amended: 07/16/25

PRA Disclosure Statement

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: July 31, 2027). The time required to complete this information collection is estimated to average 163 hours per response for a new waiver application and 78 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

☒ **Hospital as defined in 42 CFR § 440.10**

If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:

☒ **Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR § 440.160**☐ **Nursing Facility**

Select applicable level of care

☒ **Nursing Facility as defined in 42 CFR § 440.40 and 42 CFR § 440.155**

If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

☒ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR § 440.140**☒ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §**

440.150)

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

1. Request Information (3 of 3)

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

Select one:

- ☐ Not applicable
- ☒ Applicable

Check the applicable authority or authorities:

☐ Services furnished under the provisions of section 1915(a)(1)(a) of the Act and described in Appendix I

☒ Waiver(s) authorized under section 1915(b) of the Act.

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

The state's amended 1915(b)(4) waiver for case management services is effective for this waiver August 1, 2026 through July 31, 2031.

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

☐ section 1915(b)(1) (mandated enrollment to managed care)

☐ section 1915(b)(2) (central broker)

☐ section 1915(b)(3) (employ cost savings to furnish additional services)

☒ section 1915(b)(4) (selective contracting/limit number of providers)

☐ A program operated under section 1932(a) of the Act.

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

☐ A program authorized under section 1915(i) of the Act.

☐ A program authorized under section 1915(j) of the Act.

☐ A program authorized under section 1115 of the Act.

Specify the program:

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

☒ This waiver provides services for individuals who are eligible for both Medicare and Medicaid.

2. Brief Waiver Description

Brief Waiver Description. In one page or less, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

PURPOSE: The CIH waiver provides Medicaid home and community-based services(HCBS) waiver services to individuals in a range of community settings as an alternative to care in an intermediate care facility for individuals with intellectual disabilities (ICF/IID) or related conditions.

The waiver serves persons with a developmental disability, intellectual disability, or autism, and have substantial functional limitations (as defined under the paragraph for "Persons with related conditions" in 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) for service plan development. Developing the PCISP is based on the Charting the LifeCourse (CTLIC) Framework™ which is comprised of eight principles and a set of tools that support individuals and families in helping them identify how to find or develop their network of formal and informal supports. The CTLIC framework identifies an individual's health and safety needs in balance with their aspirations and preferences to develop a plan that integrates a variety of needed services and supports to help the individual identify avenues to achieve their good life. The PCISP is developed by the individual with support from the case manager along with others of the individual's choosing. This group forms the Individualized Support Team (IST). The PCISP first identifies the individual's preferences, aspirations, and health and safety needs in consideration of what existing service and support options are available or already in place. By addressing the individual's outcomes and needs, the PCISP details what the individual wants to accomplish within a given year to achieve a good life across a variety of life domains. The PCISP identifies the services and supports that are funded by the waiver and is routinely developed to cover a time frame of twelve consecutive months - these services and supports are authorized based on the individual's assessed needs in consideration of their desired life outcomes. The PCISP is subject to an annual cost limit established by the assessment process described under Appendix C-4-a, Budget Limits by Level of Support.

GOALS AND OBJECTIVES: The CIH waiver provides access to meaningful and necessary home-and community-based services and supports who meet defined needs-based criteria, seeks to implement services and supports in a manner that respects the individual's preferences, aspirations, and assessed health and safety needs, 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 non-paid social relationships in their home and work communities, and facilitates the individual's independent living.

ORGANIZATIONAL STRUCTURE: The Family and Social Services Administration (FSSA) is the Single State Medicaid Agency. The Indiana Division of Disability Aging and Rehabilitative Services (DDARS), a division under FSSA, has been given the authority to administer the CIH Waiver. The Office of Medicaid Policy and Planning (OMPP), also a division under FSSA, has been given the administrative authority for the CIH waiver by FSSA. The Bureau of Disabilities Services (BDS), a bureau under DDARS, performs the daily operational tasks of the waiver.

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

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

3. Components of the Waiver Request

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

- A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).

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

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

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

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

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

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

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

4. Waiver(s) Requested

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

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

- ☒ **Not Applicable**
- ☐ **No**
- ☐ **Yes**

C. Statewide. Indicate whether the state requests a waiver of the statewide requirements in section 1902(a)(1) of the Act (*select one*):

- ☒ **No**
- ☐ **Yes**

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

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

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

5. Assurances

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

- A. Health & Welfare:** The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
 2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,
 3. Assurance that all facilities subject to section 1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
 2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization,

psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

- A. Service Plan.** In accordance with 42 CFR § 441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR § 441.301(b)(1)(ii), waiver services are not furnished to individuals who are inpatients of a hospital, nursing facility or ICF/IID.
- C. Room and Board.** In accordance with 42 CFR § 441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR § 431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of section 1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR Part 433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. If a provider certifies that a particular legally liable third-party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The state provides the opportunity to request a Fair Hearing under 42 CFR Part 431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR § 431.210.
- H. Quality Improvement.** The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the quality improvement strategy specified in **Appendix H**.
- I. Public Input.** Describe how the state secures public input into the development of the waiver:

DDARS routinely obtains public input and collaborates with key stakeholders in the state through the following methods:

- DDARS' Executive Management Team accepts public input from nationally recognized organizations, professional trade associations, and leaders among the service providers, in addressing concerns and suggestions on behalf of the group and the participants each represents in regard to DDARS program policy and operations. This input is considered as policies are developed. With FSSA's approval, policies and updates are posted to DDARS' Website. DDARS hosts monthly provider webinars for statewide service providers announcing any waiver-related policy releases or updates authorized by FSSA, and meets with individual providers as needed or requested. DDARS also meets with small groups of parents and providers and intermittently attends other organized meetings of advocacy groups.
- DDARS hosts Building Bridges events which are opportunities for families and self-advocates to meet and speak with the Bureau of Disabilities Services (BDS) state staff. These sessions are an important part of the Bureau's efforts to create direct avenues for individuals and families to share their feedback on waiver services and supervised group living.
- The monthly Advisory Council meeting (established within IC 12-9-4) consisting of the Director of DDARS and ten other participants with knowledge of or interest in the programs administered by the Division. All ten are appointed by the Secretary of the Indiana Family and Social Services Administration, the State Medicaid Agency, and represent a wide and diverse membership including providers, parents, self-advocates, the Department of Education, and other Bureaus within the Division; including First Steps and Vocational Rehabilitation. The Council's mission is to recommend strategies and actions that will ensure DDARS empowers people with disabilities to be independent and self-sufficient.
- DDARS maintains an electronic helpline available 24 hours daily, serving as a source of answering general questions surrounding programs, policies and procedures and as a receptor of suggestions and ideas from any interested party.
- Public forums and Webinars are held as needed toward the dissemination of program or operational changes.

The public comment period for this Community Integration and Habilitation (CIH) Waiver was held for 36 days from February 11, 2026 through March 18, 2026. Electronic copies of the public notice and the entire amended waiver application were posted on the FSSA webpage at <https://www.in.gov/fssa/ddars/bds-policies/ddars-draft-policies-for-public-comment/> and the Indiana Register website at <http://iac.iga.in.gov/iac/irtoc.htm>. Additionally, paper copies of the public notice and the entire amended waiver application were made available at local Division of Family Resources offices and local Bureau of Disabilities Services (BDS) offices. The tribal consultation period was held for 60 days from January 28, 2026 through March 29, 2026.

Three webinars were hosted at which FSSA presented a summary of the amended waiver applications and how to submit comments. The webinars were recorded and made available for replay on the FSSA website.

The comment period for the CIH Waiver and the Family Supports (FS) Waiver ran concurrently. Many commenters provided broad comments that addressed elements included in both waivers or provided comments that were general to all waiver submissions. As a result, the following summary of comments is inclusive of all comments received by DDARS during this period. All public comments and dates of public notice for this amended waiver application are retained on record and available for review.

The state received comments from four-hundred and fifteen (415) commenters regarding the proposed waiver amendments. Comments are summarized below and are grouped by theme, followed by state response.

Comments Related to Proposed Changes (CIH and FS)

Benefits Counseling - Service Limitation. Two commenters noted their support for the annual service limitation for Benefits Counseling.

Response: The state appreciates commenters' support for the service limitations.

Case Management - Responsibilities. Three commenters expressed confusion whether case managers would be required to conduct face-to-face visits with the individual every 90 days or on a quarterly basis (which could allow for more than 90 days between visits as long as one visit per quarter). Two commenters inquired whether case notes must be entered

within 5 or 7 days of the activity.

Response: As stated in the revised service definition, case managers will be required to conduct face-to-face visits with the individual every 90 days. Case notes must be entered within seven (7) calendar days of an activity or event. The state will modify the documentation requirements reference the correct seven (7) calendar day timeframe.

PUBLIC INPUT FOR THE PROPOSED AUGUST 1, 2026, AMENDMENTS IS CONTINUED IN MAIN: B. OPTIONAL SECTION OF THE APPLICATION.

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

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

7. Contact Person(s)

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

Last Name:

Gilbert

First Name:

Brian

Title:

Manager, Program Administration

Agency:

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

Address:

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

Address 2:

City:

Indianapolis

State:

Indiana

Zip:

46204-2739

Phone:

(317) 233-3340

Ext:

☐

TTY

Fax:

(317) 232-7382

E-mail:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State:

Zip:

Phone:

Ext:



TTY

Fax:

E-mail:

8. Authorizing Signature

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

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name:

First Name:

Audrey

Title:

Indiana Medicaid Director

Agency:

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

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Attachments

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Attachment #1: Transition Plan

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

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

Specify the transition plan for the waiver:

Transition Plan for Benefits Counseling Service Limit:

The state is implementing a new limit on Benefits Counseling of six (6) hours per plan year. Individuals will be transitioned to the new service limit on the effective date of this amendment. Case managers are required to meet with any individuals who have plans with approved amounts of these services in an amount greater than the new limit. Individuals will be informed of the new service limits and supported by their case manager to modify their PCISP to meet their identified needs within the service-specific limits. The case manager will also provide them with notice of their fair hearing rights associated with any changes to their services. To continue to assure the health and welfare of impacted individuals, the case manager will work with the individual and their IST during the person-centered planning process to identify alternate supports available to the individual if the six (6) hours per year limit is reached. Alternate supports may include other services available through the waiver for which they are eligible, alternatives for services available through the Medicaid state plan, and/or natural supports.

For All Service Changes:

During each person's annual IST meeting their case manager will inform them of any substantive changes to services they had previously used or had included in their PCISP. Case Managers will support the individual to identify alternative services or alternative service providers who can meet their needs when applicable and will ensure they receive annual notice of their Fair Hearing rights associated with any plan changes.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

MAIN: 6. REQUIREMENTS: I. PUBLIC INPUT FOR THE PROPOSED AUGUST 1, 2026, AMENDMENT IS CONTINUED HERE:

Case Management Selective Contracting Program. Four commenters expressed support for the selective contracting program. These commenters felt that this program improves service consistency and quality. However, two commenters expressed concern that without increased oversight requirements for case managers the case management selective contracting program could result in service delays or inconsistencies across regions. Five commenters expressed concern that the case management selective contracting program would reduce individuals' choice of providers. Two commenters disliked the value-based payment system for CMO's.

Response: Response: The state appreciates commenters' support for the selective contracting program. The CMO is required to provide direct case management services, supervisory case management, and quality assurance activities for the proposed area(s) of service. The state recognizes that inclusion of these waivers in the selective contracting program will limit the individuals' choice of providers, however, this program will better position the state to assure a sufficient number of case managers are available, to assure that high quality case management services are delivered and to assure a more consistent participant experience. The value-based payment model proposed in case management selective contracting program is intended to ensure timely and accurate completion of case management responsibilities, compliance with case load sizes, and proper training of case managers by CMOs. The state is not making changes to the waiver based on the comments received. However, the state will continue to monitor implementation of these policies and may make future adjustments if needed.

Day Habilitation - Service Description and Limits. Two commenters expressed concern that introducing new staffing ratios, and restrictions on in-home service delivery may reduce access to day habilitation services in communities where few or no day programs operate. Additional commenters expressed concern regarding the proposed changes to activities not permitted under the service.

Response: The proposed changes do not modify staffing ratios for day habilitation services. Rather, the changes clarify that staffing ratios must be documented within the person-centered individualized support plan (PCISP). While the state temporarily permitted the provision of day habilitation services in an individual's home during the COVID-19 public health emergency, in-home service delivery is not currently authorized under the approved waivers. Additionally, the proposed changes to the "activities not allowed" only clarify existing service limitations. The state is not making changes to the waiver based on the comments received.

Documentation Standards - General. Two commenters expressed support for the consistency across documentation standards. Eight commenters expressed concern that revised documentation standards across various services are overly burdensome and may take time away from the provision of direct care.

Response: The state appreciates commenters' support. The purpose for revising the documentation standards is to clarify documentation requirements, improve consistency in provider recordkeeping, and align documentation standards, to the extent feasible, across all services and waivers administered by DDARS. Changes to documentation standards were initially proposed as part of the Winter 2025 waiver amendments but were removed to allow for further review. Following that review, the state revised the documentation standards and included those revisions in the proposed amendments. The state will provide additional information and guidance to providers prior to implementation of these requirements. The state is not making changes to the waiver based on the comments received.

Documentation Standards - Quarterly Reports. Six commenters supported the addition of quarterly reporting requirements, while thirteen commenters opposed the new quarterly reporting requirements suggesting that they were overly burdensome or could create financial strain for providers. Additionally, fifteen commenters requested additional details prior to implementation.

Response: The state's intent for making these changes is to clarify documentation requirements, improve consistency in provider record keeping and align documentation standards (to the extent possible) across all services and all waivers administered by DDARS. The state is working to develop quarterly reporting forms to simplify the process. The state will also provide additional information, guidance and training on quarterly reporting to providers prior to implementation of these requirements. The state is not making changes to the waiver based on the comments received.

Home Modification and Assessment Services. One commenter recommended that providers be required to conduct an on-site visit prior to submitting a bid and include written confirmation of the visit in the bid documentation. Four other commenters expressed concern that the proposed changes to this service could delay timely access to these services. To improve timeliness, commenters suggested that case managers be allowed to attend the post-modification inspection virtually.

Response: The state appreciates the commenter's recommendation regarding bid requirements and will revise these provisions accordingly. The updated requirements will specify that each bidder must conduct a site visit, meet with the individual and/or family to ensure feasibility, and verify accuracy prior to submitting a bid. The state will also require written confirmation of the site visit to be included in the bid documentation. The state is not making any other changes to the waiver based on the comments received.

Incident Reporting Revisions. One commenter requested additional details regarding the elopement and the choking reporting requirements prior to implementation.

Response: The state will provide additional information, guidance and training on reporting to providers prior to implementation of these requirements. The state is not making changes to the waiver based on the comments received.

Live-In Caregiver Rate Reduction. One-hundred and eighty commenters expressed concern about reducing RHS (Hourly) and/or PAC reimbursement rates when caregivers reside with the individual they support. Commenters noted that these caregivers provide the same services as other providers and that reduced compensation for live-in caregivers could create financial burdens for families.

Response: The proposed rate adjustment reflects the removal of a small portion of the rate intended to cover provider travel between worksites. This cost is not incurred in situations where caregivers reside with the individual they support. This adjustment should not prevent live-in caregivers' ability to support individuals in accessing community activities. Nor should this adjustment result in reduced compensation for live-in caregivers. The state is not implementing this change at this time but plans to implement through a future amendment.

Music Therapy - Service Definition. Twenty-one commenters expressed support for including "maintenance" of non-musical skills within the service definition and four commenters agreed that it was not appropriate to bill Music Therapy services when solely providing transportation. Eleven commenters requested clarification regarding documentation requirements, including quarterly reporting and the distinction between direct and indirect service time.

Response: The state appreciates commenters' support. Additionally, the state is developing quarterly reporting templates to support tracking of direct and indirect service time and will provide additional information and guidance to providers prior to implementation of these requirements. The state is not making changes to the waiver based on the comments received. However, the state will monitor quarterly reporting activities and will provide additional clarification and/or make adjustments to the template as needed.

Paid Family Caregiver Policies - Removal of Authorized Services. One-hundred and eighty commenters expressed concern regarding the removal of authorization for relatives and legal guardians to provide certain services. Of these commenters, many expressed specific concern regarding the change to Day Habilitation policies. Commenters suggested that limiting the services that family caregivers can provide would put individuals at risk of service disruption, medical instability, and loss of community-based support. Commenters also suggested that the new policies would create financial burden for families.

Response: The state's intent in removing authorization for relatives and legal guardians to provide certain services is to ensure that all providers meet appropriate qualification standards and are not subject to potential conflicts of interest. When authorizing services, the state focuses on the support needs of the individual; waiver services are designed to assist individuals to live in the community and avoid institutionalization. The state is not making changes to the waiver based on the comments received. The state is not making changes to the waiver based on the comments received.

It is important to note that the removal of the authorization for relatives and legal guardians to be paid for furnishing certain services is not a limit on the hours of service an individual can receive. This change only limits who can be paid for furnishing such services.

Paid Family Caregiver Policies - Aggregate Hour Limit. Sixty-two commenters expressed concern and confusion regarding limitations on the number of hours for which family caregivers could be paid for furnishing waiver services. Commenters suggested that these limitations would result in service reductions and/or higher use of emergency/crisis supports.

Response: The hourly limitations for paid family caregivers vary based on whether the paid family caregiver is a "legally responsible individual" or other "relative or legal guardian." In accordance with the federal description, Legally Responsible Individuals (LRIs) include ONLY the parent of a minor child or a spouse of a participant. LRI's DO NOT include the parent of an adult participant (including a parent who also may be a legal guardian) or other types of relatives.

Under the CIH waiver, the state does not make payment to LRI's for the provision of any waiver services. Additionally, the maximum combined number of hours of RHS (Hourly), Respite, and Workplace Assistance services that may be reimbursed when provided by a relative or legal guardian must not exceed forty (40) hours per week across all services for each paid relative/legal guardian caregiver.

Under the FS waiver, the state only allows payment to be made to LRIs for the provision of Participant Assistance and Care (in accordance with Appendix C-2-d) and the maximum number of hours that may be reimbursed for all LRIs combined must not exceed forty (40) hours per week. Additionally, the maximum combined number of hours of PAC, Respite and Workplace Assistance services that may be reimbursed when provided by a relative or legal guardian must not exceed forty (40) hours per week across all services for each paid relative/legal guardian caregiver.

It is important to note that the "40-hour per week" limitation for relatives/legal guardians is not a limit on the hours of service an individual can receive, nor is it a combined limit for all relatives and legal guardians of a single participant. This limit is a "40-hour per week" limit for each paid relative or legal guardian.

The state will modify the limitations specified in Appendix C-2-e of the CIH and FS waivers to clarify the payment policies described above.

Recreational Therapy - Service Definition. Nine commenters expressed support for including "maintenance" of skills within the service definition. Two commenters agreed that it was not appropriate to bill Recreational Therapy services when solely providing transportation, while others indicated that transportation is an integral component of the service and should be reimbursable under Recreational Therapy. Four commenters requested clarification regarding documentation requirements, including quarterly reporting and the distinction between direct and indirect service time. Other commenters also requested additional clarification regarding "activities not allowed."

Response: The state appreciates commenters' support. Providers are not authorized to bill Recreational Therapy services for time spent solely transporting an individual. Providers who wish to furnish transportation services may enroll separately as authorized Medicaid transportation provider and bill transportation services in accordance with applicable requirements. Additionally, the state is developing quarterly reporting templates to support tracking of direct and indirect service time and will provide additional information and guidance to providers prior to implementation of these requirements. The state is not making changes to the waiver based on the comments received. However, the state will monitor quarterly reporting activities and will provide additional clarification and/or make adjustments to the template as needed.

Remote Supports Service Definition. Two commenters expressed support for including Remote Supports in the service array. However, three commenters expressed concern that the proposed waiver definitions remove provisions requiring safeguards at the remote supports monitoring base and remove provisions requiring providers to maintain safeguards and/or backup systems. One commenter also noted that not allowing Remote Supports to be "used in place of in-home staff" does not appear to align with the intended purpose of Remote Supports.

Additionally, one commenter requested additional information regarding the requirements for the care plan. Another commenter requested additional information regarding the provider selection and billing procedures when Remote Supports services are not provided through Residential Habilitation and Support (RHS).

Response: The state appreciates commenters' support. The state agrees with commenter that the service definition should include requirements for safeguards at the remote supports monitoring base and will add previously deleted provisions back into the definition. The state also notes that the provisions regarding back-up procedures and systems were not deleted and remain in the service definition. Based on the comment received, the state will also remove the provision not allowing Remote Supports to be "used in place of in-home staff." However, it is important to clarify that RHS and Remotes supports are not billable at same time. Finally, the state will provide additional information and guidance to providers regarding the care plans and billing procedures prior to implementation.

RHS (Hourly) and RHS (Daily) Rate Models. Four commenters expressed concern about the changes made to clarify the appropriateness of RHS (Hourly) and RHS (Daily) services. Commenters felt that these clarifications were too inflexible and did not account for the realities of shared living, individual preference, or behavioral needs. Some providers suggested that the proposed changes would impact the coordinated provision of remote supports.

Response: The proposed changes do not modify how RHS services and remote supports are coordinated. Decisions regarding delivery of remote supports should be determined through the person-centered planning process and based on the individual's

needs. The state is not making changes to the waiver based on the comments received. However, the state will retain and reconsider these comments during the planning for waiver reset.

RHS Transportation Policies. Two commenters requested additional details regarding the RHS transportation policies.

Response: The state will provide additional information and guidance on the transportation policies. The state is not making changes to the waiver based on the comments received.

SFC - Typo Correction. Two commenters identified potential typographical errors in the CIH waiver regarding whether home visits required for the Structured Family Caregiving service were required monthly or quarterly.

Response: The state reviewed the Structured Family Caregiving service definition in the CIH waiver and confirmed the typographical error. The state will modify the SFC home visit requirements in the CIH to clarify that home visits are required quarterly.

SMES - 30% Mark-Up. Four commenters expressed concern that the proposed 30% cost mark-up for SMES would not be sufficient to cover providers' one-year warranty requirements (especially where manufacturer warranty is less than one year or equipment is very expensive).

Response: The state is not making changes to the waiver based on the comments received. However, the state acknowledges these concerns and will continue to monitor SMES reimbursement amounts and may make future adjustments if needed.

Short-Term Budget Requests (STBR). One commenter requested additional details regarding this requirement prior to implementation.

Response: The state will provide additional information and guidance regarding the STBR requirements to providers prior to implementation. The state is not making changes to the waiver based on the comments received.

Wait List. Eight commenters expressed concern that proposed changes do not sufficiently expand access to services. Commenters indicated that without additional waiver capacity, many individuals and families will continue to experience long delays before receiving services.

Response: DDARS is not authorized to expand waiver capacity at this time. The state is not making changes to the waiver based on the comments received.

Wellness Coordination Services. One commenter opposed the requirement that face-to-face visits occur in the individual's home and requested additional details regarding this requirement prior to implementation.

Response: The state will provide additional information and guidance to providers prior to implementation of these requirements. The state is not making changes to the waiver based on the comments received.

Comments Related to the Waivers But Beyond the Scope of the Proposed Changes

Benefits Counseling - Service Definition, Limitations, and Provider Qualifications. Two commenters requested the state provide additional details outlining when benefits counseling supports should be accessed through the waiver rather than through Vocational Rehabilitation. One commenter recommended that the state revise the qualifications for Benefits Counseling service to require providers to be trained and certified Community Partner Work Incentive Counselors (CPWICs) or Community Work Incentives Coordinators (CWICs) to align with Vocational Rehabilitation provider requirements.

Response: The waiver Benefits Counseling service is distinct from the Benefits Counseling service offered through the Indiana Vocational Rehabilitation program. To greater clarify the different scope of this service the state has revised the service definition to better reflect the intent of this service thereby clarifying why providers do not need to have the same qualifications as vocational rehabilitation providers. The state will consider adjustments to the provider qualifications for the waiver Benefits Counseling service as part of future amendments.

Case Management. One commenter expressed concern that some of the waiver amendments stated that the CMO will be responsible for LOC evaluations because these responsibilities were transferred to the LCAR contractor in 2025. Another commenter expressed concern that the quarterly face-to-face requirement and annual "in home" requirement for case

management meetings created undue burden for families.

Response: The CMO changes are not intended to impact the level of care evaluation process. The LCAR contractor is responsible for and will continue to perform nursing facility level of care evaluations for the H&W and TBI waivers. The CMOs are responsible for and will continue to perform ICF/IID level of care evaluations for the CIH, FS and TBI waivers.

Quarterly face-to-face meetings and annual "in-home" meetings are essential for on-going case management and monitoring case management. Specifically, these meetings ensure timely updates to the PCISP are made as an individual's needs, circumstances, or goals change. These regular meetings provide an opportunity for the case manager to monitor the individual's health and safety and address potential risks. The state is not making changes to the waiver based on the comments received.

Family and Caregiver Training Services. Twenty-five commenters expressed confusion and questioned why family caregiver and training services are not reimbursable to family members.

Response: To clarify reimbursement policies related to family and caregiver training (FCAR) services, the state will provide reimbursement when FCAR services are provided TO family members, but not when FCAR services are provided BY family members. The state has identified references to "uncompensated" caregivers in the FS service definition that may have contributed to the confusion regarding these policies. Therefore, the state will revise the FCAR service definition and limitations to remove the "uncompensated" caregiver language and clarify that reimbursement will not be made for training that agencies are otherwise required to provide to employees who are also paid family caregivers.

FSW Budget Limit. Two commenters felt that the budget amounts of the FS waivers should be increased support individuals' needs. The commenter suggested that budget be based upon the support needs of the individual.

Response: The state is not making changes to the waiver based on the comments received. However, the state will retain and reconsider these comments during the planning for waiver reset.

Home and Community Support Professional (HCSP) Training Program. One commenter expressed their support for the recently implemented HCSP Training Program.

Response: The state appreciates the commenter's support.

Incident Reporting Timelines. One commenter suggested that the incident reporting timelines be modified to allow 48 hours to report non-critical incidents.

Response: It is the state's policy that an initial report regarding an incident must be submitted within 24 hours of the occurrence of the incident; or the reporter becoming aware of or receiving information about an incident. The state is not making changes to the waiver based on the comments received.

New Service Requests. Eleven commenters suggested that the state add various services to the waivers. Requests for new services included, nutrition services, home delivered meal services, a separate interpreter service, skilled nursing, home health aide services, expanded technology services, services that fund recreational activities, and pest control services.

Response: The state is not making changes to the waiver based on the comments received. However, the state will retain and reconsider these comments during the planning for waiver reset.

Paid Family Caregiver Policies - Extraordinary Care Definition. Ten commenters suggested that the "extraordinary care" definition related to the circumstances under which LRI's may receive payment for furnishing waiver services is too narrow.

Response: The "extraordinary care" definitions described in Appendix C-2-d were reviewed by the DDARS Advisory Council prior to inclusion in the waivers. The state is not making changes to the waiver based on the comments received.

Personal Emergency Response System (PERS). Two commenters requested that the state expand the definition of PERS to include the GPS monthly fees for children.

Response: The state is not making changes to the waiver based on the comments received. However, the state will retain and reconsider these comments during the planning for waiver reset.

Provider/Staff Availability - General. One commenter expressed concern about a lack of provider/staff availability.

Response: The state monitors waiver provider enrollment and availability to ensure sufficient provider capacity. Additionally, the state has implemented a registry with provider training requirements for CIH and FS waiver providers to strengthen both capacity and service quality. The state is not making changes to the waiver based on the comments received.

Reimbursement/Funding Cuts - General. Twenty-one commenters expressed general concern about waiver reimbursement and funding cuts.

Response: The state develops and implements reimbursement and funding policies based on and aligned with the Medicaid budget. The state is not making changes to the waiver based on the comments received.

Reserved Capacity Criteria for CIH Waiver. Three commenters express concern regarding the current emergency placement reserved capacity criteria in the CIH waiver. Specifically, one commenter recommended that the criteria should be modified to allow for placement before the primary caregiver reaches eighty (80) years of age.

Response: This reserved waiver capacity category was implemented in 2024 in accordance with Indiana Public Law P.L.131-2024. The state is not making changes to the waiver based on the comments received.

Residential Habilitation - Billing. One commenter opposed billing separately for transportation costs related to the provision of Residential Habilitation Services.

Response: The state is not making changes to the waiver based on the comments received. However, the state will retain and reconsider these comments during the planning for waiver reset.

Structured Family Caregiving - Levels of Service. Two commenters expressed concern regarding the adequacy of the SFC Level of Service Assessment.

Response: The state is not making changes to the waiver based on the comments received. However, the state will retain and reconsider these comments during the planning for waiver reset.

Transportation Limitation. Three commenters expressed concern regarding the two trips per day transportation limit. They suggested that this limit was insufficient for some individuals and requested increased limits and/or more flexibility for this service.

Response: The state is not making changes to the waiver based on the comments received. However, the state will retain and reconsider these comments during the planning for waiver reset.

Waiver Reset. Two commenters made recommendations for the future waiver reset. Recommendation topics included assessment processes, services offerings, service delivery modalities, reimbursement rates and transition planning.

Response. The state appreciates commenter's input and will retain and reconsider these comments during the planning for waiver reset.

Winter 2025 New Assessment Tool. One commenter expressed reservations regarding the 2025 implementation and use of the interRAI Suite of Instruments to evaluate ICF/IID Level of Care because the new assessment instruments were unfamiliar to families.

Response: The interRAI Suite of Instruments was selected as a valid and reliable tool that has been rigorously researched and tested to replace the formerly utilized Level of Care Screening Instrument (LOCSI) which did not provide a developmentally appropriate assessment for kids/youth. Individuals currently have and will continue to have the right to appeal any waiver eligibility determination (including a level of care determination). Individuals and their legal representatives are provided written and oral explanations of the Medicaid Fair Hearing process (including an explanation of the types of decisions they may appeal) at the time of the individual's eligibility assessment.

Winter 2025 Behavioral Support Services Model. Two commenters expressed concern about the existing requirement that BSS providers ensure that indirect time is not billed for more than 25% of the total service time. Commenters indicated that 25% indirect time is insufficient to adequately prepare for sessions and complete required documentation. One commenter indicated their belief that requiring both the individual and guardian to approve rights restrictions can create ambiguity for providers.

Finally, one commenter felt that clinical supervision should be required for all service recipients, while another commenter felt that time spent consulting with Clinical Supervisors reduces available indirect time rather than supporting direct client care.

Response: The state is not making changes to the waiver based on the comments received. However, the state will continue to monitor implementation of the policies related to direct and indirect time and may make future adjustments if needed.

Winter 2025 Therapy Caps. Twenty-one commenters indicated they did not like the hourly therapy limitations implemented in December of 2025 for Behavioral Support Services, Music Therapy, and Recreational Therapy.

Response: The state is not making changes to the waiver based on the comments received. However, the state will continue to monitor these limitations and may make future adjustments if needed.

Other General Comments and Questions Regarding Unique Circumstances

Public Comment Process. Two commenters indicated they needed additional information regarding new live-in caregiver rates and quarterly reporting requirements.

Response: The state responded to the commenters and directed them to upcoming public comment webinars for additional information.

State Plan - Home Health Service Restrictions. Eight commenters expressed frustration regarding changes to the IHCP Home Health Services Provider Reference Module that specified family caregivers could only be paid for furnishing either home health services or waiver services (e.g. participant assistance and care) but could not be paid for furnishing both home health services and waiver services.

Response: These policies are not included in the proposed waiver amendments. Please refer to the IHCP Home Health Services Provider Reference Module for future updates.

Questions Regarding Unique Circumstances. The state received questions regarding the unique circumstances of individuals receiving waiver services.

Response: The state is ensuring these requests for support are routed to the appropriate entity/contact and addressed on a case-by-case basis.

C-1/C-3: SERVICE SPECIFICATION FOR CASE MANAGEMENT IS CONTINUED here for the 07/01/2026 AMENDMENT due to character limits in the text field:

SERVICE STANDARDS

- Case management services are based on the principles of person-centered thinking and driven by the PCISP.
- Case management services are provided in a manner that comports fully with standards applicable to person-centered planning specified in 42 CFR 441.301(c)(1) and the person-centered service plan requirements specified in 42 CFR 441.301(c)(2).
- The role of the case manager includes service and support 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 BDS-approved training entity or person; observed a facilitation; and participated in a person-centered planning meeting prior to leading an IST.
 - Complete BDS-approved certification requirements
- Case manager's average caseload size must not exceed forty-seven (47) 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 22 cases. The State will monitor adherence to this caseload limit on a quarterly basis.
- Case managers will assist individuals to transition to a new case management agency when the individual chooses a new case management agency or case manager. The goal is to assure a seamless transition for the individual. When a case manager is leaving one case management agency and going to another, the case manager may share this information with the individual

when asked directly by the individual. The case manager may not influence or persuade the individual to leave their current case management agency. Case managers may not take any individuals' files, PHI, or PII with them when they leave their employer.

- Case managers are required to uphold the principles of conflict-free case management. This means they must remain free from financial influence in the delivery of services and must not hold decision-making roles within approved Medicaid provider organizations. Additionally, there must be no financial relationship between the referring case management agency, its staff, and any providers of other HCBS waiver services.

- Technology Requirements. Case management organizations 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 hours a day, seven days a week 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 support.

- Compliance Requirements. Case management organizations must:

- 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 identify any violation of rules, regulations, or established requirements that are discovered and report them to BDS through the incident reporting system as outlined in Indiana Administrative Code, Indiana Code and BDS policy.

- Ensure that each supervisor is able to meet with their assigned case managers at least monthly, monitor their activities and responsibility and provide ongoing support. They may not carry a caseload, but may serve as backup during case manager's absence (e.g., leave of absence).

- Have a mechanism for monitoring the quality of services delivered by case managers that aligns with BDS practices; and addressing any quality issues that are discovered and reporting them to BDS.

- All DDARS-approved case management agencies specifically agree to comply with the provisions of the Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq. and 47 U.S.C. 225).

- Case management organizations must:

- Ensure compliance with any applicable FSSA/DDARS/BDS service standards, guidelines, policies and/or manuals, including policies, written agreements and the DDARS HCBS Waivers Provider Reference Module on the IHCP Provider Reference Modules webpage;

- 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 DDARS-approved case management agency obtain proof of competency demonstrated through successful completion of the DDARS/BDS- case management training curriculum and certification exam;

- Ensure case managers complete and demonstrate competency of the BDS required training;

- Ensure case managers complete the required hours of BDS approved, case management entity provided, training;

- Ensure that case managers are trained in the person-centered planning process aligned with BDS' mission, vision and values, including participation in any BDS 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.

DOCUMENTATION STANDARDS

Case management entities must adhere to all documentation standards outlined in Indiana Administrative Code and the FSSA/DDARS BDS policies and the FSSA/DDARS HCBS Waivers module on the IHCP Provider Reference Materials webpage. Additionally, the provider must comply with the following standards:

- Case managers must perform and document one meaningful encounter with or on behalf of the waiver individual each calendar month in case notes to support billing. The case note must include applicable information and activities 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

- Documentation in case notes must be completed within seven calendar days of an activity or event.

- Documentation may occur in multiple locations based upon activity and must be clearly referred to in the case notes.

- Upon request, all documentation must be made available to auditors, quality monitors, case managers and any other government entity within any/all timeframes specified by BDS.

C-1/C-3: SERVICE SPECIFICATION FOR BEHAVIORAL SUPPORTS IS CONTIUNED here for the 07/01/2026 AMENDMENT due to character limits in the text field:

DOCUMENTATION STANDARDS

- Provider must maintain all applicable documentation required under 460 IAC 6 Supported Living Services and Supports, the Behavioral Supports Services Quality Guide, the FSSA/DDARS BDS policies and the FSSA/DDARS HCBS Waivers module on the IHCP Provider Reference Materials webpage. Additionally, the provider must comply with the following standards:
- The provider must document the following data elements for each uninterrupted period of services rendered:
 - IHCP Member ID of the individual served
 - Name of individual served
 - Service rendered
 - Date of service (include month, day and year)
 - Time frame of service (include start time, end time and a.m./p.m.)
 - Number of units of service rendered
- Consultation Plan, FBA Report, BSP, and Quarterly Reports must be completed on state approved templates and uploaded to the BDS portal by the BSS provider. Failure to timely complete and upload each report may result in a citation.
- The NOA/SA identifies the name of the waiver-funded service, the name of the participant-chosen provider of that service, the cost of the service per unit, the number of units of service, and the start and end dates for each Waiver service identified on the PCISP.
- Documentation must include progress toward outcomes and any changes or modifications within the PCISP.
- Any documentation outlining research or data analysis completed to inform evidence-informed strategies customized to the individual supported must cite sources used and impact on service delivery elements. Resources to support this work must be made available upon request.
- The documentation may reside in multiple locations but must be clearly and easily linked to the individual or the standard will not be met.
- Upon request, all documentation must be made available to auditors, quality monitors, case managers and any other government entity within any/all timeframes specified by BDS.

C-1/C-3: SERVICE SPECIFICATION FOR REMOTE SUPPORT IS CONTINUED here for the 07/01/2026 AMENDMENT due to character limits in the text field:

DOCUMENTATION STANDARDS

Provider must maintain all applicable documentation required under 460 IAC 6 Supported Living Services and Supports and the FSSA/DDARS BDS policies and the FSSA/DDARS HCBS Waivers module on the IHCP Provider Reference Materials webpage. Additionally, the provider must comply with the following standards:

- The provider must document the following data elements for each day services are rendered:
 - Name of individual served
 - IHCP Member ID (RID) of the individual served
 - Service rendered
 - Date of service (include month, day and year)
 - Number of units of service rendered that day
- A remote supports care plan must be developed/updated at least annually outlining how remote supports will be used. The care plan must be attached to the PCISP.

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

- Status as a BDS-approved provider
- Case notes regarding the assessment and approval by both the IST of each individual, documented within both the DDARS

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 BDS 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
- The remote monitoring base staff shall generate a written report summarizing supports provided for each uninterrupted period of services rendered.. If the individual utilizes waiver residential services, the provider must transmit this report to the primary residential provider.
 - Each time an emergency response is generated, an incident report must be submitted to the state per the BDS and quality assurance procedures.
 - Each quarter (or more often as determined by the IST), the service provider must prepare and upload a progress 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 reporting period. Quarterly reports must be completed on state approved templates. The first reporting period must align with the start of the service. Failure to timely complete and upload each quarterly report may result in a citation.
 - The documentation may reside in multiple locations but must be clearly and easily linked to the individual or the standard will not be met.
 - Upon request, all documentation must be made available to auditors, quality monitors, case managers and any other government entity within any/all timeframes specified by BDS.

APPENDIX I-1: FINANCIAL INTEGRITY AND ACCOUNTABILITY IS CONTINUED due to character count limitations: The State implemented an Electronic Visit Verification (EVV) system, known as the Sandata EVV System, that complies with the requirements of the federal 21st Century Cures Act. The IHCP CoreMMIS claim-processing system has been configured to integrate with the Sandata EVV system. IHCP requires that providers use the EVV system to document the following: Date of the service; Location of service delivery; Individual providing the service; Type of service performed; Individual receiving the service; Time the service begins and ends. Providers may choose to use an EVV system other than Sandata. However, those providers will be required to export data from their alternate system to the Sandata "Aggregator" for integration with CoreMMIS

Appendix A: Waiver Administration and Operation

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

- ☒ **The waiver is operated by the state Medicaid agency.**

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

- ☐ **The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

- ☒ **Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.**

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

Division of Disability Aging and Rehabilitative Services (DDARS)

(Complete item A-2-a).

- ☐ **The waiver is operated by a separate agency of the state that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

The Family and Social Services Administration (FSSA) is the Single State Medicaid agency authorized to administer Indiana's Community Integration and Habilitation (CIH) waiver. The waiver is operated by the Division of Disability Aging and Rehabilitative Services (DDARS), a division under the Single State Medicaid Agency. The Office of Medicaid Policy and Planning (OMPP), a division under the Single State Medicaid Agency, is responsible for monitoring DDARS's operation of the waiver through:

- A Quality Management Plan that outlines in detail the quality assurance responsibilities and activities. This Plan is derived from the performance measures included in this waiver renewal. As part of FSSA's oversight authority for assuring individual's service plans (which include risk plans for identified health issues) are appropriate and effective, OMPP has selected several administrative authority and key health issues to monitor for individuals with developmental disabilities. Monitoring is conducted to ensure issues are identified timely and addressed appropriately.
- Ongoing and periodic reporting and analysis of data, including service utilization data, claims data, and reportable events. OMPP receives management reports from DDARS, BDS, and the fiscal agent. These reports include:
 - From BDS, the QA/QI contractor's quarterly management report, which contains aggregate data from complaints, incident reports, mortality reviews, and trend analysis; and
 - From the fiscal agent, monthly and quarterly management reports.
- Periodic inter-division meetings to discuss activities, issues, outcomes, and needs, and to jointly plan ongoing system improvements and remediation, when indicated. FSSA Management teams meet bi-weekly to review programs, recommend changes, and address programming concerns. The performance of contracting entities is reviewed, discussed, and addressed as needed during these meetings. Termination of a vendor contract is possible should the contractor be unable or unwilling to meet the expectations of the state.

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

- Annually, OMPP and Division of Finance, a division under the single State Medicaid agency, supervises the development of the CMS annual waiver expenditure reports, reviews the final report with DDARS, and identifies problem areas that may need to be discussed and resolved with DDARS prior to submission by FSSA.
- Monthly, OMPP and Division of Finance reviews Medicaid waiver expenditure reports, after which any identified problems will be discussed and resolved with DDARS.
- Daily, FSSA (or FSSA's fiscal agent) reviews, approves, and assures payment of Medicaid claims for waiver services consistent with FSSA established policy.
- On an ongoing basis, FSSA is responsible for oversight of all waiver activities (including level of care (LOC) determinations, plan of care reviews, identification of trends and outcomes, and initiating action to achieve desired outcomes), retaining final authority for approval of level of care and plans of care.
- OMPP develops Medicaid policy for the State of Indiana and on an ongoing and as needed basis, works collaboratively with DDARS to formulate policies specific to the waiver or that have a substantial impact on waiver participants.
- OMPP seeks and reviews comments from DDARS before the adoption of rules or standards that may affect the services, programs, or providers of medical assistance services for individuals with intellectual disabilities who receive Medicaid services.
- FSSA, and FSSA's fiscal agent, approves and enrolls all providers of waiver services.
- OMPP and DDARS collaborate to revise and develop the waiver application to reflect current FSSA goals and policy programs.
- OMPP reviews and approves all waiver manuals, bulletins, communications regarding waiver policy, and quality assurance/improvement plans prior to implementation or release to providers, individuals, families, or any other entity.
- FSSA retains final authority for rate-setting of provider rates and any activities reimbursed through administrative funds, and coverage and criteria for all Medicaid services including state plan services.

- b. Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the state. Thus,

this section does not need to be completed.

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Appendix A: Waiver Administration and Operation

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

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

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

A contract exists between the FSSA, the single State Medicaid Agency (or an FSSA division or bureau), and each contracted entity listed below that sets forth the responsibilities and performance requirements of the contracted entity. The contract(s) under which these entities conduct waiver operational functions are available to CMS upon request through the State Medicaid agency or the operating agency (as applicable).

Specific to the operational and administrative functions of this waiver, the following activities are conducted by contracted entities.

FISCAL AGENT is responsible for:

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

UTILIZATION MANAGEMENT CONTRACTORS: The waiver auditing function is incorporated into the Program Integrity (PI) functions of the contract between the Medicaid agency and the Fraud and Abuse Detection System (FADS) contractor. FSSA has expanded its Program Integrity activities by using a multipronged approach to PI activity that includes provider self-audits, contractor desk audits, and full on-site audits. The FADS contractor sifts and analyzes claims data and identifies providers and claims that indicate aberrant billing patterns or other risk factors, such as correcting claims.

FSSA or any other legally authorized governmental entity (or their agents) may at any time during the term of the provider agreement and in accordance with Indiana Administrative Code conduct audits for the purposes of assuring the appropriate administration and expenditure of the monies provided to the provider through this provider agreement. Additionally, FSSA may at any time conduct audits to assure appropriate administration and delivery of services under the provider agreement.

The Program Integrity activities describe post-payment financial audits to ensure the integrity of IHCP payments. Detailed information on PI policy and procedures is available in the IHCP Provider and Member Utilization Review provider reference module.

Program Integrity receives allegations of Medicaid provider fraud, waste, and abuse and tracks these in its case management system. To begin investigating these allegations, Program Integrity vets the providers with the Medicaid Fraud Control Unit (MFCU). Once it receives MFCU's clearance FSSA Audit determines how to best validate the accuracy of the allegation.

Program Integrity conducts its audit activities and develops a findings report for the provider which may include a corrective action plan and request for overpayment.

FSSA maintains oversight throughout the entire Program Integrity process. Although the FADS contractor may be incorporated in the audit process, no audit is performed without the authorization of FSSA. 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.

QUALITY ASSURANCE/QUALITY IMPROVEMENT CONTRACTOR is responsible for:

- Complaint investigation;
- Incident review;
- Mortality review;
- Quality on-site provider reviews; and

- Provider training and technical assistance.

ACTUARIAL CONTRACTOR is responsible for:

- Completing cost neutrality calculations for the waiver;
- Budget planning and forecasting;
- Waiver development;
- Developing and assessing rate methodology for home and community-based services; and
- Cost surveys and calculating rate adjustments.

NCI SURVEY CONTRACTOR is responsible for:

- National Core Indicator (NCI) surveys

SELF-DIRECTION FINANCIAL MANAGEMENT SERVICES VENDOR is responsible for:

- Administering limited criminal history background checks;
- Conducting professional licensure checks;
- Issuing paychecks per submitted timesheets;
- Filing monthly, quarterly and annual tax and labor reports;
- Issuing annual W-2 wage statements;
- Managing service units;
- Providing individuals, employers, and case managers with monthly reports of FMS vendor spending on individual's behalf; and
- Responding to questions and issues concerning the self-directed services.

(See Appendix E for additional Information)

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

Appendix A: Waiver Administration and Operation

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

- **Not applicable**
- **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

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

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

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

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

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Appendix A: Waiver Administration and Operation

- 5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

Assessment of Performance of FISCAL AGENT

OMPP is responsible for assessing performance of the Medicaid Fiscal Agent.

Assessment of Performance of UTILIZATION MANAGEMENT CONTRACTOR

The oversight of the performance of the Fraud and Abuse Detection System (FADS) contract is performed by Program Integrity (PI).

Assessment of Performance of QUALITY ASSURANCE/QUALITY IMPROVEMENT CONTRACTOR

The Bureau of Disabilities Services (BDS) conducts monitoring and oversight of the Quality Assurance/Quality Improvement contractor.

Assessment of Performance of ACTUARIAL CONTRACTOR

The OMPP has oversight responsibility of the Actuarial contractor.

Assessment of Performance of NCI SURVEY CONTRACTOR

The DDARS has oversight responsibility of the NCI Survey contractor.

Assessment and Performance of SELF-DIRECTION FINANCIAL MANAGEMENT SERVICES VENDOR

The DDARS has oversight responsibility of the self-direction FMS vendor.

Appendix A: Waiver Administration and Operation

- 6. Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

Assessment Methods and Frequency for FISCAL AGENT

OMPP oversees the Fiscal Agent to ensure waiver providers are enrolled timely and in accordance with requirements under 42 CFR 455 Subpart E. The Fiscal Agent is contractually required to enroll providers within 20 business days for paper applications and 15 business days for electronic portal submissions. OMPP reviews weekly and monthly reports from the Fiscal Agent regarding provider enrollment. Additionally, OMPP conducts onsite weekly meetings to discuss provider enrollment issues, including any quality, timeliness, or policy concerns or updates. In the event of identified deficiencies, OMPP implements a corrective action plan, liquidated damages, or other contractually agreed upon remedy.

Assessment Methods and Frequency for UTILIZATION MANAGEMENT CONTRACTOR

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

During 2011, the State of Indiana formed the Benefit Integrity Team comprised of both state and contract staff. This team meets bi-weekly to review and approve audit plans and provider communications, and to make policy recommendations to affected program areas. FSSA Compliance oversees the contractor's aggregate data to identify common problems, determine benchmarks, and offer data to providers to compare against aggregate data.

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

Assessment Methods and Frequency for QUALITY ASSURANCE/QUALITY IMPROVEMENT CONTRACTOR

The majority of primary functions of BDS are completed by a Quality Assurance/Quality Improvement (QA/QI) contractor. Specifically, the QA/QI contractor is responsible for incident review, mortality review, complaint investigation, quality on-site provider reviews, and provider training and technical assistance.

A BDS executive staff position monitors this contract using a combination of compliance and quality assurance methods to ensure that contractors perform waiver operational and administrative functions in accordance with waiver requirements.

- A BDS executive staff member meets with the QA/QI contractor's leadership on a bi-weekly basis to review and follow up on outstanding issues.
- BDS staff has weekly phone conferences with the QA/QI contractor's mortality review staff and complaint staff to review and follow-up on specific cases and issues.
- On a quarterly basis the QA/QI contractor submits a report that includes data, data analysis, identification of trends, and recommendations for improvement on each of the contract activities. The report also contains performance indicators regarding the contract activities. BDS executive staff reviews these reports and follows up with the contractor when concerns are identified.

Ultimately, the goal of the BDS is to assure that the state is aware of and has taken appropriate actions to ensure the individual's health, safety, and welfare. BDS executive staff oversees the QA/QI contractor's interactions with others, as well as monitors that the contractor implements assigned tasks.

Assessment Methods and Frequency for ACTUARIAL CONTRACTOR

OMPP is responsible for monitoring the performance of the Actuarial Contractor. The contractor performs Medicaid enrollment and expenditure forecasts, by program, which aids in monitoring expenses and supports state budgeting. Forecasting is done on both a paid basis and service incurred basis. Trends are determined and vary by population as appropriate. Trends are developed taking into account historical Indiana Medicaid trends, State and National trends, trends used by the CMS Office of the Actuary, and future program changes. Final documentation from the actuarial contractor includes an executive summary, detailed results, sources of data, methodologies, and assumptions. On an

ongoing basis, OMPP ensures the contractor complies with all requirements, deliverables, and timelines as outlined in its contract. In the event of contract non-compliance or performance deficiency, corrective action is pursued in accordance with contract terms.

The actuarial contractor is also under contract to develop and assess rate methodology for HCBS. Rate methodology for waiver services is assessed and reviewed every five years at renewal. The actuarial contractor completes the cost surveys and calculates rate adjustments. The OMPP reviews and approves the fee schedule to ensure consistency, efficiency, economy, quality of care, and sufficient access to providers for waiver services.

The Actuarial Contractor contract, is not a performance-based contract.

Assessment Methods and Frequency for NCI SURVEY CONTRACTOR

BDS exercises oversight and monitoring of the deliverables stipulated within the NCI Survey contract. A BDS executive staff member meets with the NCI Survey contractor's leadership on a monthly basis to review progress and address issues or concerns. On a quarterly basis the contractor submits a report that includes data and data analysis specific to the waiver performance measures. On an annual basis, the contractor submits a comparative analysis report which identifies trends and recommendations for systemic improvement. BDS executive staff reviews these reports and follows up with the contractor when concerns are identified.

Assessment Methods and Frequency for SELF-DIRECTION FINANCIAL MANAGEMENT SERVICES VENDOR

The DDARS through its Bureau of Disabilities Services (BDS) is responsible for monitoring the performance of the FMS vendor through weekly telephonic conference calls and weekly written reports on payments to providers. The reports include the number of waiver participants, the number of providers, dollar amounts, and which individuals have service plans but are not receiving services.

(See Appendix E for additional Information)

Appendix A: Waiver Administration and Operation

7. Distribution of Waiver Operational and Administrative Functions. In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR § 431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.* Note: Medicaid eligibility determinations can only be performed by the State Medicaid Agency (SMA) or a government agency delegated by the SMA in accordance with 42 CFR § 431.10. Thus, eligibility determinations for the group described in 42 CFR § 435.217 (which includes a level-of-care evaluation, because meeting a 1915(c) level of care is a factor of determining Medicaid eligibility for the group) must comply with 42 CFR § 431.10. Non-governmental entities can support administrative functions of the eligibility determination process that do not require discretion including, for example, data entry functions, IT support, and implementation of a standardized level-of-care evaluation tool. States should ensure that any use of an evaluation tool by a non-governmental entity to evaluate/determine an individual's required level-of-care involves no discretion by the non-governmental entity and that the development of the requirements, rules, and policies operationalized by the tool are overseen by the state agency.

Function	Medicaid Agency	Contracted Entity
Participant waiver enrollment	☒	☐
Waiver enrollment managed against approved limits	☒	☐
Waiver expenditures managed against approved levels	☒	☐
Level of care waiver eligibility evaluation	☒	☐

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. As necessary and applicable, performance measures should focus on:

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

Where possible, include numerator/denominator.

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

Performance Measure:

A.1 Number and percent of waiver policies developed by DDARS that were approved by OMPP prior to implementation. Numerator: Number of waiver policies developed by DDARS that were approved by OMPP prior to implementation. Denominator: Total number of waiver policies implemented.

Data Source (Select one):

Operating agency performance monitoring

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

Performance Measure:

A.2 Number and percent of quarterly waiver performance measure data reports submitted to the OMPP by DDARS within the required time period. Numerator: Number of quarterly waiver performance measure data reports submitted within the required time period.

Denominator: Total number of quarterly waiver performance measure data reports due.

Data Source (Select one):

Operating agency performance monitoring

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Performance Measure:

A.3 Number and percent of providers assigned a Medicaid provider number according to the required timeframe specified in the contract with the fiscal agent. Numerator: Number of providers assigned a Medicaid provider number by the fiscal agent according to the required timeframe specified in the contract. Denominator: Total number of providers assigned a Medicaid provider number.

Data Source (Select one):**Reports to State Medicaid Agency on delegated Administrative functions**

If 'Other' is selected, specify:

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

	☒ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

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

--

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

FSSA's divisions work to ensure that individual problems are addressed and corrected. FSSA staff meet at least monthly to review/aggregate data and identify/analyze individual problems. FSSA staff discuss the circumstances surrounding an issue or event and what remediation actions should be taken. In some cases, informal actions, such as obtaining an explanation of the circumstances surrounding the event, or verification that remediation actions have been taken, may be sufficient to deem

the problem resolved. In other situations, more formal actions may be taken. This may consist of elevating the issue for a cross-division executive level discussion and remediation. Formal remedial actions may include the required re-training of providers and/or case managers chosen by the individual, or the necessity of developing new division-wide training(s) specific to the identified event or circumstance if the state discovers that individual trends represent systemic deficiencies.

Between scheduled meetings, individual problems are regularly addressed by FSSA staff through written and/or verbal communications with involved parties (e.g. individuals, case managers, providers, contractors) to ensure timely remediation.

FSSA uses a centralized IT system to aggregate data and to identify systemic deficiencies. The Quality Improvement Executive Committee (QIEC) meets on a quarterly basis to review data collected from the performance measures for the waivers and identify systemic improvements needed (if any). The QIEC then follows up on the status of recommended systemic improvements at the next QIEC meeting until implementation is completed.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

☒ No

☐ Yes

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

Appendix B: Participant Access and Eligibility

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

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the state limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance*

with 42 CFR § 441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:

Target Group	Included	Target Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ Aged or Disabled, or Both - General					
	☐	Aged			☐
	☐	Disabled (Physical)			
	☐	Disabled (Other)			
☐ Aged or Disabled, or Both - Specific Recognized Subgroups					
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
☒ Intellectual Disability or Developmental Disability, or Both					
	☒	Autism	0		☒
	☒	Developmental Disability	0		☒
	☒	Intellectual Disability	0		☒
☐ Mental Illness					
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

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

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

The "other condition" (other than a sole diagnosis of mental illness) may be considered closely related to intellectual disability because that condition results in similar impairment of general intellectual functioning or adaptive behavior or requires treatment or services similar to those required for a person with an intellectual disability. The IID, DD, or other related condition must have an onset prior to age 22 to be expected to continue. Per Indiana Code, the IID, DD, or related condition must also result in substantial functional limitations in at least three (3) of the following areas of major life activities:

1. Self-care;
2. Understanding and use of language;
3. Learning;
4. Mobility;
5. Self-direction;
6. Capacity for independent living; and/or
7. Economic self-sufficiency.

These criteria are considered along with use of a level of care assessment tool and an array of collateral materials when determining eligibility for waiver services.

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

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

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

- ☒ **Not applicable. There is no maximum age limit**
- ☐ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

The limit specified by the state is (select one)

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

Specify the percentage:

- ☐ Other

Specify:

- ☐ **Institutional Cost Limit.** Pursuant to 42 CFR § 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. Complete Items B-2-b and B-2-c.

- ☐ **Cost Limit Lower Than Institutional Costs.** The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

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

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

- ☐ The following dollar amount:

Specify dollar amount:

The dollar amount (select one)

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

Specify the formula:

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

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

Specify percent:

- ☐ Other:

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

- ☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	9438
Year 2	9451
Year 3	9475
Year 4	9499

Waiver Year	Unduplicated Number of Participants
Year 5	9523

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

- ☒ The state does not limit the number of participants that it serves at any point in time during a waiver year.
- ☐ The state limits the number of participants that it serves at any point in time during a waiver year.

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

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4	
Year 5	

Appendix B: Participant Access and Eligibility

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

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

- ☐ Not applicable. The state does not reserve capacity.
- ☒ The state reserves capacity for the following purpose(s).

Purpose(s) the state reserves capacity for:

Purposes
Purpose 2: Emergency placement
Purpose 1: Eligible individuals transitioning to the community from NF, and State Psychiatric Hospital (SPH)
Purpose 5: Eligible individuals aging out of DOE, DCS, or Children's SGL
Purpose 4: Eligible individuals determined to no longer need/receive active treatment in a group home
Purpose 3: Community transition of institutionalized person due to "Money Follows the Person" initiative

Appendix B: Participant Access and Eligibility

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

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

Purpose 2: Emergency placement

Purpose *(describe):*

To prioritize waiver access to eligible individuals with intellectual disabilities and require an emergency placement under the reserved waiver capacity criteria associated with one or more of the following situations:

1. Death of a primary caregiver;
2. The primary caregiver is at least eighty (80) years of age;
3. There is evidence of abuse or neglect in the current institutional or home placement; and/or
4. There is evidence of other health and safety risks, as determined by the division director of the Division of Disability Aging and Rehabilitative Services where other available services through:
 - (a) the Medicaid program and other federal, state and local public programs; and
 - (b) supports that families and communities provide; are insufficient to address the other health and safety risks, as determined by the division director of the Division of Disability Aging and Rehabilitative Services.

This reserved waiver capacity category was implemented in 2024 in accordance with Indiana Public Law P.L.131-2024.

Describe how the amount of reserved capacity was determined:

The first emergency placement situation listed above is applicable to instances where the primary caregiver of the qualifying individual passes away and the individual is in need of immediate care that cannot be provided in any other manner. Reserved capacity in this area was calculated by reviewing the number of individuals who were granted entrance to the waiver via this category from January 2015 through December 2018. Based on demographic trends seen in the age and health of primary caregivers across the State, Indiana expects to see a 5% growth trend in this, and other, emergency placement situations during subsequent years of the renewal.

Situation two is applicable to instances where a qualifying individual's primary caregiver is 80 years old, or older, can no longer care for the individual in question and the individual is in need of immediate care that cannot be provided in any other manner. Reserved capacity in this area was calculated by reviewing the number of individuals who were granted entrance to the waiver via this category from January 2015 through December 2018. Based on demographic trends seen in the age and health of primary caregivers across the State, Indiana expects to see a 5% growth trend in this, and other, emergency placement situation during subsequent years of the renewal.

The third situation is applicable to instances where there is substantiated abuse or neglect of the qualifying individual and that individual is in need of immediate care that cannot be provided in any other manner. Reserved capacity in this area was calculated by reviewing the number of individuals who were granted entrance to the waiver via this category from January 2015 through December 2018.

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

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

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

Waiver Year	Capacity Reserved		
Year 1		250	
Year 2		250	
Year 3		250	

Waiver Year	Capacity Reserved
Year 4	250
Year 5	250

Appendix B: Participant Access and Eligibility

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

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

Purpose 1: Eligible individuals transitioning to the community from NF, and State Psychiatric Hospital (SPH)

Purpose (describe):

To prioritize waiver access to eligible individuals with intellectual disabilities and who are transitioning to the community from Nursing Facilities (NF), or SPH. This reserved waiver capacity category was implemented in accordance with Indiana Public Law 73-2008. The law directed FSSA's Office of Medicaid Policy and Planning (OMPP) and Bureau of Disabilities Services (BDS) to amend the waiver in order that individuals specified in the law be given priority in receiving services under the waiver.

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

Describe how the amount of reserved capacity was determined:

FSSA's Division of Disability Aging and Rehabilitative Services (DDARS) serves an average of 1400 individuals with intellectual disabilities in nursing facility (NF) settings in any given month. Approximately 2% of those persons elect to leave the nursing facility and enter into waiver services over the course of the waiver year. Reserved capacity for Waiver Years 1 - 5 is based on this historic trend and on the number of placements made from January 2015 through December 2018.

Currently there are 20 individuals in State Psychiatric Hospitals (SPHs), as identified by the Division of Mental Health and Addiction (DMHA), who qualify for services through DDARS. However, as these individuals exit the SPH it is unlikely that many of them will initially participate in community-based waiver services.

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

Waiver Year	Capacity Reserved
Year 1	60
Year 2	60
Year 3	60
Year 4	60
Year 5	60

Appendix B: Participant Access and Eligibility

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

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

Purpose 5: Eligible individuals aging out of DOE, DCS, or Children's SGL

Purpose (describe):

To prioritize waiver access to eligible individuals with autism, developmental disabilities, intellectual disabilities, or other conditions closely related to intellectual disability as specified in the Appendix B-1-a Target Groups and B-1-b Additional Criteria of the application who will be attaining the maximum age for any of the following settings funded by the Indiana department of education (facility, residential); the Indiana department of child services (foster care, facility, residential, group home), or Indiana Medicaid (Supervised Group Living).

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

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

Describe how the amount of reserved capacity was determined:

A review of the number of individuals who entered into waiver services via this category from January 2015 through December 2018 was taken into account to determine the reserved capacity.

FSSA's DDARS and the Department of Child Services (DCS) have developed a strong partnership working toward placement of individuals with autism, developmental disabilities, intellectual disabilities, or other conditions closely related to intellectual disability as specified in the Appendix B-1-a Target Groups and B-1-b Additional Criteria of the application into home and community based waiver settings when they age out of the foster care system. As this partnership has developed FSSA has made it a priority to serve these individuals. A review of the number of individuals who entered into waiver services via this category from January 2015 through December 2018 was taken into account to determine the reserved capacity. Indiana's FSSA continues to stand by its prior decision and will not increase the number of licensed ICF/IID beds in its Supervised Group Living (SGL) settings, including the number of beds that may be occupied by children. Given this, data regarding the number of individuals who entered into waiver services via this category from January 2015 through December 2018 was utilized to determine the reserved capacity.

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

Waiver Year	Capacity Reserved
Year 1	20
Year 2	20
Year 3	20
Year 4	20
Year 5	20

Appendix B: Participant Access and Eligibility

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

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

Purpose 4: Eligible individuals determined to no longer need/receive active treatment in a group home

Purpose (describe):

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

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

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

07/24/2026

waiver year.

Describe how the amount of reserved capacity was determined:

Historically, less than .5% of Supervised Group Living (SGL) residents required a reserved capacity priority slot under the CIH waiver due to being identified by the Indiana Department of Health (IDOH) as no longer being in need of active treatment/inappropriate placement. That historic trend has changed very little. Indiana reviewed utilization of this category from January 2015 through December 2018 and determined that the number of individuals entering into waiver services via this reserved capacity category would remain consistent.

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

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

Appendix B: Participant Access and Eligibility

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

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

Purpose 3: Community transition of institutionalized person due to "Money Follows the Person" initiative

Purpose (describe):

The State reserves capacity within the waiver to implement the vision of moving individuals from institutional care to home and community-based services. This vision is being realized through home and community-based services and dollars awarded to Indiana for a demonstration grant, "Money Follows the Person".

Describe how the amount of reserved capacity was determined:

The State reviewed the number of patients currently receiving institutional care and determined the realistic number of individuals that could be transitioned in years 2 through 5.

Indiana plans to continue transitioning persons from the ICF/IIDs to HCBS settings maximizing the MFP program.

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

Waiver Year	Capacity Reserved
Year 1	0
Year 2	145
Year 3	145
Year 4	145
Year 5	145

Appendix B: Participant Access and Eligibility

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

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

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

e. Allocation of Waiver Capacity.

Select one:

- ☒ Waiver capacity is allocated/managed on a statewide basis.
- ☐ Waiver capacity is allocated to local/regional non-state entities.

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

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

All individuals seeking the waiver are placed on the single statewide waiting list.

When there are available reserved capacity slots, eligible individuals who meet the available reserved capacity criteria specified in Appendix B-3-c will be assigned the appropriate reserved capacity slot and invited from the CIH waiver waiting list based on date of CIH application.

Upon invitation, individuals are sent an invitation letter which outlines the steps necessary to complete waiver enrollment. If the individual does not accept the waiver invitation to continue the process within 45 days of the date of the invitation letter or does accept the waiver invitation but the individual does not complete the necessary steps for waiver enrollment within 180 days of the date of the invitation letter, FSSA will rescind the invitation. The individual and legal representative (if any) will be notified in writing of the rescindment. FSSA will re-assign the available slot.

For FS waiver participants invited to the CIH waiver, the Case Manager is expected to inform the waiver participant of the array of services available under the CIH waiver so that informed choice can be made. Interested waiver participants will be assessed to determine the budget amount assigned through the objective based allocation process should the waiver participant choose to accept the CIH waiver. However, if the waiver participant and his or her Individualized Support Team determine that services under the FS Waiver are adequate to meet the needs of the waiver participant, the waiver participant and his or her legal representative, if applicable, may opt to remain on the FS Waiver.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a. 1. State Classification. The state is a (*select one*):

- ☒ Section 1634 State
- ☐ SSI Criteria State
- ☐ 209(b) State

2. Miller Trust State.

Indicate whether the state is a Miller Trust State (*select one*):

- ☐ No
- ☒ Yes

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

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

- ☒ Parents and Other Caretaker Relatives (42 CFR § 435.110)
- ☐ Pregnant Women (42 CFR § 435.116)
- ☒ Infants and Children under Age 19 (42 CFR § 435.118)
- ☒ SSI recipients
- ☐ Aged, blind or disabled in 209(b) states who are eligible under 42 CFR § 435.121
- ☐ Optional state supplement recipients
- ☒ Optional categorically needy aged and/or disabled individuals who have income at:

Select one:

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

Specify percentage:

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

Specify:

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

42 CFR 435.150 Former Foster Care Children;

42 CFR 435.226 Independent Foster Care Adolescents;

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

Sec 1925 of the Act --Transitional Medical Assistance

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

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

Select one and complete Appendix B-5.

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

Check each that applies:

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

Select one:

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

Specify percentage:

- ☐ **A dollar amount which is lower than 300%.**

Specify dollar amount:

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

Select one:

- ☐ **100% of FPL**
- ☐ **% of FPL, which is lower than 100%.**

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR § 441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR § 435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR § 435.217 group.

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

Note: For the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR § 435.217 group effective at any point during this time period.

- ☒ **Spousal impoverishment rules under section 1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses spousal post-eligibility rules under section 1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or section 1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time period after September 30, 2027 (or other date as required by law).

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law) (select one).

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

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

- **Use spousal post-eligibility rules under section 1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)
- **Use regular post-eligibility rules under 42 CFR § 435.726 (Section 1634 State/SSI Criteria State) or under § 435.735 (209b State)**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)
- **Spousal impoverishment rules under section 1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).

- b. Regular Post-Eligibility Treatment of Income: Section 1634 State and SSI Criteria State after September 30, 2027 (or other date as required by law).**

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

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

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

Select one:

- ☐ SSI standard
- ☐ Optional state supplement standard
- ☐ Medically needy income standard
- ☒ The special income level for institutionalized persons

(select one):

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

Specify the percentage:

- ☐ A dollar amount which is less than 300%.

Specify dollar amount:

- ☐ A percentage of the Federal poverty level

Specify percentage:

- ☐ Other standard included under the state plan

Specify:

- ☐ The following dollar amount

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

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

Specify:

- ☐ Other

Specify:

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

- ☒ Not Applicable
- ☐ The state provides an allowance for a spouse who does not meet the definition of a community spouse in section 1924 of the Act. Describe the circumstances under which this allowance is provided:

Specify:

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

- ☐ SSI standard
- ☐ Optional state supplement standard
- ☐ Medically needy income standard
- ☐ The following dollar amount:

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

- ☐ The amount is determined using the following formula:

Specify:

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

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

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

- ☐ The amount is determined using the following formula:

Specify:

- ☐ Other

Specify:

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

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

Select one:

- ☐ Not Applicable (see instructions) *Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

- ☒ The state does not establish reasonable limits.
- ☐ The state establishes the following reasonable limits

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).

- c. Regular Post-Eligibility Treatment of Income: 209(b) State or after September 30, 2027 (or other date as required by law).**

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

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).

- d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules after September 30, 2027 (or other date as required by law)**

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

i. Allowance for the personal needs of the waiver participant

(select one):

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

Specify percentage:

- ☐ The following dollar amount:

Specify dollar amount:

If this amount changes, this item will be revised

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

Specify formula:

- ☐ Other

Specify:

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

Select one:

- ☐ Allowance is the same
- ☐ Allowance is different.

Explanation of difference:

- iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR § 435.726 or 42 CFR § 435.735:

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

Select one:

- ☐ Not Applicable (see instructions) *Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
- ☐ The state does not establish reasonable limits.
- ☐ The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

- e. Regular Post-Eligibility Treatment of Income: Section 1634 State or SSI Criteria State - January 1, 2014 through September 30, 2027 (or other date as required by law).

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

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

- f. Regular Post-Eligibility Treatment of Income: 209(b) State - January 1, 2014 through September 30, 2027 (or other date as required by law).

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

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - January 1, 2014 through September 30, 2027 (or other date as required by law).

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

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

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

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

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

Specify the entity:

● **Other**

Specify:

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

Only individuals (FSSA employees) who are Qualified Intellectual Disabilities Professionals (QIDP) as specified by the standard within 42 CFR 483.430(a) may perform the initial Level of Care determinations.

A QIDP professional:

- (1) Has at least one year of experience working directly with persons with intellectual disability or other developmental disabilities; and
- (2) Is one of the following:
 - A doctor of medicine or osteopathy.
 - A registered nurse.
 - An individual who holds at least a bachelor's degree in a professional program services category.

For professional program services:

- (1) Professional program staff must be licensed, certified, or registered, as applicable, to provide professional services by the State in which he or she practices. Those professional program staff who do not fall under the jurisdiction of State licensure, certification, or registration requirements, specified in § 483.410(b), must meet the following qualifications:
 - (i) To be designated as an occupational therapist, an individual must be eligible for certification as an occupational therapist by the American Occupational Therapy Association or another comparable body.
 - (ii) To be designated as an occupational therapy assistant, an individual must be eligible for certification as a certified occupational therapy assistant by the American Occupational Therapy Association or another comparable body.
 - (iii) To be designated as a physical therapist, an individual must be eligible for certification as a physical therapist by the American Physical Therapy Association or another comparable body.
 - (iv) To be designated as a physical therapy assistant, an individual must be eligible for registration by the American Physical Therapy Association or be a graduate of a two year college-level program approved by the American Physical Therapy Association or another comparable body.
 - (v) To be designated as a psychologist, an individual must have at least a master's degree in psychology from an accredited school.
 - (vi) To be designated as a social worker, an individual must-
 - (A) Hold a graduate degree from a school of social work accredited or approved by the Council on Social Work Education or another comparable body; or
 - (B) Hold a Bachelor of Social Work degree from a college or university accredited or approved by the Council on Social Work Education or another comparable body.
 - (vii) To be designated as a speech-language pathologist or audiologist, an individual must-
 - (A) Be eligible for a Certificate of Clinical Competence in Speech-Language Pathology or Audiology granted by the American Speech-Language-Hearing Association or another comparable body; or
 - (B) Meet the educational requirements for certification and be in the process of accumulating the supervised experience required for certification.
 - (viii) To be designated as a professional recreation staff member, an individual must have a bachelor's degree in recreation or in a specialty area such as art, dance, music or physical education.
 - (ix) To be designated as a professional dietitian, an individual must be eligible for registration by the American Dietetics Association.
 - (x) To be designated as a human services professional an individual must have at least a bachelor's degree in a human services field (including, but not limited to: sociology, special education, rehabilitation counseling, and psychology).

- d. Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an

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

A waiver applicant/waiver participant must meet each of four basic conditions (listed below) and three of six substantial functional limitations in order to meet LOC.

The basic conditions are:

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

The substantial functional limitation categories, as defined in 42 CFR 435.1010, are:

- 1) self-care,
- 2) learning,
- 3) self-direction,
- 4) capacity for independent living,
- 5) understanding and use of language, and
- 6) mobility.

The level of care (LOC) assessment tools are FSSA-approved instruments from the InterRAI suite of instruments. Data elements will be collected in a web-based assessment platform. LOC assessments will not be accepted by the web-based assessment platform unless all data elements have been addressed.

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

- ☒ **The same instrument is used in determining the level of care for the waiver and for institutional care under the state plan.**
- ☐ **A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.**

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

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

The Family and Social Services Administration (FSSA) evaluates individuals to determine if they meet the ICF/IID level of care (LOC) criteria (as specified in Appendix B-6-d above) using the following processes.

Initial LOC Evaluation Process:

- All initial level of care evaluations of waiver applicants are performed by a BDS service coordinator.
- The BDS service coordinator:
 1. Completes the FSSA-approved assessment from InterRAI suite of instruments; and
 2. Collects and reviews of the following collateral materials:
 - A completed 450B Confirmation of Diagnosis form, signed and dated by a physician within the past year for the initial determination only.
 - Psychological records
 - Social assessment records
 - Medical records
 - Additional collateral materials necessary to have a current and valid reflection of the individual.
 - If collateral materials (specified above) are not available or are not a valid reflection of the individual, additional assessments may be obtained from contracted psychologists, physicians, nurses and/or licensed social workers.
- Based on review of the assessment results and collateral materials, a determination of whether the waiver applicant meets the ICF/IID level of care criteria necessary to be enrolled in the CIH waiver is made by the BDS service coordinator or such other designated FSSA staff member who meets the qualifications specified in Appendix B-6-c above.
- Notification of the level of care determination decision is sent to the waiver applicant, and when the waiver applicant is determined not to meet the ICF/IID level of care criteria, the individual is afforded the opportunity to request a Fair Hearing as provided in Appendix F-1.
- The results of the InterRAI assessment are documented in the web-based assessment platform, and BDS maintains copies of the assessment results, all collateral materials, written notices and other documentation related to the waiver applicant's level of care evaluation in the State's electronic case management system.

LOC Reevaluation Process:

The process for level of care reevaluation is the same as the initial level of care evaluation except as follows:

- Level of care reevaluations of waiver participants may be performed by a BDS service coordinator or by a provider of case management services.
- A new 450B Confirmation of Diagnosis form is not required at the time of reevaluation.
- When the level of care reevaluation is performed by a provider of case management services, the case manager makes a determination recommendation, which is then routed to a designated FSSA staff member (who meets the qualifications specified in Appendix B-6-c above) for subsequent approval or denial.

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

- ☐ **Every three months**
- ☐ **Every six months**
- ☐ **Every twelve months**
- ☒ **Other schedule**

Specify the other schedule:

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

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

- ☒ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ☐ **The qualifications are different.**

Specify the qualifications:

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

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

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

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

Records are maintained by the Bureau of Disabilities Services (BDS) within the State's electronic case management system and are retrievable indefinitely upon request.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

B.1 The number and percent of all applicants who received a Level of Care (LOC) evaluation prior to waiver enrollment. Numerator: Number of all applicants who

received LOC evaluation prior to waiver enrollment. Denominator: Total number of all applicants who start the waiver.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Electronic Case Management Database System

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

Data Aggregation and Analysis:

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

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

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

Performance Measures

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

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

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

Performance Measures

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

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

Performance Measure:

B.2 Number and percent of individuals whose initial levels of care assessment was completed in accordance with established LOC criteria. Numerator: Number of individuals whose initial level of care assessment was completed in accordance with

established LOC criteria. Denominator: Total number of individuals with an initial level of care assessment.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Electronic Case Management Database System

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

Data Aggregation and Analysis:

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

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

Performance Measure:

B.3 Number and percent of individuals whose annual level of care (LOC) assessment was conducted based on requirements for determining level of care in the waiver. Numerator: Number of individuals whose annual LOC assessment was conducted based on requirements for determining level of care in the waiver. **Denominator:** Total number of individuals due for an annual LOC assessment.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Electronic Case Management Database System

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

		Group:
	☒ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In

addition, provide information on the methods used by the state to document these items.

Performance measures B.1 through B.3: The report is manually generated for each review period to ensure all new enrollees had a LOC evaluation completed by the State prior to waiver enrollment. Should it be discovered that any enrollee entered into waiver services without the required LOC determination, the DDARS Central Office will remediate by determining where the process/system failure occurred, retrain and if necessary, discipline staff and/or update the electronic system that is intentionally designed to prohibit approval and entrance of new enrollees until LOC has been appropriately determined. Should violations occur, notice will be issued requiring completion of the initial LOC within seven calendar days and any deficiencies would be documented within the case notes pertaining to the enrollee.

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

The State's case management system requires a secondary review of all LOC determinations. If the secondary review of an initial or annual LOC would result in a denial, meaning that potential waiver participant or current waiver participant would not meet the requirements to enroll in or remain on the waiver, the information is submitted to BDS central office for a tertiary review. When a tertiary review proves that the potential waiver participant or current waiver participant does in fact meet the LOC requirements, the outcome of the tertiary review finalized and conveyed to the case manager.

Patterns of inappropriate decisions by FSSA employees/service coordinator or case managers will be identified and addressed with the determiner's supervisor. If the data shows a system issue resulting in inappropriate decisions, the matter will be referred to the BDS executive staff to identify, address, and monitor the training provided to service coordinators and case managers.

FSSA uses a centralized IT system to aggregate data and to identify systemic deficiencies. The Quality Improvement Executive Committee (QIEC) meets on a quarterly basis to review data collected from the performance measures for the waivers and identify systemic improvements needed (if any). The QIEC then follows up on the status of recommended systemic improvements at the next QIEC meeting until implementation is completed.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

- ☒ No
- ☐ Yes

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

Following a determination that the applicant meets the eligibility requirements for entrance into the CIH waiver, a BDDS service coordinator becomes responsible for informing the applicant and/or his or her legal representative, if applicable, of the feasible alternatives available under the waiver and given the choice of waiver services or ICF/IID services.

The service coordinator is responsible for obtaining the BDS signature page form with the "Freedom of Choice" section completed and uploading the form into the State's case management system.

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

If a potential HCBS waiver participant is currently enrolled in the Hoosier Care Connect program (the state's Risk-Based Managed Care program) or if a current HCBS waiver participant wants to transfer to the Hoosier Care Connect program (if eligible), the service coordinator or case manager is responsible for explaining eligibility under 42 CFR 435.217 (Medicaid eligible if receiving home and community-based waiver services) and the impact the selection of the Hoosier Care Connect program could have on the individual's eligibility. They also explain the array of services available under the HCBS waiver program and under the Hoosier Care Connect program. In Indiana, the Hoosier Care Connect program and HCBS waiver programs are mutually exclusive.

A PCISP is used for individuals who choose waiver services. Once a qualifying individual is offered a waiver slot, is Medicaid eligible, and has met level of care approval, a PCISP is developed. The PCISP is used for waiver participants at the time of initial determinations, updates, and annual re-determinations. Freedom of choice is demonstrated on the BDS signature page form. The waiver participant/guardian signs and dates this signature page form indicating his/her choice of waiver services or institutional services. The case manager is responsible for explaining the array of services available in an institutional setting as well as the feasible alternatives available through the CIH waiver program.

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

The initial signed and dated Freedom of Choice form is maintained within the State's electronic case management system for a minimum of three years.

At least annually, freedom of choice between waiver and institutional services is uploaded into the State's case management system.

Appendix B: Participant Access and Eligibility

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

Access to Services by Limited English Proficient Persons. Specify the methods that the state uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

As an integral part of the FSSA, the DDARS Bureau of Deaf and Hard of Hearing Services serves as a resource for interpreter services to the deaf and hard of hearing. As needed, DDARS is able to assist with referrals for sign language interpreters toward the effective communication with applicants or participants, when interpreter services are not already included on the service plan of the waiver participant.

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

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

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

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	Adult Day Services		
Statutory Service	Case Management		
Statutory Service	Day Habilitation		
Statutory Service	Prevocational Services		
Statutory Service	Rent and Food for Unrelated Live-in Caregiver		
Statutory Service	Residential Habilitation and Support (hourly)		
Statutory Service	Respite		
Extended State Plan Service	Occupational Therapy		
Extended State Plan Service	Physical Therapy		
Extended State Plan Service	Psychological Therapy		
Extended State Plan Service	Speech /Language Therapy		
Other Service	Behavioral Support Services (BSS)		
Other Service	Benefits Counseling (Effective 12/31/2025)		
Other Service	Career Exploration and Planning		
Other Service	Community Transition		
Other Service	Extended Employment Services		
Other Service	Facility Based Support Services		
Other Service	Family and Caregiver Training		
Other Service	Home Modification Assessment (Terminated as of 12/30/2025)		
Other Service	Home Modifications (Terminated as of 12/30/2025)		
Other Service	Home Modifications and Assessments (Effective 12/31/2025)		
Other Service	Intensive Behavioral Intervention (Terminated as of 12/30/2025)		
Other Service	Music Therapy		

Service Type	Service		
Other Service	Personal Emergency Response System		
Other Service	Recreational Therapy		
Other Service	Remote Supports		
Other Service	Residential Habilitation and Support - Daily (RHS Daily)		
Other Service	Specialized Medical Equipment and Supplies		
Other Service	Structured Family Caregiving		
Other Service	Transportation		
Other Service	Vehicle Modifications		
Other Service	Wellness Coordination		
Other Service	Workplace Assistance		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

Adult Day Services

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04050 adult day health

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Adult day services (ADS) are community-based group programs designed to support individuals as specified through the 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 nutritional regimen (i.e., three meals per day).

Individuals attend ADS on a planned basis.

SERVICE LEVELS

There are three service levels of adult day service: Basic, Enhanced and Intensive. The appropriate service level is determined through the person-centered planning process by completing the Adult Day Service Level of Service Assessment (ADS LOS Assessment). Case Managers complete this assessment at least annually to accurately reflect the relative support need of the individual. The ADS LOS Score determines the level of service to be utilized in the individual's next service plan.

The breakdown is as follows:

- Basic (Level 1) - ADS LOS Assessment Score of 0 - 11.
- Enhanced (Level 2) - ADS LOS Assessment Score of 12 - 22.
- Intensive (Level 3) - ADS LOS Assessment Score of 23 - 36.

REIMBURSABLE ACTIVITIES

Basic ADS (Level 1) include the following activities:

- 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) include Level 1 activities and the following additional activities:

- Hands-on assistance with two or more ADLs or hands-on assistance with bathing or other personal care.
- Health assessment with regular monitoring or intervention with health status.
- Dispensing or supervision of the dispensing of medication.
- Psychological needs assessed and addressed, including counseling as needed for 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) include Level 1 activities, Level 2 activities and the following additional activities:

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

SERVICE STANDARDS

- ADS must be included in the individual's PCISP
- ADS must address needs identified in the person-centered planning process and the ADS Level of Service Assessment Form
- ADS may be used in conjunction with transportation services.
- Each meal must meet 1/3 of the daily Recommended Dietary Allowance.
- ADS must be provided in a non-institutional, community-based setting,
- A 1/2 day unit is defined as one unit of three hours to a maximum of five hours/day. Two units is more than five hours to a maximum of eight hours/day. A maximum of two 1/2 units/day is allowed.
- A 1/4 hour unit is defined as 15 minutes. Billable only if fewer than three hours or more than eight hours of ADS have been provided on the same day. A maximum of 16 1/4 hour units/day are allowed.

DOCUMENTATION STANDARDS

Provider must maintain all applicable documentation required under 460 IAC 6 Supported Living Services and Supports and the FSSA/DDARS BDS policies and the FSSA/DDARS HCBS Waivers module on the IHCP Provider Reference Materials webpage. Additionally, the provider must comply with the following standards:

- The provider must document the following data elements for each uninterrupted period of services rendered:
 - Name of individual served
 - IHCP Member ID (RID) of the individual served
 - Service rendered
 - Date of service (include month, day and year)

- Time frame of service (include start time, end time and a.m./p.m.)
- Number of units of service rendered

- The provider must retain a copy of the completed ADS Level of Service Evaluation Form received from case manager
- Each quarter (or more often as determined by the IST), the service provider must prepare and upload a progress 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 reporting period. Quarterly reports must be completed on state approved templates. The first reporting period must align with the start of the service. Failure to timely complete and upload each quarterly report may result in a citation.
- The documentation may reside in multiple locations but must be clearly and easily linked to the individual or the standard will not be met.
- Upon request, all documentation must be made available to auditors, quality monitors, case managers and any other government entity within any/all timeframes specified by BDS.

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

Adult Day Services are limited to a maximum of twelve (12) hours per day.

Therapies provided under Adult Day Services will not duplicate services provided under the Medicaid State Plan or any other waiver service.

Adult Day services will not be reimbursed when provided by the parent of a minor child participant or the spouse of a participant (also known as a Legally Responsible Individual), Relative, or Legal Guardian as outlined in Appendix C-2-d and Appendix C-2-e of this waiver.

ACTIVITIES NOT ALLOWED:

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

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed
- ☐ Remote/via Telehealth

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

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/DDARS Approved Adult Day Service Facilities

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Services

Provider Category:

Agency

Provider Type:

FSSA/DDARS Approved Adult Day Service Facilities

Provider Qualifications**License (specify):****Certificate (specify):****Other Standard (specify):**

- Enrolled as an active Medicaid provider
- Must be FSSA/DDARS (or its designee) 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 service standards, guidelines, policies, and/or manuals, including the FSSA/DDARS HCBS Waivers provider reference module on the IHCP Provider Reference Materials webpage.
- Must obtain/maintain accreditation (specific to Indiana programs) by at least one (1) of the following organizations:
 - 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.
- All direct care staff must be registered with DDARS and must complete required competency-based training in accordance with IC 12-11-16.

Verification of Provider Qualifications**Entity Responsible for Verification:**

BDS

Frequency of Verification:

Up to 3 years.

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

HCBS Taxonomy:**Category 1:**

01 Case Management

Sub-Category 1:

01010 case management

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:****Service Definition (Scope):**

Case Management provides an array of support to connect people to integrated supports, regardless of the funding source, and to assist individuals in accessing needed waiver and other services available through the Indiana Medicaid State Plan. Case managers advocate alongside the individual to ensure their access and inclusion in their community as well as 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 is a person-centered process of needs assessment, discovery, planning, facilitation, advocacy, collaboration, problem-solving, and monitoring of the holistic needs of each individual, regardless of funding sources.

Case Managers are responsible for ensuring compliance with service definitions as a component of monitoring service delivery and individual progress toward outcomes. Case Management is responsible to ensure authorized services commensurate with identified needs and helps connect individuals with additional resources when those needs extend beyond the scope or resource availability of HCBS services.

Case management services include: (1) assessment and evaluation, (2) person-centered service planning and PCISP development and implementation, (3) integrated supports exploration, and (4) ongoing case management and monitoring.

Case management services are mandatory for all individuals accessing HCBS waivers.

REIMBURSABLE ACTIVITIES**(1) Assessment and Evaluation**

- Performing annual level of care re-evaluation activities and routing recommendation to designated FSSA staff for subsequent approval or denial.

(2) Person-Centered Planning and PCISP Development and Implementation

- Ensuring individuals have the information and support necessary to be present, actively participate, and direct the planning process and make informed choices about services, settings, and providers.
- Facilitating the person-centered planning process to ensure access to integrated supports that foster self-determination and community inclusion while identifying opportunities to build on the strengths and preferences of the individual.
- Appropriately developing and updating the initial and annual written, person-centered, strengths based PCISP that supports the individual's goals, preferences and vision of a good life through meaningful outcomes that offer opportunities for integrated supports.
- Developing, and updating when necessary, an initial and annual budget in support of the PCISP that reflects available resources and fiscal responsibility
- Convening Individualized Support Team (IST) jointly with the individual (and, if applicable, the individual's authorized representative) to facilitate the development of the PCISP. Supports include inviting people chosen by the individual to be members of the IST, scheduling the IST meetings at times and locations convenient to the individual, using plain language and accessible formats that respect cultural and linguistic needs for IST materials, offering clear conflict-resolution

strategies for IST, and maintaining conflict-of-interest guidelines for all members of the IST.

- Providing an approved and agreed upon copy of PCISP to ensure collaboration among all IST members and a shared understanding of the individual's desired outcomes.

(3) Integrated Supports Exploration

- Identifying and building on the individual's strengths and assets.
- Identifying current and potential personal, assistive and adaptive technologies that can be accessed to support the individual in their daily life.
- Identifying existing and potential new relationships that enhance and add value to aspects of the individual's life.
- Identifying and connecting individuals with community-based resources that are available to everyone.
- Connecting and supporting the individual with eligibility specific resources and supports the individual may be eligible for based on characteristics such as disability, age, income, geography, military status.

(4) Ongoing Case Management and Monitoring

- Conducting face-to-face visits with the individual and guardian, if applicable, every 90 days at a minimum for the purpose of relationship building, monitoring of services, and connecting to needed paid and unpaid resources.
 - At least one visit each year must be held inside the individual's home.
 - In addition, for individuals residing in provider owned and/or controlled settings (as defined by CMS and DDARS), case managers must ensure at least one additional visit each year is unannounced inside the home.
 - Face-to-face visits must be intentional interactions and may not be held as drop-in visits at service programs such as a day program.
 - All interactions, including face-to-face visits, team meetings, or monthly check-ins, may not be recorded via audio and/or video without the expressed written permission of the individual, their guardian and BDS.
- Promoting understanding among individuals and families regarding the overarching goals of HCBS services and the specific purpose and limitations of each authorized service.
- Convening Individualized Support Team (IST) meeting at least semi-annually (with one of these IST meetings convened for annual service planning). For all IST meetings, the case manager must record team discussions on outcomes and any related plan changes. The individual may choose to have the entire IST at every 90 day face-to-face interaction.
- IST meetings and face-to-face visits are both required in a manner that ensures in-person interaction at least every 90 days.
- Performing at least one documented meaningful encounter each month with or on behalf of the individual. A meaningful encounter may include a check in with the individual, provider and service referrals when individual is seeking a new provider for a service or services, problem solving, crisis management, and/or connection and coordination of paid and unpaid supports.
- Responding to all telephone calls, voicemails, and emails from individuals and families in a timely manner.
- Regularly reviewing and updating the PCISP including when the needs or circumstances of the individual have changed; services are added/changed; or at the request of the individual and guardian, if applicable. Updating and timely submission of service plans must be consistent with the individual's PCISP.
- 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 individuals' health and safety.
- Monitoring HCBS settings characteristics and compliance.
- Evaluating the effectiveness of all authorized services and addressing service gaps or needed modification of services.
- Monitoring the progress from identifying need to meeting outcomes/goals/preferences identified by the individual.
- Directly collaborating and coordinating with providers to ensure services are within the service definition and aligned with the individual's preferences
- Monitoring and receiving quarterly reports from service providers, reviewing status and uploading reports to the document library of the individual in the state's case management system when necessary.
- Monitoring services to ensure they are provided in compliance with the applicable service definition and notifying IST and BDS of potential non-compliance.
- Completing and processing the Monitoring Checklist within processes and timelines established by BDS.
- Coordinating and collaborating with the individual's wellness coordination provider to review any and all updates about the individual from the wellness coordination provider. The case manager shall perform follow up meetings with the individual about changes in medical and social services as well as interventions implemented by the wellness coordinator provider to ensure the individual's needs are being met. The case manager shall communicate information learned in these follow-up meetings with the wellness coordination provider and shall work together to resolve any un-met needs identified.
- Completing, submitting, and following up on incident reports within the processes and timelines established by BDS.
- Ensuring incidents requiring an investigation, as defined in BDS Policy and guidance, are completed and submitted as part of the incident reporting process.

- Completing case notes for each encounter with or on behalf of the individual within 7 calendar days of the encounter.
- Any/all necessary revisions to the PCISP should occur within 7 calendar days.
- Disseminating information including the PCISP, incident reports, all Service Authorizations/Notices of Action (SA/NOA) and forms to the individual, guardian, if applicable, and the IST.
- Maintaining files in accordance with Documentation Standards specified in this the service definition and BDS Guidance.
- Conducting mortality reviews (in the absence of a residential provider) in accordance with BDS policy and guidance.
- Educating and supporting the individual through termination procedures when an individual is no longer eligible to receive services under the waiver program or voluntarily leave the waiver program.
- Keeping the individual abreast of their Medicaid redetermination date and the necessity to maintain Medicaid to remain in HCBS services.
- When a complaint is being investigated by the state, or its designee, the case manager must respond to all requests for interviews within 48 hours or unless otherwise noted in the request. The case manager must make themselves available to the state for one on one interviews with the state or its designee.
- 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 includes the following: nursing facility, comprehensive rehabilitative management needs facility, state psychiatric facility, ICF/IDD (supervised group living) to DDARS HCBS services. The individual must be approved for Medicaid waiver services and fully transitioned into a DDARS 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 the transitional service should be clearly documented in the PCISP.

CONTINUED IN MAIN-B (OPTIONAL) SECTION

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

Case Management will not be reimbursed when provided by the parent of a minor child participant or the spouse of a participant (also known as a Legally Responsible Individual), Relative, or Legal Guardian as outlined in Appendix C-2-d and Appendix C-2-e of this waiver.

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 forty-seven (47) 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
- 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; or
 - Authorized to make financial or health-related decisions on behalf of the individual.

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed
- ☐ Remote/via Telehealth

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

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/DDARS Approved Case Management Agency

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Case Management

Provider Category:

Agency

Provider Type:

FSSA/DDARS Approved Case Management Agency

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

- Enrolled as an active Medicaid provider.
- Must be FSSA/DDARS (or its designee) approved.
- Must be eligible to provide case management services in every county.
- Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
 - 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, and
 - 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 Support for People with Disabilities, or its successor.
 - The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), 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.
- Must develop and enforce a code of ethics aligned with 460 IAC 6-14-7 and BDS policy, practices and guidance.
- 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 BDS policy.
- Ensure case managers meet with one or more of the following qualification standards:
 - (1) Hold a bachelor's degree in one of the following specialties from an accredited college or university:
 - i. Social work, Psychology, Sociology, Counseling, Gerontology, Nursing, Special education, Rehabilitation, or related degree if approved by the FSSA/DDARS/OMPP;
 - ii. Be a registered nurse with one-year experience in human services; or
 - iii. 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.
 - (2) Holding a master's degree in a related field may substitute for required experience.
 - (3) The case manager must meet the requirements for a qualified intellectual disability professional in 42 CFR 483.430(a).

Verification of Provider Qualifications

Entity Responsible for Verification:

Frequency of Verification:

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Day Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04020 day habilitation

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Day Habilitation services 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 should be individualized, person-centered and teach, model, practice, and reinforce skills necessary for meaningful community participation and successful self-direction.

REIMBURSABLE ACTIVITIES:

- Person-centered monitoring, training, education, demonstration, or support to assist the individual with the acquisition and retention of skills in the following areas:
 - Person-centered opportunities in integrated camp settings, community recreation, and public events to teach, practice, and generalize functional skills that increase independence, social engagement, and community integration.
 - Person-centered individualized supports that teach, reinforce, and generalize skills needed for everyday independence, self-advocacy, community participation, and meaningful engagement.
 - Person-centered supports that use hobbies and interests to learn and generalize functional skills that increase independence, social participation, and quality of life.
 - Unpaid work experiences (i.e. volunteer opportunities) that align with the individual's interests and/or goals identified in their PCISP.
 - Provide person-centered supports that enable individuals to establish, maintain, and strengthen relationships as a pathway to social inclusion, emotional well-being, and community participation.

SERVICE STANDARDS

- Day Habilitation services must be included on the individual's PCISP. The services will only be delivered when identified in the PCISP and tied to defined and measurable outcomes related to the individual's vision of a good life. The PCISP must document need, desired outcome, frequency, setting, duration and staffing ratio.
- Day Habilitation services must address needs identified in the person-centered planning process
- Day Habilitation services are provided in a variety of settings in the community or in a facility owned or operated by an FSSA/DDARS-approved provider.
- Services are primarily intended to occur in non-residential, community-based settings and may not occur in the individual's home. When identified in the individual's PCISP as consistent with the individual's desired goals and outcomes, services may be provided in a residential or community-setting that allows for opportunities to obtain the skills necessary for meaningful community participation and successful self-direction.
- Facility-based sites should resemble typical community settings that avoid institutional features such as regimented schedules, locked areas, or segregation from the public.
- The Day Habilitation provider shall fully comply with the federal HCBS Settings Rule and shall not impose any restriction on an individual's rights or freedoms unless the restriction meets all required criteria, is justified through a person-centered planning process, has received Human Rights Committee (HRC) approval, and includes documented informed consent from the individual and their legal representative.
- Day Habilitation services are provided as individual services or group services as determined in the person-centered planning process and documented in the PCISP. Services may be delivered using one of the following ratios:
 - Individual: 1 staff for each individual
 - Small Group: 1 staff for 2-4 individuals
 - Medium Group: 1 staff for 5-10 individuals
 - Large Group: 1 staff for 11-16 individuals, which may only be utilized in a facility setting.

*Ratios for group sizes are determined by meeting the individual's need with the smallest participant to staff ratio

DOCUMENTATION STANDARDS

Provider must maintain all applicable documentation required under 460 IAC 6 Supported Living Services and Supports and the FSSA/DDARS BDS policies and the FSSA/DDARS HCBS Waivers module on the IHCP Provider Reference Materials webpage. Additionally, the provider must comply with the following standards:

- The provider must document the following data elements for each uninterrupted period of services rendered:
 - Name of individual served
 - IHCP Member ID (RID) of the individual served
 - Service rendered
 - Date of service (include month, day and year)
 - Time frame of service (include start time, end time and a.m./p.m.)
 - Number of units of service rendered
 - Primary type of service rendered: community or facility
 - Percent of time in community
 - Percent of time in a facility
 - Primary ratio for service delivery
- Each quarter (or more often as determined by the IST), the service provider must prepare and upload a progress 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 reporting period. Quarterly reports must be completed on state approved templates. The first reporting period must align with the start of the service. Failure to timely complete and upload each quarterly report may result in a citation.
- The documentation may reside in multiple locations but must be clearly and easily linked to the individual or the standard will not be met.
- Upon request, all documentation must be made available to auditors, quality monitors, case managers and any other government entity within any/all timeframes specified by BDS.

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

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.

Day Habilitation services will not be reimbursed when provided by the parent of a minor child participant or the spouse of a participant (also known as a Legally Responsible Individual), Relative, or Legal Guardian as outlined in Appendix C-2-d and Appendix C-2-e of this waiver.

ACTIVITIES NOT ALLOWED

- Services that are available under the Rehabilitation Act of 1973 or PL 94-142.
- Skills training for any activity that is not identified as directly related to an individual's habilitation outcome such as generic craft classes without a clear habilitation objective or pastime instruction offered without a measurable skill objective.
- Activities that do not foster the acquisition and retention of skills such as staff simply supervising social time without teaching/coaching; entertainment only outings where no skill-building plan or measurable practice occurs.
- Activities that would typically be a component of a person's residential life or services, such as: routine grocery shopping, banking, household errands, appointments, etc.
- Activities that duplicate or replace supports provided through residential habilitation and support (RHS) services.

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed
- ☐ Remote/via Telehealth

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

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/DDARS-approved day habilitation service providers, which include community-based habilitation service providers and facility-based habilitation service providers.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Day Habilitation****Provider Category:**

Agency

Provider Type:

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

Provider Qualifications**License** (specify):**Certificate** (specify):**Other Standard** (specify):

- Enrolled as an active Medicaid provider
- Must be FSSA/DDARS (or its designee) approved
- Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
 - 460 IAC 6-10-5 Documentation of Criminal Histories,
 - 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance,
 - 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers,
 - 460 IAC 6-14-5 Requirements for Direct Care Staff,

- 460 IAC 6-14-4 Training,
 - 460 IAC 6-5-14 Health Care Coordination Services Provider Qualifications, and
 - 460 IAC 6-5-30 Transportation Services Provider Qualifications
- Must comply with any applicable FSSA/BDS service standards, guidelines, policies and/or manuals, including FSSA/DDARS BDS policies and the FSSA/DDARS HCBS Waivers module on the IHCP Provider Reference Materials webpage.
 - Must obtain/maintain accreditation (specific to Indiana programs) by at least one (1) of the following organizations:
 - 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
 - All direct care staff must be registered with DDARS and must complete required competency-based training in accordance with IC 12-11-16.

Verification of Provider Qualifications**Entity Responsible for Verification:**

BDS

Frequency of Verification:

Up to 3 years.

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:

Statutory Service

Service:

Prevocational Services

Alternate Service Title (if any):**HCBS Taxonomy:****Category 1:**

04 Day Services

Sub-Category 1:

04010 prevocational services

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:**

Category 4:**Sub-Category 4:****Service Definition (Scope):**

Prevocational services are supports that prepare an individual for paid employment and are intended to be a time-limited service along the continuum of employment supports. Prevocational services develop or improve job and non-job skills and increase preparedness to have a job in a competitive integrated setting through learning and work experiences, including volunteer work. This service is ideal for individuals newly exploring a possible interest in Competitive Integrated Employment (CIE) or who hope to develop, general, non-job-task-specific strengths and skills that contribute to employability in integrated community settings.

Activities within this service must be prevocational rather than vocational in nature. A service is determined to be prevocational when (1) services are not job-task oriented but are, instead, aimed at a generalized result, (2) services include activities which are not primarily directed at teaching specific job skills but at underlying rehabilitative goals or (3) participants are compensated at less than 50 percent of the minimum wage.

The use of prevocational services must be documented and support the individual's stated employment outcomes 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.

This service is part of a continuum of services that may lead to competitive integrated employment. Personal care/assistance is not a component of prevocational services.

REIMBURSABLE ACTIVITIES:

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

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

SERVICE STANDARDS

- Prevocational Services must be included on the individual's PCISP
- Prevocational Services must address needs identified in the person-centered planning process
- Prevocational Services may be delivered in a facility setting or a community setting, using an off-site enclave or mobile community work crew models.
- 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.
- Prevocational Services are provided as individual services or group services in one of the following ratios and as determined in the person-centered planning process:
 - Individual: 1 staff for each individual
 - Small Group: 1 staff for 2-4 individuals
 - Medium Group: 1 staff for 5-10 individuals
 - Large Group: 1 staff for 11-16 individuals
- Monitoring of prevocational services occurs on a quarterly basis. Monitoring should include the assessment of progress towards employment goals, the appropriateness of the service, and input from the individualized support team lead by the individual. 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 and when chosen by the individual, should be replaced with competitive integrated employment options, volunteer work experiences, and/or supports that develop job specific tasks related to the individual's employment outcomes.

DOCUMENTATION STANDARDS

Provider must maintain all applicable documentation required under 460 IAC 6 Supported Living Services and Supports and the FSSA/DDARS BDS policies and the FSSA/DDARS HCBS Waivers module on the IHCP Provider Reference Materials webpage. Additionally, the provider must comply with the following standards:

- The provider must document the following data elements for each uninterrupted period of services rendered:
 - Name of individual served
 - IHCP Member ID (RID) of the individual served
 - Service rendered
 - Date of service (include month, day and year)
 - Time frame of service (include start time, end time and a.m./p.m.)
 - Number of units of service rendered
 - Notation of the ratio for service delivery (if ratio other than 1 individual being served to 1 staff) and identification of other group participants, using the individuals' HIPAA naming convention.
- Each quarter (or more often as determined by the IST), the service provider must prepare and upload a progress 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 reporting period. Quarterly reports must be completed on state approved templates. The first reporting period must align with the start of the service. Failure to timely complete and upload each quarterly report may result in a citation.
- The provider must document (in the file of each individual receiving this service) that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).
- The documentation may reside in multiple locations but must be clearly and easily linked to the individual or the standard will not be met.
- Upon request, all documentation must be made available to auditors, quality monitors, case managers and any other government entity within any/all timeframes specified by BDS.

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

As part of a future amendment, the state intends to seek CMS approval to discontinue the facility-based component of this service. To ease this transition and reduce the abrupt service disruption that could result from the discontinuation of this service component, the state will no longer approve new requests for facility-based prevocational services starting December 31, 2025. If a new request for facility-based prevocational services is made after December 31, 2025, the state will work with the individual, their IST and the case manager (as necessary) to explain the planned discontinuation and identify alternative service options. Individuals with approved facility-based prevocational services included in their service plan as of December 31, 2025, will be allowed to continue using the service until they have exhausted their time-limited access to this service. Once all existing users of the facility-based component of this service have exhausted their time-limited access, the state will submit an amendment to CMS for approval to fully discontinue the facility-based component of this service.

This is a time-limited service that can be accessed by a given waiver participant for a total of no more than 18 months throughout their time on this waiver. Exceptions to this limit will be made on a case-by-case basis by the State following the state's determination that exceeding this limit is clearly in alignment with the person's individualized transition plan. Any provision of this service for longer than 18-months must be accompanied by a plan for transitioning which will be revisited and updated by the individual and their IST at least every six months with progress toward transition to competitive, integrated employment or another appropriate waiver service being a necessary precursor for an extension. During this time-limited 18-month period, individuals (who are not actively engaged with vocational rehabilitation services) must, with support from their case manager, complete and submit an initial vocational rehabilitation referral either online or through a local Vocational Rehabilitation office.

Prevocational services will not be reimbursed when provided by the parent of a minor child participant or the spouse of a participant (also known as a Legally Responsible Individual), Relative, or Legal Guardian as outlined in Appendix C-2-d

and Appendix C-2-e of this waiver.

ACTIVITIES NOT ALLOWED

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

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed
- ☐ Remote/via Telehealth

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

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/DDARS Approved Prevocational Agency

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Prevocational Services

Provider Category:

Agency

Provider Type:

FSSA/DDARS Approved Prevocational Agency

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

- Enrolled as an active Medicaid provider
- Must be FSSA/DDARS (or its designee) approved
- Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
 - 460 IAC 6-10-5 Documentation of Criminal Histories;
 - 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance;
 - 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers;
 - 460 IAC 6-5-20 Prevocational Services Provider Qualifications;
 - 460 IAC 6-14-5 Requirements for Direct Care Staff;
 - 460 IAC 6-14-4 Training.
- Must comply with any applicable FSSA/BDS service standards, guidelines, policies and/or manuals, including

FSSA/DDARS BDS policies and the FSSA/DDARS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

- Must obtain/maintain accreditation (specific to Indiana programs) by at least one (1) of the following organizations:
 - 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 ISO-9001 human services QA system.
 - The Council on Accreditation, or its successor.
 - An independent national accreditation organization approved by the secretary
- All direct care staff must be registered with DDARS and must complete required competency-based training in accordance with IC 12-11-16.

Verification of Provider Qualifications

Entity Responsible for Verification:

BDS

Frequency of Verification:

Up to 3 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

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

Alternate Service Title (if any):

Rent and Food for Unrelated Live-in Caregiver

HCBS Taxonomy:

Category 1:

07 Rent and Food Expenses for Live-In Caregiver

Category 2:

Category 3:

Category 4:

Sub-Category 1:

07010 rent and food expenses for live-in caregiver

Sub-Category 2:

Sub-Category 3:

Sub-Category 4:

Service Definition (Scope):

The payment for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. 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.

REIMBURSABLE ACTIVITIES

- Room and board for the unrelated live-in caregiver (who is not receiving any other financial reimbursement for the provision of this service).

SERVICE STANDARDS

- Services must be included on the individual's PCISP
- Services must address needs identified in the person-centered planning process
- Services must complement other services the individual receives and enhance increasing independence for the individual.
- The individual receiving these services lives in his or her own home.
- 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.
- "Room" means 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" means three meals a day or other full nutritional regimen.
- "Unrelated" means unrelated by blood or marriage to any degree.
- "Caregiver" means an individual providing a covered service as defined by BDS service definitions or in a Medicaid HCBS waiver, to meet the physical, social or emotional needs of the waiver participant receiving services.
- For payment to not be considered income for the waiver participant receiving services, payment for the portion of the costs of rent and food attributable to an unrelated live-in caregiver (who has no legal responsibility to support the individual) must be made directly to the live-in caregiver.

DOCUMENTATION STANDARDS

Provider must maintain all applicable documentation required under 460 IAC 6 Supported Living Services and Supports and the FSSA/DDARS BDS policies and the FSSA/DDARS HCBS Waivers module on the IHCP Provider Reference Materials webpage. Additionally, the provider must comply with the following 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
- The documentation may reside in multiple locations but must be clearly and easily linked to the individual or the standard will not be met.
- Upon request, all documentation must be made available to auditors, quality monitors, case managers and any other government entity within any/all timeframes specified by BDS.

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

Paid caregivers are not eligible for the Rent and Food for Unrelated Live-in Caregiver service.

Rent and Food for Unrelated Live-in Caregiver will not be reimbursed when provided by the parent of a minor child participant or the spouse of a participant (also known as a Legally Responsible Individual), Relative, or Legal Guardian as outlined in Appendix C-2-d and Appendix C-2-e of this waiver.

ACTIVITIES NOT ALLOWED

- 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.

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed
- ☐ Remote/via Telehealth

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

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/DDARS Approved Residential Habilitation and Support Provider

Appendix C: Participant Services

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

Service Type: Statutory Service

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

Provider Category:

Agency

Provider Type:

FSSA/DDARS Approved Residential Habilitation and Support Provider

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

- Enrolled as an active Medicaid provider
- Must be FSSA/DDARS (or its designee) approved
- Must 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.
- Must comply with any applicable FSSA/BDS service standards, guidelines, policies and/or manuals, including FSSA/DDARS BDS policies and the FSSA/DDARS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

Verification of Provider Qualifications

Entity Responsible for Verification:

BDS

Frequency of Verification:

Up to 3 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Residential Habilitation

Alternate Service Title (if any):

Residential Habilitation and Support (hourly)

HCBS Taxonomy:

Category 1:

02 Round-the-Clock Services

Sub-Category 1:

02031 in-home residential habilitation

Category 2:

08 Home-Based Services

Sub-Category 2:

08010 home-based habilitation

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Residential habilitation and support - Hourly (RHS Hourly) services means 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 his or her own home.

Note: Own home is defined as any living arrangement where the individual has control over their residence - including through ownership, rental, or a legally enforceable lease-and enjoys the same rights and responsibilities as anyone else living in the community.

RHS Hourly services are not appropriate for individuals who:

- Have been assigned an ALGO score of 3, 4, or 5 on their Objective Based Allocation (OBA); and
- Are living with housemates utilizing a shared staffing model; and
- Are living outside of their family home.

Individuals meeting these criteria will be referred to Residential habilitation and support - daily (RHS Daily) services.

SERVICE LEVELS

RHS Hourly services provide services and/or supports for individuals assigned an Algo score of 0, 1, or 2, or individuals assigned Algo level 3, 4, or 5 who are not utilizing a shared staffing model or who are living in their family home.

Billable under one of two level-specific Billing Codes:

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

The Algo scores and descriptors appear in 460 IAC 13-5-1 Algo levels

The nationally recognized Inventory for Client and Agency Planning or ICAP was selected to be the primary tool for participant assessment.

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

These two assessments determine a participant's overall Algo score, which can range from 0-5. Participants with Algo scores between 0 and 5 are considered outliers representing those who are the lowest and the highest on both ends of the functioning spectrum.

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 score (determined by the ICAP and ICAP addendum), age, employment, and living arrangement.

REIMBURSABLE ACTIVITIES

- Direct support, assistance, monitoring, modeling and coaching training to implement the PCISP outcomes for the individual
- Assistance with acquiring, enhancing, and building natural supports to decrease reliance on paid staff and increase individual's independence
- Working with the individual to meet the goals they have set for themselves on their PCISP
- Assistance to support the individual in the process of completing tasks such as personal care, meals, shopping, errands, household and leisure activities, money management, communication skills, social skills and positive behavior
- Coordination and facilitation of medical and nonmedical services to meet healthcare needs, including physician consults, medications, development and oversight of a health plan, implementation of risk plans and wellness plans, and maintenance of each individual's health record
- Transporting the individual to participate in community activities, when individual does not need assistance/support during any such activity.
- Ensuring that direct service staff are aware of and actively implementing the individuals PCISP, behavioral support plans and risk plans. When Wellness Coordination services are utilized in addition to RHS services, the Wellness Coordinator who must be an RN/LPN 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 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

- RHS (Hourly) must be included on the individual's PCISP. Staffing levels should not be dictated by the individual's algo score. Instead, staffing must be individualized and based on the person's goals, preferences, and support needs as outlined in the Person-Centered Individualized Support Plan (PCISP). Providers are responsible for ensuring that staffing arrangements reflect the supports necessary to implement the PCISP and promote health, safety, and community integration.
- RHS (Hourly) must address needs identified in the person-centered planning process

- 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.
- The RHS (Hourly) provider shall fully comply with the federal HCBS Settings Rule and shall not impose any restriction on an individual's rights or freedoms unless the restriction meets all required criteria, is justified through a person-centered planning process, has received Human Rights Committee (HRC) approval, and includes documented informed consent from the individual and their legal representative.
- All residential providers shall comply with all policies, procedures, and directives issued by the Bureau of Disabilities Services (BDS) related to transitions in residential services. This includes, but is not limited to, timely coordination with case managers, accurate documentation of transition activities, adherence to person-centered planning principles, and submission of required forms and notifications. Providers must ensure that transitions are conducted in a manner that safeguards the individual's health, safety, rights, and continuity of care and are also in compliance with the HCBS Settings Rule. Additionally, BDS is placement authority, and no transition shall occur without BDS written approval. Failure to receive BDS approval prior to an individual transitioning may result in suspension of all admissions to all residential sites managed by the provider.

RHS Hourly may be provided from the following:

- Agency Provider - an agency enrolled in the program is responsible to hire and render services
- Individual Provider - an individual enrolled in the program is responsible to render services.
- Participant Directed - the individual (or representative appointed by the individual) is the employer and acts as the agency directing their care.

DOCUMENTATION STANDARDS

Provider must maintain all applicable documentation required under 460 IAC 6 Supported Living Services and Supports and the FSSA/DDARS BDS policies and the FSSA/DDARS HCBS Waivers module on the IHCP Provider Reference Materials webpage. Additionally, the provider must comply with the following standards:

- The provider must document the following data elements for each uninterrupted period of services rendered:
 - Name of individual served
 - IHCP Member ID (RID) of the individual served
 - Service rendered
 - Date of service (include month, day and year)
 - Time frame of service (include start time, end time and a.m./p.m.)
 - Name of person providing service (if the person providing the service is required to be a professional, their title must also be included)
 - Primary location of service delivery
 - Signature of person providing the service that must at least include the person's last name and first initial. (Electronic signatures are permissible when in compliance with the Uniform Electronic Transactions Act [IC 26-2-8])
- Each staff member providing direct care or supervision of care to the individual must make at least one entry for each uninterrupted period of services rendered. All entries should describe an issue or circumstance concerning the individual.
- Each quarter (or more often as determined by the IST), the service provider must prepare and upload a progress 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 reporting period. Quarterly reports must be completed on state approved templates. The first reporting period must align with the start of the service. Failure to timely complete and upload each quarterly report may result in a citation. Quarterly reports are not required when services are self-directed.
- The documentation may reside in multiple locations but must be clearly and easily linked to the individual or the standard will not be met.
- Upon request, all documentation must be made available to auditors, quality monitors, case managers and any other government entity within any/all timeframes specified by BDS.

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

The maximum number of hours of RHS (Hourly) services that may be reimbursed when provided by Relatives, and Legal Guardians (who are NOT LRIs) or live-in caregivers must not exceed forty (40) hours per week per paid Relative caregiver, and/or paid Legal Guardian caregiver, or live-in caregiver.

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 a waiver participant, but this activity is not billable.)

RHS (Hourly) Level 1 and RHS (Hourly) Level 2 and remote support services are not billable concurrently/during the same time period.

Intermittent use of RHS (Hourly) Level 1 may not exceed thirty-five (35) hours of service per week.

RHS (Hourly) will not be reimbursed when provided by the parent of a minor child participant or the spouse of a participant (also known as a Legally Responsible Individual) as outlined in Appendix C-2-d of this waiver.

RHS (Hourly) will be reimbursed when provided by a Relative or a Legal Guardian, ONLY when all conditions specified in Appendix C-2-e of this waiver are met.

Residential Habilitation and Support (Hourly) services will not be reimbursed when provided by a Legal Guardian if the participant is self-directing this service.

As a non-entitlement home- and community-based Medicaid waiver, children ages 3 through 22, must first utilize entitlement programs including but not limited to: Medicaid and the Early Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, and free appropriate public education (FAPE) programs and resources available through a child's school as mandated by the Individuals with Disabilities Education Act (IDEA). Payment for duplicated services is prohibited.

ACTIVITIES NOT ALLOWED

- Services to individuals receiving Rent and Food for Unrelated Caregiver, Structured Family Caregiving or Children's Foster Care.
- Transportation and any other services that are available under the Medicaid State Plan.

NOTE: Per Indiana Code [IC 12-11-1.1], supported living service arrangements providing residential services may not serve more than four (4) unrelated waiver participants 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) waiver participants 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 waiver participants in the supported living setting.

Service Delivery Method (check each that applies):

- ☒ Participant-directed as specified in Appendix E
- ☒ Provider managed
- ☐ Remote/via Telehealth

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/DDARS Approved RHS Agencies
Individual	Self-Directed Residential Habilitation and Supports (Hourly) - Individual

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Residential Habilitation and Support (hourly)**Provider Category:**

Agency

Provider Type:

FSSA/DDARS Approved RHS Agencies

Provider Qualifications**License (specify):****Certificate (specify):****Other Standard (specify):**

- Enrolled as an active Medicaid provider
- Must be FSSA/DDARS (or its designee) approved
- Must 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 Health Care Coordination Services Provider Qualifications;
 - 460 IAC 6-14-5 Requirements for Direct Care Staff;
 - 460 IAC 6-14-4 Training;
 - 460 IAC 6-34-1 through 460 IAC 34-3 Transportation Services.
- Must comply with any applicable FSSA/BDS service standards, guidelines, policies and/or manuals, including FSSA/DDARS BDS policies and the FSSA/DDARS HCBS Waivers module on the IHCP Provider Reference Materials webpage.
- Must obtain/maintain accreditation (specific to Indiana programs) by at least one (1) of the following organizations:
 - 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 ISO-9001 human services QA system.
 - The Council on Accreditation, or its successor.
 - An independent national accreditation organization approved by the secretary.
- All direct care staff (including participant-directed staff) must be registered with DDARS and must complete required competency-based training in accordance with IC 12-11-16.

Verification of Provider Qualifications**Entity Responsible for Verification:**

BDS

Frequency of Verification:

Up to 3 years.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Residential Habilitation and Support (hourly)****Provider Category:**

Individual

Provider Type:

Self-Directed Residential Habilitation and Supports (Hourly) - Individual

Provider Qualifications**License (specify):****Certificate (specify):****Other Standard (specify):**

Individual/Agency providing services for individuals who self-direct their services:

- Must enroll with FMS vendor and submit forms and documentation as required by the FMS vendor
- Must be verified by FMS vendor as meeting all required qualifications.
- 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 6-14-4 Training
 - 460 IAC 6-14-5 Requirements for Direct Care Staff
- Individuals who self-direct their services, as the employer, may require additional reasonable staffing requirements based on their preferences and level of needs. Providers of self-directed services must submit forms and documentation as required by the FMS vendor. FMS vendor must ensure the individual or agency performing the service meets the required qualifications.
- Must comply with any applicable FSSA service standards, guidelines, policies, and/or manuals, including the FSSA/DDARS HCBS Waivers provider reference module on the IHCP Provider Reference Materials webpage.
- All participant-directed staff must be registered with DDARS and must complete required competency-based training in accordance with IC 12-11-16

Verification of Provider Qualifications**Entity Responsible for Verification:**

Financial Management Services Vendor

Frequency of Verification:

At least every three years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):**HCBS Taxonomy:**

Category 1:

09 Caregiver Support

Sub-Category 1:

09012 respite, in-home

Category 2:

09 Caregiver Support

Sub-Category 2:

09011 respite, out-of-home

Category 3:

02 Round-the-Clock Services

Sub-Category 3:

02033 in-home round-the-clock services, other

Category 4:**Sub-Category 4:****Service Definition (Scope):**

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 DDARS approved day habilitation facility, or in a non-private residential setting (such as a respite home).

REIMBURSABLE ACTIVITIES

- Assistance with toileting and feeding.
- Assistance with daily living skills, including assistance with accessing the community and community activities.
- Assistance with grooming and personal hygiene.
- Meal preparation, serving and cleanup.
- Administration of medications.
- Supervision/support.

SERVICE STANDARDS

- Respite services must be included on the individual's PCISP
- Respite services must address needs identified in the person-centered planning process
- Respite services are provided as individual services or group services (Unit rate divided by number of waiver participants served)
- Respite Nursing Care (RN or LPN) services may be delivered only when skilled care is required and documented in the PCISP.

Respite services may be provided from the following:

- Agency Provider - an agency enrolled in the program is responsible to hire and render services
- Individual Provider - an individual enrolled in the program is responsible to render services.
- Participant Directed - the individual (or representative appointed by the individual) is the employer and acts as the agency directing their care.

DOCUMENTATION STANDARDS

Provider must maintain all applicable documentation required under 460 IAC 6 Supported Living Services and Supports and the FSSA/DDARS BDS policies and the FSSA/DDARS HCBS Waivers module on the IHCP Provider Reference Materials webpage. Additionally, the provider must comply with the following standards:

- The provider must document the following data elements for each uninterrupted period of services rendered:
 - Name of individual served
 - IHCP Member ID (RID) of the individual served
 - Service rendered
 - Date of service (include month, day and year)
 - Time frame of service (include start time, end time and a.m./p.m.)
 - Name of person providing service (if the person providing the service is required to be a professional, their title must also be included)
 - Primary location of service delivery

- Signature of person providing the service that must at least include the person's last name and first initial. (Electronic signatures are permissible when in compliance with the Uniform Electronic Transactions Act [IC 26-2-8])
- Each staff member providing direct care or supervision of care to the individual makes at least one entry for each uninterrupted period of services rendered. All entries should describe an issue or circumstance concerning the individual.
- The documentation may reside in multiple locations but must be clearly and easily linked to the individual or the standard will not be met.
- Upon request, all documentation must be made available to auditors, quality monitors, case managers and any other government entity within any/all timeframes specified by BDS.

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

Respite services will not be reimbursed when provided by the parent of a minor child participant or the spouse of a participant (also known as a Legally Responsible Individual) as outlined in Appendix C-2-d of this waiver.

Respite services will be reimbursed when provided by a Relative or a Legal Guardian, ONLY when all conditions specified in Appendix C-2-e of this waiver are met.

Respite services will not be reimbursed when provided by a Legal Guardian if the participant is self-directing this service.

Respite services will not duplicate services provided under the Medicaid State Plan or any other waiver service.

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 participant(s).

Respite is not intended to be provided on a continuous, long-term basis as part of daily services that would enable the unpaid caregiver to go to work or to attend school.

ACTIVITIES NOT ALLOWED

- Services to individuals receiving Structured Family Caregiving waiver service or Children's Foster Care
- Reimbursement for room and board.
- Services provided to an individual living in a licensed facility-based setting (including a nursing facility).
- The cost of registration fees or the cost of recreational activities (for example, camp).
- Respite care used as day/child care.
- Respite care furnished to the individual within the educational/school setting or as a component of the individual's school day.
- Respite care used to replace skilled nursing services that should be provided under the Medicaid State Plan.

Service Delivery Method (check each that applies):

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/DDARS Approved Licensed Home Health Agencies
Agency	FSSA/DDARS Approved Respite Agencies
Individual	Self-Directed Respite - Individual

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency

Provider Type:

FSSA/DDARS Approved Licensed Home Health Agencies

Provider Qualifications

License (specify):

Home Health Agency IC 16-27-1, RN and LPN IC 25-23-1

Certificate (specify):

Home Health Aide Registered IC 16-27-1.5

Other Standard (specify):

- Enrolled as an active Medicaid provider
- Must be FSSA/DDARS (or its designee) approved
- Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
 - 460 IAC 6-10-5 Documentation of Criminal Histories;
 - 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance;
 - 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers;
 - 460 IAC 6-5-26 Respite Care Services Provider Qualifications;
 - 460 IAC 6-5-14 Health Care Coordination Services Provider Qualifications;
 - 460 IAC 6-14-5 Requirements for Direct Care Staff;
 - 460 IAC 6-14-4 Training.
- Must comply with any applicable FSSA/BDS service standards, guidelines, policies and/or manuals, including FSSA/DDARS BDS policies and the FSSA/DDARS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

Verification of Provider Qualifications

Entity Responsible for Verification:

BDS

Frequency of Verification:

Up to 3 years.

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency

Provider Type:

FSSA/DDARS Approved Respite Agencies

Provider Qualifications

License (specify):

IC 25-23 Licensed Practical Nurses and Registered Nurses

Certificate (specify):

Other Standard (specify):

- Enrolled as an active Medicaid provider
- Must be FSSA/DDARS (or its designee) approved
- Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
 - 460 IAC 6-10-5 Documentation of Criminal Histories;
 - 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance;
 - 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers;
 - 460 IAC 6-5-26 Respite Care Services Provider Qualifications;
 - 460 IAC 6-5-14 Health Care Coordination Services Provider Qualifications;
 - 460 IAC 6-14-5 Requirements for Direct Care Staff;
 - 460 IAC 6-14-4 Training.
- Must comply with any applicable FSSA/BDS service standards, guidelines, policies and/or manuals, including FSSA/DDARS BDS policies and the FSSA/DDARS HCBS Waivers module on the IHCP Provider Reference Materials webpage.
- All direct care staff (including participant-directed staff) must be registered with DDARS and must complete required competency-based training in accordance with IC 12-11-16.

Individuals providing Respite nursing care must be:

- A Registered Nurse licensed in accordance with IC 25-23-1
- A Licensed Practical Nurse licensed in accordance with IC 25-23-1

Verification of Provider Qualifications

Entity Responsible for Verification:

BDS

Frequency of Verification:

Up to 3 years.

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Individual

Provider Type:

Self-Directed Respite - Individual

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Individual/Agency providing services for individuals who self-direct their services:

- Must enroll with FMS vendor and submit forms and documentation as required by the FMS vendor

- Must be verified by FMS vendor as meeting all required qualifications.
- 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 6-14-4 Training
 - 460 IAC 6-14-5 Requirements for Direct Care Staff
- Individuals providing Respite nursing care must be:
 - A Registered Nurse licensed in accordance with IC 25-23-1; or
 - A Licensed Practical Nurse licensed in accordance with IC 25-23-1.
- Individuals who self-direct their services, as the employer, may require additional reasonable staffing requirements based on their preferences and level of needs. Providers of self-directed services must submit forms and documentation as required by the FMS vendor. FMS vendor must ensure the individual or agency performing the service meets the required qualifications.
- Must comply with any applicable FSSA service standards, guidelines, policies, and/or manuals, including the FSSA/DDARS HCBS Waivers provider reference module on the IHCP Provider Reference Materials webpage.
- All participant-directed staff must be registered with DDARS and must complete required competency-based training in accordance with IC 12-11-16

Verification of Provider Qualifications**Entity Responsible for Verification:**

Financial Management Services Vendor

Frequency of Verification:

At least every three years.

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:

Extended State Plan Service

Service Title:

Occupational Therapy

HCBS Taxonomy:**Category 1:**

11 Other Health and Therapeutic Services

Sub-Category 1:

11080 occupational therapy

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:**

Category 4:**Sub-Category 4:****Service Definition (Scope):**

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

REIMBURSABLE ACTIVITIES:

- Evaluation and training services in the areas of gross and fine motor function, self-care and sensory and perceptual motor function.
- Screening.
- Assessments.
- Planning, reporting and write-up when in association with the actual one-on-one direct care/therapy service delivery with the waiver participant.
- Direct therapeutic intervention.
- Design, fabrication, training and assistance with adaptive aids and devices.
- Consultation or demonstration of techniques with other service providers and family members.

SERVICE STANDARDS

- Occupational Therapy must be included on the individual's PCISP
- Occupational Therapy must address needs identified in the person-centered planning process
- One (1) hour of billed therapy service must include a minimum of forty-five (45) minutes of direct patient care with the balance of the hour spent in related patient services.
- If individuals under age 21 choose to utilize Occupational Therapy, they should access Occupational Therapy services through EPSDT.

DOCUMENTATION STANDARDS

Provider must maintain all applicable documentation required under 460 IAC 6 Supported Living Services and Supports and the FSSA/DDARS BDS policies and the FSSA/DDARS HCBS Waivers module on the IHCP Provider Reference Materials webpage. Additionally, the provider must comply with the following standards:

- The provider must document the following data elements for each uninterrupted period of services rendered:
 - Name of individual served
 - IHCP Member ID (RID) of the individual served
 - Service rendered
 - Date of service (include month, day and year)
 - Time frame of service (include start time, end time and a.m./p.m.)
 - Name of person providing service (if the person providing the service is required to be a professional, their title must also be included)
 - Primary location of service delivery

Occupational Therapy services documentation must also include the following:

- Documentation of an appropriate assessment
- Services provided under both the Indiana Medicaid State Plan and the waiver outlined in the PCISP
- BDS-approved provider
- Appropriate credentials for service provider
- Attendance record, therapist logs and/or chart detailing services provided, dates and times
- Service being requested on Indiana Medicaid State Plan included in the PCISP
- The documentation may reside in multiple locations but must be clearly and easily linked to the individual or the standard will not be met.
- Upon request, all documentation must be made available to auditors, quality monitors, case managers and any other government entity within any/all timeframes specified by BDS.

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

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

Therapies provided under Occupational Therapy will not duplicate services provided under the Medicaid State Plan or any other waiver service.

Occupational Therapy will not be reimbursed when provided by the parent of a minor child participant or the spouse of a participant (also known as a Legally Responsible Individual), Relative, or Legal Guardian as outlined in Appendix C-2-d and Appendix C-2-e of this waiver.

ACTIVITIES NOT ALLOWED

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

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed
- ☒ Remote/via Telehealth

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

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/DDARS Approved Agency Providing Occupational Therapy

Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Occupational Therapy

Provider Category:

Agency

Provider Type:

FSSA/DDARS Approved Agency Providing Occupational Therapy

Provider Qualifications

License (specify):

Occupational Therapist IC 25-23.5

Certificate (specify):

Other Standard (specify):

- Enrolled as an active Medicaid provider

- Must be FSSA/DDARS (or its designee) approved
- Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
 - 460 IAC 6-10-5 Documentation of Criminal Histories;
 - 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance;
 - 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers;
 - 460 IAC 6-5-17 Occupational Therapy Services Provider Qualifications.
- Must comply with any applicable FSSA/BDS service standards, guidelines, policies and/or manuals, including FSSA/DDARS BDS policies and the FSSA/DDARS HCBS Waivers module on the IHCP Provider Reference Materials webpage
- Occupational Therapists rendering waiver funded services must obtain/maintain Indiana licensure.

Verification of Provider Qualifications**Entity Responsible for Verification:**

BDS

Frequency of Verification:

Up to 3 years.

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:

Extended State Plan Service

Service Title:

Physical Therapy

HCBS Taxonomy:**Category 1:**

11 Other Health and Therapeutic Services

Sub-Category 1:

11090 physical therapy

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:****Service Definition (Scope):**

Physical Therapy Services means services provided by a licensed physical therapist

REIMBURSABLE ACTIVITIES:

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

SERVICE STANDARDS

- Physical Therapy must be included on the individual's PCISP
- Physical Therapy must address needs identified in the person-centered planning process
- One (1) hour of billed therapy service must include a minimum of forty-five (45) minutes of direct patient care with the balance of the hour spent in related patient services.
- If individuals under age 21 choose to utilize Physical Therapy services, they should access Physical Therapy services through EPSDT.

DOCUMENTATION STANDARDS

Provider must maintain all applicable documentation required under 460 IAC 6 Supported Living Services and Supports and the FSSA/DDARS BDS policies and the FSSA/DDARS HCBS Waivers module on the IHCP Provider Reference Materials webpage. Additionally, the provider must comply with the following standards:

- The provider must document the following data elements for each uninterrupted period of services rendered:
 - Name of individual served
 - IHCP Member ID (RID) of the individual served
 - Service rendered
 - Date of service (include month, day and year)
 - Time frame of service (include start time, end time and a.m./p.m.)
 - Name of person providing service (if the person providing the service is required to be a professional, their title must also be included)
 - Primary location of service delivery

Physical Therapy services documentation must also include the following:

- Documentation of an appropriate assessment
 - Services provided under both the Indiana Medicaid State Plan and the waiver outlined in the PCISP
 - BDS-approved provider
 - Appropriate credentials for service provider
 - Attendance record, therapist logs and/or chart detailing services provided, dates and times
 - Service being requested on Indiana Medicaid State Plan included in the PCISP
- The documentation may reside in multiple locations but must be clearly and easily linked to the individual or the standard will not be met.
 - Upon request, all documentation must be made available to auditors, quality monitors, case managers and any other government entity within any/all timeframes specified by BDS.

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

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.

Therapies provided under Physical Therapy will not duplicate services provided under the Medicaid State Plan or any other waiver service.

Physical Therapy will not be reimbursed when provided by the parent of a minor child participant or the spouse of a participant (also known as a Legally Responsible Individual), Relative, or Legal Guardian as outlined in Appendix C-2-d and Appendix C-2-e of this waiver.

ACTIVITIES NOT ALLOWED

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

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed
- ☒ Remote/via Telehealth

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

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/DDARS Approved Agency Providing Physical Therapy

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Extended State Plan Service****Service Name: Physical Therapy****Provider Category:**

Agency

Provider Type:

FSSA/DDARS Approved Agency Providing Physical Therapy

Provider Qualifications**License** (specify):

IC 25-27-1

Certificate (specify):**Other Standard** (specify):

- Enrolled as an active Medicaid provider
- Must be FSSA/DDARS (or its designee) approved
- Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
 - 460 IAC 6-10-5 Documentation of Criminal Histories,
 - 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance,
 - 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers,
 - 460 IAC 6-5-18 Physical Therapy Services Provider Qualifications
- Must comply with any applicable FSSA/BDS service standards, guidelines, policies and/or manuals, including FSSA/DDARS BDS policies and the FSSA/DDARS HCBS Waivers module on the IHCP Provider Reference Materials webpage.
- Physical Therapists rendering waiver funded services must obtain/maintain Indiana licensure.

Verification of Provider Qualifications

Entity Responsible for Verification:

BDS

Frequency of Verification:

Up to 3 years.

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:

Extended State Plan Service

Service Title:

Psychological Therapy

HCBS Taxonomy:**Category 1:**

10 Other Mental Health and Behavioral Services

Sub-Category 1:

10030 crisis intervention

Category 2:

10 Other Mental Health and Behavioral Services

Sub-Category 2:

10060 counseling

Category 3:

10 Other Mental Health and Behavioral Services

Sub-Category 3:

10070 psychosocial rehabilitation

Category 4:

11 Other Health and Therapeutic Services

Sub-Category 4:

11120 cognitive rehabilitative therapy

Service Definition (Scope):

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

REIMBURSABLE ACTIVITIES:

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

SERVICE STANDARDS

- Psychological Therapy must be included on the individual's PCISP
- Psychological Therapy must address needs identified in the person-centered planning process
- One (1) hour of billed therapy service must include a minimum of forty-five (45) minutes of direct patient care with the balance of the hour spent in related patient services
- If individuals under age 21 choose to utilize Psychological Therapy, they should access Psychological Therapy services through EPSDT.

DOCUMENTATION STANDARDS

Provider must maintain all applicable documentation required under 460 IAC 6 Supported Living Services and Supports and the FSSA/DDARS BDS policies and the FSSA/DDARS HCBS Waivers module on the IHCP Provider Reference Materials webpage. Additionally, the provider must comply with the following standards:

- The provider must document the following data elements for each uninterrupted period of services time services are rendered:
 - Name of individual served
 - IHCP Member ID (RID) of the individual served
 - Service rendered
 - Date of service (include month, day and year)
 - Time frame of service (include start time, end time and a.m./p.m.)
 - Name of person providing service (if the person providing the service is required to be a professional, their title must also be included)
 - Primary location of service delivery

Psychological Therapy services documentation must also include the following:

- Documentation of an appropriate assessment
- Services provided under both the Indiana Medicaid State Plan and the waiver outlined in the PCISP
- BDS-approved provider
- Appropriate credentials for service provider
- Attendance record, therapist logs and/or chart detailing services provided, dates and times
- Service being requested on Indiana Medicaid State Plan included in the PCISP

- The documentation may reside in multiple locations but must be clearly and easily linked to the individual or the standard will not be met.

- Upon request, all documentation must be made available to auditors, quality monitors, case managers and any other government entity within any/all timeframes specified by BDS.

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

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.

Therapies provided under Psychological Therapy will not duplicate services provided under the Medicaid State Plan or any other waiver service.

Psychological Therapy will not be reimbursed when provided by the parent of a minor child participant or the spouse of a participant (also known as a Legally Responsible Individual), Relative, or Legal Guardian as outlined in Appendix C-2-d and Appendix C-2-e of this waiver.

ACTIVITIES NOT ALLOWED

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

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed
- ☒ Remote/via Telehealth

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

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/DDARS Approved Qualified Agencies

Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Psychological Therapy

Provider Category:

Agency

Provider Type:

FSSA/DDARS Approved Qualified Agencies

Provider Qualifications

License (specify):

Mental Health Counselor: IC 25-23.6
 Clinical Social Worker: IC 25-23.6
 Licensed Psychologist: IC 25-33-1-5.1
 Marriage/Family Therapist: IC 25-23.6

Certificate (specify):

Other Standard (specify):

- Enrolled as an active Medicaid provider
- Must be FSSA/DDARS (or its designee) approved
- Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
 - 460 IAC 6-10-5 Criminal Histories,
 - 460 IAC 6-12 Insurance,
 - 460 IAC 6-11 Provider Financial Status,
 - 460 IAC 6-5-21 (Psychological) Therapy Provider qualifications
- Must comply with any applicable FSSA/BDS service standards, guidelines, policies and/or manuals, including FSSA/DDARS BDS policies and the FSSA/DDARS HCBS Waivers module on the IHCP Provider Reference Materials webpage.
- Where licensure is required, providers rendering waiver funded services must obtain/maintain Indiana-specific licensure.

Verification of Provider Qualifications

Entity Responsible for Verification:

BDS

Frequency of Verification:

Up to 3 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Service Title:

HCBS Taxonomy:
Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Speech-Language Therapy Services means services provided by a licensed speech pathologist.

REIMBURSABLE ACTIVITIES:

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

SERVICE STANDARDS

- Speech-Language Therapy must be included on the individual's PCISP
- Speech-Language Therapy must address needs identified in the person-centered planning process
- One (1) hour of billed therapy service must include a minimum of forty-five (45) minutes of direct patient care/therapy with the balance of the hour spent in related patient services.
- If individuals under age 21 choose to utilize Speech/Language Therapy, they should access Speech/Language Therapy services through EPSDT.

DOCUMENTATION STANDARDS

Provider must maintain all applicable documentation required under 460 IAC 6 Supported Living Services and Supports and the FSSA/DDARS BDS policies and the FSSA/DDARS HCBS Waivers module on the IHCP Provider Reference Materials webpage. Additionally, the provider must comply with the following standards:

- The provider must document the following data elements for each uninterrupted period of services rendered:
 - Name of individual served
 - IHCP Member ID (RID) of the individual served
 - Service rendered
 - Date of service (include month, day and year)
 - Time frame of service (include start time, end time and a.m./p.m.)
 - Name of person providing service (if the person providing the service is required to be a professional, their title must also be included)

Speech/Language Therapy services documentation must also include the following:

- Documentation of an appropriate assessment
 - Services provided under both the Indiana Medicaid State Plan and the waiver outlined in the PCISP
 - BDS-approved provider
 - Appropriate credentials for service provider
 - Attendance record, therapist logs and/or chart detailing services provided, dates and times
 - Service being requested on Indiana Medicaid State Plan included in the PCISP
- The documentation may reside in multiple locations but must be clearly and easily linked to the individual or the standard will not be met.
 - Upon request, all documentation must be made available to auditors, quality monitors, case managers and any other government entity within any/all timeframes specified by BDS.

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

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.

Therapies provided under Speech-Language Therapy will not duplicate services provided under the Medicaid State Plan or any other waiver service.

Speech-Language Therapy will not be reimbursed when provided by the parent of a minor child participant or the spouse of a participant (also known as a Legally Responsible Individual), Relative, or Legal Guardian as outlined in Appendix C-2-d and Appendix C-2-e of this waiver.

ACTIVITIES NOT ALLOWED

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

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed
- ☒ Remote/via Telehealth

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

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/DDARS Approved Agency providing Speech/Language Therapy

Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Speech /Language Therapy

Provider Category:

Agency

Provider Type:

FSSA/DDARS Approved Agency providing Speech/Language Therapy

Provider Qualifications

License (specify):

IC 25-35.6 licensed Speech/Language Therapist

Certificate (specify):

Other Standard (specify):

- Enrolled as an active Medicaid provider
- Must be FSSA/DDARS (or its designee) approved
- Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
 - 460 IAC 6-10-5 Documentation of Criminal Histories,
 - 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance,
 - 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers,
 - 460 IAC 6-5-21 Therapy Services Provider Qualifications
- Must comply with any applicable FSSA/BDS service standards, guidelines, policies and/or manuals, including FSSA/DDARS BDS policies and the FSSA/DDARS HCBS Waivers module on the IHCP Provider Reference Materials webpage.
- Speech/Language Therapists rendering waiver funded services must obtain/maintain Indiana licensure.

Verification of Provider Qualifications

Entity Responsible for Verification:

BDS

Frequency of Verification:

Up to 3 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Behavioral Support Services (BSS)

HCBS Taxonomy:**Category 1:**

10 Other Mental Health and Behavioral Services

Sub-Category 1:

10040 behavior support

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:****Service Definition (Scope):**

Behavioral Support Services is an array of direct and indirect supports that help an individual achieve more positive outcomes when unwanted behaviors or lack of positive skills interfere with an individual's trajectory toward their good life. Behavioral Support Services are intended to empower individuals and families (by leveraging their strengths and unique abilities) to achieve self-determination, independence, productivity, and a sense of belonging in all facets of life across all environments, throughout the lifespan.

Behavioral Support Services should not replace other services that the individual may need to engage in the community, increase independence in the home environment or participate in outpatient mental health and psychiatric services; rather, this service should supplement these supports and act as a cohesive collaborator to maximize the effectiveness of all chosen supports, both paid and natural (unpaid) supports.

Behavioral Support Services can be consultative, may involve functional behavioral assessment, and will lead to the development of proactive strategies, positive teaching, and training toward individualized success. Appropriate application within the required tenants of Positive Behavioral Supports should lead to the intended reduction of unwanted behaviors and facilitate progress on the trajectory toward a good life.

There are three direct service components available within Behavioral Support Services in addition to Clinical Supervision, which is an indirect component. Individuals can choose one component or combine components over the plan year to achieve the desired outcomes; however, direct components may not overlap within a single month. All providers of this service will use the tenants of Positive Behavioral Supports and individuals will choose one provider agency from which to receive the direct service components. The goal is to fade support across environments as the individual achieves progress.

The components of Behavioral Support Services include:

- **Consultation:** Sometimes individuals, their individualized support team (IST), family members and natural supports can benefit from streamlined behavioral consultation. This component would be appropriate when intermittent behavior coaching and general consultation by a Behavioral Consultant could be helpful. Provision of this component does not require a full Functional Behavior Assessment (FBA) or a Behavioral Support Plan (BSP). Consultation may be used independently or when supports have faded over time and intermittent, ongoing consultation is needed to maintain an individual's progress. The Behavioral Consultant must develop Consultation support using the state approved Consultation Plan template. Additionally, a quarterly report is required during the provision of this service component.
- **Functional Behavioral Assessment:** The FBA process identifies both unwanted behaviors that may need to be decreased, as well as positive behaviors to be increased. The FBA process is an integral way to determine the relationship between targeted behaviors and an individual's environment. The Behavioral Consultant is the facilitator of the FBA process, which should include input of the IST. Through the FBA process, the Behavioral Consultant explores why the behavior happens and makes recommendations so the individual can achieve better outcomes.

As a result of the FBA process, the Behavioral Consultant must develop a written report including recommendations, using

the state approved FBA Report template. The FBA process does not need to be completed annually but should be affirmed in the BSP when comprehensive behavioral supports are being utilized. A new FBA may be completed when a significant life change or new diagnosis is made. A quarterly report is not required during the provision of this service component as the FBA Report will substantiate progress and ongoing recommendations for support.

- **Comprehensive Behavioral Supports:** A completed FBA Report is required which identifies the need for Comprehensive Behavioral Supports prior to the utilization. The Behavioral Consultant will develop and maintain a BSP that identifies strategies that are trauma-informed and use only evidenced-informed practices and techniques. The BSP will be written using the state approved BSP template. Additionally, a quarterly report is required during the provision of this service component.

Comprehensive Behavioral Supports include BSP development and updates, training on the BSP to the individual and their IST, collaborating with their IST and integrating necessary supplemental supports such as outpatient mental health counseling and psychotropic medication monitoring as appropriate.

- **Clinical Supervision:** If an individual's BSP includes the use of restrictive interventions, supervision provided by a Clinical Supervisor is a required component. For individuals that present behavioral complexities, but do not have restrictive interventions, this service may be a choice but is not required. The Clinical Supervisor must be different than the Behavioral Consultant authoring documents or delivering direct service components. A quarterly report is not required during the provision of this service component because it is an indirect service documented in the BSP.

REIMBURSABLE ACTIVITIES

- For all direct service components of Behavioral Support Services (Consultation, Functional Behavioral Assessment and Comprehensive Behavioral Supports:)

- behavior coaching, training, and consultation with the individual, chosen providers, and their IST to work toward the reduction of unwanted behaviors and increasing positive behaviors, across all environments

- data collection and analysis

- completion of state approved document templates for identified service components including consultation plans, FBA reports, BSPs, and quarterly reports as required.

- For Functional Behavioral Assessment:

- 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 potential new learning.

- For Comprehensive Behavioral Supports:

- development and maintenance of an updated BSP that is based on the functional behavior assessment. This includes devising proactive and reactive strategies designed to support the individual. It is imperative that least intrusive/restrictive methods are attempted, documented, and exhausted prior to implementation of any restrictive interventions. Any restrictive interventions included as part of the BSP must be approved, in writing, by a qualified Clinical Supervisor and a human rights committee. These restrictive interventions must be time-limited and regularly reviewed for elimination or reduction over time.

- For Clinical Supervision (indirect):

- review and approval of the Behavioral Support Plan and assurance that BSP is in line with the findings in the Functional Behavior Assessment.

- clinical guidance, assuring consensus of the IST that the BSP is feasible for implementation, uses the least restrictive methods possible, and are evidence-informed.

- approval of Consultation Plan, Functional Behavioral Assessment Report and Quarterly reports are not required but may be a choice if the IST requires this level of supervision on high acuity cases.

SERVICE STANDARDS:

- Consultation Plan, FBA, BSP, and Quarterly Reports must be completed on state approved templates and uploaded to the BDS portal by the BSS provider of all BSS services delivered.

- It is expected that an average of at least 75% of billable services be provided in direct consultation with the individual and their IST. Indirect services (paperwork, research, consultation with Clinical Supervisor should not comprise more than 25% of all billable activities.

- Upon initial approval of a direct service component, a meeting must occur in person and within 30 calendar days.

- Consultation: Behavioral Consultant should meet with individual to begin collaborating on the Consultation Plan within 30 calendar days of joining the individual's IST.
- The Functional Behavior Assessment report should be completed within 60 calendar days of first meeting the individual.
- The Behavioral Support Plan as an integral and required document of Comprehensive Behavioral Supports should be implemented (including required approvals, informed consent, initial staff training and HRC and Clinical Supervision if required) within 60 calendar days of the original FBA Report being completed or after BSS has been added to the individual's PCISP.
- Clinical Supervision: For a BSP that includes restrictive interventions, plan review and approval should occur as part of the 60-calendar day period allowed for the BSP implementation. Ongoing clinical supervision and approval of BSP updates throughout the year may occur at any time as outlined in the individual's PCISP and shall not exceed units allowable on the NOA/SA.
- 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 contribute to achieving the identified outcomes.
 - Concurrent service delivery should be time limited with a plan to reduce and eliminate the need for concurrent service delivery when appropriate.
- Supports may be delivered in the community when a behavioral need is identified in that specific setting. Services may not be provided in a public or private school setting.
- BSP must be updated no less than annually and should be updated at any time that a significant life event or change has occurred.

CONTINUED IN MAIN-B (OPTIONAL) SECTION

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

Behavioral Support Services are limited to a maximum of twelve (12) hours per month.

Within the monthly limit, the following limitations apply to the provision of behavioral support services components:

- Multiple delivery of direct service components may be used within a plan year with only one direct service component being delivered within one month.
- Consultation is limited to an average of three hours monthly or a maximum of 36 hours per plan year.
- The Functional Behavioral Assessment component is limited to a maximum of 20 hours per plan year and should be completed within a 60-day period.
- Comprehensive Behavioral Supports are limited to an average of 12 hours monthly or a maximum of 144 hours per plan year.
- The Clinical Supervision component is limited to an average of one hour monthly or a maximum of 12 hours per plan year.

Services provided under Behavioral Support Services must not duplicate or replace services provided under the Medicaid State Plan or any other waiver service.

Behavioral Support Services will not be reimbursed when provided by the parent of a minor child participant or the spouse of a participant (also known as a Legally Responsible Individual), Relative, or Legal Guardian as outlined in Appendix C-2-d and Appendix C-2-e of this waiver.

ACTIVITIES NOT ALLOWED:

- Aversive techniques. Any intervention intended to cause pain or other unpleasant sensation is strictly prohibited.
- The use of restrictive interventions without the express, written authorization of the individual, their legal representative, their IST, a Clinical Supervisor and the human rights committee. The HRC should ensure review of the justification,

alternatives tried, informed consent, data collection and time-limits for re-review. The HRC should include a diverse group including: an individual receiving services or a guardian, a community member not employed by the provider, other professionals with expertise (i.e., medical staff, psychologists, or behavior clinicians), and provider representatives. The representation should be balanced ensuring that provider representatives participate without holding a majority or exerting disproportionate influence.

- Restrictive interventions without documented evidence that less restrictive attempts have been implemented without success accompanied by a timeframe for review with a written fading plan integrated into the BSP.
- Service components provided by anyone other than Behavioral Consultants or Clinical Supervisors that meet the respective qualifications.
- Any component of Behavioral Support Services furnished to the individual within the educational/school setting or as a component of the individual's school day.
- Behavioral Consultant or Clinical Supervision Services provided by a parent(s), step-parent(s), legal guardian, sibling, spouse or any other person in a "dual role" that could impair the consultant's objectivity, competence or effectiveness.
- Provision of any component of behavioral support services billed to more than one individual in services at a time.
- Provision of more than one direct component of behavioral support services at a one time

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed
- ☐ Remote/via Telehealth

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

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/DDARS Approved Behavioral Support Services Agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Behavioral Support Services (BSS)

Provider Category:

Agency

Provider Type:

FSSA/DDARS Approved Behavioral Support Services Agency

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

- Enrolled as an active Medicaid provider
- Must be FSSA/DDARS (or its designee) approved
- Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
 - 460 IAC 6-10-5 Documentation of Criminal Histories,
 - 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance,

- 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers,
- 460 IAC 6-5-4 Behavioral Support Services Provider Qualifications,
- 460 IAC 6-18-1 to 460 IAC 6-18-7 Behavioral Support Services

• Must comply with any applicable FSSA/BDS service standards, guidelines, quality guides, policies and/or manuals, including FSSA/DDARS BDS policies and the FSSA/DDARS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

Individuals providing Behavioral Support Services must be employed by the specified agency and meet the following criteria:

- A Behavioral Consultant (i.e. a rendering provider of the direct service of Consultation, Functional Behavior Assessment of Comprehensive Behavioral Supports within Behavioral Support Services) must have a Master's Degree in:
 - clinical psychology, counseling psychology, school psychology, or another applied health service area of psychology;
 - special education;
 - social work;
 - counseling;
 - applied behavior analysis; or
 - be a licensed marriage and family therapist licensed under IC 25-23.6;
 - be a licensed clinical social worker under IC 25-23.6;
 - be a licensed mental health counselor under IC 25-23.6; or
 - have a master's degree in a human services field and be able to demonstrate to the BDS Provider Services that the individual has either coursework in or five (5) years of experience in devising, implementing, and monitoring behavioral support plans.
- A Clinical Supervisor (i.e. a rendering provider of the Clinical Supervision component of Behavioral Support Services), must:
 - Be a licensed psychologist under IC 25-33 and have an endorsement as a health service provider in psychology, or
 - have at least five (5) years supervising the work of Behavioral Consultants providing Behavioral Support Services in home and community based settings with one of the following endorsements:
 - (1) Licensed clinical social worker (LCSW) under IC 25-23.6-5.
 - (2) Licensed marriage and family therapist (LMFT) licensed under IC 25-23.6-8.
 - (3) Licensed mental health counselor (LMHC) under IC 25-23.6-8.5.
- To maintain approval as a behavioral support services provider, the Behavioral Consultant and the Clinical Supervisor shall:
 - obtain annually at least ten (10) continuing education hours related to the practice of behavioral supports from a Category I sponsor as provided in 868 IAC 1.1-15

Verification of Provider Qualifications

Entity Responsible for Verification:

BDS

Frequency of Verification:

Up to 3 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

07/24/2026

in statute.

Service Title:

Benefits Counseling (Effective 12/31/2025)

HCBS Taxonomy:

Category 1:

17 Other Services

Sub-Category 1:

17990 other

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Benefits Counseling services assist an individual to understand the potential impact of employment on the individual's public benefits, such as Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), Medicaid, Medicare, food/nutrition programs, housing assistance, ABLE accounts, and other federal, state, and local benefits and to provide support and technical assistance as needed to understand and complete administrative and reporting tasks related to employment which could impact their public benefits (e.g., submitting wages to Social Security Administration, applying relevant work incentives) when employed. This service is intended to dispel myths, misinformation, and address fears about work-related income compromising benefits by providing the individual with the information they need to make an informed choice regarding pursuing employment or career advancement and to address any concerns or issues that arise related to benefits following successfully obtaining competitive integrated employment.

Benefits Counseling can be provided to individuals considering or seeking competitive integrated employment or self-employment, career advancement or to individuals who need financial problem-solving assistance to maintain competitive integrated employment or self-employment.

REIMBURSABLE ACTIVITIES

- Individualized education regarding potential impact of employment on their government assistance and insurance programs
- Education regarding income reporting requirements and available work incentives that can support transition to maximizing competitive integrated employment
- Technical assistance to complete and submit appropriate forms and supporting documentation required for applicable work incentives

SERVICE STANDARDS

- Benefits Counseling services must be included on the individual's PCISP
- Benefits Counseling services must address needs identified in the person-centered planning process
- Benefits Counseling services may be delivered, or in the individual's home, the community, the benefit counselor's office, or a location of the individual's choice.

DOCUMENTATION STANDARDS

Provider must maintain all applicable documentation required under 460 IAC 6 Supported Living Services and Supports and the FSSA/DDARS BDS policies and the FSSA/DDARS HCBS Waivers module on the IHCP Provider Reference Materials webpage. Additionally, the provider must comply with the following standards:

- The provider must document the following data elements for each uninterrupted period of services rendered:
 - Name of individual served
 - IHCP Member ID (RID) of the individual served
 - Service rendered
 - Date of service (include month, day and year)
 - Time frame of service (include start time, end time and a.m./p.m.)
 - Number of units of service rendered
- Documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).
- Each quarter (or more often as determined by the IST), the service provider must prepare and upload a progress 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 reporting period. Quarterly reports must be completed on state approved templates. The first reporting period must align with the start of the service. Failure to timely complete and upload each quarterly report may result in a citation.
- The documentation may reside in multiple locations but must be clearly and easily linked to the individual or the standard will not be met.
- Upon request, all documentation must be made available to auditors, quality monitors, case managers and any other government entity within any/all timeframes specified by BDS.

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

This service can be utilized prior to opening or following the conclusion of an open case with Vocational Rehabilitation.

Benefits Counseling services are limited to a maximum of six (6) hours per plan year. To continue to assure the health and welfare of impacted individuals, the case manager will work with the individual and their IST during the person-centered planning process to identify alternate supports available to the individual if the six (6) hours per year limit is reached. Alternate supports may include other services available through the waiver for which they are eligible, community resources, and/or other unpaid supports.

Benefits Counseling services will not be reimbursed when provided by the parent of a minor child participant or the spouse of a participant (also known as a Legally Responsible Individual), Relative, or Legal Guardian as outlined in Appendix C-2-d and Appendix C-2-e of this waiver.

ACTIVITIES NOT ALLOWED

- Services that are available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed
- ☐ Remote/via Telehealth

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

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/DDARS approved Benefits Counseling Agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Benefits Counseling (Effective 12/31/2025)

Provider Category:

Agency

Provider Type:

FSSA/DDARS approved Benefits Counseling Agency

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

- Enrolled as an active Medicaid provider
- Must be FSSA/DDARS (or its designee) approved
- Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
 - 460 IAC 6-10-5 Documentation of Criminal Histories
 - 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance
 - 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers
 - 460 IAC 6-14-5 Requirements for Direct Care Staff
 - 460 IAC 6-14-4 Training
- Must comply with any applicable FSSA service standards, guidelines, policies, and/or manuals, including the FSSA/DDARS HCBS Waivers provider reference module on the IHCP Provider Reference Materials webpage.

Verification of Provider Qualifications

Entity Responsible for Verification:

BDS

Frequency of Verification:

Up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Career Exploration and Planning

HCBS Taxonomy:**Category 1:**

03 Supported Employment

Sub-Category 1:

03030 career planning

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:****Service Definition (Scope):**

Career exploration and planning is a targeted service designed to help an individual make an informed choice about whether they wish to pursue competitive integrated employment (CIE) including self-employment, obtain information to dissuade myths around or hesitation about CIE, and to identify the career path they would like to pursue either independently or with other available supports. This service is ideal for individuals newly transitioning from school-based services who are unsure as to their path toward CIE and may be used to gather information in preparation for a referral to Vocational Rehabilitation Services, an American Jobs Center, or other employment supports. If the individual is employed, career exploration may be used to explore advancement opportunities in their chosen career, or to explore other CIE career objectives which are more consistent with their skills and interests.

Career exploration and planning is not appropriate for individuals who have determined their desired career path and are already actively seeking CIE in that career path, either independently or with employment supports. Individuals with identified career outcomes documented in the PCISP should be referred to Vocational Rehabilitation Services, American Job Centers, or other employment supports.

This service also includes, when applicable, introductory education on the numerous work incentives for individuals receiving publicly funded benefits (e.g., SSI, SSDI, Medicaid, Medicare, etc.), and how Supported Employment services work (including Vocational Rehabilitation services). Educational information is provided to the individual and the legal guardian and/or most involved family member(s), if applicable, to ensure legal guardian/family support for the individual's choice to pursue CIE. The educational aspects of this service shall include addressing any concerns, hesitations or objections of the individual and the legal guardian/family, if applicable.

REIMBURSABLE ACTIVITIES

- Activities to identify an individual's specific interests and aptitudes for CIE, including experience and skills transferable to CIE.
- Exploration of CIE opportunities in the local area that are specifically related to the individual's identified interests, experiences and/or skills can include:
 - business tours
 - informational interviews
 - job shadows
 - work experiences.
- Set-up, preparation for, and debriefing of each exploration opportunity.
- Introductory education on available employment supports, work incentives, supported employment services, and benefits of working in competitive integrated employment settings.
- Development of documentation around individual's interests and aptitudes, stated career objectives, and development of a strengths-based career profile for use and guidance when seeking individual employment support. This profile must include the individual's determined career path and outcome documented in the PCISP. Career profiles may also be used to develop an individual's resume and inform outreach to local employers.
- When applicable, career profiles should include:
 - dreams, goals, and interests,

- talents, skills, and knowledge,
- learning styles,
- positive personality traits and values,
- workplace and environmental preferences,
- dislikes and situations/careers to avoid,
- previous work experiences,
- support system and community resources,
- specific challenges and possible solutions (including benefits considerations and accommodation needs),
- career opportunities (including preferred career paths and potential contributions to community employers).
- Transportation between the individual's place of residence and career exploration and planning services site(s).

SERVICE STANDARDS

- Career Exploration and Planning must be included on the individual's PCISP
- Career Exploration and Planning must address needs identified in the person-centered planning process
- Service may be provided on an individual basis or in groups dependent on participant choice. When group services are offered, the group shall not exceed 4 persons and must be formed based on shared CIE interests of the group members. • Services must be provided in community settings.

DOCUMENTATION STANDARDS

Provider must maintain all applicable documentation required under 460 IAC 6 Supported Living Services and Supports and the FSSA/DDARS BDS policies and the FSSA/DDARS HCBS Waivers module on the IHCP Provider Reference Materials webpage. Additionally, the provider must comply with the following standards:

- The provider must document the following data elements for each uninterrupted period of services rendered:
 - Name of individual served
 - IHCP Member ID (RID) of the individual served
 - Service rendered
 - Date of service (include month, day and year)
 - Number of units of service rendered
 - Time frame of service (include start time, end time and a.m./p.m.)
 - Notation of the ratio for service delivery (if ratio other than 1 individual being served to 1 staff) and identification of other group participants, using the individuals' HIPAA naming convention.
- Completed Career Profile developed with the individual.
- Each quarter (or more often as determined by the IST), the service provider must prepare and upload a progress 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 reporting period. Quarterly reports must be completed on state approved templates. The first reporting period must align with the start of the service. Failure to timely complete and upload each quarterly report may result in a citation.
- The documentation may reside in multiple locations but must be clearly and easily linked to the individual or the standard will not be met.
- Upon request, all documentation must be made available to auditors, quality monitors, case managers and any other government entity within any/all timeframes specified by BDS.

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

Career Exploration and Planning services are intended to be a time-limited service along the continuum of employment supports. Career Exploration and Planning services shall not exceed twenty (20) hours a month for six (6) months in any twelve (12) month period. The state will reevaluate this limit and any need for an exceptions policy prior to future waiver amendments.

Career Exploration and Planning will not be reimbursed when provided by the parent of a minor child participant or the spouse of a participant (also known as a Legally Responsible Individual), Relative, or Legal Guardian as outlined in Appendix C-2-d and Appendix C-2-e of this waiver.

ACTIVITIES NOT ALLOWED

- Services that are available under section 110 of the Rehabilitation Act of 1973 or section 602(16) & (17) of Individual with

Disabilities Education Act (IDEA). Documentation must be maintained verifying that the service is not otherwise available or funded under the Rehabilitation Act of 1973 as amended, or the IDEA

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed
- ☐ Remote/via Telehealth

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

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Approved Employment Exploration and Career Planning Provider Agencies

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Career Exploration and Planning

Provider Category:

Agency

Provider Type:

Approved Employment Exploration and Career Planning Provider Agencies

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

- Enrolled as an active Medicaid provider
- Be FSSA/DDARS (or its designee) approved
- Comply with Indiana Administrative Code, 460 IAC 6, including:
 - 460 IAC 6-10-5 Documentation of Criminal Histories
 - 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance
 - 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers
 - 460 IAC 6-5-20 Prevocational Services Provider Qualifications
 - 460 IAC 6-14-5 Requirements for Direct Care Staff
 - 460 IAC 6-14-4 Training
- Must comply with any applicable FSSA service standards, guidelines, policies, and/or manuals, including the FSSA/DDARS HCBS Waivers provider reference module on the IHCP Provider Reference Materials webpage.
- Must 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, 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 FSSA Secretary
- All direct care staff must be registered with DDARS and must complete required competency-based training in accordance with IC 12-11-16.

Verification of Provider Qualifications**Entity Responsible for Verification:**

BDS

Frequency of Verification:

Up to 3 years.

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:

Other Service

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

Service Title:

Community Transition

HCBS Taxonomy:**Category 1:**

16 Community Transition Services

Sub-Category 1:

16010 community transition services

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:****Service Definition (Scope):**

Community transition services (CTS) are specified in the PCISP and include reasonable, set-up expenses for individuals who make the transition from an institution to their own home where the person is directly responsible for their own living expenses in the community and will not be reimbursable on any subsequent move.

Note: Own home is defined as any living arrangement where the individual has control over their residence - including through ownership, rental, or a legally enforceable lease-and enjoys the same rights and responsibilities as anyone else living in the community.

Items purchased through community transition Services are the property of the individual receiving the service, and the individual takes the property with them in the event of a move to another residence, even if the residence from which they are moving is owned by a provider agency.

REIMBURSABLE ACTIVITIES:

- Security deposits and application fees 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 but not limited to a bed, table or chairs, assembly of flat-packed furniture, window coverings, one (1) telephone, eating utensils, housekeeping supplies, food preparation items, hygiene products, microwave, and bed or bath linens.
- Set-up fees or deposits for utility or service access including telephone, electricity, heating, internet and water.
- Health and safety assurances including pest eradication, allergen control, or one time cleaning prior to occupancy.

SERVICE STANDARDS

- CTS must be included on the individual's PCISP
- CTS must address needs identified in the person-centered planning process
- When the individual is receiving residential habilitation and support, Structured Family Caregiving services or Day Habilitation services under the Community Integration and Habilitation (CIH) waiver, the Community Transition service is included in the service authorization.
- 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, DDARS/BDS may approve the one-time use of Community Transition funds subsequent to the emergency transition of an individual.

DOCUMENTATION STANDARDS

Provider must maintain all applicable documentation required under 460 IAC 6 Supported Living Services and Supports and the FSSA/DDARS BDS policies and the FSSA/DDARS HCBS Waivers module on the IHCP Provider Reference Materials webpage. Additionally, the provider must comply with the following standards:

- The provider must maintain receipts for all expenditures as well as itemized documentation that details each purchase and its purpose. Each itemization must also include a statement of ownership, affirming the purchased goods belong to the individual and they participated in selection.
- The documentation may reside in multiple locations but must be clearly and easily linked to the individual or the standard will not be met.
- Upon request, all documentation must be made available to auditors, quality monitors, case managers and any other government entity within any/all timeframes specified by BDS.

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

CTS is limited to a lifetime cap for set-up expenses, up to \$2,500.

CTS must be identified, ordered, and delivered within 3 months of the individual's discharge from the qualifying institution.

Community Transition Services are furnished only to the extent that they are reasonable and necessary as determined through the service plan development process, clearly identified in the service plan and the person is unable to meet such expense or when the services cannot be obtained from other sources.

Allergen control will not be used to fund the mitigating or removal of items that would be the responsibility of the landlord or homeowner.

Nursing Facilities will not be reimbursed for CTS because those services are part of the provider's per diem.

The state will not bill for FFP until after the individual departs the institution and meets waiver eligibility.

CTS will not be reimbursed when provided by the parent of a minor child participant or the spouse of a participant (also known as a Legally Responsible Individual), Relative, or Legal Guardian as outlined in Appendix C-2-d and Appendix C-2-e of this waiver.

ITEMS NOT ALLOWED

- Monthly rental or mortgage expenses.
- Food.

- Regular utility charges
- Large household appliances.
- Diversional or recreational items such as hobby supplies.
- Cable TV access.
- Streaming video services (e.g. Netflix)
- VCRs or DVD players

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed
- ☐ Remote/via Telehealth

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

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/DDARS Approved Residential Habilitation and Support Agencies, Structured Family Caregiving Agencies, Day Habilitation, or Community-Based Habilitation Agencies

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Community Transition

Provider Category:

Agency

Provider Type:

FSSA/DDARS Approved Residential Habilitation and Support Agencies, Structured Family Caregiving Agencies, Day Habilitation, or Community-Based Habilitation Agencies

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

- Enrolled as an active Medicaid provider
- Must be FSSA/DDARS (or its designee) 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 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, and
 - 460 IAC 6-14-4 Training.
- Must comply with any applicable FSSA/BDS service standards, guidelines, policies and/or manuals, including FSSA/DDARS BDS policies and the FSSA/DDARS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

Verification of Provider Qualifications**Entity Responsible for Verification:**

BDS

Frequency of Verification:

Up to 3 years.

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:

Other Service

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

Service Title:

Extended Employment Services

HCBS Taxonomy:**Category 1:**

17 Other Services

Sub-Category 1:

17990 other

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:****Service Definition (Scope):**

Extended Employment Services are ongoing employment support services which enable an individual to maintain integrated competitive employment in a community setting. Competitive integrated employment is 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 co-workers without disabilities. Community settings are non-residential, integrated settings that are in the community.

Additionally, Extended Employment Services may include supports that enable an individual to maintain self-employment (if the individual chooses self-employment) and work from their own home or in the community when the work is competitive and could also be performed in an integrated environment by and among persons without disabilities.

Individuals must be self-employed (as described above) or employed in a competitive and integrated job in a community setting that pays at or above minimum wage in order to access this service.

The initial job placement, training, stabilization may be provided through Indiana Vocational Rehabilitation Services. Extended Employment Services provide the additional on-going work-related supports needed by the individual to continue to be as independent as possible in self-employment (as described above) or employment in a competitive integrated job in a community setting that pays at or above minimum wage. If an employed individual has obtained self-employed (as described above) or employment in a competitive integrated job in a community setting without Vocational Rehabilitation's services, the individual is still eligible to receive Extended Employment Services, as long as the individual meets the qualifications below.

REIMBURSABLE ACTIVITIES

- Ensuring that natural supports at the work site are secured through interaction with supervisors and staff. A tangible outcome of this activity would be a decrease in the number of hours of extended employment 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 job site is allowable as part of the delivery of this service.

SERVICE STANDARDS

- Extended Employment Services must be included on the individual's service plan
- Extended Employment Services must address needs as are necessary to maintain employment and identified in the person-centered planning process
- Extended employment services are not time limited
- Individuals may also utilize workplace assistance during any hours of competitive integrated employment in conjunction with their use of extended employment services.
- Individual (one-on-one) services can be billed in 15 minute increments.
- For Extended Employment 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 employment services service definition to be applicable to either an individual or to a group. 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 the individuals in the group have similar training needs.

DOCUMENTATION STANDARDS

Provider must maintain all applicable documentation required under 460 IAC 6 Supported Living Services and Supports and the FSSA/DDARS BDS policies and the FSSA/DDARS HCBS Waivers module on the IHCP Provider Reference Materials webpage. Additionally, the provider must comply with the following standards:

- The provider must document the following data elements for each uninterrupted period of services rendered:
 - Name of individual served
 - IHCP Member ID (RID) of the individual served
 - Service rendered
 - Date of service (include month, day and year)
 - Time frame of service (include start time, end time and a.m./p.m.)
 - Number of units of service rendered
 - Notation of the ratio for service delivery (if ratio other than 1 individual being served to 1 staff) and identification of other group participants, using the individuals' HIPAA naming convention.
- Each quarter (or more often as determined by the IST), the service provider must prepare and upload a progress 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 reporting period. Quarterly reports must be completed on state approved templates. The first reporting period must align with the start of the service. Failure to timely complete and upload each quarterly report may result in a citation.

- The provider must document (in the file of each individual receiving this service) that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).
- The documentation may reside in multiple locations but must be clearly and easily linked to the individual or the standard will not be met.
- Upon request, all documentation must be made available to auditors, quality monitors, case managers and any other government entity within any/all timeframes specified by BDS.

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

Group services may only be rendered at the discretion of the IST. Group sizes must not exceed one (1) staff to four (4) individuals to or such smaller group size determined by the IST for each group participant and documented in the PCISP.

Extended employment services must not be provided in sheltered workshops, other specialized facilities where similar types of vocational services are furnished, or any non-community based setting where the majority (51% or more) of the individuals have a disability.

Reimbursement is not made for and federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses, including (i) incentive payments made to an employer to encourage or subsidize the employer's participation in extended employment services; (ii) payments that are passed through to users of extended employment services; and (iii) payments for vocational training that is not directly related to the individual's needs necessary to maintain employment and as outlined in the individual's service plan.

Extended Employment Services will not be reimbursed for the following activities:

- Supervisory activities rendered as a normal part of the business setting
- Provision of public relations
- Provision of transportation

Extended Employment services will not be reimbursed when provided by the parent of a minor child participant or the spouse of a participant (also known as a Legally Responsible Individual), Relative, or Legal Guardian as outlined in Appendix C-2-d and Appendix C-2-e of this waiver.

ACTIVITIES NOT ALLOWED

- Services that are available under section 110 of the Rehabilitation Act of 1973 or section 602(16) & (17) of Individual with Disabilities Education Act (IDEA). Documentation must be maintained verifying that the service is not otherwise available or funded under the Rehabilitation Act of 1973 as amended, or the IDEA.
- Services supporting sheltered work observation, sheltered work participation, or volunteer endeavors.
- Group supports delivered to individuals with different needs to maintain employment.

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed
- ☐ Remote/via Telehealth

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

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/DDARS Approved Extended Employment Services Agencies

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Extended Employment Services

Provider Category:

Agency

Provider Type:

FSSA/DDARS Approved Extended Employment Services Agencies

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

- Enrolled as an active Medicaid provider
- Must be FSSA/DDARS (or its designee) approved
- Must 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 Training,
- Must comply with any applicable FSSA/BDS service standards, guidelines, policies and/or manuals, including FSSA/DDARS BDS policies and the FSSA/DDARS HCBS Waivers module on the IHCP Provider Reference Materials webpage.
- Must obtain/maintain Indiana accreditation 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 Commission on Quality Assurance, or its successor.
 - The ISO-9001 human services QA system.
 - An independent national accreditation organization approved by the secretary
- In order to be eligible to perform this service a provider must meet the standards as a Community Rehabilitation Provider as outlined in Indiana Code 12-12-1-4.1.
- All direct care staff must be registered with DDARS and must complete required competency-based training in accordance with IC 12-11-16.

Verification of Provider Qualifications

Entity Responsible for Verification:

Frequency of Verification:

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

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

Service Title:

HCBS Taxonomy:
Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

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

REIMBURSABLE ACTIVITIES

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

SERVICE STANDARDS

- Facility based services must be included on the individual's PCISP
- Facility based services must address needs identified in the person-centered planning process
- These services must be provided in a congregate setting in groups not to exceed a ratio of 1 staff for 16 individuals.
- 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

DOCUMENTATION STANDARDS

Provider must maintain all applicable documentation required under 460 IAC 6 Supported Living Services and Supports and the FSSA/DDARS BDS policies and the FSSA/DDARS HCBS Waivers module on the IHCP Provider Reference Materials webpage. Additionally, the provider must comply with the following standards:

- The provider must document the following data elements for each uninterrupted period of services rendered:
 - Name of individual served
 - IHCP Member ID (RID) of the individual served
 - Service rendered
 - Date of service (include month, day and year)
 - Time frame of service (include start time, end time and a.m./p.m.)
 - Number of units of service rendered
 - Primary ratio for service delivery
- Each quarter (or more often as determined by the IST), the service provider must prepare and upload a progress 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 reporting period. Quarterly reports must be completed on state approved templates. The first reporting period must align with the start of the service. Failure to timely complete and upload each quarterly report may result in a citation.
- The documentation may reside in multiple locations but must be clearly and easily linked to the individual or the standard will not be met.
- Upon request, all documentation must be made available to auditors, quality monitors, case managers and any other government entity within any/all timeframes specified by BDS.

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

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.

Facility Based Support services will not be reimbursed when provided by the parent of a minor child participant or the spouse of a participant (also known as a Legally Responsible Individual), Relative, or Legal Guardian as outlined in Appendix C-2-d and Appendix C-2-e of this waiver.

ACTIVITIES NOT ALLOWED

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

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed
- ☐ Remote/via Telehealth

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

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/DDARS Approved Facility Based Support Services Agencies

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Facility Based Support Services

Provider Category:

Agency

Provider Type:

FSSA/DDARS Approved Facility Based Support Services Agencies

Provider Qualifications**License (specify):****Certificate (specify):****Other Standard (specify):**

- Enrolled as an active Medicaid provider
- Must be FSSA/DDARS (or its designee) approved
- Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
 - 460 IAC 6-10-5 Documentation of Criminal Histories,
 - 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance,
 - 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers,
 - 460 IAC 6-14-5 Requirements for Direct Care Staff,
 - 460 IAC 6-14-4 Training,
 - 460 IAC 6-5-14 Health Care Coordination Services Provider Qualifications, and
 - 460 IAC 6-5-30 Transportation Services Provider Qualifications
- Must comply with any applicable FSSA/BDS service standards, guidelines, policies and/or manuals, including FSSA/DDARS BDS policies and the FSSA/DDARS HCBS Waivers module on the IHCP Provider Reference Materials webpage.
- All direct care staff must be registered with DDARS and must complete required competency-based training in accordance with IC 12-11-16.

Verification of Provider Qualifications**Entity Responsible for Verification:**

BDS

Frequency of Verification:

Up to 3 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Family and Caregiver Training

HCBS Taxonomy:**Category 1:**

09 Caregiver Support

Sub-Category 1:

09020 caregiver counseling and/or training

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:****Service Definition (Scope):**

Family and caregiver training services provide education and support directly to the family caregiver of an individual in order to increase the confidence and stamina of the caregiver 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 the Family and Caregiver Training are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

REIMBURSABLE ACTIVITIES

- 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 and other resources and supports;
 - Developing or enhancing key parenting strategies;
 - Developing advocacy skills; and
 - Supporting the individual in developing self-advocacy skills.
- Education and training does not include counseling and must be aimed at assisting caregivers who support the individual to understand and address individual needs as specified in the PCISP.

SERVICE STANDARDS

- Family and Caregiver Training must be included on the individual's PCISP
- Family and Caregiver Training must address needs identified in the person-centered planning process

DOCUMENTATION STANDARDS

Provider must maintain all applicable documentation required under 460 IAC 6 Supported Living Services and Supports and the FSSA/DDARS BDS policies and the FSSA/DDARS HCBS Waivers module on the IHCP Provider Reference Materials webpage. Additionally, the provider must comply with the following standards:

- Services outlined in the PCISP
- State-approved and signed Service Authorization/NOA
- Receipt of payment for activity
- Proof of participation in activity if payment is made directly to individual/family

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

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

Family and Caregiver Training services are limited to a maximum of \$5,000 per plan year.

Family and Caregiver Training will not be reimbursed when provided by the parent of a minor child participant or the spouse of a participant (also known as a Legally Responsible Individual), Relative, or Legal Guardian as outlined in Appendix C-2-d and Appendix C-2-e of this waiver.

Reimbursement will not be made for training that agencies are otherwise required to provide to employees who are also paid family caregivers.

ITEMS/ACTIVITIES NOT ALLOWED

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

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed
- ☐ Remote/via Telehealth

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

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/DDARS Approved Family and Caregiver Training Agencies

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service

Service Name: Family and Caregiver Training

Provider Category:

Agency

Provider Type:

FSSA/DDARS Approved Family and Caregiver Training Agencies

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

- Enrolled as an active Medicaid provider
- Must be FSSA/DDARS (or its designee) approved
- Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
 - 460 IAC 6-10-5 Documentation of Criminal Histories,
 - 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance,
 - 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers,
 - 460 IAC 6-5-13 Family and Caregiver Training Services Provider Qualifications, and
 - 460 IAC 6-23-1 Requirements for Provision of Services,
 - 460 IAC 6-14-4 Training,
- Must comply with any applicable FSSA/BDS service standards, guidelines, policies and/or manuals, including FSSA/DDARS BDS policies and the FSSA/DDARS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Frequency of Verification:

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

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

Service Title:

HCBS Taxonomy:**Category 1:**

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

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

Service Definition (Scope):

AS REQUIRED BY CMS - AS OF THE CIH IN.0378 FIRST AMENDMENT EFFECTIVE 12.31.2025, HOME MODIFICATION ASSESSMENT AND HOME MODIFICATIONS SERVICES ARE NOW COMBINED AS HOME MODIFICATIONS AND ASSESSMENTS SERVICES. REFER TO ALL SPECIFICATIONS IN THE HOME MODIFICATIONS AND ASSESSMENTS SERVICE.

The service will be used to objectively determine the specifications for a home modification that is safe, appropriate and feasible in order to ensure accurate bids and workmanship. All participants must receive a home modification assessment with a certified waiver provider selected by the participant prior to any subsequent home modifications as well as a home modification inspection upon completion of the work. A home modification will not be reimbursed until the final inspection has been completed.

The home modification assessment will assess the home for physical adaptations to the home, which as indicated by individual's service plan, are necessary to ensure the health, welfare and safety of the individual and enable the individual to function with greater independence in the home, and without which the individual would require institutionalization.

The assessor will be responsible for writing the specifications, review of feasibility and the post-project inspection. Upon completion of the specifications, and review of feasibility, the Assessor will prepare and submit the project specifications to the case manager and individual for the bidding process and be paid first installment for completion of home specifications. Once the project is complete, the assessor, consumer and case manager will each be present on an agreed upon date and time to inspect the work and sign-off indicating that it was completed per the agreed upon bid and be paid the final installment of the home modification work. In the event the participant, provider, assessor and/or case manager become aware of discrepancies for complaints about the work being completed, the provider shall stop work immediately, and contact the case manager and Bureau of Disabilities Services (BDS) for further instruction.

The BDS also has the ability to request additional assessment visits to help resolve a disagreement between the home modification provider and the participant. This payment is not included in the actual home modification cost category and shall not be subtracted from the participant's lifetime cap for home modifications. The case management provider entity will be responsible for maintaining related records that can be accessed by the state.

ALLOWABLE ACTIVITIES

- Evaluation of the current environment, including the identification of barriers, underneath the home, electrical and plumbing, which may prevent the completion of desired modifications.
- Reimbursement for non-feasible assessments.
- Drafting of specifications
- Preparation/submission of specifications
- Examination of the modification (inspection/approve)
- Contact county code enforcement

SERVICE STANDARDS

- Need for home modification must be indicated in the participant's plan of care
- Modification must address the participant's level of service needs
- Proposed specifications for modification must conform to the requirements and limitations of the current approved service definition for home modification services

Assessment should be conducted by an approved, qualified individual who is independent of the entity providing the home modifications.

Contact appropriate authority regarding potential code violations.

DOCUMENTATION STANDARDS

- Need for home modification must be indicated in the participant's plan of care
- Modification must address the participant's level of service needs
- Any discrepancy noted by the provider, case manager and/or participant shall be detailed in the final inspection, and

addressed by the assessor.

AS REQUIRED BY CMS - AS OF THE CIH IN.0378 FIRST AMENDMENT EFFECTIVE 12.31.2025, HOME MODIFICATION ASSESSMENT AND HOME MODIFICATIONS SERVICES ARE NOW COMBINED AS HOME MODIFICATIONS AND ASSESSMENTS SERVICES. REFER TO ALL SPECIFICATIONS IN THE HOME MODIFICATIONS AND ASSESSMENTS SERVICE.

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

AS REQUIRED BY CMS - AS OF THE CIH IN.0378 FIRST AMENDMENT EFFECTIVE 12.31.2025, HOME MODIFICATION ASSESSMENT AND HOME MODIFICATIONS SERVICES ARE NOW COMBINED AS HOME MODIFICATIONS AND ASSESSMENTS SERVICES. REFER TO ALL SPECIFICATIONS IN THE HOME MODIFICATIONS AND ASSESSMENTS SERVICE.

An annual cap of \$574.38 is available for home modification assessment services, unless the BDS requests an additional assessment to help mediate disagreements between the home modification provider and the participant.

ACTIVITIES NOT ALLOWED

- Home Modification Assessment services shall not be performed by the same provider that performs the subsequent Home Modification.
- Home modification assessment services will not be reimbursed when the owner of the organization is a parent of a minor child participant, the spouse of a participant, the attorney-in-fact (POA) of a participant, the Health care representative (HCR) of a participant, or the legal guardian of a participant.
- This service must not be used for living arrangements that are owned or leased by providers of waiver services.

Payment will not be made for home modifications under this service.

AS REQUIRED BY CMS - AS OF THE CIH IN.0378 FIRST AMENDMENT EFFECTIVE 12.31.2025, HOME MODIFICATION ASSESSMENT AND HOME MODIFICATIONS SERVICES ARE NOW COMBINED AS HOME MODIFICATIONS AND ASSESSMENTS SERVICES. REFER TO ALL SPECIFICATIONS IN THE HOME MODIFICATIONS AND ASSESSMENTS SERVICE.

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed
- ☐ Remote/via Telehealth

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

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	FSSA/DDRS approved Home Modification Assessment Individual
Individual	Architect

Appendix C: Participant Services

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

Service Type: Other Service**Service Name: Home Modification Assessment (Terminated as of 12/30/2025)**

Provider Category:

Individual

Provider Type:

FSSA/DDRS approved Home Modification Assessment Individual

Provider Qualifications**License (specify):**

IC 25-20.2 Home Inspector

Certificate (specify):

In addition to the licensure standard, either a Certified Aging-In-Place Specialist (CAPS Certification - National Association of Home Builders) OR

a Executive Certificate in Home Modifications (University of Southern California)

Other Standard (specify):

Enrolled as an active Medicaid provider

Must be FSSA/DDRS-approved

Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:

460 IAC 6-10-5 Documentation of Criminal Histories,

460 IAC 6-12 Insurance, and

460 IAC 6-11 Financial Status of Providers

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

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

Verification of Provider Qualifications**Entity Responsible for Verification:**

BDS

Frequency of Verification:

Up to 3 years.

Appendix C: Participant Services

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

Service Type: Other Service**Service Name: Home Modification Assessment (Terminated as of 12/30/2025)**

Provider Category:

Individual

Provider Type:

Architect

Provider Qualifications**License (specify):**

IC 25-4

Certificate (specify):**Other Standard (specify):**

Enrolled as an active Medicaid provider

Must be FSSA/DDRS-approved

07/24/2026

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 Insurance, and
460 IAC 6-11 Financial Status of Providers

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:
BDS

Frequency of Verification:
Up to 3 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:
Home Modifications (Terminated as of 12/30/2025)

HCBS Taxonomy:

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

Service Definition (Scope):
AS REQUIRED BY CMS - AS OF THE CIH IN.0378 FIRST AMENDMENT EFFECTIVE 12.31.2025, HOME
MODIFICATION ASSESSMENT AND HOME MODIFICATIONS SERVICES ARE NOW COMBINED AS HOME
MODIFICATIONS AND ASSESSMENTS SERVICES. REFER TO ALL SPECIFICATIONS IN THE HOME

MODIFICATIONS AND ASSESSMENTS SERVICE.

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

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

REIMBURSABLE ACTIVITIES:

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

AS REQUIRED BY CMS - AS OF THE CIH IN.0378 FIRST AMENDMENT EFFECTIVE 12.31.2025, HOME MODIFICATION ASSESSMENT AND HOME MODIFICATIONS SERVICES ARE NOW COMBINED AS HOME MODIFICATIONS AND ASSESSMENTS SERVICES. REFER TO ALL SPECIFICATIONS IN THE HOME MODIFICATIONS AND ASSESSMENTS SERVICE.

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

AS REQUIRED BY CMS - AS OF THE CIH IN.0378 FIRST AMENDMENT EFFECTIVE 12.31.2025, HOME MODIFICATION ASSESSMENT AND HOME MODIFICATIONS SERVICES ARE NOW COMBINED AS HOME MODIFICATIONS AND ASSESSMENTS SERVICES. REFER TO ALL SPECIFICATIONS IN THE HOME MODIFICATIONS AND ASSESSMENTS SERVICE.

Reimbursement for Home Modification Supports has a lifetime limit or of \$15,000 per waiver.

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

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

ACTIVITIES NOT ALLOWED

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

AS REQUIRED BY CMS - AS OF THE CIH IN.0378 FIRST AMENDMENT EFFECTIVE 12.31.2025, HOME MODIFICATION ASSESSMENT AND HOME MODIFICATIONS SERVICES ARE NOW COMBINED AS HOME MODIFICATIONS AND ASSESSMENTS SERVICES. REFER TO ALL SPECIFICATIONS IN THE HOME MODIFICATIONS AND ASSESSMENTS SERVICE.

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed
- ☐ Remote/via Telehealth

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

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Home Modifications (Terminated as of 12/30/2025)

Provider Category:

Individual

Provider Type:

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

Provider Qualifications

License (specify):

Home Inspector IC 25-20.2

Plumber IC 25-28.5

Physical Therapist IC 25-27-1

Occupational Therapist IC 25-23.5

Speech/Language Therapist IC 25-35.6

Certificate (specify):

Architect IC 25-4-1

Other Standard (specify):

Enrolled as an active Medicaid provider

Must be FSSA/DDRS-approved

Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:

460 IAC 6-10-5 Documentation of Criminal Histories,

460 IAC 6-12 Insurance,

460 IAC 6-11 Financial Status of Providers, and

460 IAC 6-5-11 Environmental Modification Supports Provider Qualifications

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

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

Verification of Provider Qualifications**Entity Responsible for Verification:**

BDS.

Frequency of Verification:

Up to 3 years.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service

Service Name: Home Modifications (Terminated as of 12/30/2025)

Provider Category:

Agency

Provider Type:

FSSA/ DDRS Approved Agencies

Provider Qualifications**License (specify):**

Home Health Agencies IC 16-27-1

Service provided by Licensed OT (IC 25-23.5), PT (IC 25-27-1), ST (IC 25-35.6)

Certificate (specify):**Other Standard (specify):**

Enrolled as an active Medicaid provider

Must be FSSA/DDRS-approved

Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:

460 IAC 6-10-5 Documentation of Criminal Histories,

460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance,

460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers,

460 IAC 6-5-11 Environmental Modification Supports Provider Qualifications

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

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

Verification of Provider Qualifications**Entity Responsible for Verification:**

BDS

Frequency of Verification:

Up to 3 years.

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:

Other Service

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

Service Title:

Home Modifications and Assessments (Effective 12/31/2025)

HCBS Taxonomy:**Category 1:**

14 Equipment, Technology, and Modifications

Sub-Category 1:

14020 home and/or vehicle accessibility adaptations

Category 2:

17 Other Services

Sub-Category 2:

17030 housing consultation

Category 3:**Sub-Category 3:****Category 4:****Sub-Category 4:****Service Definition (Scope):**

This service includes "home modifications" and corresponding "home modification assessments." Home modifications are physical adaptations to the home, as required by the individual's service plan, which are necessary to ensure the health, welfare and safety of the individual, and enable the individual to function with greater independence in their home. Home modification assessments are services used to (1) review the feasibility of a requested home modifications, (2) develop objective specifications for a safe and appropriate home modifications, and (3) inspect completed home modifications.

Home Ownership

Homes owned by a waiver participant are allowed to be modified. Rented homes or apartments or family-owned homes are allowed to be modified only when a signed agreement from the property owner is obtained.

Assessment Requirement

All individuals must receive home modification assessment services. The feasibility review and specification development must be performed prior to initiation of the work and the inspection must be performed upon completion of the work.

Bid Requirements

At least two (2) bids must be obtained for any home modification expected to exceed \$5,000.00. Bids must be the most cost effective or conservative means to meet the individual's specific needs. If two bids cannot be obtained, it must be documented to show what efforts were made to secure two bids and include an explanation. The documentation should show provider names, dates of contact, and response received. Each bidder must conduct a site visit and meet with the individual/family to ensure feasibility and verify accuracy prior to submitting any bid. Each bid must be itemized with cost for each major component of the modification and include:

- Confirmation of site visit on form developed by DDARS/BDS and signed by the individual or their representative.
- Existing and proposed drawings for bathroom modifications, kitchen modifications and ramps
- Written warranty for new products or services in the form of a binding document stating that, for a period of not less than one (1) year, the service provider shall replace or repair any product or installation.
- Note: Individuals or entities with a financial interest in more than one provider agency may submit a bid from only one of those agencies in response to any procurement opportunity. Submitting bids from multiple agencies in which the same person or entity holds ownership or financial interest is prohibited and will result in disqualification of all related bids.

Choice of Provider

The individual chooses the certified provider to perform home modification assessment services. Home modification assessment services must not be performed by the same provider that performs the subsequent home modification.

The individual chooses the certified providers to submit bids for the home modifications. If the individual chooses to continue with the home modification after receiving the bids, then the lowest bid that meets the minimum requirements shall be chosen.

Prior Authorization

All home modifications must be approved by the Bureau of Disabilities Services (BDS) or its designee prior to services being rendered. Requests for modifications at two or more locations may only be approved at the discretion of the BDS director or its designee. Requests for modifications may be partially approved or denied in its entirety if the BDS director or its designee determines the documentation does not support residential stability and/or the service requested.

Any changes to approved home modifications must be approved by the Bureau of Disabilities Services (BDS) or its designee prior to making such changes.

REIMBURSABLE ACTIVITIES

Home modification assessments may include but are not limited to the following:

- Evaluation of the current environment, including the identification of barriers, underneath the home, electrical and plumbing, which may prevent the completion of desired modifications. Reimbursement may be made for evaluations that determine a home modification is not feasible.
- Drafting, preparation and submission of specifications
- Examination of the completed modification (inspection/approve)
- Contact county code enforcement

Home modifications may include but are not limited to the following:

- Installation of ramps - Limited to one per individual primary residence, and only when no other accessible ramp exists •

Widening doorways

- Exterior doorways (maximum one per individual primary residence when no other accessible door exists).
- Interior-as needed to allow for access (Pocket doors may be requested when insufficient room for door swing).

Modification of existing bathroom facilities

- Removal of existing bathtub, toilet and/or sink; and/or
- Installation of roll in shower, walk-in tub, grab bars, toilet and/or wall-mounted sink; and/or
- Installation of replacement incidental items such as flooring, storage space, cabinets that are necessary due to the bath modification.

Installation of specialized electric and plumbing systems necessary for the welfare of the individual

- Anti-scald devices
- Door alarms
- Handheld shower head

Installation of adaptive door openers, locks, and home control units, including switches and buttons to control:

- Medical equipment
- Lights
- Heat and air conditioning

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

Modification of existing kitchen facilities to promote accessibility for the individual

• Installation of vertical lift and/or stair 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 and if required for access to areas of the home necessary to meet the direct medical or remedial benefit of the individual.

• Replacement of existing glass windows with plexi-glass or other shatterproof material when there is a documented medical/behavioral reason(s).

• Fence- limited to 200 linear feet and accompanied by documentation of elopement

• Single room / Portable air conditioning units

• Maintenance and repair of the items and modifications provided through a HCBS waiver.

SERVICE STANDARDS

- Home Modification and Assessment services must be included on the individual's service plan, identify the direct medical or remedial benefit for the individual, and authorized on the Request for Approval (RFA) form and linked to the individual's service plan.
- Home Modification and Assessment services must address needs identified in the person-centered planning process and must be for the direct medical or remedial benefit of the individual
- Home modification assessments must be conducted by a provider who is independent of the entity providing the home modifications.
- Proposed specifications for modifications must conform to and be provided in accordance with:
 - the requirements and limitations of the current approved service definition for home modification services
 - applicable state and/or local building codes
- All products shall meet applicable standards of manufacture, design and installation.
- Providers must contact appropriate authority regarding potential code violations.
- Land survey may be required when exterior modification(s) approach property line.
- Residential liens are prohibited.
- In the event the individual, provider, assessor and/or case manager become aware of discrepancies or complaints about the work being completed, the provider shall stop work immediately, and contact BDS for further instruction within 48 hours.
- Provider must notify case manager, and case manager must notify BDS of additional changes identified during work for prior approval before initiating changes. Any changes to an approved scope, materials, or costs that are made without prior BDS review and written approval may be denied reimbursement.
- Waiver funding covers only basic modifications, and requests for upgraded products or materials will not be approved; however, during completion of the modification, the room will be matched as closely as possible to its previous color, style, and design, including paint, wall texture, wall coverings, doors, trim, and flooring. The individual or family must receive a detailed, itemized bid that they sign to indicate agreement; the bid must clearly state the exact work to be completed, the specific materials to be used, applicable warranties, and the expected timeline for completion.
- Once the project is complete, the assessor, individual and case manager will each be present on an agreed upon date and time to inspect the work and sign-off indicating that it was completed per the agreed upon bid. Any identified discrepancy must be detailed in the final inspection, and addressed by the assessor.
- If BDS or its designee determines the provider is at fault for poor and/or incorrect work during the home modification, then the provider is responsible for correcting work at the cost of the provider. The post-work assessment will assess the work to determine if the work was done per the specifications as outlined in the bid.

DOCUMENTATION STANDARDS

Provider must maintain all applicable documentation required under 460 IAC 6 Supported Living Services and Supports and the FSSA/DDARS BDS policies and the FSSA/DDARS HCBS Waivers module on the IHCP Provider Reference Materials webpage. Additionally, the provider must comply with the following standards:

- The assessor and installing provider must provide written documentation to the individual explaining any non-covered costs that may be necessary to make the modification functional (i.e., a larger capacity water heater). The individual/family must sign written acknowledgement confirming understanding of any costs not covered by the waiver and their agreement to proceed with the modification.
- The individual or family must receive a detailed, itemized bid that they sign to indicate agreement; the bid must clearly state the exact work to be completed, the specific materials to be used, applicable warranties, and the expected timeline for completion.
- Need for home modification must be indicated in the individual's PCISP. Modification must address the individual's level of service needs. Any discrepancy noted by the provider, care manager and/or individual shall be detailed in the final inspection, and addressed by the assessor.
- State-approved and signed Service Authorization/NOA
- Each provider must maintain receipts for all expenses incurred related to the modification; must be in compliance with FSSA and Division specific guidelines and/or policies.
- The documentation may reside in multiple locations but must be clearly and easily linked to the individual or the standard will not be met.
- Upon request, all documentation must be made available to auditors, quality monitors, case managers and any other

government entity within any/all timeframes specified by BDS.

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

The Home Modification Assessment component of this service is limited to a maximum of \$628 per plan year, unless BDS requests an additional assessment in order to help mediate disagreements between the home modification provider and the individual.

The Home Modification component of this service is limited to a lifetime cap of \$20,000.

The cap represents a cost for basic modification of an individual's home for accessibility and accommodates the individual's needs for housing modifications. The cost of a home modification includes all materials, equipment, labor, and permits to complete the project. No parts of a home modification may be billed separately as part of any other service category (e.g. Specialized Medical Equipment). If the lifetime cap is fully used, and a need is identified, the case manager will work with other available funding streams and community agencies to fulfill the need.

In addition to the applicable lifetime cap for the home modification component, up to \$1,000.00 is allowable per plan year for the maintenance and repair of an existing home modification that was funded by a Home and Community Based Services (HCBS) waiver. Requests for maintenance/repair services must detail cost of part(s) and cost of labor. If the need for maintenance/repair services exceeds \$1000.00, the case manager will work with other available funding streams and community agencies to fulfill the need. If maintenance/repair service costs exceed the annual limit, those parts and labor costs funded through the waiver must be itemized clearly to differentiate the waiver service provision from those parts and labor funded through a non-waiver funding source.

Home modification and assessment services will not be reimbursed when provided by the parent of a minor child participant or the spouse of a participant (also known as a Legally Responsible Individual), Relative, or Legal Guardian as outlined in Appendix C-2-d and Appendix C-2-e of this waiver.

ACTIVITIES NOT ALLOWED

- Modifications to the home that are of general utility or routine home maintenance
- Modifications which do not address accessibility or are not of direct medical or remedial benefit to the individual such as:
 - central heating and air conditioning;
 - replacement of carpeting and other floor coverings not related to bath/kitchen modifications
 - roof repair;
 - structural repair;
 - driveways, decks, patios, sidewalks, household furnishings;
 - swimming pools, spas, or hot tubs;
 - outside storage spaces;
 - garage door replacement or repair;
 - home security or video monitoring systems;
 - adaptive switches or buttons to control devices intended for entertainment, employment, or education
 - 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
 - home generators or air purifiers
 - elevators
 - ceiling track lift systems
 - storage (for example, cabinets, shelving, closets, sheds)
- Modifications that create living space or facilities where they did not previously exist (e.g. installation of a bathroom in a garage/basement, etc.);
- Adaptations which add to the total square footage of the home;
- Modifications that duplicate existing accessibility (for example, second accessible bathroom, a second means of egress from home and so forth)
- Individuals living in foster homes, group homes, assisted living facilities, or homes for special services (any licensed residential facility) are not eligible to receive this service. (Note: The responsibility for home modifications rests with the facility owner or operator);
- Individuals living in a provider owned or controlled residence are not eligible to receive this service. (Note: The responsibility for home modifications rests with the facility owner or operator);
- This service must not be used for living arrangements that are owned or leased by providers of waiver services.
- Completion of, or modifications to, new construction or significant remodeling/reconstruction are excluded unless there is documented evidence of a significant change in the individual's medical or remedial needs that now require the requested

modification.

- Adaptations that have not been approved on a Request for Approval to Authorize Services form
- Home modification services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

The following activities are not allowed under Home Modification Assessment services:

- Home Modification Assessment services shall not be performed by the same provider that performs the subsequent Home Modifications.
- Home Modification Assessment services must not be used for living arrangements that are owned or leased by providers of waiver services.

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed
- ☐ Remote/via Telehealth

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

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/ DDARS Approved Home Modification - Agency Contractor

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Home Modifications and Assessments (Effective 12/31/2025)

Provider Category:

Agency

Provider Type:

FSSA/ DDARS Approved Home Modification - Agency Contractor

Provider Qualifications

License (specify):

Any applicable licensure, including but 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

Certificate (specify):

Any applicable certification, including but not limited to:

- IC 25-4 Architect: Certificate of registration with effect of license

In addition to the licensure standard, home modification assessor must:

- Be a Certified Aging-In-Place Specialist (CAPS Certification - National Association of Home Builders)

OR

- Hold an Executive Certificate in Home Modifications (University of Southern California)

Other Standard (specify):

- Enrolled as an active Medicaid provider
- Must be FSSA/DDARS (or its designee) approved
- Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
 - 460 IAC 6-10-5 Documentation of Criminal Histories,
 - 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance,
 - 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers,
 - 460 IAC 6-5-11 Environmental Modification Supports Provider Qualifications
- All individuals rendering waiver-funded services must obtain/maintain Indiana registration/licensure or other certification (as applicable).
- Must comply with any applicable FSSA/BDS service standards, guidelines, policies and/or manuals, including FSSA/DDARS BDS policies and the FSSA/DDARS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

Verification of Provider Qualifications**Entity Responsible for Verification:**

BDS

Frequency of Verification:

Up to 3 years.

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:

Other Service

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

Service Title:

Intensive Behavioral Intervention (Terminated as of 12/30/2025)

HCBS Taxonomy:**Category 1:**

10 Other Mental Health and Behavioral Services

Sub-Category 1:

10040 behavior support

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

Service Definition (Scope):

AS OF THE CIH IN.0378 FIRST AMENDMENT EFFECTIVE 12.31.2025, INTENSIVE BEHAVIORAL INTERVENTIONS SERVICES ARE NOW COMBINED WITH BEHAVIORAL SUPPORT SERVICES. REFER TO ALL SPECIFICATIONS IN THE BEHAVIORAL SUPPORT SERVICES SERVICE.

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

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

Skills training under IBI must include:

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

REIMBURSABLE ACTIVITIES:

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

- Errorless teaching or other prompting procedures that have been found to support successful intervention. These procedures focus on the prevention of errors or incorrect responses while also monitoring when to fade the prompts to allow the learner to demonstrate ongoing and successful completion of the desired activity.
- Additional methods that occur and are empirically-based.
- Specific and ongoing objective measurement of progress, with success closely monitored via detailed data collection.

Note: An appropriate range of hours per week is generally between 20-30 hours of direct service. It is recommended that Intensive Behavioral Intervention Services be delivered a minimum of 20 hours per week. When fewer than 20 hours per week will be delivered, justification must be submitted explaining why the IST feels a number fewer than the recommended minimum is acceptable. A detailed IBI support plan is required. Services are usually direct and one-to-one, with the exception of time spent in training the caregiver(s) and the family; ongoing data collection and analysis; goal and plan revisions.

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

AS OF THE CIH IN.0378 FIRST AMENDMENT EFFECTIVE 12.31.2025, INTENSIVE BEHAVIORAL INTERVENTIONS SERVICES ARE NOW COMBINED WITH BEHAVIORAL SUPPORT SERVICES. REFER TO ALL SPECIFICATIONS IN THE BEHAVIORAL SUPPORT SERVICES SERVICE.

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

AS OF THE CIH IN.0378 FIRST AMENDMENT EFFECTIVE 12.31.2025, INTENSIVE BEHAVIORAL INTERVENTIONS SERVICES ARE NOW COMBINED WITH BEHAVIORAL SUPPORT SERVICES. REFER TO ALL SPECIFICATIONS IN THE BEHAVIORAL SUPPORT SERVICES SERVICE.

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

Activities Not Allowed:

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

AS OF THE CIH IN.0378 FIRST AMENDMENT EFFECTIVE 12.31.2025, INTENSIVE BEHAVIORAL INTERVENTIONS SERVICES ARE NOW COMBINED WITH BEHAVIORAL SUPPORT SERVICES. REFER TO ALL SPECIFICATIONS IN THE BEHAVIORAL SUPPORT SERVICES SERVICE.

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed
- ☐ Remote/via Telehealth

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	FSSA/DDRS Approved Intensive Behavioral Intervention - Individual
Agency	FSSA/DDRS Approved Intensive Behavioral Intervention Agency

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Intensive Behavioral Intervention (Terminated as of 12/30/2025)****Provider Category:**

Individual

Provider Type:

FSSA/DDRS Approved Intensive Behavioral Intervention - Individual

Provider Qualifications**License (specify):**

For IBI Director:

Psychologist licensed under IC 25-33, or

Psychiatrist Licensed under IC 25-22.5

Certificate (specify):

For IBI Case Supervisor:

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

Other Standard (specify):

Enrolled as an active Medicaid provider

Must be FSSA/DDRS-approved

Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:

460 IAC 6-10-5 Documentation of Criminal Histories,

460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance,

460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers,

460 IAC 6-14-5 Requirements for Direct Care Staff,

460 IAC 6-14-4 Training

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

Verification of Provider Qualifications**Entity Responsible for Verification:**

BDS

Frequency of Verification:

Up to 3 years.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Intensive Behavioral Intervention (Terminated as of 12/30/2025)**

Provider Category:

Agency

Provider Type:

FSSA/DDRS Approved Intensive Behavioral Intervention Agency

Provider Qualifications**License (specify):**

For IBI Director:

Psychologist licensed under IC 25-33, or

Psychiatrist licensed under IC 25-22.5

Certificate (specify):

For IBI Case Supervisor:

IBI Case Supervisor must be BCBA or BCABA certified

Other Standard (specify):

Enrolled as an active Medicaid provider

Must be FSSA/DDRS-approved

Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:

460 IAC 6-10-5 Documentation of Criminal Histories,

460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance,

460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers,

460 IAC 6-14-5 Requirements for Direct Care Staff,

460 IAC 6-14-4 Training

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

Verification of Provider Qualifications**Entity Responsible for Verification:**

BDS

Frequency of Verification:

Up to 3 years.

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:

Other Service

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

Service Title:

Music Therapy

HCBS Taxonomy:

Category 1:

11 Other Health and Therapeutic Services

Sub-Category 1:

11130 other therapies

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:****Service Definition (Scope):**

Music therapy is service provided for the systematic application of musical interventions in the treatment of the physiological and psychosocial aspects of an individual's disability and focusing on the acquisition, maintenance or improvement of nonmusical skills and behaviors necessary for the individual's independence, community participation, and/or overall well-being.

REIMBURSABLE ACTIVITIES:

- Therapy to improve:
 - Self-image and body awareness
 - Fine and gross motor skills
 - Auditory perception
- Therapy to increase:
 - Communication skills
 - Ability to use energy purposefully
 - Interaction with peers and others
 - Attending behavior -Independence and self-direction
- Therapy to prevent or reduce the likelihood of certain behaviors that interrupt or interfere with the 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 delivery of one-on-one direct therapeutic interventions with the individual.

SERVICE STANDARDS

- Music Therapy must be included on the individual's PCISP
- Music Therapy must address needs identified in the person-centered planning process and must be delivered in accordance with an individualized plan of care that identifies musical interventions tied to measurable therapeutic outcomes.
- Music therapy providers must routinely evaluate the individual's response to the musical interventions and modify the plan of care to ensure continued progress toward identified therapeutic outcomes.
- One (1) hour of billed therapy service must include a minimum of forty-five (45) minutes of direct therapeutic interventions with the balance of the hour spent in related patient services.
- To determine if the 45/15-minute rule is met, the BDS looks to ensure that units were billed accurately and supported with documentation and that the number of direct units billed exceeds the number of indirect units reflecting a general ratio of 75% direct units billed to 25% indirect units billed. The 75/25 ratio determination may occur through each encounter or over a period of time.
- Music Therapy services are provided as individual services or group services. Group services in group sizes no greater than four (4) waiver participants to one (1) Music Therapist (Unit rate divided by number of Music Therapy waiver participants served).
- Music therapy providers must not bill music therapy services for any period of time in which the provider is solely transporting the individual. Providers who wish to furnish transportation may enroll separately as an authorized Medicaid transportation provider. When enrolled, transportation may be billed only under the applicable transportation service and

must comply with all provider qualifications, documentation standards, and billing requirements.

DOCUMENTATION STANDARDS

Provider must maintain all applicable documentation required under 460 IAC 6 Supported Living Services and Supports and the FSSA/DDARS BDS policies and the FSSA/DDARS HCBS Waivers module on the IHCP Provider Reference Materials webpage. Additionally, the provider must comply with the following standards:

- The provider must document the following data elements for each uninterrupted period of services rendered:
 - Name of individual served
 - IHCP Member ID (RID) of the individual served
 - Service rendered
 - Date of service (include month, day and year)
 - Time frame of service (include start time, end time and a.m./p.m.)
 - Name of person providing service (if the person providing the service is required to be a professional, their title must also be included)
 - Primary location of service delivery
 - A summary of services rendered (including specific reimbursable activities that were performed and the outcomes realized from those activities) noting Indirect/Direct service delivery.
- Each quarter (or more often as determined by the IST), the service provider must prepare and upload a progress 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 reporting period. Quarterly reports must be completed on state approved templates. The first reporting period must align with the start of the service. Failure to timely complete and upload each quarterly report may result in a citation.
- Documentation must include progress toward therapeutic outcomes and any changes or modifications to the plan of care.
- The documentation may reside in multiple locations but must be clearly and easily linked to the individual or the standard will not be met.
- Upon request, all documentation must be made available to auditors, quality monitors, case managers and any other government entity within any/all timeframes specified by BDS.

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

Music Therapy services are limited to a maximum of six (6) hours per month. To continue to assure the health and welfare of impacted individuals, the case manager will work with the individual and their IST during the person-centered planning process to identify alternate supports available to the individual if the six (6) hours per month limit is reached. Alternate supports may include other services available through the waiver for which they are eligible, alternatives for therapy services available through the Medicaid state plan, and/or natural supports.

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.

Music Therapy will not be reimbursed when provided by the parent of a minor child participant or the spouse of a participant (also known as a Legally Responsible Individual), Relative, or Legal Guardian as outlined in Appendix C-2-d and Appendix C-2-e of this waiver.

ACTIVITIES NOT ALLOWED

- 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 needed for the provision of Music Therapy Services should be purchased under "Specialized Medical Equipment and Supplies."
- Music therapy services delivered in a nursing facility.
- Music therapy services billed while solely transporting individuals.

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed
- ☐ Remote/via Telehealth

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

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency that Employs FSSA/DDARS Approved Music Therapist

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Music Therapy

Provider Category:

Agency

Provider Type:

Agency that Employs FSSA/DDARS Approved Music Therapist

Provider Qualifications

License (specify):

Certificate (specify):

Certified Music Therapist by a Certification Board for Music Therapists that is Accredited by a National Commission for Certifying Agencies.

Other Standard (specify):

- Enrolled as an active Medicaid provider
- Must be FSSA/DDARS (or its designee) approved
- Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
 - 460 IAC 6-10-5 Documentation of Criminal Histories,
 - 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance,
 - 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers,
 - 460 IAC 6-5-15 Music Therapy Services Provider Qualifications
- Must comply with any applicable FSSA/BDS service standards, guidelines, policies and/or manuals, including FSSA/DDARS BDS policies and the FSSA/DDARS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

Verification of Provider Qualifications

Entity Responsible for Verification:

BDS

Frequency of Verification:

Up to 3 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

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

Service Title:

HCBS Taxonomy:
Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Personal Emergency Response System (PERS) is an electronic device that enables individuals to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed 24 hours daily/ 7 days per week by trained professionals.

REIMBURSABLE ACTIVITIES:

- Device installation service.
- Ongoing monthly maintenance of device.

SERVICE STANDARDS

- PERS must be included on the individual's service plan
- PERS must address needs identified in the person-centered planning process
- The monitor positions must be determined during the person-centered service planning process. Remote monitors will not be placed in bedrooms or bathrooms.
- The persons responsible for monitoring must be determined during the person-centered service planning process including the provider.
- The mainframe location must be determined by the provider.
- A back-up plan must be in place in the event of equipment failure.
- Compliance with applicable building codes and permits

DOCUMENTATION STANDARDS

Provider must maintain all applicable documentation required under 460 IAC 6 Supported Living Services and Supports and the FSSA/DDARS BDS policies and the FSSA/DDARS HCBS Waivers module on the IHCP Provider Reference Materials webpage. Additionally, the provider must comply with the following standards:

- The provider must document the following data elements for services rendered:
 - Name of individual served
 - IHCP Member ID (RID) of the individual served
 - Service rendered
 - Date of installation.
 - Expense for installation.
 - Monthly rental fee.
 - Ongoing monthly maintenance of device.
- Each month, the PERS provider must prepare and provide written notification to case managers of any individual who experienced a fall within a one-month timeframe.
- The documentation may reside in multiple locations but must be clearly and easily linked to the individual or the standard will not be met.
- Upon request, all documentation must be made available to auditors, quality monitors, case managers and any other government entity within any/all timeframes specified by BDS.

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

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 support.

PERS will not be reimbursed when provided by the parent of a minor child participant or the spouse of a participant (also known as a Legally Responsible Individual), Relative, or Legal Guardian as outlined in Appendix C-2-d and Appendix C-2-e of this waiver.

ACTIVITIES NOT ALLOWED

- Replacement cost of lost or damaged equipment
- Reimbursement for PERS when the individual requires constant support to maintain health and safety.

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed
- ☐ Remote/via Telehealth

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

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/DDARS Approved Personal Emergency Response System Agencies

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Personal Emergency Response System

Provider Category:

Agency

Provider Type:

FSSA/DDARS Approved Personal Emergency Response System Agencies

Provider Qualifications**License (specify):****Certificate (specify):****Other Standard (specify):**

- Enrolled as an active Medicaid provider
- Must be FSSA/DDARS (or its designee) approved
- Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
 - 460 IAC 6-10-5 Documentation of Criminal Histories,
 - 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance,
 - 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers,
 - 460 IAC 6-5-18 Personal Emergency Response System Supports Provider Qualifications
- Must comply with any applicable FSSA/BDS service standards, guidelines, policies and/or manuals, including FSSA/DDARS BDS policies and the FSSA/DDARS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

Verification of Provider Qualifications**Entity Responsible for Verification:**

BDS

Frequency of Verification:

Up to 3 years.

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:

Other Service

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

Service Title:

Recreational Therapy

HCBS Taxonomy:**Category 1:**

11 Other Health and Therapeutic Services

Sub-Category 1:

11130 other therapies

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Recreational therapy services are medically approved recreational interventions used to restore, remediate, or rehabilitate an individual in order to:

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

REIMBURSABLE ACTIVITIES:

- Organizing and directing adapted sports, dramatics, arts and crafts, social activities, and other recreation services designed to restore, remediate or rehabilitate.
- Planning, reporting and write-up when in association with the delivery of one-on-one direct therapeutic interventions with the individual.

SERVICE STANDARDS

- Recreational Therapy must be included on the individual's PCISP
- Recreational Therapy must address needs identified in the person-centered planning process and must be delivered in accordance with an individualized plan of care that identifies recreational interventions tied to measurable therapeutic outcomes.
- Recreational therapy providers must routinely evaluate the individual's response to the recreational interventions and modify the plan of care to ensure continued progress toward identified therapeutic outcomes.
- One (1) hour of billed therapy service must include a minimum of forty-five (45) minutes of direct therapeutic interventions with the balance of the hour spent in related patient services.
- To determine if the 45/15-minute rule is met, the BDS looks to ensure that units were billed accurately and supported with documentation and that the number of direct units billed exceeds the number of indirect units reflecting a general ratio of 75% direct units billed to 25% indirect units billed. The 75/25 ratio determination may occur through each encounter or over a period of time.
- Recreational Therapy services are provided as individual services or group services. Group services in group sizes no greater than four (4) waiver participants to one (1) Recreational Therapist (Unit rate divided by number of Recreational Therapy waiver participants served).
- Recreational therapy providers must not bill recreational therapy services for any period of time in which the provider is solely transporting the individual. Providers who wish to furnish transportation may enroll separately as an authorized Medicaid transportation provider. When enrolled, transportation may be billed only under the applicable transportation service and must comply with all provider qualifications, documentation standards, and billing requirements.

DOCUMENTATION STANDARDS

Provider must maintain all applicable documentation required under 460 IAC 6 Supported Living Services and Supports and the FSSA/DDARS BDS policies and the FSSA/DDARS HCBS Waivers module on the IHCP Provider Reference Materials webpage. Additionally, the provider must comply with the following standards:

- The provider must document the following data elements for each uninterrupted period of services rendered:
 - Name of individual served
 - IHCP Member ID (RID) of the individual served
 - Service rendered
 - Date of service (include month, day and year)

- Time frame of service (include start time, end time and a.m./p.m.)
- Name of person providing service (if the person providing the service is required to be a professional, their title must also be included)
- Primary location of service delivery
- A summary of services rendered (including specific reimbursable activities that were performed and the outcomes realized from those activities) noting Indirect/Direct service delivery.

- Each quarter (or more often as determined by the IST), the service provider must prepare and upload a progress 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 reporting period. Quarterly reports must be completed on state approved templates. The first reporting period must align with the start of the service. Failure to timely complete and upload each quarterly report may result in a citation.

- Documentation must include progress toward therapeutic outcomes and any changes or modifications to the plan of care.

- The documentation may reside in multiple locations but must be clearly and easily linked to the individual or the standard will not be met.

- Upon request, all documentation must be made available to auditors, quality monitors, case managers and any other government entity within any/all timeframes specified by BDS.

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

Recreational Therapy services are limited to a maximum of six (6) hours per month. To continue to assure the health and welfare of impacted individuals, the case manager will work with the individual and their support team during the person-centered planning process to identify alternate supports available to the individual if the six (6) hours per month limit is reached. Alternate supports may include other services available through the waiver for which they are eligible, alternatives for therapy services available through the Medicaid state plan, and/or natural supports.

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

Recreational Therapy will not be reimbursed when provided by the parent of a minor child participant or the spouse of a participant (also known as a Legally Responsible Individual), Relative, or Legal Guardian as outlined in Appendix C-2-d and Appendix C-2-e of this waiver.

ACTIVITIES NOT ALLOWED

- Payment for the cost of the recreational activities, registrations, memberships or admission fees associated with the activities being planned, organized or directed.
- Any services that are reimbursable through the Medicaid State plan.
- Therapy services furnished to the individual within the educational/school setting or as a component of the individual's school day.
- Recreational Therapy delivered in a nursing facility.
- Recreational therapy services billed while solely transporting individuals.

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed
- ☐ Remote/via Telehealth

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

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/DDARS Approved Agency that Employs Approved Recreational Therapists

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Recreational Therapy

Provider Category:

Agency

Provider Type:

FSSA/DDARS Approved Agency that Employs Approved Recreational Therapists

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

- Enrolled as an active Medicaid provider
- Must be FSSA/DDARS (or its designee) approved
- Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
 - 460 IAC 6-10-5 Documentation of Criminal Histories,
 - 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance,
 - 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers,
 - 460 IAC 6-5-22 Recreational Therapy Services Provider Qualifications
- Must comply with any applicable FSSA/BDS service standards, guidelines, policies and/or manuals, including FSSA/DDARS BDS policies and the FSSA/DDARS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

Verification of Provider Qualifications

Entity Responsible for Verification:

BDS

Frequency of Verification:

Up to 3 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Remote Supports

HCBS Taxonomy:**Category 1:**

08 Home-Based Services

Sub-Category 1:

08010 home-based habilitation

Category 2:

17 Other Services

Sub-Category 2:

17990 other

Category 3:**Sub-Category 3:****Category 4:****Sub-Category 4:****Service Definition (Scope):**

Remote supports includes a wide range of technology-based services that allows for delivery of supports to an individual in their home and/or community designed to promote independence in the least-restrictive environment and promotes skill acquisition. Remote supports allows an individual to live in their home without the intrusive presence of an in-person caregiver; or at least a reduction in hours an in-person caregiver would provide. 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. This support not only allows the individual to be more independent and have increased autonomy, but directly supports community integration, rather than institutionalization, since the participant receives their needed supports in their chosen community and in a person-centered way.

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 will allow an individual more autonomy to move around their living space without the presence of someone right beside them, often doing things for them. Individuals will be given the opportunity to complete tasks on their own and have the ability to ask for help, if and when they need it. 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 that is both the primary point of contact for the Remote Support vendor and the entity to send paid staff person(s) on-site when needed. Unpaid backup support may be provided by a family member, friend, or other person who the individual chooses.

Radio frequency identification (RFID) is a wireless system that uses tags and readers. Information is passed between a tag and the reader through radio waves at different frequencies. For use in remote support, this would look like out of bed detection/fall detection, monitoring the individual (through sensors) and equipment tracking. Remote Support is intended to be a less-intrusive way of supporting an individual in their home. Live audio feed is referring to client or provider-initiated video calls. The client can initiate a video call anytime with their remote support provider, and the provider can initiate a video call if they have not heard from the client or monitoring data suggests there is a problem. Calls initiated by the provider must be answered by the client- the provider cannot just turn on the video call. If the client chooses to include video monitoring in their remote support plan, they can turn the camera on or off at any time.

Providers engage with an individual through technology equipment with the capability for live two-way communication. Based on the person-centered plan and client choice, there may be consistent monitoring through the use of non-video sensors that can capture movement and baseline movements. Equipment used to meet this requirement shall include one or more of the following components:

1. Motion-sensing system
2. Radio frequency identification
3. Video calling via assistive technology
4. Live audio feed
5. Web-based monitoring systems

All necessary equipment to deliver Remote Supports is the responsibility of the Remote Supports provider and that the cost for this equipment is built into the rate for Remote Supports. Any technology equipment that must be purchased separately would be the property of the individual. Need for service is based on the person-centered planning process and requested by the waiver participant.

REIMBURSABLE ACTIVITIES:

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

SERVICE STANDARDS

- Remote Supports must be included on the individual's PCISP that must reflect how the remote supports are being used to meet the individual's needs, vision for their good life, and health and welfare needs. The PCISP should also reflect how many hours/days per week and individual will receive this support as well as an identified back up plan.
- Remote Supports must address needs identified in the person-centered planning process
- The provider delivering services remotely will be responsible for using an approved delivery platform that the individual is able and willing to use and will provide basic technical assistance as necessary during their service delivery (device on and off, volume control, etc.).
- 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 location
- Remote Supports services are provided as individual services or group services
- The unit rate for each hour of remote supports service utilization shall be divided by and among the number of waiver participants present in the home during any portion of the hour for which reimbursement is requested. Dividing the unit rate by and among waiver individuals applies only to individuals for whom remote supports are included on the plan.
- 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 person-centered individualized support plan 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. Use of the system may be restricted to certain hours.
 - 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 DDARS/BDS office, the guardian (if applicable), and in the home file. If the individual desires to withdraw consent, he or she would notify the case manager. As informed consent is a prerequisite for utilization of remote supports services, a meeting of the IST would be needed to discuss available options for any necessary alternate supports. All residing adult and youth participants, their guardians and their support teams impacted by the decision to withdraw consent must be immediately informed of the decision and use of remote supports in the setting must be discontinued. PCISPs should reflect how individuals want to inform visitors of the use of remote supports in the setting if video monitoring is being utilized under this service. Use of the system may be restricted to certain hours through the PCISPs of the individuals involved.
 - 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.

Back-up safeguards are required when used 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.
- 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 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's need. Remote Supports may be provided independently of Residential Habilitation Services (RHS) ; however, when an individual receives both services, the respective providers may need to establish a formal agreement to ensure coordination of services; particularly if the RHS provider is required to deliver the backup staff coverage. Responsibilities of each shall also be clarified in the PCISP.

CONTINUED IN MAIN-B (OPTIONAL) SECTION

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

Remote Supports will not be reimbursed when provided by the parent of a minor child participant or the spouse of a participant (also known as a Legally Responsible Individual), Relative, or Legal Guardian as outlined in Appendix C-2-d and Appendix C-2-e of this waiver.

ACTIVITIES NOT ALLOWED:

- Remote supports may not be used concurrently with structured family caregiving service or in the structured family caregiving home.
- Remote supports systems may not be used to monitor direct care staff.
- Remote Supports may not be a replacement for residential habilitation and support (RHS) Level 1 and Level 2 services; therefore, 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.
- Remote supports systems may not be used in ICFs/IID licensed under IC 16-28 and 410 IAC 16.2.
- Remote supports systems used in place of in-home staff.
- Cameras are not permitted in bathrooms or bedrooms unless there are clear permissions from the individual, the ability for the individual to turn off the camera if they choose and/or would like privacy. The use of the cameras should be clearly outlined in the PCISP and have the appropriate Human Rights Committee approval that is in compliance with the HCBS Settings Rule.
- Remote Support cannot pay for internet, data plans, or Wi-Fi access separately. If internet is included as a component of the remote support technology, it may be included in the rate for the remote support service.
- Remote Support is limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.
- Remote Supports must never be used to restrict a person from and in their home, community, or body autonomy.
- Services under this waiver are intended to supplement, and not supplant, the child welfare services and supports a child or youth is entitled to from the Department of Children, Youth, and Families (DCYF) or from Title IV-E of the Social Security Act or from other sources.

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed
- ☐ Remote/via Telehealth

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

☐ Legally Responsible Person

☐ Relative

☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/DDARS Approved Remote Support

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Remote Supports

Provider Category:

Agency

Provider Type:

FSSA/DDARS Approved Remote Support

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

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

- Be an entity approved by FSSA/DDARS/BDS (or its designee) to provide remote supports services
- Assure that the system must be monitored by a staff person trained and oriented to the specific needs of each individual served as outlined in his or her PCISP.
- Assure that the paid support staff meet the qualifications for direct support professionals as set out in DDARS BDS policy on requirements and training for direct support professional staff.
- If the backup support is unpaid, natural supports such as family, a guardian or a person the individual chooses; the need for backup support to meet qualifications for direct support professionals would not be applicable.
- Assure that the individual, family, guardian, team, and backup provider, if applicable, are trained on the use of Remote Supports equipment.
- Enrolled as an active Medicaid provider
- Must be FSSA/DDARS-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/BDS service standards, guidelines, policies and/or manuals, including FSSA/DDARS BDS policies and the FSSA/DDARS HCBS Waivers module on the IHCP Provider Reference Materials webpage.
- To ensure safety and HIPAA compliance, the provider of remote support services must comply with all state privacy, security, and electric data interchange regulations and have appropriate, stable, and redundant connections. This should include, but is not limited to, backup generators, multiple internet service connections, battery backups, etc.
- All direct care staff must be registered with DDARS and must complete required competency-based training in accordance with IC 12-11-16.

Verification of Provider Qualifications

Entity Responsible for Verification:

07/24/2026

BDS

Frequency of Verification:

Up to 3 years.

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:

Other Service

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

Service Title:

Residential Habilitation and Support - Daily (RHS Daily)

HCBS Taxonomy:**Category 1:**

02 Round-the-Clock Services

Sub-Category 1:

02031 in-home residential habilitation

Category 2:

08 Home-Based Services

Sub-Category 2:

08010 home-based habilitation

Category 3:**Sub-Category 3:****Category 4:****Sub-Category 4:****Service Definition (Scope):**

Residential habilitation and support - daily (RHS daily) services means 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 his or her own home.

Note: Own home is defined as any living arrangement where the individual has control over their residence - including through ownership, rental, or a legally enforceable lease-and enjoys the same rights and responsibilities as anyone else living in the community.

RHS Daily services are not appropriate for individuals who:

- Have been assigned an ALGO score of 0,1, or 2 on their Objective Based Allocation (OBA); or
- Have been assigned an ALGO score of 3, 4, or 5 on their Objective Based Allocation (OBA) and who are not utilizing a

shared staffing model or who are living in their family home.

Individuals meeting these criteria will be referred to Residential habilitation and support - hourly (RHS Hourly) services.

SERVICE LEVELS

RHS (Daily) services provide services and/or supports for individuals assigned an ALGO score of 3, 4, or 5 on their Objective Based Allocation (OBA) and who are living with housemates utilizing a shared staffing model and living outside their family home.

The Algo scores and descriptors appear in 460 IAC 13-5-1 Algo levels

The nationally recognized Inventory for Client and Agency Planning or ICAP was selected to be the primary tool for participant assessment.

The ICAP assessment determines a participant'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 a participant's overall Algo score, which can range from 0-5. Participants with Algo scores between 0 and 5 are considered outliers representing those who are the lowest and the highest on both ends of the functioning spectrum.

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 score (determined by the ICAP and ICAP addendum), age, employment, and living arrangement.

REIMBURSABLE ACTIVITIES

- Direct support, assistance, monitoring, modeling and coaching training to implement the PCISP outcomes for the individual
- Assistance with acquiring, enhancing and building natural supports to decrease reliance on paid staff and increase individual's independence
- Working with the individual to meet the goals they have set for themselves on their PCISP.
- Assistance to support the individual in the process of completing tasks such as personal care, meals, shopping, errands, household and leisure activities, money management, communication skills, social skills and positive behavior
- Coordination and facilitation of medical and nonmedical services to meet healthcare needs, including physician consults, medications, development and oversight of a health plan, implementation of risk plans and wellness plans, and maintenance of each individual's health record
- Transporting the individual to participate in community activities, when individual does not need assistance/support during any such activity.
- Ensuring that direct service staff are aware of and actively implementing the individuals PCISP, behavioral support plans and risk plans.

**When wellness coordination services are utilized in addition to RHS services, the Wellness Coordinator who must be an RN/LPN 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

- RHS (Daily) must be included on the individual's PCISP. Staffing levels should not be dictated by the individual's algo score. Instead, staffing must be individualized and based on the person's goals, preferences, and support needs as outlined in the Person-Centered Individualized Support Plan (PCISP). Providers are responsible for ensuring that staffing arrangements reflect the supports necessary to implement the PCISP and promote health, safety, and community integration.
- RHS (Daily) must address needs identified in the person-centered planning process. Reimbursement of RHS (Daily) assumes an average of 8 hours a day per person of support.
- 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.
- 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.
- The RHS (Daily) provider shall fully comply with the federal HCBS Settings Rule and shall not impose any restriction on an individual's rights or freedoms unless the restriction meets all required criteria, is justified through a person-centered planning process, has received Human Rights Committee (HRC) approval, and includes documented informed consent from the individual and their legal representative.
- All residential providers shall comply with all policies, procedures, and directives issued by the Bureau of Disabilities Services (BDS) related to transitions in residential services. This includes, but is not limited to, timely coordination with case managers, accurate documentation of transition activities, adherence to person-centered planning principles, and submission of required forms and notifications. Providers must ensure that transitions are conducted in a manner that safeguards the individual's health, safety, rights, and continuity of care and are also in compliance with the HCBS Settings Rule. Additionally, BDS is placement authority, and no transition shall occur without BDS written approval. Failure to receive BDS approval prior to an individual transitioning may result in suspension of all admissions to all residential sites managed by the provider.

DOCUMENTATION STANDARDS

Provider must maintain all applicable documentation required under 460 IAC 6 Supported Living Services and Supports and the FSSA/DDARS BDS policies and the FSSA/DDARS HCBS Waivers module on the IHCP Provider Reference Materials webpage. Additionally, the provider must comply with the following standards:

- The provider must document the following data elements for each uninterrupted period of services rendered:
 - Name of individual served
 - IHCP Member ID (RID) of the individual served
 - Service rendered
 - Date of service (include month, day and year)
 - Time frame of service (include start time, end time and a.m./p.m.)
 - Name of person providing service (if the person providing the service is required to be a professional, their title must also be included)
 - Primary location of service delivery
 - Signature of person providing the service that must at least include the person's last name and first initial. (Electronic signatures are permissible when in compliance with the Uniform Electronic Transactions Act [IC 26-2-8])
- Each staff member providing direct care or supervision of care to the individual must make at least one entry for each uninterrupted period of services rendered. All entries should describe an issue or circumstance concerning the individual.
- Each quarter (or more often as determined by the IST), the service provider must prepare and upload a progress 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 reporting period. Quarterly reports must be completed on state approved templates. The first reporting period must align with the start of the service. Failure to timely complete and upload each quarterly report may result in a citation. Quarterly reports are not required when services are self-directed.
- The documentation may reside in multiple locations but must be clearly and easily linked to the individual or the standard will not be met.

• Upon request, all documentation must be made available to auditors, quality monitors, case managers and any other government entity within any/all timeframes specified by BDS.

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

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. Sleep staff is not allowed under any circumstances.

Providers will not be reimbursed separately for remote support services for individuals receiving RHS daily services. Remote support is built into the daily of RHS daily services. Providers must adhere to all remote support service standards as defined within the remote support service definition.

RHS (Daily) will not be reimbursed when provided by the parent of a minor child participant or the spouse of a participant (also known as a Legally Responsible Individual) as outlined in Appendix C-2-d of this waiver.

RHS (Daily) will be reimbursed when provided by a Relative or a Legal Guardian, ONLY when all conditions specified in Appendix C-2-e of this waiver are met.

As a non-entitlement home- and community-based Medicaid waiver, children ages 3 through 22, must first utilize entitlement programs including but not limited to: Medicaid and the Early Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, and free appropriate public education (FAPE) programs and resources available through a child's school as mandated by the Individuals with Disabilities Education Act (IDEA). Payment for duplicated services is prohibited.

ACTIVITIES NOT ALLOWED

- Services to individuals receiving Rent and Food for Unrelated Caregiver, Structured Family Caregiving services.
- Transportation and any other services that are available under the Medicaid State plan.

NOTE: Per Indiana Code [IC 12-11-1.1], supported living service arrangements providing residential services may not serve more than four (4) unrelated waiver participants 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) waiver participants 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 waiver participants in the supported living setting.

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed
- ☐ Remote/via Telehealth

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/DDARS Approved RHS Agencies

Appendix C: Participant Services

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

Service Type: Other Service

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

Provider Category:

Agency

Provider Type:

FSSA/DDARS Approved RHS Agencies

Provider Qualifications**License (specify):****Certificate (specify):****Other Standard (specify):**

- Enrolled as an active Medicaid provider
- Must be FSSA/DDARS (or its designee) approved
- Must 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 Health Care Coordination Services Provider Qualifications,
 - 460 IAC 6-14-4 Training,
 - 460 IAC 6-5-30 Transportation Services Provider Qualifications, and
 - 460 IAC 6-5-31 Transportation Supports Provider Qualifications.
- Must comply with any applicable FSSA/BDS service standards, guidelines, policies and/or manuals, including FSSA/DDARS BDS policies and the FSSA/DDARS HCBS Waivers module on the IHCP Provider Reference Materials webpage.
- Must obtain/maintain accreditation (specific to Indiana programs) by at least one (1) of the following organizations:
 - 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 ISO-9001 human services QA system.
 - The Council on Accreditation, or its successor.
 - An independent national accreditation organization approved by the secretary.
- All direct care staff must be registered with DDARS and must complete required competency-based training in accordance with IC 12-11-16.

Verification of Provider Qualifications**Entity Responsible for Verification:**

BDS

Frequency of Verification:

Up to 3 years.

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:

Other Service

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

in statute.

Service Title:

Specialized Medical Equipment and Supplies

HCBS Taxonomy:

Category 1:

14 Equipment, Technology, and Modifications

Sub-Category 1:

14031 equipment and technology

Category 2:

17 Other Services

Sub-Category 2:

17020 interpreter

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

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's functional limitations.

Professional Evaluation Requirements

- Any individual item expected to cost 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. The evaluation should be signed by the qualified professional and include medical necessity, how the item meets a specific need for the individual, how it assists with any defined goals for the individual, and what device or supply specification is recommended.

Bid Requirements

- At least two (2) bids must be obtained for any individual item expected to exceed \$1,000.00. Bids must be the most cost effective or conservative means to meet the individual's specific needs.
- If only one bid is obtained the case manager must document the date of contact, the provider name, and why the bid was not obtained from that provider.
- Each bid must be itemized and include:
 - Picture of equipment; and
 - Written warranty for new products.
- The Provider warrants that any bid, invoice, or charge submitted for specialized medical equipment and supplies delivered under this agreement will not include a markup in excess of thirty percent (30%) above the Provider's documented acquisition cost. Acquisition cost is defined as the Provider's actual paid cost for the item, including shipping and handling, less any discounts, rebates, or allowances received.
- Additional fees are not allowed and will not be approved.

Prior Request for Approval to Authorize Services Requirements

- All Specialized Medical Equipment and Supplies must be approved by the Bureau of Disabilities Services (BDS) or its designee prior to the service being rendered.
- Requests for Specialized Medical Equipment and Supplies may be partially approved or denied in their entirety if the BDS director or its designee determines that:
 - Requestor did not first exhaust eligibility of the desired equipment or supplies through Indiana Medicaid State Plan,

which may require Prior Authorization (PA); or

- The request for Specialized Medical Equipment and Supplies did not include documentation of Indiana Medicaid State Plan Prior Authorization (PA) request and denial decision and reason for denial, if requested item is covered under State Plan; or

- Requested Specialized Medical Equipment and Supplies duplicate equipment or supplies covered under the Indiana Medicaid State Plan; or

- Specialized Medical Equipment and Supplies are being requested because a Medicaid vendor refused to accept the Medicaid reimbursement through the Medicaid State Plan; or

- Specialized Medical Equipment and Supplies are being requested because requestor prefers a specific brand name but the Indiana Medicaid State Plan covers like equipment but does not cover the specific brand requested (When this occurs, the individual is limited to the Medicaid State Plan covered service/brand); or

- The provider claim did not follow the correct Medicaid billing practices.

- Requests for Specialized Medical Equipment and Supplies may be partially approved or denied in their entirety if the BDS director or its designee determines the documentation does not support the service requested

REIMBURSABLE ACTIVITIES:

- Self-help devices - including over the bed tables, reachers, adaptive plates, bowls, cups, drinking glasses, eating utensils, scissors, and writing devices.

- Voice activated smart devices.

- Lift chairs-The HCBS program will cover the chair. State Plan should be pursued first for prior approval of the lift mechanism.

- 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.

- Manual wheelchairs - when required to facilitate safe mobility.

- Posture chairs, feeding chairs, sensory rocking chairs - As prescribed by physician, occupational therapist or physical therapist.

- Portable air purifiers and portable generators.

- Medication Dispensers.

- Toileting and/or incontinence supplies that do not duplicate State Plan Services.

- Slip resistant socks, adaptive or compression clothing.

- Weighted or compression items.

- Adaptive equipment and supplies to promote independence or accessibility.

- GPS tracking and seizure detection devices when the individual has supporting documentation showing the need.

- Communication devices.

- Non-Bluetooth noise cancelling headphones.

- 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.

- Items necessary for life support, and ancillary supplies and equipment needed for the proper functioning of such items.

- Durable medical equipment not available under Indiana Medicaid State Plan that is necessary to address the individual's functional limitations.

- Nondurable medical equipment not available under Indiana Medicaid State Plan that is necessary to address the individual's functional limitations.

- Maintenance and repair of the items provided through a HCBS waiver

- Items requested which are not listed above, will be submitted in the service plan /RFA and will be reviewed and approved by the State BDS Director or its designee, if the request meets the individual's need.

SERVICE STANDARDS

- Specialized Medical Equipment and Supplies must be included on the individual's service plan and authorized on the Request for Approval (RFA) form and linked to the individual's service plan.

- Specialized Medical Equipment and Supplies must address needs identified in the person-centered planning process and must be of direct medical or remedial benefit to the individual. The service plan must also describe the how the equipment is expected to improve the individual's quality of life.

- All items shall meet applicable standards of manufacture, design, and service specifications.

DOCUMENTATION STANDARDS

Provider must maintain all applicable documentation required under 460 IAC 6 Supported Living Services and Supports and the FSSA/DDARS BDS policies and the FSSA/DDARS HCBS Waivers module on the IHCP Provider Reference Materials webpage. Additionally, the provider must comply with the following standards:

- The provider must document the following data elements for services rendered:
 - Name of individual served
 - IHCP Member ID (RID) of the individual served
 - Service rendered
 - Date of installation (include month, day and year)
- State-approved and signed Service Authorization/NOA
- Provider responsible for maintaining receipts for all expenditures, showing the amount and what item(s) were supplied; must be in compliance with FSSA and Division specific guidelines and/or policies.
- The documentation may reside in multiple locations but must be clearly and easily linked to the individual or the standard will not be met.
- Upon request, all documentation must be made available to auditors, quality monitors, case managers and any other government entity within any/all timeframes specified by BDS.

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

Up to \$1,000.00 is allowable per plan year for the maintenance and repair of previously obtained specialized medical equipment that was funded by a Home and Community Based Services (HCBS) waiver. Requests for maintenance/repair services must detail cost of part(s) and cost of labor. If the need for maintenance/repair services exceeds \$1,000.00, the case manager will work with other available funding streams and community agencies to fulfill the need. If maintenance/repair service costs exceed the annual limit, those parts and labor costs funded through the waiver must be itemized clearly to differentiate the waiver service provision from those parts and labor provided through a non-waiver funding source.

If the requested Specialized Medical Equipment or supplies are covered under Medicaid State Plan, the reimbursement amount is limited to the Medicaid State Plan fee schedule.

The services under specialized medical equipment and supplies are limited to additional services not otherwise covered under the Indiana Medicaid State Plan, including Early and Periodic Screening, Diagnosis and Treatment (EPSDT), but consistent with waiver objectives of avoiding institutionalization.

Specialized Medical Equipment and Supplies will not be reimbursed when provided by the parent of a minor child participant or the spouse of a participant (also known as a Legally Responsible Individual), Relative, or Legal Guardian as outlined in Appendix C-2-d and Appendix C-2-e of this waiver.

ACTIVITIES/ITEMS NOT ALLOWED

- Unallowable items include the following:
 - hospital beds, air fluidized suspension mattresses/beds;
 - therapy mats;
 - scales;
 - paraffin machines or baths;
 - therapy balls;
 - books, games, toys;
 - electronics - such as televisions, iPads, cell phones, bluetooth headphones, projectors, white noise machines, LED lights, computers and software, tech hubs for cubby beds, food processors, and other similar items;
 - furniture such as standard recliners, couches, entertainment center, inflatable furniture, beanbag chairs;
 - 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;
 - gymnastics equipment, exercise equipment, wagons
 - swimming pools, spas, hot tubs, portable whirlpool pumps;
 - mattresses (such as, but not limited to, Tempur-Pedic), positioning devices, pillows;

- motorized scooters;
- barrier creams, lotions, personal cleaning cloths;
- essential oils
- totally enclosed cribs and barred enclosures used for restraint purposes;
- car seats and standard high chairs
- standard clothing items
- Equipment and services available through Medicaid State Plan (a Medicaid State Plan prior authorization denial is required before reimbursement is available through the Medicaid waiver for this service).
- Equipment and services that are not of direct medical or remedial benefit to the individual.
- Any equipment or items purchased or obtained by the individual, their family members, or other non- waiver providers.

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed
- ☐ Remote/via Telehealth

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

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/DDARS approved Specialized Medical Equipment and Supplies Agency

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type:** Other Service**Service Name:** Specialized Medical Equipment and Supplies**Provider Category:**

Agency

Provider Type:

FSSA/DDARS approved Specialized Medical Equipment and Supplies Agency

Provider Qualifications**License** (specify):

Any applicable licensure, including but not limited to:

- Home Medical Equipment Services Providers IC 25-26-21
- Physical Therapist IC 25-27-1
- Occupational Therapist IC 25-23.5
- Speech/Language Therapist IC 25-35.6
- Pharmacy IC 25-26-13-18

Certificate (specify):

IC 6-2.5-8-1 - Registered retail merchant's certificate; application; filing fee

Other Standard (specify):

- Enrolled as an active Medicaid provider
- Must be FSSA/DDARS (or its designee) approved
- Must comply with Indiana Administrative Code, 4460 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 service standards, guidelines, policies, and/or manuals, including the FSSA/DDARS HCBS Waivers provider reference module on the IHCP Provider Reference Materials webpage.
- Where licensure is required, providers rendering waiver funded services must obtain/maintain Indiana licensure.

Verification of Provider Qualifications

Entity Responsible for Verification:

BDS

Frequency of Verification:

Up to 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Structured Family Caregiving

HCBS Taxonomy:

Category 1:

02 Round-the-Clock Services

Sub-Category 1:

02031 in-home residential habilitation

Category 2:

02 Round-the-Clock Services

Sub-Category 2:

02023 shared living, other

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Structured Family Caregiving means a caregiving arrangement in which an individual lives with a principal caregiver who provides daily care and support to the individual based on the individual's daily care needs. The person responsible for providing day-to-day support (hereafter known as principal caregiver) may be a non-family member or a family member (except as limited below) who lives with the individual in the private home of the individual or the principal caregiver. Structured Family Caregiving agencies (hereafter known as provider agencies) are the Medicaid provider of this service and are responsible for identifying principal caregivers and substitute caregivers as needed, assessing the home setting, and

providing ongoing oversight and support.

Necessary support services are provided by the principal caregiver as part of Structured Family Caregiving. Principal caregivers must be qualified to meet all Federal and State regulatory guidelines, and be able to provide care and support to an individual based on the individual's needs as identified in the person-centered planning process. Principal caregivers receive training based on their assessed needs and are paid a per diem stipend for the care and support they provide to individuals.

Structured Family Caregiving preserves the dignity, self-respect and privacy of the individual by ensuring high quality care in a non-institutional setting. The goal of this service is to provide necessary care while fostering and emphasizing the individual's independence through a range of care options as the needs of the individual change. The goal is reached through a cooperative relationship between the individual (or the individual's legal guardian), the principal caregiver, the waiver case manager, and the provider agency. Individual needs shall be addressed in a manner that support and enable the individual to maximize abilities to function at the highest level of independence possible while principal caregivers receive initial and ongoing support in order to provide high quality care. The service is designed to provide options for alternative long-term care waiver participants whose needs can be met in Structured Family Caregiving.

Only agencies may be Structured Family Caregiving providers, with the home settings being assessed and accessible, and all paid caregivers (including principal caregivers) being qualified as able to meet the individual's needs. The provider agency must conduct a minimum of one home visit per quarter. Home visits are conducted in accordance with the person-centered plan of care and by any of the following support professionals as determined by the assessed need:

- a registered nurse (RN)
- a licensed practical nurse (LPN)
- a caregiver trainer
- a SFC home manager who is employed by the agency and who does not live in the home.

In addition to conducting one home visit per quarter, one of the support professionals (specified above) must also attend each separate quarterly case management monitoring meeting. Additional home visits and ongoing communication with the principal caregiver may occur based on the identified needs of the individual and the principal caregiver.

The Provider Agency must make a substitute caregiver available to allow opportunities for primary caregiver wellness and skill development in alignment with the needs of the primary caregiver as identified by the caregiver trainer, up to 15 days per year. The provider agency must capture daily notes that are completed by the principal caregiver in an electronic format, and use the information collected to monitor the individual's health and principal caregiver support needs. The agency provider must make such notes available to waiver case managers and the State, upon request.

SERVICE LEVELS

There are three service levels of structured family caregiving each with a unique rate. The applicable rate is determined through completion of the Adult Family Care/Structured Family Care Level of Service Assessment (AFC/SFC LOS Assessment). Case Managers complete this assessment at least annually to accurately reflect the relative support need of the individual. The AFC/SFC LOS Score determines the reimbursement rate to be utilized in the individual's next service plan.

The breakdown is as follows:

- Level 1 - AFC/SFC LOS Assessment Score of 0 - 35.
- Level 2 - AFC/SFC LOS Assessment Score of 36 - 60.
- Level 3 - AFC/SFC LOS Assessment Score of 61+.

REIMBURSABLE ACTIVITIES

Structured Family Caregiving includes (Levels 1-3)

- Services provided by a principal caregiver. Principal caregiver may NOT be the spouse of the participant or the parent of the minor participant (Legally Responsible Persons).
- Personal care support.
- Homemaker or chore support.
- Companion care.
- Medication oversight (to the extent permitted under State law).
- Escorting for necessary appointments, whenever possible, such as transporting individuals to doctor. When provided, such transportation is incidental and not duplicative of any other State Plan or waiver service.

- Appointments and community activities that are therapeutic in nature or assist with maintaining natural supports.
- Other appropriate supports as described in the individual's service plan.

SERVICE STANDARDS

- SFC services must be included on the individual's service plan
- SFC services must address needs identified in the person-centered planning process and the AFC/SFC LOS Assessment Form
- Structure Family Caregiving provider agencies develop, implement and provide ongoing management and support of a person-centered service plan that addresses the individual's level of service needs.
- The supports provided within the home and community are managed and completed by the principal caregiver throughout the day based on the individual's daily needs.
- Structured Family Caregiving is provided in a private residence and affords all of the rights, dignity and qualities of living in a private residence including privacy, comfortable surroundings, and the opportunity to modify one's living area to suit one's individual preferences.
- Provider agencies must conduct, at a minimum, one home visit per quarter based on the individual's needs and caregiver training needs identified in the person-centered planning process. Additionally, an agency support professional must attend each separate quarterly case management monitoring meeting.
 - The Provider Agency must identify the skill development and wellness needs of the primary caregiver and provide access to a qualified substitute caregiver as needed for up to 15 days per year.
- Principal caregivers receive a minimum of 8 hours annual training that reflects the individual's and principal caregiver's assessed needs. Training may be delivered during home visits, or in another manner that is flexible and meaningful for the caregiver.
- Provider agencies must work with individuals and principal caregivers to establish backup plans for emergencies and other times when the principal caregiver is unable to provide care.
- Structured Family Caregiving emphasizes the individual's independence in a setting that protects and encourages the individual's dignity, choice, and decision-making while preserving self-respect.
- Provider agencies who provide medication oversight, as addressed under Reimbursable Activities, must receive necessary instruction from a doctor, nurse, or pharmacist regarding medications prescribed to the individual.

DOCUMENTATION STANDARDS

SFC provider agency Provider must maintain all applicable documentation required under 460 IAC 6 Supported Living Services and Supports and the FSSA/DDARS BDS policies and the FSSA/DDARS HCBS Waivers module on the IHCP Provider Reference Materials webpage. Additionally, the SFC provider agency must comply with the following standards:

- The SFC provider agency must document the following data elements for each day services are rendered:
 - Name of individual served
 - IHCP Member ID (RID) of the individual served
 - Service rendered
 - Date of service (include month, day and year)
 - Principal caregiver daily notes (captured in electronic format by provider agency) that record and track the individual's status, including updates or significant changes in the individual's health status or behaviors, participation in community-based activities, and other notable or reportable events.
- The SFC provider agency must retain a copy of the completed AFC/SFC LOS Assessment Form
- The SFC provider agency must conduct regular reviews of caregiver notes to understand and respond to changes in the individual's health status and identify potential new issues in an effort to better communicate changes with the individual's doctors or healthcare providers and avoid unnecessary hospitalizations or emergency room use. Review documentation must include:
 - Documentation of investigation and submission of reportable events to BDS and notification to the Waiver Case manager.
 - Documentation demonstrating collaboration and communication with other service providers and healthcare professionals (as appropriate), waiver case managers and other caregivers or individuals important to the individual regarding changes in the individual's health status and reportable events.
- The SFC provider agency must document all home visits conducted by the provider agency and all quarterly case management monitoring meetings attended by the provider agency.

- The SFC provider agency must document education/skills training provided to principal caregiver as outlined in the PCISP
- The SFC provider agency must maintain documentation of all qualified caregivers (including paid substitute caregivers).
- The SFC provider agency must maintain medication management records (if applicable).
- Each quarter (or more often as determined by the IST), the SFC provider agency must prepare a progress report based on principal caregiver notes and upload this progress 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 reporting period. Quarterly reports must be completed on state approved templates. The first reporting period must align with the start of the service. Failure to timely complete and upload each quarterly report may result in a citation.
- The documentation may reside in multiple locations but must be clearly and easily linked to the individual or the standard will not be met.
- Upon request, all documentation must be made available to auditors, quality monitors, case managers and any other government entity within any/all timeframes specified by BDS.

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

Not more than four waiver participants may reside in a single structured family caregiving household. When participants have a familial relationship, this maximum may be exceeded on a case-by-case basis as approved by the state.

Separate payment will not be made for Home and Community Assistance or Attendant Care services furnished to an individual receiving Structured Family Caregiving as these activities are integral to and inherent in the provision of Structured Family Caregiving.

Structured Family Caregiving will not be reimbursed when provided by the parent of a minor child participant or the spouse of a participant (also known as a Legally Responsible Individual) as outlined in Appendix C-2-d of this waiver.

Structured Family Caregiving will be reimbursed when provided by a Relative or a Legal Guardian, ONLY when all conditions specified in Appendix C-2-e of this waiver are met.

ACTIVITIES NOT ALLOWED

- Services to individuals receiving Residential Habilitation and Supports waiver services.

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed
- ☐ Remote/via Telehealth

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/DDARS Approved Structured Family Caregiving Agencies

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Structured Family Caregiving

Provider Category:

Agency

Provider Type:

FSSA/DDARS Approved Structured Family Caregiving Agencies

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

- Enrolled as an active Medicaid provider
- Must be FSSA/DDARS (or its designee) 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 6-5-3 Adult Foster Care Services Provider Qualifications,
 - 460 IAC 6-14-5 Requirements for Direct Care Staff,
 - 460 IAC 6-14-4 Training
- All individuals rendering waiver-funded services must obtain/maintain Indiana registration/licensure (as applicable).
- Must comply with any applicable FSSA/BDS service standards, guidelines, policies and/or manuals, including FSSA/DDARS BDS policies and the FSSA/DDARS HCBS Waivers module on the IHCP Provider Reference Materials webpage.
- All direct care staff must be registered with DDARS and must complete required competency-based training in accordance with IC 12-11-16.

Verification of Provider Qualifications

Entity Responsible for Verification:

Frequency of Verification:

Appendix C: Participant Services

C-1/C-3: Service Specification

Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

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

Service Title:

Transportation

HCBS Taxonomy:

Category 1:

15 Non-Medical Transportation

Sub-Category 1:

15010 non-medical transportation

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

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 non-medical community services, resources/destinations, or places of employment, as well as maintain or improve their mobility within the community, increase independence and community participation and prevent institutionalization as specified by the PCISP.

SERVICE TYPES:

Transportation services are reimbursed at three (3) types of service:

- 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 (e.g., ambulette).

REIMBURSABLE ACTIVITIES

- Two one-way trips per day to or from a non-medical community service or resource as specified on the PCISP and provided by an approved provider of residential habilitation and support, day habilitation, adult day services or transportation services.
- Bus passes or alternate methods of transportation may be utilized for Level 1 or Level 2. Bus passes may be purchased on a monthly basis or on a per-ride basis, whichever is most cost effective in meeting the individual's transportation needs as outlined in the PCISP.

SERVICE STANDARDS

- Transportation must be included on the individual's PCISP, which must include level of Transportation needed
- Transportation must address needs identified in the person-centered planning process
- May be used in conjunction with other services, including day habilitation and adult day services.
- Whenever possible, family, neighbors, friends or community agencies, which can provide transportation services without charge will be utilized.

DOCUMENTATION STANDARDS

Provider must maintain all applicable documentation required under 460 IAC 6 Supported Living Services and Supports and the FSSA/DDARS BDS policies and the FSSA/DDARS HCBS Waivers module on the IHCP Provider Reference Materials webpage. Additionally, the provider must comply with the following standards:

- Except for bus passes and alternative rideshare, the provider must document the following data elements for each trip rendered:
 - Name of individual served
 - IHCP Member ID (RID) of the individual served
 - Service rendered
 - Date of service (include month, day and year)
 - Pick-up point and destination for trip
- For bus passes and alternative rideshare, provider must maintain receipts for all expenditures, showing the amount and what item was covered.
- The documentation may reside in multiple locations but must be clearly and easily linked to the individual or the standard will not be met.
- Upon request, all documentation must be made available to auditors, quality monitors, case managers and any other government entity within any/all timeframes specified by BDS.

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

Transportation Services are limited to a maximum of two one-way trips per day to or from a non-medical community service or resource as specified on the PCISP and provided by an approved provider of residential habilitation and support, day habilitation, adult day services or transportation services.

Each level of Transportation Services limited to the following maximum amounts per plan year:

- \$7530 for Level 1 Transportation
- \$8255 for Level 2 Transportation
- \$8980 for Level 3 Transportation

Services provided under Transportation service will not duplicate services provided under the Medicaid State Plan or any other waiver service.

Transportation Services will not be reimbursed when provided by the parent of a minor child participant or the spouse of a participant (also known as a Legally Responsible Individual) as outlined in Appendix C-2-d of this waiver. Transportation Services will be reimbursed when provided by a Relative or a Legal Guardian, ONLY when all conditions specified in Appendix C-2-e of this waiver are met.

ACTIVITIES NOT ALLOWED

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

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed
- ☐ Remote/via Telehealth

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/DDARS Approved Transportation Provider - Agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Transportation

Provider Category:

Agency

Provider Type:

FSSA/DDARS Approved Transportation Provider - Agency

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

- Enrolled as an active Medicaid provider
- Must be FSSA/DDARS (or its designee) approved
- Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
 - 460 IAC 6-10-5 Documentation of Criminal Histories,
 - 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance,
 - 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers,
 - 460 IAC 6-5-30 Transportation Services Provider Qualifications,
 - 460 IAC 6-5-31 Transportation Supports Provider Qualifications, and
 - 460 IAC 6-34-1 to 460 IAC 6-34-3 Transportation Services,
 - 460 IAC 6-14-5 Requirements for Direct Care Staff,
 - 460 IAC 6-14-4 Training
- Must comply with any applicable FSSA/BDS service standards, guidelines, policies and/or manuals, including FSSA/DDARS BDS policies and the FSSA/DDARS HCBS Waivers module on the IHCP Provider Reference Materials webpage.

Verification of Provider Qualifications

Entity Responsible for Verification:

BDS

Frequency of Verification:

Up to 3 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Vehicle Modifications

HCBS Taxonomy:

Category 1:

14 Equipment, Technology, and Modifications

Sub-Category 1:

14020 home and/or vehicle accessibility adaptations

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

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

Bid Requirements

- At least two (2) bids must be obtained for any vehicle modification expected to exceed \$1,000.00. Bids must be the most cost effective or conservative means to meet the individual's specific needs.
- If only one bid is obtained the case manager must document the date of contact, the provider name, and why the bid was not obtained from that provider.
- Each bid must be itemized and include:
 - Picture of equipment; and
 - Written warranty for new products.

Prior Request for Approval to Authorize Services Requirements

- All vehicle modifications must be approved by the Bureau of Disabilities Services (BDS) or its designee prior to the service being rendered.
- The vehicle to be modified must meet all of the following:
 - The individual or primary caregiver (including a family member with whom the individual lives or has consistent and on-going contact, or a non-relative who provides primary long-term support to the individual and is not a paid provider of such services) 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 a Family and Social Services Administration (FSSA) approved provider.
- 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 for vehicle modifications may be partially approved or denied in their entirety if the BDS director or its designee determines that the documentation does not support the service requested.

REIMBURSABLE ACTIVITIES

- 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;
- Items requested which are not listed above, will be submitted in the service plan/RFA and will be reviewed and approved by the State BDS Director or its designee, if the request meets the medical or social needs of the individual.

SERVICE STANDARDS

- Vehicle modifications must be included on the individual's PCISP, identify the direct medical or remedial benefit for the individual, and authorized on the Request for Approval (RFA) form and linked to the individual's service plan.
- Vehicle modifications must address needs identified in the person-centered planning process.
- Pricing must be consistent with the fair market price for such modification(s).
- Many automobile manufacturers offer a rebate for waiver participants 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.
- All products shall meet applicable standards of manufacture, design and installation.

DOCUMENTATION STANDARDS

Provider must maintain all applicable documentation required under 460 IAC 6 Supported Living Services and Supports and the FSSA/DDARS BDS policies and the FSSA/DDARS HCBS Waivers module on the IHCP Provider Reference Materials webpage. Additionally, the provider must comply with the following standards:

- The provider must document the following data elements for services rendered:
 - Name of individual served
 - IHCP Member ID (RID) of the individual served
 - Service rendered
 - Date of installation (include month, day and year)
- State-approved and signed Service Authorization/NOA
- Provider responsible for maintaining receipts for all expenditures, showing the amount and what item(s) were supplied for the vehicle modification; must be in compliance with FSSA and Division specific guidelines and/or policies.
- The documentation may reside in multiple locations but must be clearly and easily linked to the individual or the standard will not be met.
- Upon request, all documentation must be made available to auditors, quality monitors, case managers and any other government entity within any/all timeframes specified by BDS.

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

Vehicle Modification services are limited to a 10-year cap of \$15,000.00 for one (1) vehicle per every ten (10) year period for an individual's household.

In addition to the applicable 10-year cap for vehicle modifications, up to \$1,000.00 is allowable per plan year for the maintenance and repair to an existing vehicle modification that was funded by a Home and Community Based Services (HCBS) waiver. Requests for maintenance/repair services must detail cost of part(s) and cost of labor. If the need for maintenance/repair services exceeds \$1000.00, the case manager will work with other available funding streams and community agencies to fulfill the need. If maintenance/repair service costs exceed the annual limit, those parts and labor costs funded through the waiver must be itemized clearly to differentiate the waiver service provision from those parts and labor provided through a non-waiver funding source.

Vehicle modifications will not be reimbursed when provided by the parent of a minor child participant or the spouse of a participant (also known as a Legally Responsible Individual), Relative, or Legal Guardian as outlined in Appendix C-2-d and Appendix C-2-e of this waiver.

ACTIVITIES NOT ALLOWED

- Unallowable items 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
- Vehicle modifications that are available under the Rehabilitation Act of 1973 or PL 94-142.

Payment may not be made to adapt the vehicles that are owned or leased by paid providers of waiver services.

The cost of purchasing or leasing of a vehicle is excluded from the service.

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed
- ☐ Remote/via Telehealth

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

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/DDARS Approved Vehicle Modification Provider

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service

Service Name: Vehicle Modifications

Provider Category:

Agency

Provider Type:

FSSA/DDARS Approved Vehicle Modification Provider

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

- Enrolled as an active Medicaid provider
- Must be FSSA/DDARS (or its designee) 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/BDS service standards, guidelines, policies and/or manuals, including FSSA/DDARS BDS policies and the FSSA/DDARS HCBS Waivers module on the IHCP Provider Reference Materials webpage.
- Where licensure is required, providers rendering waiver funded services must obtain/maintain Indiana licensure.

Verification of Provider Qualifications**Entity Responsible for Verification:**

BDS

Frequency of Verification:

Up to 3 years.

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:

Other Service

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

Service Title:

Wellness Coordination

HCBS Taxonomy:**Category 1:**

05 Nursing

Sub-Category 1:

05020 skilled nursing

Category 2:

11 Other Health and Therapeutic Services

Sub-Category 2:

11010 health monitoring

Category 3:**Sub-Category 3:****Category 4:****Sub-Category 4:****Service Definition (Scope):**

Wellness coordination services ensure the effective development, implementation, and monitoring of individualized

wellness coordination plans for persons with high medical needs. These services are designed to provide oversight and coordination beyond routine medical care covered under the Medicaid State Plan.

Wellness Coordination Services apply to individuals who require the assistance of a licensed nurse (Registered Nurse [RN] or Licensed Practical Nurse [LPN]) to properly coordinate their medical needs. These services are intended to supplement, not replace, standard physician or health care visits.

SERVICE LEVELS

Tier I: Health care needs require a face to face visit once in the individual's residence a month with an RN/LPN and consultations/reviews based on the individual's current health care needs.

Tier II: Health care needs require a face to face visit in the individual's residence twice a month with an RN/LPN and consultations/reviews based on the individual's current health care needs.

Tier III: Health care needs require a face to face visit in the individual's residence once a week with an RN/LPN and consultations/reviews based on the individual's current health care 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/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.

REIMBURSABLE ACTIVITIES:

Coordination of wellness services by the Wellness Coordinator must include, but is not limited to the following:

- Development, oversight and maintenance of a wellness coordination plan which includes medical risk plans when appropriate.
- Completion of a medical risk assessment using information gathered by the individual and their individualized support team and documented by the case manager in the PCISP
- Wellness coordination plans and medical risk plans include:
 - Determination of the appropriate mode of training to be used for the direct support professional to ensure implementation of medical 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.
 - Ensuring the completion of training of direct support professionals to ensure implementation of medical Risk Plans.
 - Description of individuals medical needs
 - Description of the activities of consultation and care coordination with the individual's health care providers.
 - Face to face consultations in the person's home with the individual as described in the support plan based on Tier level.
 - Consultation with the IST
 - Active involvement at annual team meetings and additional meetings when appropriate, reporting on the wellness coordination plan as it relates to the individual's full array of services as listed in the PCISP.

SERVICE STANDARDS

- Wellness Coordination must be included on the individual's PCISP, which must reflect that individual requires assistance in coordinating medical needs beyond what can be provided through routine doctor/health care visits.
- Wellness Coordination must address needs identified in the person-centered planning process
- Providers will develop and complete a Wellness Coordination plan for the individual. Within the wellness coordination plan, the provider must document what level of consultation/visits has been deemed necessary or appropriate for the individual.

DOCUMENTATION STANDARDS

Provider must maintain all applicable documentation required under 460 IAC 6 Supported Living Services and Supports and the FSSA/DDARS BDS policies and the FSSA/DDARS HCBS Waivers module on the IHCP Provider Reference Materials webpage. Additionally, the provider must comply with the following standards:

- Wellness Coordination services must be documented in agency files:
 - Weekly consultations/reviews

- Face-to-face visits with the individual
- Other activities, as appropriate

- The provider of wellness coordination will provide a written report completed on state approved template to pertinent parties at least quarterly. ("Pertinent parties" include the individual, guardian, BDS service coordinator and waiver case manager.)
- Each quarter (or more often as determined by the IST), the service provider must prepare and upload a progress 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 reporting period. Quarterly reports must be completed on state approved templates. The first reporting period must align with the start of the service. Failure to timely complete and upload each quarterly report may result in a citation.
- Within the wellness coordination plan, the provider must document what level of consultation/visits has been deemed necessary or appropriate for the individual.
- The documentation may reside in multiple locations but must be clearly and easily linked to the individual or the standard will not be met.
- Upon request, all documentation must be made available to auditors, quality monitors, case managers and any other government entity within any/all timeframes specified by BDS.

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

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.

Wellness Coordination will not be reimbursed when provided by the parent of a minor child participant or the spouse of a participant (also known as a Legally Responsible Individual), Relative, or Legal Guardian as outlined in Appendix C-2-d and Appendix C-2-e of this waiver.

ACTIVITIES NOT ALLOWED

Reimbursement for wellness coordination services is not available under the following circumstances:

- The individual does not require wellness coordination services.

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed
- ☒ Remote/via Telehealth

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

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/DDARS Approved Wellness Coordination Agencies

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Wellness Coordination**Provider Category:**

Agency

Provider Type:

FSSA/DDARS Approved Wellness Coordination Agencies

Provider Qualifications**License (specify):**

Wellness Coordinator must be either a registered nurse (RN) or a licensed practical nurse (LPN) under IC 25-23-1 working under the supervision of an RN

Certificate (specify):**Other Standard (specify):**

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

- 460 IAC 6-10-5 Documentation of Criminal Histories,
- 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance,
- 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers,
- 460 IAC 6-14-5 Requirements for Direct Care Staff,
- 460 IAC 6-14-4 Training
- 460 IAC 6-5-14 Health Care Coordination Services Provider Qualifications

**noting that Wellness Coordination is referred to as Health Care Coordination within 460 IAC 6

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

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

Verification of Provider Qualifications**Entity Responsible for Verification:**

BDS

Frequency of Verification:

Up to 3 years.

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:

Other Service

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

Service Title:

Workplace Assistance

HCBS Taxonomy:**Category 1:**

08 Home-Based Services

Sub-Category 1:

08030 personal care

Category 2:

03 Supported Employment

Sub-Category 2:

03021 ongoing supported employment, individual

Category 3:**Sub-Category 3:****Category 4:****Sub-Category 4:****Service Definition (Scope):**

Workplace assistance services provide a range of personal care services and/or supports during paid competitive community employment hours and in a competitive community employment setting to enable 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 cuing to prompt 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 services that 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.

REIMBURSABLE ACTIVITIES

- 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, etc.).

SERVICE STANDARDS

- Workplace Assistance must be included on the individual's PCISP
- Workplace Assistance must address needs identified in the person-centered planning process
- Workplace Assistance services may only be delivered in the employment setting.
- Allowed staffing ratio - Individual, 1:1
- Workplace Assistance services may be used in conjunction with Extended Services.
- Workplace Assistance services may be utilized with each hour the individual is engaged in paid competitive community employment.
- Workplace Assistance services should complement but not duplicate Day Habilitation services being provided in other settings.
- There is no requirement for a physician's prescription or authorization. The need for Workplace Assistance services is determined entirely by the IST.

Workplace Assistance may be provided from the following:

- Agency Provider - an agency enrolled in the program is responsible to hire and render services
- Individual Provider - an individual enrolled in the program is responsible to render services.
- Participant Directed - the individual (or representative appointed by the individual) is the employer and acts as the agency directing their care.

DOCUMENTATION STANDARDS

Provider must maintain all applicable documentation required under 460 IAC 6 Supported Living Services and Supports and

the FSSA/DDARS BDS policies and the FSSA/DDARS HCBS Waivers module on the IHCP Provider Reference Materials webpage. Additionally, the provider must comply with the following standards:

- The provider must document the following data elements for each uninterrupted period of services rendered:
 - Name of individual served
 - IHCP Member ID (RID) of the individual served
 - Service rendered
 - Date of service (include month, day and year)
 - Time frame of service (include start time, end time and a.m./p.m.)
 - Number of units of service rendered
- Each quarter (or more often as determined by the IST), the service provider must prepare and upload a progress 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 reporting period. Quarterly reports must be completed on state approved templates. The first reporting period must align with the start of the service. Failure to timely complete and upload each quarterly report may result in a citation. Quarterly reports are not required when services are self-directed.
- The documentation may reside in multiple locations but must be clearly and easily linked to the individual or the standard will not be met.
- Upon request, all documentation must be made available to auditors, quality monitors, case managers and any other government entity within any/all timeframes specified by BDS.

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

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

Workplace Assistance will not be reimbursed when provided by the parent of a minor child participant or the spouse of a participant (also known as a Legally Responsible Individual) as outlined in Appendix C-2-d of this waiver.

Workplace Assistance will be reimbursed when provided by a Relative or a Legal Guardian, ONLY when all conditions specified in Appendix C-2-e of this waiver are met.

Workplace Assistance services will not be reimbursed when provided by a Legal Guardian if the participant is self-directing this service.

ACTIVITIES NOT ALLOWED

Reimbursement is not available through workplace assistance services under the following circumstances:

- 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 support 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 off-site monitoring when the monitoring directly relates to maintaining a job.
- Workplace assistance is not to be used for the provision of skilled job trainers who accompany the 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 waiver participants, or other appropriate professional or informed advisors, in order to reinforce and stabilize the job placement.
- Workplace assistance is not to be used for the facilitation of natural supports at the work site.
- Workplace assistance is not to be used for waiver participant 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.

Service Delivery Method (check each that applies):

- ☒ Participant-directed as specified in Appendix E
- ☒ Provider managed
- ☐ Remote/via Telehealth

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	FSSA/DDARS Approved Workplace Assistance - Agencies
Individual	Self-Directed Workplace Assistance - Individual

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Workplace Assistance

Provider Category:

Agency

Provider Type:

FSSA/DDARS Approved Workplace Assistance - Agencies

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

- Enrolled as an active Medicaid provider
- Must be FSSA/DDARS (or its designee) approved
- Must comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
 - 460 IAC 6-10-5 Documentation of Criminal Histories,
 - 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance,
 - 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers,
 - 460 IAC 6-14-5 Requirements for Direct Care Staff,
 - 460 IAC 6-14-4 Training,
 - 460 IAC 6-5-30 Transportation Services Provider Qualifications, and
 - 460 IAC 6-5-31 Transportation Supports Provider Qualifications.
- Must comply with any applicable FSSA/BDS service standards, guidelines, policies and/or manuals, including FSSA/DDARS BDS policies and the FSSA/DDARS HCBS Waivers module on the IHCP Provider Reference Materials webpage.
- All direct care staff (including participant-directed staff) must be registered with DDARS and must complete required competency-based training in accordance with IC 12-11-16.

Verification of Provider Qualifications

Entity Responsible for Verification:

BDS

Frequency of Verification:

Up to 3 years.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Workplace Assistance

Provider Category:

Individual

Provider Type:

Self-Directed Workplace Assistance - Individual

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Individual/Agency providing services for individuals who self-direct their services:

- Must enroll with FMS vendor and submit forms and documentation as required by the FMS vendor
- Must be verified by FMS vendor as meeting all required qualifications.
- 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 6-14-4 Training
 - 460 IAC 6-14-5 Requirements for Direct Care Staff
- Individuals who self-direct their services, as the employer, may require additional reasonable staffing requirements based on their preferences and level of needs. Providers of self-directed services must submit forms and documentation as required by the FMS vendor. FMS vendor must ensure the individual or agency performing the service meets the required qualifications.
- Must comply with any applicable FSSA service standards, guidelines, policies, and/or manuals, including the FSSA/DDARS HCBS Waivers provider reference module on the IHCP Provider Reference Materials webpage.
- All participant-directed staff must be registered with DDARS and must complete required competency-based training in accordance with IC 12-11-16

Verification of Provider Qualifications

Entity Responsible for Verification:

Financial Management Services Vendor

Frequency of Verification:

At least every three years

Appendix C: Participant Services

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ☐ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ☒ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- ☒ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid state plan service under section 1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☐ **As a Medicaid state plan service under section 1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☐ **As an administrative activity.** *Complete item C-1-c.*
- ☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*
- ☐ **As a Medicaid state plan service under section 1945 and/or section 1945A of the Act (Health Homes Comprehensive Care Management).** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants and the requirements for their training on the HCBS settings regulation and person-centered planning requirements:

Providers of case management services are required to complete twenty (20) hours of training regarding case management services in each calendar year regardless of their date of hire. Ten (10) hours of this training shall be BDS approved training provided through the Case Management Training Series. The Case Management Training Series is a series of online training modules designed to provide education and training on topics related to the provision of case management, including HCBS settings and person-centered planning requirements. Achievement of the training requirements is demonstrated by viewing the trainings taken in their entirety and the successful completion of the related quiz.

d. Remote/Telehealth Delivery of Waiver Services. Specify whether each waiver service that is specified in Appendix C-1/C-3 can be delivered remotely/via telehealth.

Service
Occupational Therapy
Physical Therapy
Psychological Therapy
Speech /Language Therapy
Wellness Coordination

1. Will any in-person visits be required?

- ☒ **Yes.**
- ☐ **No.**

2. *By checking each box below, the state assures that it will address the following when delivering the service remotely/via telehealth.*

- ☒ **The remote service will be delivered in a way that respects privacy of the individual especially in instances of toileting, dressing, etc.** *Explain:*

"Telehealth" means the delivery of health care services using interactive electronic communications and information technology (including secure videoconferencing, store and forward technology, or remote patient monitoring technology) between a provider in one (1) location and a patient in another location.

Telehealth services must be provided in compliance with Indiana Code 25-1-9.5 and the federal Health Insurance Portability and Accountability Act (HIPAA). Individuals must have an informed choice between in-person and telehealth services.

The appropriateness of telehealth services, equipment locations and providers must be determined during the person-centered service planning process. Equipment related to remote service delivery will not be placed by providers in bedrooms or bathrooms except in such instances where it has been reviewed and approved by a Human Rights Committee and been shown to be a necessary to ensure health and safety. Any equipment related to remote service delivery will only enter the home under full agreement of all adults who reside in the home, and their guardians (when applicable) and use of remote monitoring must be documented in the individual's person-centered service plan prior to use. The individual maintains the ability to turn off the device independently and may do so when they so choose.

☒ **How the telehealth service delivery will facilitate community integration. *Explain:***

The use of telehealth services will not block, prohibit or discourage the use of in-person services or access to the community. Telehealth services will not be used for the provider's convenience. Telehealth services are available as an option for individuals who may not want to receive services in person or when they would otherwise be unable to do so due to illness, transportation issues, pandemics, or other personal reasons.

☒ **How the telehealth will ensure the successful delivery of services for individuals who need hands on assistance/physical assistance, including whether the service can be rendered without someone who is physically present or is separated from the individual. *Explain:***

Prior to commencing any telehealth service the case manager will lead the person's team through a conversation regarding how to ensure the service can be maximally effective given the person's specific needs. In some circumstances, the individual and their team may identify that due to the need for hands on assistance telehealth delivery may not be a good fit. In other circumstances the team may identify ways that natural supports can be maximized to offer any hands-on physical assistance that may be needed during the delivery of the telehealth service.

☒ **How the state will support individuals who need assistance with using the technology required for telehealth delivery of the service. *Explain:***

The providers or vendors who supply the technology necessary for the telehealth delivery of services provide training and guidance on how to use the technology to the individual, their family, support staff, and others who may need to interface with the technology. The person's case manager is also responsible for helping to identify additional available resources regarding technology training and support for the individual when needed. Prior to adding a telehealth service to the person-centered plan the team will discuss the types and amounts of support the individual will likely require with the technological aspects of the service. This will extend to establishing the willingness and capacity of the person's family, guardian, and/or residential support provider to provide ongoing technology support.

Monitoring will be completed by the provider who is offering the service as they are required to ensure all service elements are met and the goals and purpose of the service are being effectuated.

Where the telehealth or remote service is essential to health and safety of the individual, back-up plans in the circumstances of technology failure or power loss are discussed and incorporated into the person's plan.

The individual has full control of the device. The individual can turn off the device and end services at any time they wish. The person's case manager is also responsible for informing the individual of this option.

☒ **How the telehealth will ensure the health and safety of an individual. *Explain:***

Telehealth can help to ensure the health and safety of the individual in that it offers options for service provision in circumstances where the individual might otherwise go without the identified service or where obtaining an in-person service would put the person at risk.

A provider may refuse at any time to provide telehealth services if the provider believes:

- (1) that the individual's health quality may be negatively impacted by the use of telehealth services; or
- (2) the provider would be unable to provide the same standards of care as those provided in an in-person setting.

If the provider determines that telehealth services (which have been approved in the individual's service plan) are no longer appropriate, the provider will notify the individual, their legal guardian (if applicable) and the individual's case manager.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ☐ **No. Criminal history and/or background investigations are not required.**
- ☒ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

- a) All waiver providers who have direct contact with waiver participants (including every employee, officer, or agent involved in the management, administration or provision of services under the CIH Waiver) must have criminal history checks.
- b) Documented proof of the limited criminal history investigation is required with the initial application for approval as a new provider and must be obtained from the Indiana central repository by the prospective provider agency before submitting the prospective provider's application for approval to provide services to the Family and Social Services Administration's (FSSA) Division of Disability Aging and Rehabilitative Services (DDARS) Bureau of Disabilities Services (BDS). The documented proof must be on file at the time of original (initial) provider approval for all current employees.

Criminal history documentation requirements for providers are specified under 460 IAC 6-10-5 General Administrative Requirements for Providers and supported by the DDARS BDS Documentation of Criminal Histories policy. The scope of the limited criminal history check is within the state and shall verify that the employee, officer, or agent has not been convicted of the following under Indiana Code Title 35. Criminal Law and Procedure or Title 31. Family Law and Juvenile Law:

- A sex crime (IC 35-42-4)
- Exploitation of an endangered adult (IC 35-46-1-12)
- Failure to report battery, neglect, or exploitation of an endangered adult (IC 35-46-1-13) or abuse or neglect of a child (IC 31-33-22-1)
- Theft (IC 35-43-4), if the person's conviction for theft occurred less than ten (10) years before the person's employment application date, except as provided in IC 16-27-2-5(a)(5)
- Murder (IC 35-42-1-1)
- Voluntary manslaughter (IC 35-42-1-3)
- Involuntary manslaughter (IC 35-42-1-4)
- Felony battery
- A felony offense relating to a controlled substance

The provider shall also obtain a criminal history check from each county in which an employee, officer or agent involved in the management, administration or provision of services has resided and/or worked within the three (3) years before the criminal history check is requested from the county. If an employee, officer, or agent resides and/or worked in a county that does not offer a criminal history check, the Indiana limited criminal history is sufficient, or providing a current copy of the Mycase record indicating no record. The provider must verify that a county criminal history check or Indiana limited criminal history was completed.

- c) FSSA's BDS reviews applications for approval to provide waiver services as submitted by the prospective provider. In the absence of documented proof of the limited criminal history for each employee listed on the provider's organizational chart, the application shall not be approved.

On an ongoing basis, when an allegation of an issue with a criminal background check arises during a complaint investigation or a mortality review. BDS completes a review of the provider's records to ensure that the provider completes a criminal history background check on new hires. BDS does this on a sample basis, sampling a minimum of two staff and a maximum of 20 staff per provider. Sampled staff are randomly chosen from a census list supplied by the provider agency. If the agency cannot provide documentation of conducting this background check they are directed to develop a corrective action plan. Providers are required to develop and implement systemic corrective actions. If an issue does not arise during a complaint investigation or a mortality review, BDS completes a review of the provider's records at least every two years during the provider reverification process.

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

- ☐ **No. The state does not conduct abuse registry screening.**
- ☒ **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; (c) the process for ensuring that mandatory screenings have been conducted; and (d) the process for ensuring continuity of care for a waiver participant whose service provider was added to the abuse registry. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

a) The State of Indiana has a registry of professional licenses that is available online at <https://mylicense.in.gov/eVerification/>

b) The FSSA's BDS requires each provider or prospective provider conduct and document the screening against this license verification website.

c) BDS reviews applications for approval to provide waiver services as submitted by the prospective provider. In the absence of the license verification for each direct care staff employed by the provider, the application shall not be approved.

Indiana's abuse registry is hosted by the Indiana Professional Licensing Agency (IPLA) at <https://www.in.gov/pla/> but information is maintained by the Indiana Department of Health (IDOH). If a registered aide has an abuse finding, IDOH places a finding on their certification within <https://www.in.gov/health/ltc/aide-training-and-certification/> so the aide will not show up as active on the registry.

d) If an individual's waiver provider is added to the registry, FSSA staff and case manager work together to ensure transition to new provider and continuity of care. Provider agencies are responsible for coordinating new direct care staff with oversight by FSSA.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

Note: Required information from this page is contained in response to C-5.

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law or regulations to care for another person (e.g., the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child). At the option of the state and under extraordinary circumstances specified by the state, payment may be made to a legally responsible individual for the provision of personal care or similar services. *Select one:*

- ☐ **No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ☐ **Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the types of legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) the method for determining that the amount of personal care or similar services provided by a legally responsible individual is "*extraordinary care*", exceeding the ordinary care that would be provided to a

person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization; (c) the state policies to determine that the provision of services by a legally responsible individual is in the best interest of the participant; (d) the state processes to ensure that legally responsible individuals who have decision-making authority over the selection of waiver service providers use substituted judgement on behalf of the individual; (e) any limitations on the circumstances under which payment will be authorized or the amount of personal care or similar services for which payment may be made; (f) any additional safeguards the state implements when legally responsible individuals provide personal care or similar services; and, (g) the procedures that are used to implement required state oversight, such as ensuring that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

- ☐ **The state does not make payment to relatives/legal guardians for furnishing waiver services.**
- ☒ **The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the types of relatives/legal guardians to whom payment may be made, the services for which payment may be made, the specific circumstances under which payment is made, and the method of determining that such circumstances apply. Also specify any limitations on the amount of services that may be furnished by a relative or legal guardian, and any additional safeguards the state implements when relatives/legal guardians provide waiver services. Specify the state policies to determine that the provision of services by a relative/legal guardian is in the best interests of the individual. When the relative/legal guardian has decision-making authority over the selection of providers of waiver services, specify the state's process for ensuring that the relative/legal guardian uses substituted judgement on behalf of the individual. Specify the procedures that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

In accordance with the federal description, Legally Responsible Individuals (LRIs) include ONLY the parent of a minor child or a spouse of a participant. LRI's DO NOT include the parent of an adult participant (including a parent who also may be a legal guardian) or other types of relatives. Under this definition, the state does not make payments to legally responsible individuals for any waiver services.

Policies Regarding Relatives:

The state allows payment to be made to Relatives (as defined below in this Appendix C-2-e) for the provision of the following waiver services ONLY when the conditions outlined below are met:

- Residential Habilitation and Support (Hourly) (including participant-directed RHS hourly services)
- Respite (including participant-directed Respite services)
- Residential Habilitation and Support - Daily
- Structured Family Caregiving
- Transportation
- Workplace Assistance (including participant-directed Workplace Assistance services)

The state will not allow payment to be made to Relatives for the provision of any other waiver services.

Relatives may be paid by an FSSA-approved provider agency (or by the financial management services (FMS) vendor when services are authorized to be participant-directed) for the provision of the services (specified above) ONLY when the following conditions are met:

- the services are provided in alignment with the waiver service definitions and limitations found in Appendix C of this waiver;
- the individual providing such services is qualified to provide such services in alignment with the qualifications found in Appendix C of this waiver; and
- the individual providing such services is employed by or contracts with (i) a FSSA-approved agency, or (ii) an individual who self-directs their services. Payment for such services provided by a Relative is only made to an (i) FSSA-approved provider agency, or (ii) the FMS vendor for participant-directed services. Payment for such services is never made directly to the Relative.

"Relatives" means the following types of Relatives (natural, adoptive and/or step relationships, whether by blood or by marriage, inclusive of half and/or in-law status):

- Parent of an Adult (natural, step, adopted, in-law) • Grandparent (natural, step, adopted)
- Uncle (natural, step, adopted)
- Aunt (natural, step, adopted)
- Brother (natural, step, half, adopted, in-law)
- Sister (natural, step, half, adopted, in-law)
- Child (natural, step, adopted)
- Grandchild (natural, step, adopted)
- Nephew (natural, step, adopted)
- Niece (natural, step, adopted)
- First cousin (natural, step, adopted)

Policies Regarding Legal Guardians:

The state allows payment to be made to Legal Guardians for the provision of the following waiver services ONLY when the conditions outlined below are met:

- Residential Habilitation and Support (Hourly) (excluding participant-directed RHS hourly services)
- Respite (excluding participant-directed Respite services)
- Residential Habilitation and Support - Daily
- Structured Family Caregiving
- Transportation
- Workplace Assistance (excluding participant-directed Workplace Assistance services)

The state will not allow payment to be made to Legal Guardians for the provision of participant-directed services (Residential Habilitation and Support (Hourly), Respite, or Workplace Assistance) or any other waiver services.

Legal Guardians may be paid by an FSSA-approved provider agency for the provision of the services (specified above) ONLY when the following conditions are met:

- the services are not participant-directed;
- the services are provided in alignment with the waiver service definitions and limitations found in Appendix C of this waiver;
- the individual providing such services is qualified to provide such services in alignment with the qualifications found in Appendix C of this waiver; and
- the individual providing such services is employed by or contracts with a FSSA-approved agency. Payment for such services provided by a Legal Guardian is only made to an FSSA-approved provider agency. Payment for such services is never made directly to the Legal Guardian.

Limitations:

- The maximum number of hours of RHS (Hourly), Respite, and Workplace Assistance services that may be reimbursed when provided by Relatives and or Legal Guardians (who are NOT LRIs) must not exceed forty (40) hours per week across all services for each paid relative/legal guardian caregiver.
- RHS (Hourly), Respite and Workplace Assistance services will not be reimbursed when provided by a Legal Guardian if the participant is self-directing this service.

Safeguards:

Relatives and Legal Guardians who receive payment for waiver services (as specified above in this Appendix C-2-e) will be subject to service plan monitoring as described in Appendix D-2-a. These practices will ensure that the selection of service providers during the planning meeting is based on an understanding of what the individual wants in accordance with Appendix D-1 and that services delivered will continue to meet the needs and goals as well as the best interest of the individual.

As with all other waiver-funded services, service delivery is authorized via the Service Authorization/Notice of Action (SA/NOA) issued by the state upon approval of the individual's person-centered individualized support plan (PCISP). Providers (including Relatives and Legal Guardians) are required to ensure that waiver services are provided as authorized and to document service delivery, allowing access to that documentation at any time by the state or its agents, including the case manager. As explained in Appendix I-2-d of the waiver application, the state uses a billing validation process to ensure claims are paid only for necessary services that were properly authorized and actually provided to the individual within the authorized timeframe. Billing is subject to audit by the state in look behind efforts of BDS as well as by the FSSA's surveillance and utilization unit.

The state ensures that the legally responsible individual uses substituted judgement on behalf of the individual by requiring that (1) the decision for the relative to provide services to a waiver individual is part of the PCISP planning process, which indicates that the relative is the best choice of persons to provide services from the state-approved provider agency, and this decision is recorded and explained in the PCISP, (2) there is detailed justification as to why the relative is providing service, and (3) 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.

- **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

- **Other policy.**

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR § 431.51:

Prospective providers of CIH waiver services may apply to become a provider at any time. The application approval process is managed/performed by Bureau of Disabilities Services (BDS). As applications are received and reviewed by the BDS, the prospective provider is given the opportunity to respond to any questions or additional information requested. The staff is available, upon request, to discuss in person questions regarding the application.

The BDS works with the potential provider to ensure all required documentation is obtained. Once a prospective provider has been determined to have met the relevant provider requirements for the services they propose to provide, the provider is referred to Indiana's Medicaid fiscal agent to enroll as a Medicaid provider. (Medicaid enrollment is required for all waiver service providers.) When the provider is enrolled, BDS is notified and the provider is added to the active provider database.

Under the State's administrative rules, the provider is given 15 calendar days from the date of notice to appeal the application decision. The case would be assigned to the Office of Administrative Law Proceedings for a hearing.

Information regarding the provider approval/enrollment process, provider qualifications required for particular services and other helpful information is also available to prospective services providers on the internet at the DDARS website and by accessing the Indiana Medicaid HCBS Waiver Provider Manual and/or the Bureau of Disabilities Services Provider Services Helpline.

Providers access the Indiana Medicaid (Indiana Health Coverage Programs (IHCP)) HCBS Waiver Provider Manual and/or the BDS Provider Services Helpline electronically. The DDARS HCBS Waiver Provider Manual is posted on the "manuals" link of IHCP website, with a direct link of <https://www.in.gov/medicaid/providers/469.htm>. The BDS Provider Services Helpline address is BDSProviderServices@fssa.in.gov.

Providers are required to undergo provider reverification by DDARS within twelve (12) months of initial approval and based on accreditation term, every two (2) or four (4) years. The reverification process consists of an annual/biennial review of provider documentation; and, based on the accreditation term, and previous reverification determination term (as applicable), an additional review of the provider's data on incident reports, complaints, mortalities, outstanding corrective action plans, sanctions, as well as any other monitoring data deemed applicable.

Providers are notified by BDS when due for reverification and are required to fully cooperate in the process by submitting all requested forms and participating in discussions as needed as BDS facilitates the process. The Reverification Guide is attached to their notice to aid in successful completion of the review.

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

Once submitted, BDS will review the submitted documents and issue corrective action if an issue is identified. Once all issues have been corrected, BDS issues a reverification determination of the provider's new approval term of either two (2) or four (4) years.

Reverified providers must submit a newly executed signed Provider Agreement to BDS.

g. State Option to Provide HCBS in Acute Care Hospitals in accordance with Section 1902(h)(1) of the Act. Specify whether the state chooses the option to provide waiver HCBS in acute care hospitals. *Select one:*

- ☐ **No, the state does not choose the option to provide HCBS in acute care hospitals.**
- ☒ **Yes, the state chooses the option to provide HCBS in acute care hospitals under the following conditions.** *By checking the boxes below, the state assures:*
 - ☒ **The HCBS are provided to meet the needs of the individual that are not met through the provision of acute care hospital services;**
 - ☒ **The HCBS are in addition to, and may not substitute for, the services the acute care hospital is obligated to provide;**
 - ☒ **The HCBS must be identified in the individual's person-centered service plan; and**

- ☒ The HCBS will be used to ensure smooth transitions between acute care setting and community-based settings and to preserve the individual's functional abilities.

And specify: (a) The 1915(c) HCBS in this waiver that can be provided by the 1915(c) HCBS provider that are not duplicative of services available in the acute care hospital setting; (b) How the 1915(c) HCBS will assist the individual in returning to the community; and (c) Whether there is any difference from the typically billed rate for these HCBS provided during a hospitalization. If yes, please specify the rate methodology in Appendix I-2-a.

The following services under this waiver may be provided in acute care hospitals in accordance with Section 1902(h)(1) of the Act:

- Residential Habilitation and Support (hourly)
- Residential Habilitation and Support - Daily (RHS Daily)

HCBS provided during an acute care hospitalization assists the individual to maintain current levels of functioning and support, provides ongoing coordination of care, assurance that new or additional needs are identified and addressed by the person-centered planning team as the individual prepares to return to the community.

There is no difference from the typically billed rate for these HCBS provided during a hospitalization.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

- a. *Sub-Assurance: The state verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.*

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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

Performance Measure:

C/L.1 Number and percent of newly enrolled licensed/certified waiver providers that met the provider qualifications prior to providing waiver services. Numerator:

Number of newly enrolled licensed/certified waiver providers that met the provider qualifications prior to providing waiver services. Denominator: Total number of newly enrolled licensed/certified waiver providers.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Provider Application Spreadsheet

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

Data Aggregation and Analysis:

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

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

Performance Measure:

C/L.2 Number and percent of existing enrolled licensed/certified waiver providers that continue to meet provider qualifications. Numerator: Number of existing enrolled licensed/certified waiver providers continuing to meet provider qualifications. Denominator: Number of existing enrolled licensed/certified waiver providers.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Provider Application Spreadsheet

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

		Group:
	☒ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

Performance Measure:

C/L.3 Number and percent of current licensed/certified waiver providers reviewed in a waiver year who conduct criminal background checks as required. Numerator: Number of current licensed/certified waiver providers reviewed in a waiver year who conduct criminal background checks as required. Denominator: Total number of current licensed/certified waiver providers reviewed in a waiver year.

Data Source (Select one):

Other

If 'Other' is selected, specify:

FSSA Provider Relations Tracking Database

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

Data Aggregation and Analysis:

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

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

b. Sub-Assurance: The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

For each performance measure the state will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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

Performance Measure:

C.3 Number and percent of current non-licensed/non-certified (NL/NC) waiver providers reviewed in a waiver year who conduct criminal background checks as required. Numerator: Number of current NL/NC waiver providers reviewed in a waiver year who conduct criminal background checks as required. Denominator: Total number of current NL/NC waiver providers reviewed in a waiver year.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Complaints/Mortality/Provider Reverification

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

		Interval =
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☒ Continuously and Ongoing	☒ Other Specify: Providers will be reviewed when an allegation is received or once every four years.
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

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

Performance Measure:

C.2 Number and percent of existing non-licensed/non-certified (NL/NC) waiver providers that continue to meet provider qualifications. Numerator: Number of existing NL/NC waiver providers reviewed that continue to meet provider qualifications. **Denominator:** Total number of existing NL/NC waiver providers reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Provider Reverification Tracking Sheet

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

		100% over a 4 year period
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

Performance Measure:

C.1 Number and percent of newly enrolled non-licensed/non-certified (NL/NC) waiver providers that met the provider qualifications prior to providing waiver services. Numerator: Number of newly enrolled NL/NC waiver providers that met the provider qualifications prior to providing waiver services. Denominator: Total number of newly enrolled NL/NC waiver providers.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Gainwell report

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

Data Aggregation and Analysis:

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

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

c. Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.

For each performance measure the state will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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

Performance Measure:

C.5 Number and percent of enrolled case managers who completed required case management training. Numerator: Number of enrolled case managers who completed required case management training. Denominator: Total number of enrolled case managers.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Case Management Training Tracking Sheet

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

Specify: 		Describe Group:
	☒ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

Performance Measure:

C.4 Number and percent of current waiver providers who enroll staff in mandated HCSP training. Numerator: Number of current waiver providers who enroll staff in mandated HCSP training. Denominator: Total number of current waiver providers who employ HCSP's.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Mandated Provider Training Tracking

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

Data Aggregation and Analysis:

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

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

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

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

C/L.1 and C.1.: Providers who submit an incomplete, inaccurate, or nonresponsive application are rejected. Note that for provider applications that are substantially complete and responsive, but may need additional information, a "request for information" (RFI) is sent. Providers have 30 calendar days from the date of the RFI to supply the clarifying information or the application is denied. As needed, DDARS will follow up with provider and/or complete application review. Only DDARS approved applications are referred to the Medicaid Agency for final approval.

C/L.2 and C.2.: To assure existing providers continue to meet provider qualifications, providers undergo a formal service review by DDARS at least every four (4) years.

C/L.2, C.2, C/L.3, C.3, C.4 and C.5: Providers that do not meet state requirements or standards are required to develop CAPs to address issues identified in their compliance reviews. BDS reviews and approves CAPs, and validates that providers are implementing these as stated.

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

Periodic reports on remediation actions are presented to the QIEC for review.

FSSA uses a centralized IT system to aggregate data and to identify systemic deficiencies. The Quality Improvement Executive Committee (QIEC) meets on a quarterly basis to review data collected from the performance measures for the waivers and identify systemic improvements needed (if any). The QIEC then follows up on the status of recommended systemic improvements at the next QIEC meeting until implementation is completed.

ii. Remediation Data Aggregation

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

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

☒ No

☐ Yes

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

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

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

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

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is

authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

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

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

A budget allocation limit is in place for the waiver participant to ensure a uniform objective method of determining the amount of funding needed to meet each waiver participant's needs. This budget allocation limit pertains to all waiver services except Transportation and up to \$500 per year for maintenance and repair of prior home modifications funded by a waiver service under the Home Modification service. The amount is determined using assessment information that reflects the needs of the waiver participant. This assessment information is collected and used by the State to determine the level of supports a waiver participant needs in order to live in a community setting. The assessment to determine a waiver participant's Algo score is performed as if no services were provided.

The ICAP assessment tool is used to determine a waiver participant's level of functioning for broad independence and general maladaptive factors. The ICAP Addendum determines a waiver participant's level of functioning on behavior and health factors. These two uniform assessments are used statewide to determine a waiver participant's overall functioning and level of need (algorithm or "Algo" score) from which an objective based allocation limit is assigned.

After the assessments are completed and the information is received by the State, the waiver participants and their ISTs are required to review the information and ensure that it accurately reflects the waiver participant who was assessed. Upon completion the waiver participant will be notified of the allocation limit through his or her case manager. ISTs may request a formal review of the allocation limit through the case manager. ISTs are asked to review the ICAP and ICAP addendum and provide supporting documentation to substantiate a waiver participant's need for a different Algo score. The supporting documentation is reviewed as well as the PCISP, behavioral support plans, high risk plans and any other documentation needed to analyze the waiver participant's Algo score. Any request for formal review is submitted to the State through the case manager.

An individual may appeal the ICAP assessment if the individual feels it is inaccurate. The individual has the right to appeal any waiver-related decision of the State within 33 calendar days of a Service Authorization (SA)/Notice of Action (NOA). An SA/NOA is issued with the release of each State decision pertaining to a PCISP. Each SA/NOA contains the appeal rights of the consumer as well as instructions for filing an appeal.

Waiver participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.

Individuals receiving services on the Community Integration and Habilitation (CIH) Medicaid Waiver can request additional funds above their objective-based allocation (OBA) through a short-term budget request (STBR) or a long-term budget request (LTBR) as set forth in 460 IAC 13-8-1.

Long-Term Budget Requests

Long-term adjustments to the allocation limit may be authorized when the individual 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.

The IST, driven by the individual receiving services and/or their legal guardian, determines if a review of the assigned allocation limit is needed and if a long-term budget request (LTBR) (previously known as a budget review questionnaire (BRQ)) should be submitted.

In the LTBR/BRQ responses, the IST must detail the exploration of other services supports, including but not limited to: Home and Community-based Services (HCBS) Medicaid waiver services, natural/integrated supports, remote supports, non-paid community services/supports, Medicaid state plan services (e.g. MA prior authorization), etc. Additionally, the IST must demonstrate compliance with the HCBS Final Settings Rule.

Prior to the LTBR submission, the case manager will ensure the following requirements are met:

- A team meeting (phone/virtual/in-person) has occurred once the need for an LTBR/BRQ has been identified. The team meeting must occur prior to the initial LTBR/BRQ submission in the state's case management system by either the provider or case manager.
- A comprehensive case note has been entered in the state's case management system which must be linked to the LTBR/BRQ.
 - At a minimum, the following must be documented: date of the team meeting, who attended the team meeting, individual or legal guardian/legal representative consent for the request and/or if any IST member disagreed with the request.
 - If the individual/legal guardian/legal representative does not agree to the request, the LTBR/BRQ will be denied.
- All supporting documentation is included with the LTBR/BRQ and is current/updated and signed, as appropriate, by all noted individuals.
- The LTBR/BRQ is submitted in the state's case management system to DDARS/BDS.

The required documentation for all LTBRs is as follows:

- Medical conditions have changed:
 - The individual's medical needs and the interventions needed to manage them (i.e., sleep apnea-CPAP machine).
 - (1) Please describe the individual's diet consistency i.e., mechanical, pureed, regular with no modifications etc.).
 - (2) Please list the individual's medications and the reasons each are prescribed.
 - Please list the individual's medications and the reasons each are prescribed.
 - Diagnosis and medications
 - Medical needs and interventions
 - High-risk plans (HRPs)
 - Doctor's letters/orders
 - Summary of Incident Reports (IRs)
 - Medicaid Prior Authorization (MA PA) referral
- Behavior conditions have changed:
 - Current behavioral support plan (BSP)
 - The total monthly average for each targeted behavior for the past year. Include a summary of the incident reports filed as a result of the individual's behavior. Also include information regarding if any injuries, police involvement and /or hospitalizations have occurred as a result of the individual's behavior.
 - Incident reports (IRs)
- ALGO needs to be reviewed:
 - Current behavioral support plan (BSP)
 - 6-12 months of behavior data (preferably 12 months)
 - Summary of incident reports (IRs)
 - ICAP changes
 - Diagnosis and medications
 - Medical needs and interventions
 - High-risk plans (HRPs)
 - Doctor's letters/orders
- Health and medical condition negates Day Programs:
 - The individual's medical needs and the interventions needed to manage them (i.e., sleep apnea-CPAP machine).
 - (1) Please describe the individual's diet consistency i.e., mechanical, pureed, regular with no modifications etc.).
 - (2) Please list the individual's medications and the reasons each are prescribed.
 - Diagnosis and medications
 - Medical needs and interventions
 - High-risk plans (HRPs)
 - Doctor's letters/orders
 - Summary of incident reports (IRs)
 - Medicaid Prior Authorization (MA PA) referral
- Finished school:

- "Certificate of Completion" and/or documentation from academic institution that individual is no longer in school.
- Wellness coordination health score review:
 - The individual's medical needs and the interventions needed to manage them (i.e., sleep apnea-CPAP machine).
- (1) Please describe the individual's diet consistency i.e., mechanical, pureed, regular with no modifications etc.).
- (2) Please list the individual's medications and the reasons each are prescribed.
 - Diagnosis and medications
 - High-risk plans (HRPs)
 - Doctor's letters/orders
 - Summary of incident reports (IRs)
 - Medicaid Prior Authorization (MA PA) referral

The IST must provide required supporting documentation that might lead to an adjustment in the allocation limit.

LTBRs must be submitted in the state's case management system as soon as the IST has identified the need. Once submitted, reviews are conducted by State staff within DDARS for approval or denial. If appropriate, adjustments and/or recommendations are provided by the DDARS review team.

Short-Term Budget Request

For short-term budget requests, individualized support teams (ISTs) must be aware of and adhere to the following policies and procedures:

- 1) The short-term budget request must demonstrate a current assessed need and be agreed to by the individual receiving services (or guardian, where applicable).
- 2) Short-term budget requests are for a period of six months or less from the first date the qualifying event started.
- 3) Prior to each STBR submission, the IST must ensure the following has occurred:
 - Explore and document the active pursuit/implementation of other services and supports, including but not limited to: natural/integrated supports, non-paid community services/supports, Medicaid state plan services (e.g., Medicaid prior authorization), as well as other Home and Community-Based Medicaid Waiver Services (HCBS), including remote supports and shared staffing (as an example).
 - Identify the date of the first day of the qualifying event.
 - Develop a written plan demonstrating how support will continue during and after the temporary supports are no longer available or necessary, including use of integrated supports.
 - Gather the documentation necessary to support the STBR.
 - Conduct a team meeting (via phone\virtual\in-person) once the need for an STBR has been identified.
- 4) The IST must ensure that the STBR qualifying event is appropriate.
- 5) Each STBR must include all required and other relevant documentation with the STBR submission, or it may be denied.
- 6) The case manager must include the attestation form with the submission.
- 7) BDS will only issue one (1) request for information (RFI) per STBR. If the requested information/clarification is not provided with the RFI response, the STBR may be denied.
- 8) STBRs will not be approved for more than six (6) months. If the IST feels that the qualifying event will exceed six (6) months, a long-term budget request should be discussed and submitted, if appropriate.
- 9) Only one STBR for the same time period may be submitted for an individual regardless of the qualifying event. Qualifying events include the following:
 - Loss of housemate
 - Loss of employment
 - Health/medical conditions have changed
 - Behavior conditions have changed
 - Medicaid prior authorization (PA) has been suspended
 - Loss of primary caregiver
 - Crisis situation (abuse, neglect, state intervention, etc.)
- 10) If an STBR is denied, a subsequent STBR for the same time period may also be denied.

ISTs should be proactively working together to ensure an individual can be supported within their available resources, inclusive of natural or informal supports, community resources, and paid services and supports in alignment with the federal Home and Community Based Services settings rule established by the Centers for Medicare and Medicaid Services (CMS) and as set forth in 42 CFR 441.301 and IC 12-8-1.6-8 .



Other Type of Limit. The state employs another type of limit.

Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

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

1. Description of the settings in which 1915(c) HCBS are received. *(Specify and describe the types of settings in which waiver services are received.)*

The Indiana Family and Social Services Administration (FSSA) attests that all settings are compliant with the HCBS Settings requirements at 42 CFR 441.301(c)(4)-(5).

Individuals receiving HCBS under the CIH waiver may reside in the following settings:

- Privately owned or rented homes by themselves or with family members, friends, or roommates
- Residential Habilitation and Support: Residential services offering an increased level of support in a home or apartment-like setting.
- Structured Family Caregiving (SFC) homes: Residential service arrangement in which an individual lives together with a related or non-related principal caregiver who provides daily care and support.

CIH 1915(c) waiver services are provided in the individual's home and community, based upon their preference. Additionally, Adult Day Services, Prevocational Services, and Day Habilitation are activities provided in a group setting, outside the individual's home. Settings for service delivery are chosen by the individual during the service planning process and identified in the individual's PCISP. To ensure compliance of all settings, HCBS questions are addressed and recorded in the PCISP.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and in the future as part of ongoing monitoring. *(Describe the process that the state will use to assess each setting including a detailed explanation of how the state will perform on-going monitoring across residential and non-residential settings in which waiver HCBS are received.)*

FSSA has developed and utilizes a variety of tools to establish HCBS settings criteria compliance and monitor on-going compliance for all provider-owned or controlled settings as well as any other settings where HCBS services are provided. These tools include the following:

- Provider application/reverification process that is conducted at least every 4 years.
- Service plan development/review process that is conducted at least annually.
- Quality Onsite Provider Review (QOPR) process that is conducted at least every 6 years.
- Complaint Investigation Process that is conducted on a continuously and on-going basis.

Provider Application and Reverification Process: The provider application process assesses for compliance by ensuring providers fully embrace person-centered values, practices, and planning by requiring new providers to demonstrate an understanding of the purpose of HCBS by articulating how they will support individuals in a way that complies with the HCBS Settings requirements at 42 CFR 441.301(c)(4)-(5).

Service Plan Development Process: HCBS settings questions are addressed and recorded in the PCISP. For provider owned or controlled residential settings a systemic verification process has been embedded within the service plan development process to ensure ongoing monitoring of HCBS settings compliance.

Provider Compliance Review Process: The oversight process for continuous compliance with HCBS settings requirements is conducted through the Provider Compliance Review. The Provider Compliance Review process includes an assessment tool that includes indicators to support determining if individual outcomes are being achieved as well as the providers compliance with the HCBS Settings requirements. Through this process FSSA reviews providers compliance with state and federal rules as well as speaks directly to individuals to make sure they are receiving person-centered quality services.

Complaint Investigation Process: Individuals can report any instances of non-compliance directly to their case manager or BDS field staff. BDS Quality Assurance also provides an online complaint form as well as a complaint hotline to submit reports of non-compliance.

Any individual, guardian, family member, and/or community member has the right to file a complaint on the behalf of an individual receiving waiver services through the CIH waiver. A complaint can be filed if it is felt the provider has not followed state and/or federal rules or program requirements. FSSA will then investigate the complaint and determine the best course of action to assess the situation.

FSSA applies a combination of existing guidelines to address any necessary remedial strategies including providing additional education and technical assistance. In the event a provider has gone through remediation activities and continues to demonstrate non-compliance with HCBS requirements, FSSA will apply its authority under IC 12-11-1.1-11 that allows for the issuance of citations in the form of developing corrective actions up to and including provider sanctions."

3. By checking each box below, the state assures that the process will ensure that each setting will meet each requirement:

- ☒ The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
- ☒ The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board. (see Appendix D-1-d-ii)
- ☒ Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.
- ☒ Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
- ☒ Facilitates individual choice regarding services and supports, and who provides them.
- ☒ Home and community-based settings do not include a nursing facility, an institution for mental diseases, an intermediate care facility for individuals with intellectual disabilities, a hospital; or any other locations that have qualities of an institutional setting.

Provider-owned or controlled residential settings. (Specify whether the waiver includes provider-owned or controlled settings.)

- ☐ No, the waiver does not include provider-owned or controlled settings.
- ☒ Yes, the waiver includes provider-owned or controlled settings. (By checking each box below, the state assures that each setting, in addition to meeting the above requirements, will meet the following additional conditions):
 - ☒ The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the state must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.
 - ☒ Each individual has privacy in their sleeping or living unit:
 - ☒ Units have entrance doors lockable by the individual.
 - ☒ Only appropriate staff have keys to unit entrance doors.
 - ☒ Individuals sharing units have a choice of roommates in that setting.
 - ☒ Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
 - ☒ Individuals have the freedom and support to control their own schedules and activities.
 - ☒ Individuals have access to food at any time.
 - ☒ Individuals are able to have visitors of their choosing at any time.
 - ☒ The setting is physically accessible to the individual.
 - ☒ Any modification of these additional conditions for provider-owned or controlled settings, under § 441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan (see Appendix D-1-d-ii of this waiver application).

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Person-Centered Individualized Support Plan (PCISP)

a. Responsibility for Service Plan Development. Per 42 CFR § 441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals. Given the importance of the role of the person-centered service plan in HCBS provision, the qualifications should include the training or competency requirements for the HCBS settings criteria and person-centered service plan development. *(Select each that applies):*

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

- ☐ **Social Worker**
Specify qualifications:

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

Appendix D: Participant-Centered Planning and Service Delivery

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

b. Service Plan Development Safeguards. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for service plan development except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *Select one:*

- ☒ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- ☐ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant. *Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can develop the service plan:***

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in service plan development. *By checking each box, the state attests to having a process in place to ensure:*

- ☐ **Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;**

- ☐ An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;
- ☐ Direct oversight of the process or periodic evaluation by a state agency;
- ☐ Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and
- ☐ Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

In advance of service plan development, case managers are responsible for providing information about the range of services and supports offered through the waiver to participants and other individuals selected by the participant to be a part of their Individualized Support Team (IST). Additionally, case managers are responsible for providing the information and supports necessary for the participant (and/or others designated by the participant) to direct the PCISP process.

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

All case managers are trained on the principles and tools of CtLC and the application of the principles and tools in the development of the PCISP. Case managers use the tools in partnership with the individual which are then shared with the individual as well as included in their PCISP as an attachment. Individuals also have access through the publicly available LifeCourse Nexus Training and Technical Assistance Center website located at <https://www.lifecoursetools.com/>.

(b) The individual designates the persons he or she wishes to participate in the development of his or her PCISP. The case manager is then responsible for inviting the selected persons to the meeting.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

- d. i. Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; (g) how and when the plan is updated, including when the participant's needs changed; (h) how the participant engages in and/or directs the planning process; and (i) how the state documents consent of the person-centered service plan from the waiver participant or their legal representative. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency

or the operating agency (if applicable):

(a) and (b)

The PCISP development process begins after informal and formal assessments are conducted using a combination of intake and referral data, standardized assessment tools, and direct observation of the individual. The PCISP is developed by the individual with support from the case manager. In accordance with 42 CFR 431.301, the person-centered service plan must be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation. FSSA requires that case managers furnish providers with a copy of the service plan initially, annually, and when there is a change or revision to the plan. Others of the individual's choosing may also participate in the development of the PCISP. This group forms the Individualized Support Team (IST). When developing the PCISP, the IST must meet in person at a time and location convenient to the individual. The PCISP first identifies the individual's preferences, aspirations, and health and safety needs. Then, by addressing the individual's identified outcomes and needs, the PCISP details what the individual wants to accomplish within a given year to achieve a good life across a variety of life domains. The PCISP documents how services and supports will be delivered to support the individual to meet his or her desired outcomes while addressing health and safety needs.

Case managers must have face-to-face contact with the waiver participant at least every 90 days and one unannounced home visit per year for individuals residing in provider- owned or controlled settings. IST meetings are required at least semi-annually, or when requested by the individual, family, the Bureau of Disabilities Services (BDS), or other team members. However, face-to-face contact and team meeting requirements for individuals with high risk or health needs remain unchanged from those previously stated in Appendix D, at least every 90 days but more often as determined by the IST.

The PCISP is updated at least annually, with a goal of determining the individual's needs, wants, and desires using person-centered planning philosophy processes. To be person-centered, the plan is required to be reflective of the individual's strengths and preferences related to relationships, community participation, employment, income and savings, health and wellness, and education.

The individual has the right and power to command and direct the entire PCISP process with focus on his or her preferences, dreams, and needs. The process empowers individuals to create life plans and allows individuals to direct the planning and allocation of resources to meet their self-directed life goals. The PCISP identifies the services and supports that are funded by the waiver and is routinely developed to cover a time frame of 12 consecutive months. The PCISP is developed by the participant-chosen case manager a minimum of six weeks prior to the initial start date of services or six weeks prior to the end date of the current annual service plan.

Utilized at initial intake and at least annually thereafter, the PCISP process accounts for and documents the individual's preferences, desires, and needs, including his or her likes and dislikes, means of learning, decision-making processes, management of finances, and desire to be productive and employed. It is the case manager's responsibility to ensure a person-centered planning process is conducted using plain language and that the process is timely, occurring at times/locations of convenience to the individual. Each individual's PCISP will then be reviewed at least every 90 calendar days during visits by the case manager. Needed updates are brought to the attention of the IST, which will meet more frequently than the required semi-annual basis if needed or desired.

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

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

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

(d) The PCISP is developed based upon the outcomes of the initial, annual, or subsequent meeting of the IST during which the PCISP is developed, reviewed, and/or updated. Person-centered service plans document the options based on the individual's needs, preferences, and, for residential settings, individual waiver participant resources available for room and board. This entire process is driven by the individual and is designed to recognize the individual's needs and desires. The case manager follows the PCISP process discussed under items (a) and (b) above. The overall emphasis of the process will be to determine what is important to and what is important for the individual, with a goal of presenting a good balance of the two within the service plan. The case manager facilitates the IST meeting, reviews the individual's desired outcomes, his or her health and safety needs and preferences, and reviews covered services, other sources of services and support (paid and unpaid), and the budget development process for waiver services. The case manager then finalizes the PCISP.

(e) Case managers are responsible for the implementation and monitoring of the PCISP, and for monitoring the individual's health and welfare on an on-going basis. Coordination of waiver services and other services is completed by the case manager. Within 30 calendar days of implementation of the plan, the case manager is responsible for ensuring that all identified services and supports have been implemented as identified in the PCISP. The case manager is responsible for monitoring and coordinating services on an ongoing basis and is required to record at least one monthly case note for each individual. At least once every 90 calendar days, a review is 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. Each waiver provider is required to submit a quarterly report summarizing the level of support provided to the individual based upon the identified supports and services in the PCISP. The case manager reviews these reports for consistency with the PCISP and works with providers as needed to address findings from this review.

(f) The PCISP identifies the services needed by the individual to pursue his or her desired outcomes and to address his or her health and safety needs. The PCISP identifies all paid and unpaid services and supports, and includes the name of the provider, the service, and the responsible staffing position(s) within the chosen service agency or agencies for waiver-funded services. The individual may be responsible for outcomes of the PCISP if they so determine. The PCISP identifies the following: the name of the waiver-funded service, the name of the participant-chosen provider of that service, the cost of the service per unit, the number of units of service, and the start and end dates for each waiver service identified on the PCISP.

(g) The PCISP is 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 may request a change to the PCISP at any point. Changes may include a new service provider, a change in the type of service, or a change in the amount of service. If a change to the PCISP is determined necessary during that time, the individual and/or family or legal representative and IST will meet to discuss the change. The case manager makes any subsequent updates to the PCISP based upon the individual and the IST discussion and determination.

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

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

ii. HCBS Settings Requirements for the Service Plan. *By checking these boxes, the state assures that the following will be included in the service plan:*

- ☐ The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.
- ☒ For provider owned or controlled settings, any modification of the additional conditions under 42 CFR § 441.301(c)(4)(vi)(A) through (D) must be supported by a specific assessed need and justified in the person-centered service plan and the following will be documented in the person-centered service plan:
 - ☒ A specific and individualized assessed need for the modification.
 - ☒ Positive interventions and supports used prior to any modifications to the person-centered service plan.
 - ☒ Less intrusive methods of meeting the need that have been tried but did not work.
 - ☒ A clear description of the condition that is directly proportionate to the specific assessed need.
 - ☒ Regular collection and review of data to measure the ongoing effectiveness of the modification.
 - ☒ Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
 - ☒ Informed consent of the individual.
 - ☒ An assurance that interventions and supports will cause no harm to the individual.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Risks to the individual are first assessed during the initial PCISP development process. Risks are assessed based upon the following processes:

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

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

Case management providers schedule additional IST meetings as necessary when a change in the individual's status is identified. Any risk issues (i.e. health, behavioral, physical management, and environmental management) identified through the PCISP process are addressed through participant-specific risk plans to proactively and reactively address the risk issue(s). The outcomes of the assessment are used to guide the IST in the development of the individual's risk plan(s) or to review and revise the risk plan(s) as appropriate.

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

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

When individuals receive waiver services in their own homes the service plan must include a back-up plan to address contingencies such as emergencies. Back-up plans are specified within the PCISP and include contacting the case management provider's 24/7 line for assistance, contingency arrangements such as telephone calls to family, friends, neighbors, police or 911 emergency responders, walking to the home of a neighbor, or the use of a personal emergency response system when approved on the PCISP. Providers of case management services maintain a 24/7 emergency response system that does not rely upon the area 911 system and provides assistance to all waiver participants of the CIH. The 24/7 line staff 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.

The State maintains an extensive list of resource materials on the Bureau of Disabilities Services (BDS) Resource Materials webpage to assist with risk mitigation.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

An electronic database is maintained by DDARS that contains information regarding all qualified waiver providers for each service on the CIH. Case managers are able to generate a list of all qualified providers for each service on the waiver for the individuals' use.

As a service is identified, the individual or guardian with the support team are encouraged to call and interview potential service providers and make their own choice. Case managers can assist the individual with interviewing potential providers and obtaining references on potential providers, if desired by the individual.

The individual can request a change of any service provider at any time while receiving CIH services. The case manager will assist the individual with obtaining information about any and all providers available for a given service.

Case managers are not allowed to give their personal or professional opinion on any waiver service provider. The case manager is responsible for the coordination of the transition of a provider once determined by the individual.

The Choice List is updated automatically in the state's electronic case management system.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR § 441.301(b)(1)(i):

FSSA is the Single State Medicaid Agency. The Office of Medicaid Policy and Planning (OMPP) and the Division of Disability Aging and Rehabilitative Services (DDARS) are divisions within FSSA. The Bureau of Disabilities Services (BDS) is a bureau within DDARS.

All service plans (which are called Person Centered Individualized Support Plans or PCISPs) are subject to the approval of the state Medicaid agency. Oversight of PCISPs has been delegated to DDARS and its BDS. Initial PCISPs that require confirmation of facility discharge and PCISPs that include variable rate services are reviewed to verify the individual's needs and receipt of sufficient supporting documentation. Designated staff from BDS are responsible for making the determination to approve, deny or request additional information on a PCISP.

An in-depth review of a sample of service plans is conducted on a routine basis as described below. Note the in-depth review of service plans by BDS includes all PCISP components, not just the components outlined in the state's reportable Performance Measures.

Prior to the start of each waiver year, BDS generates a valid representative sample with a confidence interval of 95% for the full (active) waiver population. This representative sample is then allocated across the case management organizations (CMO) proportionate to the number of individuals each CMO serves. The annual sample size and CMO allocation is reviewed on a semi-annual basis and adjusted for growth as needed.

The CMO is required to review 1/12 of their allocated sample each month. For each individual selected, the CMO is required to complete a rubric and a file review.

Additionally, on a quarterly basis, BDS conducts its own in-depth review to verify the rubric and file review findings reported to BDS by the CMOs. The BDS sample randomly selects at least 20% of the review findings reported by CMOs for the quarter. Designated staff from BDS verify that all required components of the PCISPs are in place.

The PCISP includes natural and other non-paid supports.

As the result of the Quality Improvement Executive Committee (QIEC) meetings where performance measures are monitored and discussed, OMPP receives quarterly reports from BDS that contain performance-related data pertaining to oversight of the PCISPs.

Appendix D: Participant-Centered Planning and Service Delivery

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

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update, when the individual's circumstances or needs change significantly, or at the request of the individual, to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ☐ Every three months or more frequently when necessary
- ☐ Every six months or more frequently when necessary
- ☐ Every twelve months or more frequently when necessary
- ☒ Other schedule

Specify the other schedule:

The PCISP is reviewed and updated no less than annually. The PCISP is reviewed by the case manager at least once every 90 calendar days. The individual can request a change at any time.

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR § 92.42. Service plans are maintained by the following (*check each that applies*):

- ☒ Medicaid agency
- ☐ Operating agency
- ☐ Case manager
- ☒ Other

Specify:

Electronic documents of the PCISP are maintained in the State's case management data system for a minimum of three years.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan, participant health and welfare, and adherence to the HCBS settings requirements under 42 CFR §§ 441.301(c)(4)-(5); (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

Case managers are responsible for the implementation and monitoring of the PCISP, and for monitoring waiver participant health and welfare. To facilitate the development and implementation of the PCISP, the case manager contacts the individual prior to the initial/annual person-centered planning meeting to discuss their needs. This discussion may include questions about the individual's satisfaction with current services. Additionally, the IST meets at least semi-annually to ensure individual continues to be satisfied with current services.

A minimum of one face-to-face contact between the case manager and the individual is required at least every 90 calendar days, and as frequently as needed to support the individual. In each meeting, the individual's current concerns and progress, as well as implementation of the PCISP, are reviewed.

At least once every 90 calendar days, the monitoring checklist is completed. The monitoring checklist is an automated tool that is utilized by the case manager in order to systematically review the PCISP. In addition, the monitoring checklist facilitates the review of reports from providers or from any behavioral support program, choice and rights, medical needs, medications, including psychotropic medications (if applicable), seizure management (if applicable), nutritional/dining needs, community integration, staffing issues, fiscal issues, and any other issues that may be identified in regard to the satisfaction and health and welfare of the individual.

The case manager is required to document at least one monthly case activity note in the state's electronic case management system (BDS Portal). This monthly case note must indicate the progress and implementation of the PCISP.

The case manager maintains regular contact with the individual, family/guardian, and the provider(s) of services through home and community visits or by phone to coordinate care, monitor progress, and address any immediate needs. During each of these contacts the case manager assesses implementation of the plan as well as monitors the individual's needs. Contact information is in place in the home, including the telephone numbers for Adult Protective Services or Child Protective Services and BDS.

The monitoring and follow up method used by the case manager may 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 phone contacts. The case manager asks:

- Are the services being rendered in accordance with the plan of care?
- 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 back up plans?
- Is the individual's health and welfare being ensured?
- Do individual have access to non-waiver services identified in the plan of care including access to health services?

The implementation and effectiveness of the plan of care is reviewed at least once every 90 calendar days by the case manager and at least semi-annually in meetings of the IST.

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

Service Problems

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

- Case managers conduct a face-to-face visit with each individual no less frequently than once every 90 calendar days to review the monitoring checklist, obtaining agreement of the IST for any needed updates.
- Case managers investigate the quality of waiver participant services, and indicate on the checklist if any problems related to waiver participant services were not yet identified.
- For each identified problem, case managers identify the timeframe and person responsible for corrective action, communicate this information to the IST, and monitor to ensure that corrective action takes place by the designated deadline.
- Case management supervisors, directors, or other identified executive management staff within each case management entity monitor each problem quarterly via a report from the state's case management system to ensure that case managers are following up on, and closing out any pending corrective actions for identified problems.

At least once every 90 calendar days, in conjunction with the monitoring checklist, case managers document the individual's progress to indicate if all providers and other team members are current and accurate in their implementation of plan activities on behalf of the individual.

Any lack of compliance on the part of provider entities or other team members is noted within participant-specific case notes, indicating any need for follow up and communicated to the noncompliant entity for resolution. Case managers monitor occurrences of noncompliance to ensure completion of all identified outcomes for each individual, filing a formal complaint with BDS as described in Appendix F-3, when resolution is not achieved.

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

Alleged, suspected or actual abuse, neglect or exploitation of an individual. An incident in this category must also be reported to Adult Protective Services or Child Protective Services. In cases where staff is involved, the provider shall suspend staff involved in an incident from duty pending investigation by the provider.

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

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

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

BDS QA/QI Contractor's incident reviewers review these follow-up reports to determine the following: 1) if the individual's immediate safety has been secured, and 2) that plans are in place to prevent reoccurrences. Only when both of these criteria are satisfied will BDS QA/QI Contractor's incident reviewers close an incident report. Case managers are required to continue providing follow-up reports at a minimum of every seven calendar days until an incident is closed. The case management supervisors, directors, or other identified executive management staff within each case management entity monitor the timeliness of follow up on incident reports by the case managers.

Upon receipt of information regarding ongoing, systemic behaviors on the part of a provider of service that are not in accordance with established standards of practice, the case manager will:

- Attempt to resolve the issue verbally with the provider in question
- If no resolution is made, put the issue in writing to the provider. If then no resolution is made, bring the issue to the attention of the local BDS service coordinator.

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

Problems as identified within the monitoring checklist are reviewed quarterly at a minimum for follow up and closure by the case management supervisors, directors or other identified executive management staff within each case management entity.

Untimely and/or incomplete progress toward identified outcomes for each individual must be presented and discussed with the IST by the case manager. Issues are initially addressed within the scope of the team and provider agency, and may be escalated to DDARS via the filing of a formal complaint, mediation with the BDS service coordinator, or via an incident report should the problems prove to be systemic and/or otherwise not resolvable at the case management level.

The statewide Bureau of Disabilities Services ombudsman is available to receive, investigate, and attempt to resolve

complaints and concerns that are made by or on behalf of individuals who have a disability and receive services administered by the Bureau of Disabilities Services (BDS). Complaints may be received via the toll free number 1-800-622-4484, via e-mail, in hard copy format or by referral. Types of complaints received include complaints initiated by families and/or individuals, complaints involving rights or issues of individual choice, and complaints requiring coordination between legal services, DDARS services and provider services.

b. Monitoring Safeguard. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for monitoring the implementation of the service plan except, at the option of the state, when providers are given this responsibility because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *Select one:*

- **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may not provide other direct waiver services to the participant.**
- **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may provide other direct waiver services to the participant because they are the only the only willing and qualified entity in a geographic area who can monitor service plan implementation.** *(Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can monitor service plan implementation).*

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in monitoring of service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements. *By checking each box, the state attests to having a process in place to ensure:*

- ☐ **Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;**
- ☐ **An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;**
- ☐ **Direct oversight of the process or periodic evaluation by a state agency;**
- ☐ **Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and**
- ☐ **Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.**

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

- a. Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

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

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

Performance Measure:

D.4 Number and percent of sampled individuals whose PCISP addressed their assessed risks (as applicable). Numerator: Number of sampled individuals whose PCISP addressed their assessed risks (as applicable). Denominator: Total number of sampled individuals who have a PCISP with identified assessed risks requiring mitigation.

Data Source (Select one):

Other

If 'Other' is selected, specify:

CMGT Rubric/Case file review

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

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

Data Aggregation and Analysis:

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

Performance Measure:

D.1 Number and percent of sampled individuals who report that their service plan includes things that are important to them. Numerator: Number of sampled individuals who report that their service plan includes things that are important to them. **Denominator:** Total number of sampled individuals who provided a valid response to the service plan importance question.

Data Source (Select one):

Other

If 'Other' is selected, specify:

National Core Indicators (NCI)

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
☐ State Medicaid Agency	☐ Weekly	☐ 100% Review
☒ Operating Agency	☐ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☒ Quarterly	☐ Representative Sample Confidence Interval =
☒ Other Specify: NCI Survey Contractor	☐ Annually	☐ Stratified Describe Group:
	☒ Continuously and Ongoing	☒ Other Specify: Representative Sample; Confidence Interval = 95%; Proportional and stratified across state districts
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

Performance Measure:

D.3 Number and percent of sampled individuals whose PCISP included a risk assessment. Numerator: Number of sampled individuals whose PCISP included a risk assessment. **Denominator:** Total number of sampled individuals who have a PCISP and were assessed for risk assessment inclusion.

Data Source (Select one):

Other

If 'Other' is selected, specify:

CMGT Rubric

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

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

Data Aggregation and Analysis:

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

Performance Measure:

D.2 Number and percent of sampled individuals whose PCISP addresses their needs and abilities. Numerator: Number of sampled individuals whose PCISP addresses their needs and abilities. Denominator: Total number of sampled individuals.

Data Source (Select one):

Other

If 'Other' is selected, specify:

CMGT Case file reviews

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
☐ State Medicaid Agency	☐ Weekly	☐ 100% Review
☒ Operating Agency	☐ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☒ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☒ Continuously and Ongoing	☒ Other Specify: Representative Sample; Confidence Interval = 95%; Proportional and stratified across state districts
	☐ Other Specify:	

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Data Aggregation and Analysis:

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

- b. Sub-assurance: Service plans are updated/revised at least annually, when the individual's circumstances or needs change significantly, or at the request of the individual.**

Performance Measures

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

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

- c. Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration, and frequency specified in the service plan.**

Performance Measures

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

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

Performance Measure:

D.5 Number and percent of sampled individuals whose PCISP was reviewed and changed (as needed) when their needs changed. Numerator: Number of sampled individuals whose PCISP was reviewed and changed (as needed) when their needs changed. Denominator: Total number of sampled individuals.

Data Source (Select one):

Other

If 'Other' is selected, specify:

CMGT Rubric/Case file review

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

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

Data Aggregation and Analysis:

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

Performance Measure:

D.6 Number and percent of individuals whose PCISPs were updated/revised within 365 days of the previously approved annual PCISP. Numerator: Number of individuals whose PCISPs were updated/revised within 365 days of the previously approved annual PCISP. Denominator: Total number of individuals enrolled in the waiver who are due for an annual PCISP.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Electronic Case Management Database

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
☐ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☐ Monthly
☐ Sub-State Entity	☒ Quarterly

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

d. Sub-assurance: Participants are afforded choice between/among waiver services and providers.

Performance Measures

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

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

Performance Measure:

D.7 Number and percent of individuals who received the waiver services/supports in their PCISPs in the stipulated type, scope, amount, duration, and frequency.

Numerator: Number of sampled individuals who received the waiver services/supports in their PCISPs in the stipulated type, scope, amount, duration, and frequency. **Denominator:** Total number of sampled individuals.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Monitoring Checklist

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

		Sample Confidence Interval = 95%
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☒ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

- e. **Sub-assurance:** *The state monitors service plan development in accordance with its policies and procedures.*

Performance Measures

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

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

Performance Measure:

D.8 Number and percent of individuals who were afforded a choice between/among waiver services and providers. Numerator: Number of sampled individuals who were afforded a choice between/among waiver services and providers. **Denominator:** Total number of sampled individuals.

Data Source (Select one):

Other

If 'Other' is selected, specify:

CMGT Rubric/Case file review

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

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

Data Aggregation and Analysis:

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

Performance Measure:

D.9 Number and percent of sampled individuals who responded that the case manager (CM) asks what the individual wants as part of service plan. Numerator: Number of sampled individuals who responded that the CM asks what the individual wants as part of service plan. **Denominator:** Total number of sampled individuals who responded.

Data Source (Select one):

Other

If 'Other' is selected, specify:

National Core Indicators (NCI)

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
☐ State Medicaid Agency	☐ Weekly	☐ 100% Review
☒ Operating Agency	☐ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☒ Quarterly	☐ Representative Sample Confidence Interval =
☒ Other Specify: NCI Survey Contractor	☐ Annually	☐ Stratified Describe Group:
	☒ Continuously and Ongoing	☒ Other Specify: Representative Sample; Confidence Interval = 95%; Proportional and stratified across state districts
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

For measures D.1 and D.9, a PCISP is developed to support the individual in attaining a good life. Indiana utilizes the NCI In-Person Survey to assess whether an individual's services and supports identified in the PCISP are supporting him or her in moving towards a good life. A face-to-face survey is conducted in which the individual is asked a series of questions regarding satisfaction. One of the questions is specific to whether the individual believes the services and supports help him or her live a good life. The NCI response data is collected during the survey process but the specific individual is not identified. The data is reviewed on a quarterly basis by QIEC and when a trend is identified, guidance and education for the entire stakeholder community is developed and communicated. DDARS has conducted training on the LifeCourse Framework™ and the implementation of the PCISP.

For measures D.2, D.3, D.4, D.5, and D.8, BDS and each Case Management Organization conducts monthly rubric and case reviews utilizing a waiver-specific valid sampling methodology. BDS and CMO staff review waiver individuals records for case manager compliance with Indiana Administrative Code rules related to the PCISP as well as adherence to person-centered principles and thinking. Additional aspects of the case review include: review of the PCISP, risk assessment (embedded in the PCISP), identified risk plans, Medicaid services (BDS signature page/freedom of choice section), signed choice lists for each service, and an updated PCISP when an individual's conditions or circumstances change.

Each item reviewed that is not in compliance, is documented on the review template. CMOs are responsible for remediating the issue upon discovery. Each CMO shares their results with BDS and BDS conducts a comparative analysis of the data. The comparative analysis is shared with each CMO. During the CMO's quarterly meeting with BDS, BDS discusses data as well as trends identified during the reviews. The data is tracked from quarter to quarter to identify any additional deficiencies surfacing over time. This process allows for identification of issues that may require additional training and education.

While D.6 and D.7 are reports that gather information from the required activities by the case managers. The annual PCISP and monitoring checklist are required to be completed within established timeframes. When a deficiency is identified, the CMO is required to complete a corrective action. BDS monitors the issue until the issue is corrected. The specific case and identified trends are also discussed with the CMO during their quarterly meeting.

FSSA uses a centralized IT system to aggregate data and to identify systemic deficiencies. The Quality Improvement Executive Committee (QIEC) meets on a quarterly basis to review data collected from the performance measures for the waivers and identify systemic improvements needed (if any). The QIEC then follows up on the status of recommended systemic improvements at the next QIEC meeting until implementation is completed.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

☒ No

☐ Yes

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

Appendix E: Participant Direction of Services

Applicability (from Application Section 3, Components of the Waiver Request):

☒ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

☐ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

- a. Description of Participant Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

The case manager will provide detailed information during the service planning development phase to individuals, caregivers, and families about the option to direct the following services:

- Residential Habilitation & Support (Hourly)
- Respite
- Workplace Assistance

If an individual chooses to self-direct any of these services, they are empowered to choose their own self-directed worker. This program allows individuals receiving care, or their representatives on their behalf, to select, schedule, train, supervise, and terminate their own self-directed workers. The individual directing care or their representative takes on all of the responsibilities of being an employer except for payroll management, which is handled by the financial management services (FMS) vendor.

Some of the opportunities afforded to the individual who is self-directing services include:

- An opportunity to exercise more autonomy, to arrange services more conveniently, and to work with self-directed workers who they choose.
- An alternative to agency-based services or services provided by independent care providers.
- The opportunity to arrange for services from more than one self-directed worker or from a combination of agency-based services and self-directed services, depending on their service plan.

Self-directed workers shall be recruited, hired, trained, paid, and supervised under the authority of the individual, the individual's parent(s) if the person is a minor or the individual's guardian. The individual may designate a representative to assist or assume their own self-direction of their services. The individual or their representative may assume the responsibility to initiate self-directed service(s) and exercise judgment regarding the manner in which those services are delivered, including the decision to employ, train, and dismiss a self-directed worker.

Case managers are an integral part of the success of the INCharge Self-Directed Program. The case manager is responsible for oversight and monitoring of the Service Plan of the individual; assisting the individual who is directing care; evaluating how participant-directed services can appropriately meet the individual's needs; and assessing whether the individual or the individual's representative is interested in taking on the responsibilities associated with participant-direction.

For participant-direction, the case manager is required to have face-to-face contact with the individual at least every ninety (90) days, or more often as the needs of the individual change. The case manager reviews the person-centered service plan with the individual for continuing use of participant-directed services every ninety (90) days. The case manager shall evaluate for quality and ask the individual to verify whether they are satisfied with the services they are receiving. Representatives directing care on behalf of the individual will be required to verify services provided by the self-directed worker to ensure appropriate time reporting and support to the individual.

The Division of Disability Aging and Rehabilitative Services, a division under the single state Medicaid agency, contracts with FMS vendors whose responsibilities serving as the payroll department include; obtaining limited criminal background history checks on providers; issuing paychecks per submitted timesheets; withholding all necessary taxes; filing monthly, quarterly, and annual tax and labor reports; issuing annual W-2 wage statements; managing service units; providing individuals, employers and case managers with monthly reports of spending on individual's behalf; and responding to all questions posed by DDARS, the individual, self-directed worker, and state officials.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver.*Select one:*

- ☐ **Participant: Employer Authority.** As specified in *Appendix E-2, Item a*, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ☐ **Participant: Budget Authority.** As specified in *Appendix E-2, Item b*, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ☒ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in *Appendix E-2*. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies:*

- ☒ Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.
- ☐ Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.
- ☐ The participant direction opportunities are available to persons in the following other living arrangements

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy (*select one*):

- ☐ Waiver is designed to support only individuals who want to direct their services.
- ☒ The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.
- ☐ The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

Individuals residing in Indiana and receiving participant-directed services on the CIH Waiver are offered the option to self-direct by case managers. Information about the self-directed option will be provided in advance of service planning and at least annually. The Self-directed services toolkit will be provided to individuals, their families, and representatives (if applicable), which includes descriptions of benefits and responsibilities to help them make an informed choice.. Information pertaining to individual/representative responsibilities is provided to individuals when they are contemplating accessing self-direction opportunities prior to beginning a new self-directed service arrangement. At that time, the case manager must make sure the individual receives appropriate training/support and understands these roles and responsibilities by providing the online training from Medicaid.gov for individuals who self-direct or wish to self-direct. The training series consists of six, self-guided modules, each covering a different aspect of direct service worker recruitment, training and retention and is available in multiple accessible formats. The series can be found at: <https://www.medicaid.gov/medicaid/long-term-services-supports/direct-care-workforce/online-training-for-self-directed-hcbs/index.html> The case manager must discuss what support is chosen by the individual to assist them to self-direct their services; if no support is needed or desired, case managers must, at a minimum, provide training on the following:

- How the self-directed option works.
- Employer of record duties, including hiring, firing, training, and timekeeping.
- How to engage with Indiana's FMS vendors.
- A written copy of the person-centered service plan and self-directed budget is provided to all members of the individual's support team.

Individuals are empowered to choose their own self-directed workers. This program enables individuals receiving care or their representatives to select, schedule, train, supervise, and dismiss their own self-directed workers. The individual, and/or the individual's representative (if applicable), directing care takes on all of the responsibilities of being an employer, except for payroll management, which is handled by the FMS vendor.

Case Managers are responsible for assessing individual interest in self-direction and providing them with information regarding the philosophy and availability of self-direction. The information provided must include:

- A clear explanation that participation in participant-direction is voluntary;
- An overview of the supports and resources available to assist individuals to participate to the extent desired in participant-direction; and
- An overview of the individual's rights and responsibilities, including actions that may result in removal of participation in the participant-direction, and the individual's right to participate in the grievance process.

The individual and the case manager will create a self-directed worker reimbursement budget based on the self-directed spend plan methodology. Individuals will receive monthly financial budget reports detailing the funds spent and remaining for the year.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative (*select one*):

- ☐ The state does not provide for the direction of waiver services by a representative.
- ☒ The state provides for the direction of waiver services by representatives.

Specify the representatives who may direct waiver services: *(check each that applies)*:

- ☒ Waiver services may be directed by a legal representative of the participant.
- ☒ Waiver services may be directed by a non-legal representative freely chosen by an adult participant.

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Individuals are permitted to have a non-legal representative assist them in participating in participant-direction when they have the ability to designate a person to serve as their representative. Representatives must meet the following minimum requirements:

- Be at least 18 years of age;
- Have a personal relationship with the individual and understand their support needs;
- Know the individual's daily schedule and routine, medical and functional status, medication regimen, likes and dislikes, and strengths and weaknesses; and
- Be physically present in the individual's residence on a regular basis or at least at a frequency necessary to supervise and evaluate each self-directed worker. This frequency can be determined through the person-centered service planning process.

Representatives have decision-making authority related to the role of employer or record for self-directed services included in the plan.

An individual's representative will not receive payment for serving in this capacity and will not serve as the individual's self-directed worker for participant-direction. Parents of minor children participants, spouses of participants, individuals with power of attorney, legal guardians, and health care representatives may not be hired as paid self-directed workers

The case manager is required to use a representative agreement developed by BDS to document an individual's choice of a representative for participant-direction, the representative's contact information, and to confirm the representative's agreement to serve as the representative and to accept the responsibilities and perform the associated duties defined therein. The representative agreement is signed by the individual (or person authorized to sign on individual's behalf) and the representative in the presence of the case manager.

Individuals may change their representative at any time. The case manager verifies the new representative meets the required qualifications and a new representative agreement is completed and signed, in the presence of the case manager, prior to the new representative assuming their respective responsibilities. The case manager is responsible for facilitating a seamless transition to the new representative. As part of the service plan development process, the case manager must educate the individual about the importance of notifying the case manager prior to changing a representative.

The case manager is required to monitor the individual's participation in participant-direction, including any patterns such as frequent turnover of representatives which may warrant intervention.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Respite	☒	☒
Residential Habilitation and Support (hourly)	☒	☒
Workplace Assistance	☒	☒

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

- **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies:*

☐ **Governmental entities**

☒ **Private entities**

- **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one:*

- **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

- **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

The Bureau of Disabilities Services (BDS), through the procurement process, contracts with an FMS vendor for participant-directed services. The FMS vendor is responsible for serving as the payroll department; Verify self-directed worker citizenship status and processing of timesheets (see document if needed); administering limited criminal history background checks; professional licensure checks; issuing paychecks per submitted timesheets; filing monthly, quarterly and annual tax and labor reports; issuing annual W-2 wage statements; managing service units; providing individuals, employers, contractors and case managers with monthly reports of FMS vendor spending on the individual's behalf; and responding to questions and issues concerning participant-direction.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

The FMS vendor is compensated for administrative activities which include compensation for performing payroll and related functions for individuals who are self-directing their care. The administrative activity costs are divided equally per month throughout the length of the contract. The FMS vendor is also reimbursed based upon an established fee-for-service basis for each quarter hour of services provided by the individual's self-directed worker on the approved service plan. The ratio between the administrative activities and the fee-for-service activities is 1-4 or 25% to 75%. Therefore, the administrative activities equal 25% percent of the total cost of the self-directed care program and the fee for service equals 75% of the cost of the self-directed services.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies):*

Supports furnished when the participant is the employer of direct support workers:

- ☒ Assist participant in verifying support worker citizenship status
- ☒ Collect and process timesheets of support workers
- ☒ Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance
- ☒ Other

Specify:

Administers limited criminal history background check.

Supports furnished when the participant exercises budget authority:

- ☒ Maintain a separate account for each participant's participant-directed budget
- ☒ Track and report participant funds, disbursements and the balance of participant funds
- ☒ Process and pay invoices for goods and services approved in the service plan
- ☒ Provide participant with periodic reports of expenditures and the status of the participant-directed budget
- ☐ Other services and supports

Specify:

Additional functions/activities:

- ☐ Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency
- ☒ Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency
- ☒ Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget
- ☐ Other

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

DDARS through its Bureau of Disabilities Services (BDS) is responsible for monitoring the performance of the FMS vendor through monthly and quarterly reports and meetings with FSSA.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services,

participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (*check each that applies*):

- ☒ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

Case managers are an integral part of the success of the participant-directed services as the case manager is responsible for oversight and monitoring of the individual's service plan. One of the case manager's responsibilities is to have face-to-face contact with the individual at least every ninety (90) days, or more often as the needs of the individual change. The role of the case manager is to empower the individual in directing care and in evaluating whether self-direction is appropriate for meeting the individual's needs and whether the individual or the individual's representative is able to fulfill all the responsibilities to manage the participant-directed services. The individual and the case manager will be asked to verify weekly face-to-face visits between the self-directed worker and the individual. The case manager also helps to provide administrative guidance to the individual, or the individual's representative, regarding the self-directed services implementation process. This process includes: training on the program; assisting with obtaining and/or completion of the employer and employee packets involved in hiring the self-directed worker; directing the employer to the FMS vendor's help line if assistance is needed with the completion of the FMS vendor forms and paperwork; and monitoring the outcomes of the participant-directed services.

- ☒ **Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (*check each that applies*):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Speech /Language Therapy	☐
Prevocational Services	☐
Recreational Therapy	☐
Music Therapy	☐
Intensive Behavioral Intervention (Terminated as of 12/30/2025)	☐
Wellness Coordination	☐
Behavioral Support Services (BSS)	☐
Home Modification Assessment (Terminated as of 12/30/2025)	☐
Case Management	☒
Transportation	☐
Residential Habilitation and Support - Daily (RHS Daily)	☐
Facility Based Support Services	☐
Personal Emergency Response System	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Respite	☐
Vehicle Modifications	☐
Day Habilitation	☐
Family and Caregiver Training	☐
Remote Supports	☐
Home Modifications and Assessments (Effective 12/31/2025)	☐
Occupational Therapy	☐
Extended Employment Services	☐
Specialized Medical Equipment and Supplies	☐
Community Transition	☐
Home Modifications (Terminated as of 12/30/2025)	☐
Adult Day Services	☐
Residential Habilitation and Support (hourly)	☐
Career Exploration and Planning	☐
Benefits Counseling (Effective 12/31/2025)	☐
Rent and Food for Unrelated Live-in Caregiver	☐
Structured Family Caregiving	☐
Workplace Assistance	☐
Psychological Therapy	☐
Physical Therapy	☐

- ☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy (select one).

- No. Arrangements have not been made for independent advocacy.
- Yes. Independent advocacy is available to participants who direct their services.

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

- l. Voluntary Termination of Participant Direction.** Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

An individual may voluntarily withdraw from participant-direction at any time. The individual and/or representative will be advised to notify the case manager as soon as they determine that they are no longer interested in participating in participant-direction. Upon receipt of an individual's request to withdraw from participant-direction, the case manager will conduct a face-to-face visit and update the individual's service plan, as appropriate, to initiate the process to transition the individual to agency-provided services. The case manager will provide information regarding other service options and assure selected services are able meet the individual's needs and assure their health and safety during transition.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

- m. Involuntary Termination of Participant Direction.** Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Individuals shall be involuntarily terminated from participant-direction and offered traditional waiver services when it has been determined by the Bureau of Disabilities Services (BDS) the individual is unable to perform the functions and duties required to self-direct their services independently or with the support of a designated representative.

Self-directed workers shall be identified for involuntary termination from participant-direction when it has been determined by the case manager that any of the following exist: (A) An immediate health and safety risks associated with the individual, such as, imminent risk of death or irreversible or serious bodily injury related to the provision of Waiver services; or (B) misuse of funds following notification, assistance and support from the FMS vendor and/or case manager; or (C) failure to follow and implement policies of participant-direction after receiving technical assistance and guidance from the FMS vendor and/or case manager; or (D) providing false information and/or documentation; or (E) self-directed worker is in violation of 455 IAC 2-15- 2; or (F) individual abuse and/or neglect. Requests for involuntary termination must be sent by the case manager to BDS for review and approval.

The case manager assists the individual with accessing needed and appropriate services through the traditional waiver services option, ensuring that no lapse in necessary services occurs for which the individual is eligible. The case manager will provide information regarding other service options and assure selected services are able meet the individual's needs and assure their health and safety during transition. This process will not circumvent the individual's right to a fair hearing as detailed in Appendix F-1.

When an individual or paid self-directed worker is involuntarily terminated, they shall be ineligible to reapply for participant-directed services as either a waiver participant or self-directed worker for twenty-four (24) months following the date of termination.

The case manager must work with the FMS vendor to ensure that the issues previously identified as reasons for termination have been adequately addressed prior to reinstatement.

Individuals who are determined for involuntary termination from self-direction may choose to reengage in self-direction under the following conditions:

- Designation of a representative when no representative existed at time of involuntary termination; or
- Designation of a new representative when representative at time of involuntary termination was determined to not be fulfilling duties; or
- Two years have elapsed since involuntary termination.

All individuals who wish to re-engage in self-direction after an involuntary termination must prior to re-engagement:

- Complete the Self-Direction Exploration Tool; and
- Complete the online training for Self-Directed HCBS.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 1		189
Year 2		378
Year 3		569
Year 4		760
Year 5		952

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both:*

- ☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

- ☒ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise:*

- ☒ **Recruit staff**
- ☐ **Refer staff to agency for hiring (co-employer)**
- ☐ **Select staff from worker registry**
- ☒ **Hire staff common law employer**
- ☐ **Verify staff qualifications**
- ☐ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

- ☒ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

All self-directed workers must submit a criminal background check as required by 460 IAC 6-10-5. The criminal background check must not show any evidence of acts, offenses, or crimes affecting the applicant's character or fitness to care for waiver consumers in their homes or other locations. The FMS vendor verifies receipt of documentation as a part of the self-directed worker enrollment. Criminal history checks are maintained in the FMS vendor files and are available upon request.

- ☒ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
- ☒ **Determine staff wages and benefits subject to state limits**
- ☒ **Schedule staff**
- ☒ **Orient and instruct staff in duties**
- ☒ **Supervise staff**
- ☒ **Evaluate staff performance**
- ☒ **Verify time worked by staff and approve time sheets**
- ☒ **Discharge staff (common law employer)**
- ☐ **Discharge staff from providing services (co-employer)**
- ☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more:*

- ☐ **Reallocate funds among services included in the budget**
- ☒ **Determine the amount paid for services within the state's established limits**
- ☒ **Substitute service providers**
- ☒ **Schedule the provision of services**
- ☒ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- ☒ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- ☒ **Identify service providers and refer for provider enrollment**
- ☒ **Authorize payment for waiver goods and services**
- ☒ **Review and approve provider invoices for services rendered**
- ☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

- ii. Participant-Directed Budget** Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Individuals who decide to self-direct their services will have a budget for each self-directed service in their service plan. During the person-centered planning process, units of service will be approved, based on assessed need, and those units will then be converted into a dollar amount that the individual can use to hire their own staff to provide the identified service. A percentage will be deducted from the resulting budget amount for the administrative costs associated with participant-direction. Individuals will determine the wage paid to their self-directed workers within a specified range according to the service.

The case manager is responsible for determining the appropriate and necessary number of hours through the person-centered planning process. That number of hours is then entered into the spend plan tool within the case management system and calculated consistently for each individual when determining the self-directed budget.

Information about the self-directed budgets will be made publicly available on the state's website.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

- iii. Informing Participant of Budget Amount.** Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The case manager will assess the needs and preferences of the individual through a person-centered planning process. The case manager and IST will develop a person-centered service plan to meet those needs and service requests. The total allowance of the self-directed service budget is determined with the assessed need identified during the person-centered planning process. The case manager will explain how the budget is determined, the total amount of the budget, how an individual can request a change in the budget, and what the ramifications are if the individual exceeds the budget. The case manager and FMS vendor are responsible for monitoring the allocation of funds to the individual and the individual's paid self-directed worker. Individuals will receive monthly financial statement detailing the funds spend and remaining for the year.

Adjustments to the self-directed budget may be made through the person-centered planning process. Participants retain fair hearing rights in accordance with 42 CFR Part 431, Subpart E as further described in Appendix F.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority**iv. Participant Exercise of Budget Flexibility.** *Select one:*

- **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services**E-2: Opportunities for Participant-Direction (6 of 6)****b. Participant - Budget Authority**

- v. Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Case managers are an integral part of safeguarding individual's depletion of a self-directed budget and are responsible for the following prevention activities:

- (A) discuss with individual or their representative the available amount in the budget;
- (B) assist the individual or their representative with the development and modification of the participant-directed budget;
- (C) submit request to the Bureau of Disabilities Services (BDS) for review and approval prior to the case manager's approval of the participant-directed budget;
- (D) approve the participant-directed budget and modifications;
- (E) assist the individual or their representative to develop or revise an emergency back-up plan;
- (F) provide the FMS vendor a copy of the authorized participant-directed budget and any modifications;
- (G) monitor implementation of the service plan;
- (H) ensure services are initiated within required time frames;
- (I) conduct ongoing monitoring of plan implementation and the individual's health and welfare;
- (J) specify additional self-directed worker qualifications in the service plan based on the individual's needs and preferences when such qualifications are consistent with approved waiver qualifications.

The individual and/or representative will have their own login with the FMS vendor to track their self-directed budget on a continuous basis. Case managers will be reviewing the self-directed budget status during 90 day check-ins. The state will have periodic audits of the self-directed budgets in the FMS vendor portal.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Waiver applicants and their legal representatives are provided written and oral explanations of the Medicaid Fair Hearing process (including an explanation of the types of decisions they may appeal) at the time of the individual's initial eligibility assessment by the case manager.

Case managers will send formal notification to waiver applicants and waiver participants of any action that affects the individual's Medicaid benefits related to waiver eligibility determination, service delivery, or budget allocation amount, including the following adverse actions:

- Denying new applicants entrance to the waiver (including denial of level of care);
- Not providing an individual the choice of home and community-based services as an alternative to institutional care;
- Reducing budget allocation amount;
- Denying an individual the service(s) of their choice or the provider(s) of their choice; and
- Denying, suspending, reducing or terminating previously authorized services.

This formal notification of action will be provided in writing to the waiver applicant or waiver participant and their legal representatives within 10 business days of the issue date specified on the formal notification and in advance of the effective date of the action. The notice will include the following information:

- Description of the decision that was made;
- Description of the individual's appeal rights;
- Instructions for how the waiver applicant or waiver participant may appeal the decision/action by requesting a Fair Hearing;
- Timeliness requirements for an appeal - within 33 days of the issue date specified on the formal notification;
- Description of the appeal process and procedures; and
- Option for waiver applicants and waiver participants to have representation by an attorney, relative or other spokesperson.

Additionally, whenever an action is taken that adversely affects a waiver participant post-enrollment (e.g., services are denied, reduced or terminated), the notice will inform the individual that, if they file an appeal in a timely manner, their services will be continued during the period the appeal is under consideration by the Office of Administrative Law Proceedings.

Each formal notification is generated from and stored within the electronic eligibility systems. The case manager documents the request for an appeal in a case note. Additionally, the request for an appeal and a fair hearing is also recorded at the Office of Administrative Law Proceedings.

Upon request, the case manager assists the individual in preparing the written request for an appeal. The case manager advises the individual of the required timeframes for submission of an appeal, the address for submission of the appeal, and provides an opportunity to discuss the issue being appealed.

Appendix F: Participant-Rights

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- ☐ **No. This Appendix does not apply**
- ☒ **Yes. The state operates an additional dispute resolution process**

- **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The Division of Disability Aging and Rehabilitative Services (DDARS) operates a separate dispute resolution process that is available when there is a disagreement about service provision. Resolution of the dispute is designed to address the individual's needs.

Any issues that involve an individual's health and welfare are not addressed through the dispute resolution process but are instead immediately referred to the Bureau of Disabilities Services (BDS) for action in order to ensure the individual's health and welfare.

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

The dispute resolution process is available for the IST to use, but it is not required before an individual or guardian can request an appeal. The case manager is responsible for the monitoring of services and ensuring that the individual understands that the dispute process is not a prerequisite or substitute for the individual's right to request an appeal. The dispute resolution process is not the appropriate avenue for addressing situations resulting from a HCBS waiver provider's unilateral actions that endanger the health or welfare of an individual such that an emergency exists. Under these circumstances, BDS takes actions to protect the health and welfare of the individual as described in Indiana Administrative Code.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ☐ **No. This Appendix does not apply**
- ☒ **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**
- **Operational Responsibility.** Specify the state agency that is responsible for the operation of the grievance/complaint system:

DDARS operates a separate complaint process system through BDS (IC 12-11-1.1).

DDARS also employs a statewide Bureau of Disabilities Services ombudsman per IC 12-11-13, independent of BDS, for the benefit of individuals with a disability who are receiving services administered by the Bureau of Disabilities Services (BDS) and who wish to file a complaint.

- **Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

a) TYPES OF GRIEVANCES/COMPLAINTS INDIVIDUALS MAY REGISTER

Bureau of Disabilities Services (BDS), a bureau within DDARS, accepts complaints from any person or entity, when such complaints are related to individuals receiving HCBS services that are coordinated and administered by the DDARS. BDS will investigate allegations of violations of state and federal code, requirement, or regulation.

Complaints not specific to the BDS are referred to the appropriate entity (agency/division/authority):

- Complaints alleging fraudulent billings or falsified time records will be researched through claims management and referred to the Surveillance and Utilization Review (SUR) Unit, as appropriate, for follow-up or action within four (4) business days.
- Systemic complaints may be referred to internal FSSA investigators or the Attorney General's office for consumer protection.

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

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

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

Complaint investigation activities include:

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

Complaints are acted upon by the BDS and its QA/QI contractor in accordance with the nature of the complaint:

- Complaints that immediately affect an individual's health and welfare are classified as "Urgent." Urgent complaints require an immediate response to ensure the health and welfare of the individual. Within one business day, a Quality Reviewer will perform an unannounced onsite visit/phone contact to ensure the individual's health and welfare and to begin the investigation. A summary of investigation report of findings (allegations found/not found) is issued to the provider within 30 business days and contains a request for a Corrective Action Plan (CAP) for found issues.
- Complaints that do not immediately affect an individual's health and welfare are classified as "Critical". Within two business days, a Quality Reviewer will perform an unannounced onsite visit/phone contact to ensure the individual's health and welfare and to begin the investigation. A summary of investigation report of findings (allegations found/not found) is issued to the provider within 45 business days and contains a request for a CAP for found issues.

If a CAP is required, BDS or its QA/QI contractor issues the CAP to the provider. The provider must either complete the CAP as directed or submit an alternate CAP within the established timeframe. If an alternate CAP is submitted, the QA/QI Specialist reviews the CAP; documents a decision to accept/not accept the CAP; and communicates to provider whether the CAP is accepted/not accepted. Upon successful implementation of the CAP, the CAP is validated by BDS or its QA/QI contractor. Complaints are closed once the CAP is validated. If a CAP accepted or cannot be validated after two attempts, a recommendation is made to refer the provider to the sanctions committee. The provider is notified electronically of complaint closure/referral to the sanctions committee.

The Statewide Bureau of Disabilities Services Ombudsman:

Per IC 12-11-13, the role of the statewide Bureau of Disabilities Services ombudsman is to receive, investigate, and attempt to resolve complaints and concerns that are made by or on behalf of individuals who have a disability and receive services administered by the Bureau of Disabilities Services (BDS). Complaints may be received via the toll free number 1-800-622-4484, via e-mail, in hard copy format, or by referral. Types of complaints received include complaints initiated by families and/or individuals, complaints involving rights or issues of individual choice, and complaints requiring coordination between legal services, DDARS services, and provider services.

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

With the consent of the 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 Bureau of Disabilities Services ombudsman must be provided access to the name, address and telephone number of the individual's legal representative.

A provider of services or any employee of a provider of 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 Bureau of Disabilities Services 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 Bureau of Disabilities Services ombudsman coordinates his or her activities among the programs that provide legal services for individuals with a disability, DDARS, providers of services to individuals with disabilities, 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, 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 Bureau of Disabilities Services 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, DDARS, and the members of Indiana's interim study committee on public health, behavioral health, and human services. Trends are identified so that recommendations for needed changes in the service delivery system can be implemented.

DDARS is required to maintain a statewide toll free telephone line continuously open to receive complaints regarding individuals with disabilities and receive services administered by the Bureau of Disabilities Services (BDS). All complaints received from the toll free line must be forwarded to the statewide Bureau of Disabilities Services ombudsman, who will advise the individual that the complaint process is not a pre-requisite or a substitute for a Medicaid Fair Hearing when the problem falls under the scope of the Medicaid Fair Hearing process described in Appendix F-1.

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

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program. *Select one:*

- ☒ **Yes. The state operates a Critical Event or Incident Reporting and Management Process** (*complete Items b through e*)
- ☐ **No. This Appendix does not apply** (*do not complete Items b through e*)

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

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b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Indiana's administrative code requires all providers of HCBS waiver services, including case managers, to submit incident reports to BDS when specific events occur.

Incidents that require reporting include, but are not limited to those listed below and are defined as any event or occurrence characterized by risk or uncertainty resulting in or having the potential to result in significant harm or injury to an individual or death of an individual:

1) Alleged, suspected, or actual abuse, neglect, or exploitation (ANE) of an individual. An incident in this category must also be reported to adult protective services (APS) or the department of child services (DCS) as applicable. The provider shall suspend from duty any staff suspected, alleged, or involved in an incident of ANE of an individual, pending investigation by the provider. If needed, the case manager coordinates replacement services for the individual. In the event that the case manager is the alleged perpetrator the individual will be given a new pick list from which a new case manager will be selected. If APS or DCS has reason to believe that an individual is endangered, they will investigate the complaint or cause the complaint to be investigated by law enforcement or another agency and make a determination as to whether the individual is endangered.

• "Abuse" is defined as:

1. Intentional or willful infliction of physical injury.
2. Unnecessary physical or chemical restraints or isolation.
3. Punishment with resulting physical harm or pain.
4. Sexual molestation, rape, sexual misconduct, sexual coercion, and sexual exploitation.
5. Verbal or demonstrative harm caused by oral or written language, or gestures with disparaging or derogatory implications.
6. Psychological, mental, or emotional harm caused by unreasonable confinement, intimidation, humiliation, harassment, threats of punishment, or deprivation.

• "Neglect" is defined as a failure to provide appropriate supervision, training, clean and sanitary environment, appropriate personal care, food, medical services including routine medical and specialty consultations, or medical supplies or safety devices to an individual as indicated in the Person-Centered Individualized Support Plan (PCISP).

• "Exploitation" is defined as an unauthorized use of the personal services, the property, or the identity of an individual; any other type of criminal exploitation for one's own profit or advantage or for the profit or advantage of another.

2) Death of an individual. All deaths must be reported to APS or DCS as applicable. If the death is a result of alleged criminal activity, the death must be reported to law enforcement. An internal review of the death shall occur by the residential-based provider. In the absence of a residential-based provider then case manager shall conduct the review.

3) A residence and/or service delivery site that compromises the health and safety of an individual while the individual is receiving services:

- a) A significant interruption of a major utility, such as electricity, heat, water, air conditioning, plumbing, fire alarm, carbon monoxide alarm or sprinkler system;
- b) Environmental or structural problems associated with a service site that compromises the health and safety of an individual, including but not limited to inappropriate sanitation, serious lack of cleanliness, rodent or insect infestation, structural damage or failure, damage caused by flooding, tornado or other acts of nature, or environmental hazards such as toxic or noxious chemicals.

4) Fire, residential or service delivery site (e.g., day services), resulting in health and safety concerns for an individual receiving services. This includes but is not limited to relocation, personal injury, or property loss.

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

6) Missing person-when an individual whose whereabouts are unknown and who may be at risk of injury or death and law enforcement has been notified.

7) Alleged, suspected, observed, or actual criminal activity by (a) a provider's staff member, employee, or agent of a provider, when it affects or has the potential to affect the individual's care; (b) a family member of an individual receiving services when it affects or has the potential to affect the individual's care or services; or (c) an individual receiving

services. This may include:

- Police arrest of the individual or any person responsible for the care of the individual
- A major disturbance or threat to public safety created by the individual

8) An event with the potential for causing significant harm or injury and requiring medical or psychiatric treatments or services to or for an individual receiving services.

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

10) Any injury to an individual that requires medical intervention beyond basic first aid. This includes, but is not limited to, the following types of injuries and causes:

- a) A fracture; or
- b) A burn greater than first degree; or
- c) Contusions or lacerations; or
- d) Choking that requires intervention.

11) Misuse or unauthorized use of any physical restraint, and if any injury occurs while an individual is restrained the injury must also be specified in incident report.

12) Use of any mechanical restraint.

13) Any attempt of suicide made by the individual

14) Suicidal ideation that results in police, EMS, mobile crisis team or other first responder involvement or any medical intervention.

15) A medication error except for refusal to take medications, including the following:

- a) Medication given that was not prescribed or ordered for the individual;
- b) Failure to administer medication as prescribed, including:
 - Incorrect dosage;
 - Medication administered incorrectly;
 - Missed medication; and
 - Failure to give medication at the appropriate time.

It should be documented if any of the following occurs: phone call or consult with a poison control center, ED visit, urgent care visit, hospitalization, or death.

16) Inadequate staff support for an individual, including inadequate supervision, with the potential for:

- a) Significant harm or injury to an individual; or
- b) Death of an individual.

17) Use of any aversive technique, including but not limited to:

- a) Seclusion;
- b) Painful or noxious stimuli; and
- c) Denial of a health-related necessity.

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

19) Admission of an individual to a nursing facility, excluding respite stays.

20) Inadequate medical support for an individual, including failure to obtain:

- a) Necessary medical services;
- b) Routine dental or physician services; or
- c) Medication timely resulting in missed medications.

21) Use of any PRN medication related to an individual's behavior. An incident report related to the use of PRN medication related to an individual's behavior must include the following information:

- a) The length of time of the individual's behavior that resulted in the use of the PRN medication related to the individual's behavior.
- b) A description of what precipitated the behavior resulting in the use of PRN medication related to the individual's behavior.
- c) A description of the steps that were taken prior to the use of the PRN medication to avoid the use of a PRN medication related to the individual's behavior.
- d) If a PRN medication was used before a medical or dental appointment, a description of the desensitization plan in place to lessen the need for a PRN medication for a medical or dental appointment.
- e) The criteria the provider has in place for use of a PRN medication related to an individual's behavior.
- f) A description of the provider's PRN medication protocol related to an individual's behavior, including the provider's:
 - (i) Notification process regarding the use of a PRN medication related to an individual's behavior; and
 - (ii) Approval process for the use of a PRN medication related to an individual's behavior.
- g) The name and title of the staff approving the use of the PRN medication related to the individual's behavior.
- h) The medication and dosage that was approved for the PRN medication related to the individual's behavior.
- i) The date and time of any previous PRN medication given to the individual related to the individual's behavior based on current records.

22) Alleged Medicaid fraud by provider

23) Unauthorized residential transitions

24) Eviction/Displacement - the cause/setting should be specified: POCOS, family home, individuals own home, etc.

An incident described in this section must be reported by a provider or an employee or agent of a provider who:

- Is providing services to the individual at the time of the incident; or
- Becomes aware of or receives information about an alleged incident.

An initial report regarding an incident must be submitted within 24 hours of:

- The occurrence of the incident; or
- The reporter becoming aware of or receiving information about an incident.

The case manager must submit a follow-up report to the Bureau of Disabilities Services (BDS) concerning the incident at the following timeframes:

- Within seven days of the date of the initial report; and
- Every seven days thereafter until the incident is resolved.

All information required to be submitted to BDS must also be submitted to the case manager.

The Bureau of Disabilities Services (BDS) uses a web-based system to report and manage incident reports. All incident reports are to be submitted using this web-based system. If the web-based system is down, the incident may be submitted via email. While providers encourage their staff to report incidents through their own internal systems, anyone with an internet connection can report an incident through the State's system.
an incident through the State's system.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

At intake and annually case managers have discussions with individuals about how to identify and report abuse, neglect, and exploitation. At these meetings, case managers provide individuals a copy of the grievance procedure and a copy of the State's "The Individual and Guardian Rights and Responsibilities" policy.

Additionally, case management organizations are required to provide each waiver participant with a link to the Indiana Health Coverage Programs (IHCP) Division of Disability Aging and Rehabilitative Services (DDARS) HCBS Module, a resource document for individuals and support teams. When requested by the individual, guardian and/or family, a paper/hard copy of the IHCP DDARS HCBS Module will be provided by the case manager.

Waiver participants are required to sign and date that they received the grievance procedure and a link and/or copy of the above mentioned IHCP DDARS HCBS Module.

Case managers are required to complete annual training regarding incident reporting and critical incidents regarding abuse, neglect, and exploitation. On a monthly basis, BDS holds a provider and case manager webinar that includes information regarding incident reporting. Additional resources and on-demand training videos are available in the BDS Portal and on the BDS website.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Bureau of Disabilities Services (BDS) is responsible for the oversight of the incident reporting system, which includes receiving and evaluating all incident reports. Incident reviewers use the web-based complaint and incident reporting systems to evaluate each of the incident reports to determine whether or not the provider has taken appropriate and sufficient actions to remedy the situation, prevent chances for reoccurrence, and to assure the individual's immediate safety.

Incident reviewers also evaluate whether incidents meet the criteria of being a critical event. Incidents of suspected abuse, neglect, or exploitation of an adult or child, or the death of an adult or child is reported to APS or DCS, as appropriate. The incident reporting system automatically generates an e-mail to the individual's BDS service coordinator and a designated distribution list to alert them of the incident and to indicate whether or not a follow-up report is required. A follow-up report is required if immediate protective measures were not included in the initial incident report.

To ensure the individual's health and safety, the case manager makes either a face-to-face or phone contact with the provider within 24 hours of notification of the critical event and documents this interaction via a follow-up report submitted in the State's web-based incident reporting system within 72 hours of the incident. The Critical event remains open until protective measures are in place. The incident report remains open until there is documentation that the provider took the appropriate actions to resolve the issue.

Case managers are responsible for following-up on all incident reports while BDS oversees how timely and effectively case managers respond to incident reports. On a weekly basis the BDS QA/QI contractor's incident management staff reviews all unresolved critical events. When documentation ensuring health and safety is confirmed, the critical status is closed. The BDS QA/QI contractor submits a weekly report of unresolved critical events to BDS and BDS executive staff. All incident information is uploaded to the case management system and cases with open incidents display a message to facilitate follow-up.

The individual's case manager, along with input from the Individualized Support Team (IST), is responsible for electronically submitting follow-up reports within seven calendar days of the incident being reported and every seven calendar days thereafter until the incident is resolved to the satisfaction of BDS. Follow-up reports for critical events are required every 72 hours and every 72 hours thereafter until protective measure are in place. Follow-up reports provide the necessary documentation of actions taken to address incident-related issues. To assist with this, providers are able to download incident report information, including outstanding incident reports, through the BDS QA/QI contractor's system. BDS ensures that case managers are completing required follow-up reports until incidents are closed.

At the discretion of BDS, service coordinators may conduct an onsite review of the individual's environment to ensure that the team's proposed measures to ensure the individual's health and safety are in place and appropriate.

Case managers continue to be responsible for notifying families/guardians of incidents reported and sharing results of the provider's investigation when the case manager is authorized to disclose such information with those parties.

To further clarify the role of the case manager:

- At a minimum, case managers will meet with individuals four times per year, not less than once every 90 calendar days. Case managers shall monitor the effectiveness of the PCISP outcomes using documented review between the individual or representative. Three of the four meetings may take place outside the home. One unannounced visit in the home is required for waiver participants residing in provider owned or controlled settings.
- For individuals with high risk or high health needs, case managers have monthly face-to-face interactions with the individual.
- Case managers are responsible for ensuring the individual's immediate protection from harm when individuals have had critical events which includes making contact with the provider and/or waiver participant/guardian within 24 hours of receiving incident.
- Pre- and post-monitoring of transitions (movement to a new residential services provider or home) are the responsibility of the case manager.

BDS QA/QI contractor manages the state's web-based incident management system. The QA/QI contractor's incident management staff have 24 hours to review incident reports and code them according to potential for impacting individuals' health or safety, and whether immediate follow-up is necessary. Providers are responsible for taking appropriate and effective measures to secure the individual's immediate safety, implementing preventative measures, and investigating reported incidents. Case managers then validate and use follow-up reports to document the provider's

actions to safeguard the individual. Case managers enter follow-up reports into the state's web-based incident management system at minimum every seven calendar days until the incident is closed. BDS QA/QI contractor's incident management staff review these follow-up reports to determine: 1) whether the individual's immediate safety has been secured, and 2) that plans are in place to prevent reoccurrences. Only when both of these criteria are satisfied will BDS QA/QI contractor's incident management staff close the incident report.

All open incidents are posted in the BDS case management system on the case manager's dashboard to facilitate timely follow-up. Additionally, all incident information, including open, closed, and criticals, are posted in the individual's documents section of the BDS case management system.

In emergency situations, Indiana Administrative Code allows the State the authority to remove an individual from the provider's services, issue a moratorium on the provider taking new waiver participants, and/or to terminate the provider's agreement to provide waiver services. The State also has the authority to issue civil sanctions. The DDARS sanctions committee (consisting of BDS and members of DDARS executive leadership) recommends to the DDARS director specific sanctions to be issued against providers. The BDS director (or its designee) then communicates this decision to the provider.

DDARS requires all uses of restrictive interventions (including those that are previously authorized) to be reported. Incident reports are required to be submitted within 24 hours of the incident occurring or the reporter becoming aware of the incident. Providers are responsible for investigating all incidents. In addition to investigating any incidents of unauthorized restraint and restrictive practices, DDARS's policy on the use of restrictive interventions requires providers to convene a team meeting as soon as possible, but no later than three business days, following a behavioral emergency where a restrictive intervention was used to discuss the behavioral emergency, the emergency intervention used, and the supports needed to minimize future uses of restrictive interventions.

As a part of the State's required follow up reports, case managers indicate that they have notified the family/guardian of the incident outcome.

The investigation surrounding an incident report (IR) is conducted by the provider but the case manager is responsible for ongoing follow up to ensure the investigation is completed and the incident can be closed by the State. As such, the timeframes for informing the individual of the investigation results would be dependent upon the unique range of activity required to complete each investigation and the policies of each individual case manager. Informing the individual of the investigation results is a requirement, but one for which a timeframe has not been identified. As teams meet at least once every 90 calendar days, it would be rare for the case manager to wait longer than 90 calendar days to report the results to the individual.

- e. Responsibility for Oversight of Critical Incidents and Events.** Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

Bureau of Disabilities Services (BDS) oversees incident reporting and management and works closely with BDS staff, case managers, and providers to assure that the same incidents do not continue to occur.

Providers are able to download incident report data through BDS QA/QI contractor's data management system. At least quarterly, the BDS QA/QI contractor compiles aggregate incident data and provides a trend analysis to BDS leadership. On a monthly basis, the incident management review committee reviews incident trends and proposes interventions for consideration.

BDS also oversees the mortality review process. All deaths are reviewed by BDS QA/QI contractor's mortality review triage team. Deaths with suspect circumstances are reviewed by the full mortality review committee (MRC) facilitated by BDS. While the review of deaths takes place on an ongoing basis, the MRC meets monthly.

BDS facilitates the quality improvement executive committee (QIEC), which is the decision-making body charged with identifying needed system improvements, and then designing, implementing, and monitoring the effectiveness of those improvements. Committee members include representatives from all of the entities involved in overseeing waiver services which include the Office of Medicaid Policy and Planning (OMPP), BDS, and the BDS QA/QI contractor.

When trends are identified, the QIEC uses a worksheet to document the opportunity for improvement, the data source to be improved, a desired outcome that is measurable, measurement criteria, and a draft mitigation strategy that identifies people responsible and timelines for implementation, and a timeframe to measure how the identified issue has changed. If no change or negative change has occurred, the plan is to develop another mitigation strategy to attempt to resolve the problem.

The Bureau of Disabilities Services (BDS) works in collaboration with OMPP, the FSSA office responsible for administration and operation of Indiana's PathWays waiver. BDS and OMPP meet to identify cross-waiver issues such as provider trends requiring system-wide remediation across waiver programs. These meetings occur on a bi-annual basis, and ad hoc as needed to respond to identified issues.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

- a. Use of Restraints.** *(Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

- ☐ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

- ☒ **The use of restraints is permitted during the course of the delivery of waiver services.** Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The State allows the use of restraints when used in conjunction with a Behavioral Support Plan and when approved by the human rights committee or in an emergency situation but only to prevent significant harm to the individual or others.

A restrictive intervention may be used in an emergency situation without being planned when all of the following are present:

- An unanticipated behavioral emergency exists;
- An individual's behavior poses an imminent threat of harm to self or others;
- There is no approved behavioral support plan that addresses the behavioral emergency, or there is an approved plan but it has been found to be ineffective and a more restrictive intervention is indicated based upon the individual's behavioral emergency; and
- The intervention chosen is determined to be the least restrictive measure required to quell the unanticipated behavioral emergency.

Indiana code applicable to waiver services does not differentiate between personal restraints, but includes them as "restrictive interventions" in its implementation of safeguards. Drugs used as a method of restraint are also addressed as a "restrictive intervention" while requiring additional safeguards.

In order for a provider to initiate an emergency restrictive intervention, the provider must first establish a written plan which includes all of the following components:

- The specific, defined emergency interventions to be used;
- Any appropriately trained staff that is authorized to select and initiate in emergency intervention;
- The training needed for staff prior to implementing emergency interventions; and
- Directions for documenting: a description of the emergency, a description of the emergency intervention implemented, the persons implementing the emergency intervention, the duration of the emergency intervention, the individual's response to the emergency intervention.

When an emergency restrictive intervention (i.e. chemical restraint, physical restraint, or removal of an individual from the individual's environment) is implemented, the IST is then required to meet not later than five working days after the emergency restrictive intervention in order to:

- (1) Review the circumstances of the emergency restrictive intervention (i.e. chemical restraint, physical restraint, or removal of an individual);
- (2) Determine the need for a functional analysis, behavioral support plan or both, and to document recommendations. If a provider of behavioral support services is not a member of the IST, a provider of behavioral support services must be added to the IST.

The State has established provider standards prohibiting abuse, neglect, exploitation, or mistreatment of an individual, or violation of an individual's rights. In addition to the requirements in the Incident Reporting policy, abuse may require a provider to file a police report.

Also prohibited are practices that violate an individual's rights. The prohibited practices include: denying an individual any of the following without a physician's order: sleep, shelter, food, drink, physical movement for prolonged periods of time, medical care or treatment, or use of bathroom facilities; corporal punishment inflicted by the application of painful stimuli to the body, which includes: forced physical activity, hitting, pinching, the application of painful or noxious stimuli, the use of electric shock, or the infliction of physical pain; seclusion; verbal abuse including: screaming, swearing, name-calling, belittling, or other verbal activity that may cause damage to an individual's self-respect or dignity; and work or chores benefitting other without pay unless authorized by the US Department of Labor, the services occur in the individual's own residence as a normal and customary part of housekeeping and maintenance duties, or the individual desires to volunteer in the community.

Providers are required to limit the use of highly restrictive procedures, including physical restraint or medications to assist in the managing of behavior, and are instead to focus on behavioral supports that begin with less intrusive or restrictive methods before more intrusive or restrictive methods are used.

Indiana requires that any behavioral support plans, person-centered individualized support plans, or high risk plans that utilize any restrictive interventions or modifications contain the following safeguards to ensure

compliance with the HCBS Settings Rule:

- (1) A functional analysis (or functional behavioral analysis when a behavioral support plan exists) that establishes a specific assessed need and identifies the why behind the targeted behavior for which a restriction or modification is being considered;
- (2) Documentation that the risks of the targeted behavior have been weighed against the risk of a restriction or modification;
- (3) Documentation of each lesser restrictive strategy that has been tried and why/how they were unsuccessful;
- (4) Justification that the restriction is tailored to the individual, and is not applied broadly due to staff or individual's legal representative requests;
- (5) Documentation in the PCISP including rationale, implementation details, and monitoring plan;
- (6) Documentation that the individual, the IST and the applicable human rights committee agree that the use of a restriction or modification is required to prevent significant harm to the individual or others;
- (7) Informed written consent from the individual and/or the individual's legal representative;
- (8) Restriction has a defined duration and a plan for tracking effectiveness. The data collection must be ongoing and completed before and during the restriction to monitor its need and effectiveness. This includes frequency and duration, effectiveness measures, adverse effect, individual's feedback, staff observations, and demonstration of continuous improvement;
- (9) Documentation of a clear timeline for re-evaluation by the IST and Human Rights Committee (HRC). Re-evaluation must be conducted annually, at a minimum, or more often as determined by the IST; and
- (10) HRC approval or denial must be specific to every restriction/modification in the relevant plan. The HRC should ensure review of the justification, alternatives tried, informed consent, data collection and time-limits for re-review. The HRC should include a diverse group including: an individual receiving services or a guardian, a community member not employed by the provider, other professionals with expertise (i.e., medical staff, psychologists, or behavior clinicians), and provider representatives. The representation should be balanced ensuring that provider representatives participate without holding a majority or exerting disproportionate influence.

To ensure the individual's safety, the IST participates in meetings with the behavioral support staff, when applicable. This includes the individual, his/her parent or guardian, case manager, and applicable service providers. The team reviews the behavioral clinician's quarterly reports, other applicable reports based on the restriction, behavior data tracking sheets, lesser restrictions or modifications that have been tried, and verbal input from team members. The quarterly report covers the prior quarter's progress on the behavioral support plan including targeted behaviors and any need for an amendment to the plan.

Indiana requires that providers' staff be trained to implement the individual's specific behavior plan and all other plans.

Behavioral support plans are developed and implemented as needed to avoid use of restraints, or any other restrictions or modifications, whenever possible. Behavioral support providers are required to train appropriate staff /personnel of approved providers. At minimum, personnel who are involved in the administration of restraints must meet the education and training requirements specified in 460 IAC 6-5-4 and 6-14-4 and be trained by the provider of behavioral support services.

The State's list of excluded (aversive) techniques includes but is not limited to:

1. Contingent exercise
2. Contingent noxious stimulation
3. Corporal punishment
4. Negative practice
5. Overcorrection
6. Seclusion
7. Visual or facial screening
8. Any other technique that:
 - a) incorporates the use of painful or noxious stimuli;
 - b) incorporates denial of any health related necessity; or
 - c) degrades the dignity of an individual;
9. Any restriction that prevents an individual from freely exiting their home through doors or windows. This

includes, but is not limited to, the use of double-sided locks, keyed deadbolts on interior doors, window bars, or any device that requires staff assistance to exit.

Additionally, any restrictive intervention used for convenience of discipline, prone restraint where an individual is face down on their stomach, or any aversive technique and mechanical restraint are also excluded, unless ordered as a medical restraint by a licensed physician or dentist.

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

The Bureau of Disabilities Services (BDS) and OMPP are responsible for overseeing the use of restrictive interventions and ensuring that State safeguards concerning their use are followed. Oversight of the use of restrictive interventions at the individual level occurs through the IST and the case management function.

Unauthorized use of restrictive interventions and violations of rights is monitored through the incident reporting process, the complaint process, and the case management function, as well as review during required team meetings.

Data is entered into and collected from the State's electronic Incident Reporting system. It is aggregated quarterly and normed annually, so that is reviewed as it relates to all providers. The data is then used during the provider re-approval process to evaluate providers' quality assurance/quality improvement systems and ensure policies and procedures are in place to address the use of restraints.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

- b. Use of Restrictive Interventions.** *(Select one):*

- ☒ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

- ☐ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

- i. Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

The State allows the use of restrictive interventions when used in conjunction with a behavioral support plan, or in an emergency situation only to prevent harm to the individual or others. Behavioral support standards require that behavior plans employ non-aversive methods to replace maladaptive behaviors with functional and useful behaviors.

Indiana requires that any behavioral support plans, person-centered individualized support plans, or high risk plans that utilize any restrictive interventions or modifications contain the following safeguards to ensure compliance with the HCBS Settings Rule:

- (1) A functional analysis (or functional behavioral analysis when a behavioral support plan exists) that establishes a specific assessed need and identifies the why behind the targeted behavior for which restriction or modification is being considered;
- (2) Documentation that the risks of the targeted behavior have been weighed against the risk of a restriction or modification;
- (3) Documentation of each lesser restrictive strategy that has been tried and why/how they were unsuccessful;
- (4) Justification that the restriction is tailored to the individual, and is not applied broadly due to staff or individual's legal representative requests;
- (5) Documentation in the PCISP including rationale, implementation details, and monitoring plan;
- (6) Documentation that the individual, the IST and the applicable human rights committee agree that the use of a restriction or modification is required to prevent significant harm to the individual or others;
- (7) Informed written consent from the individual and/or the individual's legal representative;
- (8) Restriction has a defined duration and a plan for tracking effectiveness. The data collection must be ongoing and completed before and during the restriction to monitor its need and effectiveness. This includes frequency and duration, effectiveness measures, adverse effect, individual's feedback, staff observations, and demonstration of continuous improvement;
- (9) Documentation of a clear timeline for re-evaluation by the IST and Human Rights Committee (HRC). Re-evaluation must be conducted annually, at a minimum, or more often as determined by the IST; and
- (10) HRC approval or denial must be specific to every restriction/modification in the relevant plan. The HRC should ensure review of the justification, alternatives tried, informed consent, data collection and time-limits for re-review. The HRC should include a diverse group including: an individual receiving services or a guardian, a community member not employed by the provider, other professionals with expertise (i.e., medical staff, psychologists, or behavior clinicians), and provider representatives. The representation should be balanced ensuring that provider representatives participate without holding a majority or exerting disproportionate influence.

To ensure the individual's safety, the IST participates in meetings with the behavioral support staff, when applicable. This includes the individual and his/her parent or guardian, case manager, and applicable service providers. The team reviews the behavioral clinician's quarterly reports, other applicable reports based on the restriction, behavior data tracking sheets, lesser restrictive interventions that have been tried, and verbal input from team members. The quarterly report covers the prior quarter progress on the behavioral support plan including targeted behaviors and any need for an amendment to the plan.

Indiana code establishes a prohibition against violating individuals' rights. Providers are directed to adopt policies and procedures that prohibit abuse, neglect, exploitation, and mistreatment of individuals.

Inappropriate restrictive measures that constitute abuse are reported immediately upon discovery to APS or DCS. This situation would constitute a critical incident and also be subject to BDS critical incident interventions at the individual and provider level which may include referral of a provider to the sanctions committee and identification and selection of new providers of behavioral services by individuals

At a minimum, personnel who are involved in the administration of restraints must meet the education and training requirements specified in 460 IAC 6-5-4 and 6-14-4 and be trained by the provider of behavioral support services.

- ii. **State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

The Bureau of Disabilities Services (BDS) and OMPP are responsible for overseeing the use of restrictive interventions and ensuring that State safeguards concerning their use are followed. Oversight of the use of restrictive interventions at the individual level occurs through the IST and as a case management function.

Unauthorized use of restrictive interventions and violations of rights is monitored through the incident reporting process, the complaint process, and the case management function, as well as review during required team meetings.

Data is entered into and collected from the State's electronic Incident Reporting system. It is aggregated quarterly and normed annually, so that it is reviewed as it relates to all providers. The data is then used during the provider re-approval process to evaluate providers' quality assurance/quality improvement systems and ensure policies and procedures are in place to address the use of restraints.

Additionally, BDS QA/QI contractor processes all IRs and reviews individuals' incidents as they are reported to look for trends/patterns. Any trends are escalated to BDS administration for review and follow-up.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

- ☒ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

Seclusion is not allowed as a behavioral intervention and is considered an act of abuse.

Unauthorized use of seclusion is monitored through the incident reporting process, the complaint process, and the case management function, as well as review during required team meetings. For any confirmed or suspected use of seclusion, an incident report is required.

Indiana policy specifies that "seclusion" means placing an individual alone in a room or other area from which exit is prevented is specifically prohibited from use. BDS policy lists seclusion among prohibited practices. Per DDARS's incident reporting and management policy, incidents to be reported to BDS include any event or occurrence characterized by risk or uncertainty resulting in or having the potential to result in significant harm or injury to an individual. Seclusion is categorized as an aversive technique. Per Indiana policy, "abuse" includes unnecessary physical or chemical restraints or isolation, and the use of seclusion/isolation is a violation of rights.

The State does utilize restrictive interventions, but documents within this section that seclusion is not allowed as a behavioral intervention and is considered an act of abuse.

Bureau of Disabilities Services (BDS) reviews all incident reviews for any reporting of seclusion. If a reported incident appears to be seclusion, detailed follow-up is requested of the provider. Additionally, the incident in question is escalated to BDS and DDARS administration for review and follow-up.

- **The use of seclusion is permitted during the course of the delivery of waiver services.** Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- ☐ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ☒ **Yes. This Appendix applies** *(complete the remaining items)*

- **Medication Management and Follow-Up**

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Medication Management and Follow-Up is viewed broadly within this waiver as part of the duties related to coordinating an individual's health care.

The person identified in the PCISP is responsible for coordinating the individual's health care and may be the individual or individual's family, a residential provider and/or a provider of wellness coordination services working with their health care provider.

Per Indiana policy, coordinating health care includes ensuring the individual accesses necessary health care services including annual physical, dental and vision examinations ordered by the physician, routine examinations and screenings, and referrals to specialists as needed. The ordering physician or other health care professional permitted to prescribe medications has responsibility for first-line management of an individual's medication.

The IST at each meeting reviews the individual's medications as part of the comprehensive PCISP review, and the case manager is responsible for ensuring that questions that arise related to medication management during this meeting are addressed by the most appropriate/qualified individuals. The case manager responsibilities may include supporting the individual to schedule an appointment with the individual's physician to review their medications and/or address related questions. The case manager will complete these tasks with the individual's informed consent.

A checklist developed by the state is utilized to ensure that identified areas are assessed and results communicated to the state.

A significant part of coordinating health care includes needing to document the services the person has received. Per Indiana policy, providers with this responsibility need to maintain the dates of health and medical services, a description of those services, and an organized system for documenting that medications are administered, which also speaks to medication management and follow-up.

The system for medication administration must include a documentation system, a system for communicating among all providers that administer medication, and the monitoring of medication side effects. All providers are required to have a health-related incident management system to provide an internal review process for any health-related reportable incident - of which one is medication errors.

Case managers conduct visits with individuals and ISTs, and such visits include monitoring providers' compliance with medication administration systems. The purpose of this monitoring is to detect potentially harmful practices and then to follow-up to address these practices. Case managers use a standardized checklist to conduct these monitoring visits. The incident reporting and complaint processes provide an additional monitoring resource.

When behavior modifying medications are used, the State mandates the IST to be in agreement with the use of medication and have the approval of the human rights committee prior to implementation.

Monitoring activities by the case manager address all medications actions, not just a percentage. At each semiannual IST meeting, or more often if indicated by the PCISP, case managers monitor the administration of medications, including Psychotropic and Non-Psychotropic medications, with members of the IST.

Regarding psychotropic medications:

- Does the individual's record confirm the use of psychotropic medication?
- Is there informed consent and human rights committee approval for administration of the psychotropic medication to the individual?
- Is there a written titration plan that has been reviewed by the prescribing physician within the past year present for the psychotropic medication being administered?
- Is the psychotropic medication titration plan being implemented per the written plan?
- Are the behaviors for which the psychotropic medication is administered identified?
- Is the identified behavior data being documented consistently and in accordance with the titration plan?
- Does the PCISP include an identified timeframe for psychiatric consults/visits?
- Has the individual seen a psychiatrist within the identified referral and follow-up timeframes?

Regarding non-psychotropic medications:

- Is there a written medication administration plan and a medication administration record available for the individual?
- Does the medication administration record** confirm that all currently prescribed medications are being administered without error?
- Is medication being administered in compliance with the individual's medication administration plan?
- Are medications being stored per the individual's medication administration plan?
- Does observation of the individual, review of the individual's medication side effect documentation, and discussion with staff, the individual and the legal guardian if indicated, confirm the absence of medication side effects for the individual?

**For some individuals, the family or legal guardian is identified as the responsible party for medication administration. As natural and un-paid providers of care, families are not required to maintain medication administration records (MAR).

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

Per 460 IAC 6-25-4, the State requires providers have an organized system for medication administration for each individual receiving medications, which is fundamental to conducting oversight and follow-up. The provider is required to document the system in writing and distribute the document to all providers administering medication to the individual. The documentation is placed in the individual's file maintained by all providers administering medication to the individual.

This required system must contain at least the following elements:

- Identification and description of each medication required for the individual;
- Documentation that the individual's medication is administered only by trained and authorized personnel unless the individual is capable of self-administration of medication as provided for in the PCISP;
- Documentation of the administration of medication, including administration of medication from original labeled prescription containers; the name of medication administered; the amount of medication administered; the date and time of administration; and the initials of the person administering the medication;
- Procedures for the destruction of unused medication;
- Documentation of medication administration errors;
- A system for the prevention or minimization of medication administration errors;
- When indicated as necessary by an individual's PCISP, procedures for the storage of medication;
- Documentation of an individual's refusal to take medication;
- A system for communication among all providers that administer medication to an individual; and
- All providers administering medication to the individual shall implement and comply with the organized system of medication administration designed by the provider.

Bureau of Disabilities Services (BDS) oversees provider compliance with state standards and requirements through the provider approval and enrollment process, mandatory provider training, ongoing provider monitoring performed by case managers during face-to-face contact with individuals and during review of the PCISP and through quality improvement review activities. Results of the reviews are shared with OMPP. In addition, medication management issues may be identified as a result of incident reporting, mortality reviews, the complaint process, and from quality on-site provider reviews.

Case managers analyze data at the individual level, identify trends, and work with providers to develop remediation plans. BDS conducts the same activities but for provider-specific and systemic trend analysis. When issues are identified, BDS will issue a corrective action plan to the provider. Providers have two opportunities to develop an acceptable corrective action plan and two opportunities to validate that plan. Noncompliant providers are forwarded to the BDS director (or its designee) for progressive discipline.

BDS utilizes the quality improvement executive committee (QIEC), which includes OMPP, to develop and implement mitigation strategies to address potentially harmful practices and improve quality.

At the provider level, corrective action plans (CAP) may be required as well as provider-specific training to address medication management issues. As with all performance-related issues and issues related to waiver participant health and safety, existing processes are utilized to address urgent issues (through the incident reporting system) or repeated non-compliance (through referral to the sanctions committee).

The State uses the following methods facilitated by BDS:

1. Incident reporting - all issues related to medication administration are reported within the State's Incident Reporting system. Medication administration data is aggregated and reviewed at least annually by the QIEC. With representation from multiple entities within FSSA, (DDARS, BDS and OMPP), the QIEC makes recommendations for system improvement as trends surface.

2. Within the mortality review committee, the physician and registered nurse who serve on the mortality review triage team, review medications and potential side effects/implications to give the committee a comprehensive picture of how medical issues may have impacted the individual's overall health and well-being.

Additionally, the State offers wellness coordination services to eligible waiver participants of the CIH waiver. For individuals who choose this service, medication management and oversight occurs at least weekly as a component of the routine consultation and review conducted by the licensed nurse coordinating the medical needs of the individual. The timely discovery and remediation of potentially harmful practices, both individually and systemically, is one expectation of this relatively new service.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- ☐ **Not applicable.** *(do not complete the remaining items)*
- ☒ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*
 - **State Policy.** Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Indiana policy requires that all direct care staff be trained in administering medication. The state has an approved curriculum available for providers to use to conduct this training.

The system for medication administration must include a documentation system, a system for communication among all providers that administer medication and the monitoring of medication side effects. All providers are to have a health-related incident management system to provide an internal review process for any health-related reportable incident - of which one is medication errors (460 IAC 6-9-4 and the BDS incident reporting and management policy).

Additionally, the following sections of Indiana administrative code contain information related to medication administration:

460 IAC 6-14-4 requires training specific to medication administration and medication side effects, which includes but is not limited to the following training topics:

- i. Medication administration and side effects training by a licensed nurse; and
- ii. Competency in medication administration documented by a licensed nurse

This policy also requires that prior to providing services to an individual, all direct support professional staff will be trained to competency in the individual specific interventions for each individual they are working with, including but not limited to the individual's medication administration needs and the side effects for any prescribed medications.

460 IAC 6-17-3 requires that, at minimum, the onsite records pertaining to the individual contain all medication administration recording forms for the previous two months.

460 IAC 6-17-4 requires that, with the exception of the prior or previous two months' of documentation that is maintained at the site of service delivery as described in the "Individuals' Personal Information: Site of Service Delivery" policy, the Individual's personal information shall include at minimum include all medication administration recording forms.

460 IAC 6-25-10 requires that the primary services provider shall also provide a narrative review of the deceased individual's medication administration records.

460 IAC 6-9-5 and the DDARS Incident Reporting & Management policy require the reporting of any medication error, except for refusal to take medications, including the following:

- a) Medication given that was not prescribed or ordered for the individual;
- b) Failure to administer medication as prescribed, including:

- Incorrect dosage;
- Medication administered incorrectly;
- Missed medication; and
- Failure to give medication at the appropriate time.

This policy also requires the reporting of the use of any PRN medication related to an individual's behavior.

460 IAC 6-10-10 and the DDARS Quality Assurance & Quality Improvement System policy require that whenever medication is administered to an individual by a provider, the provider must develop a process for:

- i. identifying all medication errors;
- ii. analyzing all medication errors and the persons responsible for them
- iii. developing and implementing a risk reduction plan to mitigate and eliminate future medication errors; and
- iv. a monthly review of the risk reduction plan to assess progress and effectiveness

- **Medication Error Reporting.** *Select one of the following:*
 - **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
Complete the following three items:

- (a) Specify state agency (or agencies) to which errors are reported:

Medication errors, except medication refusals, must be reported to BDS through the incident reporting process detailed within Appendix G-1-a of this application.

- (b) Specify the types of medication errors that providers are required to *record*:

Any medication error, including refusal to take medications, must be recorded by the provider. This includes the following:

- a) Medication given that was not prescribed or ordered for the individual;
- b) Failure to administer medication as prescribed, including:
 - Incorrect dosage;
 - Medication administered incorrectly;
 - Missed medication; and
 - Failure to give medication at the appropriate time.

Providers must conduct medication administration training through a licensed RN or LPN. While providers can conduct their own medication administration training, DDARS has an approved Core A and B medication administration training curriculum available to assist providers' trainers. For this specific training, the State requires that only RNs or LPNs participate in this train-the-trainer training.

(c) Specify the types of medication errors that providers must *report* to the state:

Any medication error, except for refusal to take medications, must be reported to the state via the incident reporting process detailed within Appendix G-1-a of this application. Such errors include the following:

- a) Medication given that was not prescribed or ordered for the individual;
- b) Failure to administer medication as prescribed, including:
 - Incorrect dosage;
 - Medication administered incorrectly;
 - Missed medication; and
 - Failure to give medication at the appropriate time

- **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

- **State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Bureau of Disabilities Services (BDS) and OMPP are responsible for overseeing provider performance in the administration of medications.

BDS monitors provider compliance with state standards and requirements for medication administration through ongoing provider monitoring performed by case managers during face-to-face contact with individuals and during review of the PCISP by the IST.

Medication error reporting or inappropriate use of medications may be received by BDS through the incident reporting system or the complaint system. On a quarterly basis, a trend analysis of medication error data is completed by BDS QA/QI contractor and the data is reviewed by the QIEC.

Depending on the specific situation and severity of the incident, immediate actions will be taken that range from provider contact, remediation through provider training and provider development of a CAP, up to and including referral to the sanctions committee for egregious violations of policies related to medication safeguards.

While the State utilizes one Appendix G Performance Measure to address critical events regarding medication administration errors that result in medical treatment, additional data related to a broader range of medication errors is also collected, reviewed, and analyzed by BDS. On a quarterly basis, data trends involving medication errors are reviewed and discussed as part of the work of the QIEC, which also includes OMPP. QIEC identifies potential activities and remedies to address and mitigate identified issues.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.

i. Sub-Assurances:

a. Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.

Performance Measures

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

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

Performance Measure:

G.2 Number and percent of sampled individuals who reported that paid staff are

respectful. Numerator: Number of sampled individuals who reported paid staff are respectful. **Denominator:** Total number of sampled individuals who responded.

Data Source (Select one):

Other

If 'Other' is selected, specify:

National Core Indicators (NCI)

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach (check each that applies):
☐ State Medicaid Agency	☐ Weekly	☐ 100% Review
☒ Operating Agency	☐ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☒ Quarterly	☐ Representative Sample Confidence Interval =
☒ Other Specify: NCI Survey Contractor	☐ Annually	☐ Stratified Describe Group:
	☒ Continuously and Ongoing	☒ Other Specify: Representative Sample; Confidence Interval = 95%; Proportional and stratified across state districts
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

Performance Measure:

G.4 Number and percent of reported incidents of alleged abuse, neglect, or exploitation (ANE) that are monitored to appropriate resolution. Numerator: Number of reported incidents of alleged ANE that are monitored to appropriate resolution. **Denominator:** Total number of reported incidents of alleged ANE.

Data Source (Select one):**Critical events and incident reports**

If 'Other' is selected, specify:

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

QA/QI Contractor		
	☒ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

Performance Measure:

G.5 Number and percent of unexpected deaths reviewed by the mortality review triage team according to policy. Numerator: Number of unexpected deaths reviewed by the mortality review triage team according to policy. Denominator: Total number of unexpected deaths.

Data Source (Select one):**Other**

If 'Other' is selected, specify:

Mortality Review Triage Team

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
☐ QA/QI Contractor	
	☒ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:

G.3 Number and percent of sampled individuals who reported they do not feel afraid/scared in their home or day program. Numerator: Number of sampled individuals who reported they do not feel afraid/ scared in their own home or day program. Denominator: Total number of sampled individuals who have a home or day program placement and provided a valid response to the safety/fear assessment question.

Data Source (Select one):

Other

If 'Other' is selected, specify:

National Core Indicators (NCI)

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

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

Data Aggregation and Analysis:

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

Performance Measure:

G.1 Number and percent of substantiated complaint allegations of abuse, neglect, or exploitation (ANE) where the corrective action was implemented. Numerator: Number of substantiated complaint allegations of ANE where the corrective action was implemented. **Denominator:** Total number of substantiated complaint allegations of ANE requiring corrective action.

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
QA/QI Contractor	
	☒ Continuously and Ongoing
	☐ Other Specify:

- b. Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.**

Performance Measures

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

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

Performance Measure:

G.8 Number and percent of reported incidents that were resolved within the stipulated time period. Numerator: Number of reported incidents resolved within the stipulated time period. Denominator: Total number of incidents reported.

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

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

☒ Other Specify: QA/QI Contractor	☐ Annually	☐ Stratified Describe Group:
	☒ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

Performance Measure:

G.6 Number and percent of incidents that were reported within the required time period. Numerator: Number of incidents that were reported within the required time period. Denominator: Total number of incident reports submitted.

Data Source (Select one):**Critical events and incident reports**

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
☐ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☐ Monthly
☐ Sub-State Entity	☒ Quarterly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
☒ Other Specify: QA/QI Contractor	☐ Annually
	☒ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:

G.7 Number and percent of individuals enrolled in the waiver with 3 or less critical incidents within the last 365 days. Numerator: Number of individuals enrolled in the waiver with 3 or less critical incidents within the last 365 days. Denominator: Total number of individuals enrolled in the waiver.

Data Source (Select one):**Critical events and incident reports**

If 'Other' is selected, specify:

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

	☐ Other Specify: 	

Data Aggregation and Analysis:

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

- c. **Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.**

Performance Measures

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

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

Performance Measure:

G/R.1 Number and percent of reported uses of restraints by staff that did not result in medical treatment. Numerator: Number of reported uses of restraints by staff that

did not result in medical treatment. Denominator: Total number of reported uses of restraints by staff.

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
☐ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☐ Monthly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
☐ Sub-State Entity	☒ Quarterly
☒ Other Specify: QA/QI Contractor	☐ Annually
	☒ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:

G/R.2 Number and percent of restraints implemented by staff that were in accordance with state regulations and policy. Numerator: Number of restraints implemented by staff that were in accordance with state regulations and policy. Denominator: Total number of restraints implemented by staff.

Data Source (Select one):**Critical events and incident reports**

If 'Other' is selected, specify:

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

	☒ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

Performance Measure:

G.9 Number and percent of reported incidents by staff that were not coded as a prohibitive intervention (i.e. seclusion, aversive technique, prone restraint, etc.).

Numerator: Number of reported incidents by staff not coded as a prohibitive intervention. **Denominator:** Total number of reported incidents by staff.

Data Source (Select one):**Critical events and incident reports**

If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

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

- d. Sub-assurance:** *The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.*

Performance Measures

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

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

Performance Measure:

G.12 Number and percent of sampled individuals who report having a complete physical exam in the past year. Numerator: Number of sampled individuals who report having a complete physical exam in the past year. **Denominator:** Total number of sampled individuals who responded.

Data Source (Select one):

Other

If 'Other' is selected, specify:

National Core Indicators (NCI)

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

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

Data Aggregation and Analysis:

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

Performance Measure:

G.13 Number and percent of sampled individuals indicating their health care needs are being addressed. Numerator: Number of sampled individuals indicating their current health care needs are being addressed. **Denominator:** Total number of sampled individuals.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Electronic case management database

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
☐ State Medicaid Agency	☐ Weekly	☐ 100% Review
☒ Operating Agency	☐ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☒ Quarterly	☒ Representative Sample Confidence Interval = 95%
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☒ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

Performance Measure:

G.11 Number and percent of sampled individuals who report having a primary doctor or practitioner. Numerator: Number of sampled individuals who report having a primary doctor or practitioner. **Denominator:** Total number of sampled individuals.

Data Source (Select one):

Other

If 'Other' is selected, specify:

National Core Indicators (NCI)

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

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

Data Aggregation and Analysis:

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

Performance Measure:

G.10 Number and percent of medication errors by staff that did not result in medical treatment. Numerator: Number of medication errors by staff that did not result in medical treatment. **Denominator:** Total number of medication errors by staff.

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

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

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

HCBS waiver providers are responsible for taking appropriate and effective measures to secure the individual's immediate safety, implementing preventative measures, and investigating reported incidents. Additionally, HCBS waiver providers and case managers are responsible for following up on all reported incidents, regardless of incident type or severity.

Bureau of Disabilities Services (BDS) is responsible for the oversight of the incident reporting system, which includes receiving and evaluating all incident reports. Incident reviewers use the web-based incident reporting systems to evaluate each of the incident reports to determine whether or not the provider has taken appropriate and sufficient actions to remedy the situation, prevent chances for reoccurrence, and to assure the individual's immediate safety.

Case managers enter follow-up reports into the State's web-based incident management system at minimum every seven calendar days until the incident is closed. BDS QA/QI contractor's incident management staff review these follow-up reports to determine: 1) whether the individual's immediate safety has been secured, and 2) that plans are in place to prevent reoccurrences. Only when both of these criteria are satisfied will the BDS QA/QI contractor's incident management staff close the incident report.

The BDS QA/QI contractor submits a weekly report of unresolved critical events to BDS and BDS executive staff. All incident information is uploaded to the case management system and cases with open incidents display a message to facilitate follow-up.

In emergency situations, Indiana Administrative Code gives the State the authority to remove an individual from them provider's services, issue a moratorium on the provider taking new waiver participants, and/or to terminate the provider's agreement to provide waiver services. The State also has the authority to issue civil sanctions. The DDARS sanctions committee (consisting of BDS and members of DDARS executive leadership) recommends to the BDS director specific sanctions to be issued against providers. The BDS director then communicates this decision to the provider.

Systemic incident reporting data is routinely analyzed for quality improvement purposes in QIEC meetings. Remediation resulting from these meetings has included issuing new and revising current policies.

FSSA uses a centralized IT system to aggregate data and to identify systemic deficiencies. The Quality Improvement Executive Committee (QIEC) meets on a quarterly basis to review data collected from the performance measures for the waivers and identify systemic improvements needed (if any). The QIEC then follows up on the status of recommended systemic improvements at the next QIEC meeting until implementation is completed.

FSSA uses a centralized IT system to aggregate data and to identify systemic deficiencies. The Quality Improvement Executive Committee (QIEC) meets on a quarterly basis to review data collected from the performance measures for the waivers and identify systemic improvements needed (if any). The QIEC then follows up on the status of recommended systemic improvements at the next QIEC meeting until implementation is completed.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of health and welfare that are currently non-operational.

☒ No

☐ Yes

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

Appendix H: Quality Improvement Strategy (1 of 3)

Under Section 1915(c) of the Social Security Act and 42 CFR § 441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a

finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver quality improvement strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a quality improvement strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the quality improvement strategy.

Quality Improvement Strategy: Minimum Components

The quality improvement strategy (QIS) that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's QIS is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its QIS, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the QIS spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the QIS. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The foundation of an effective quality improvement strategy is the capability to compile and analyze meaningful data across the program so that issues can be identified and addressed. The Division of Disability Aging and Rehabilitative Services (DDARS) uses a centralized IT system to administer the day-to-day operations of the waiver program. DDARS has made, and continues to make, many efforts to ensure that the information it collects from each of its monitoring activities can be aggregated so that provider-specific and systemic data can be reviewed. DDARS uses a multi-tier strategy for collecting and addressing person-specific, provider-specific, and systemic trends.

Tier I

This tier focuses on ensuring that concerns by or on behalf of an individual are identified and addressed timely and appropriately. Case managers are responsible for monitoring services, advocating with the individual, and following-up on issues identified through their routine contacts with the individual. Case managers also take a lead role in facilitating individualized support team (IST) meetings while supporting the individual to lead their meeting to the best of their ability. The case manager and individual meet at least every 90 calendar days, and the IST meet at least semiannually and annually. The IST is responsible for reviewing documentation and discussing if an individual's outcomes are being met, whether the Person-Centered Individualized Support Plan (PCISP) is effective or if it should be revised, whether any needed behavior plan/risk plan is being implemented accurately, and if further staff training is necessary.

Information gathered by the ISTs which may be used to make decisions include:

- Data from the case manager's required IST meetings where a full assessment of the individual's service implementation is conducted;
- Service providers' quarterly summaries;
- Incident reports;
- Monitoring checklist;
- Complaint investigations; and
- Quality On-site Provider Reviews

Tier II

In this tier, data is aggregated systemically and reviewed at the State level. The Quality Improvement Executive Committee (QIEC) meets on a quarterly basis to review data collected from the performance measures for the CIH and FSW waivers. Each meeting is dedicated to a defined set of performance measures. At each QIEC meeting, the data team develops and presents a report with the data obtained in the time period being covered (typically in the form of charts and graphs), along with analysis, and remedial steps taken thus far to address areas with issues. The group then discusses the data and systemic remediation that DDARS should take to improve the quality of services being delivered and individuals' health outcomes.

Following QIEC meetings the report presented to the committee is updated with any further systemic remediation plans that were discussed. The state team ensures that these remediation plans are implemented and then follows up with those performance measure reports at the next QIEC meeting.

Examples of systemic improvements the QIEC has made include: revising DDARS provider policies, educating providers/ individuals with intellectual disabilities, and their families on key health and safety issues, revising the information required to report an incident, and collaborating with provider groups to obtain better training for direct care staff. In collaboration with the Office of Medicaid Policy and Planning (OMPP), DDARS shares the data reviewed and remediation actions taken with CMS in the annual CMS-372 reports and in periodic evidence-based reports.

QIEC membership from entities within Family and Social Services Administration (FSSA) consists of:

- Bureau of Disabilities Services (BDS) leadership
- BDS provider services representative
- BDS Home and community-based services (HCBS) program representative
- OMPP representative
- BDS Home and community-based services (HCBS) policy team representative
- BDS QA/QI contractor

- BDS data analysts

DDARS participates in the National Core Indicators (NCI) project to obtain individuals with disabilities perspectives on how the waiver service delivery system is operating overall. These data gathered expand DDARS's quality assurance system. Ongoing, as we collect and analyze Indiana's interview results and make comparisons to other states' performance, we will be better able to identify gaps between NCI data and information gathered through DDARS's other monitoring activities. NCI project data will help DDARS establish priorities and make recommendations for improvement.

While DDARS's routine system to collect and analyze data and make changes is functioning, changes in monitoring activities may be driven by outside forces such as organizational redesigns, legislative demands, and different amounts of funding available. An example of this is the legislature's approval of a bill to add accreditation to the provider qualifications for day program providers. As a result, when a provider shows evidence of an accredited service, BDS adjusts the reverification timelines based on the accreditation term.

DDARS Mortality Review System

An important part of DDARS's quality improvement strategy is the mortality review process. BDS conducts mortality reviews for all deaths of individuals receiving services through FSW and the CIH waivers.

As described in Indiana Administrative Code (460 IAC 6-9-5) on incident reporting, all deaths of individuals receiving DDARS-funded services are required to be reported to the State through the BDS Incident Reporting system. Upon receipt of the death report, BDS's mortality review triage team (MRTT) assesses whether an individual's housemates may be at risk for similar circumstances.

An Others at Risk (OAR) questionnaire is generated and emailed to the provider within twenty-four (24) hours of receipt of death report. A score is generated and if red, the MRTT will determine if an expedited death review or complaint review should be completed. If it is determined that a home site visit is needed, the BDS QA/QI contractor will complete an information sheet that includes demographics, documents needed and reason for the visit. The BDS District Office will visit the home in which the individual resided to gather the requested information. If a complaint investigation is warranted the BDS QA/QI contractor may conduct the site visit. For example, if someone died due to choking, a BDS representative would go to the individual's home to assess staff performance in adhering to risk plans related to choking. If an issue was identified, the provider would be directed to complete a corrective action plan (CAP), which would include immediate staff training related to risk plans. BDS validates implementation of all CAPs, and noncompliant providers may be referred to the DDARS sanctions committee.

Per 460 IAC 6-25-10 Investigation of Death, the provider identified in a individual's PCISP as responsible for the health care of the individual is required to conduct internal investigations of individual deaths. The DDARS mortality review policy describes all the specific documentation that providers need to review as part of their internal investigation process. Providers send completed internal mortality investigations, along with the individual's medical history and other related documentation to the BDS's MRTT. The MRTT reviews all deaths. Discussions include the events prior to the death, supports/services in place at the time of death, and whether additional documentation is needed for review. The MRTT also determines whether each death meets criteria to be brought before the mortality review committee (MRC). The BDS director or any other DDARS staff with a concern can also refer deaths to the MRC.

The MRC is facilitated by the BDS QA/QI contractor. Committee members include representatives from BDS Central Office, Adult Protective Services (APS), the Department of Health, OMPP, Indiana coroner's association, Statewide Bureau of Disabilities Services ombudsman, BDS field service staff, and community advocates.

Based on its discussion, the MRC makes recommendations for systemic improvements such as developing new policy, revising policy, training, or sharing key information. The MRC also makes provider-specific recommendations for BDS to review key areas of a provider's system that appear to have not been in place or to have been ineffective at the time of an individual's death. Providers may be required to develop CAPs to address identified issues and to prevent other individuals from experiencing negative outcomes. To date, the communication topics have included Coumadin monitoring, malfunctioning feeding tubes, choking versus

aspiration, pain management, medication administration, healthcare coordination, staff training on risk plans, and the fatal four in individuals with developmental and intellectual disabilities.

ii. System Improvement Activities

Responsible Party(<i>check each that applies</i>):	Frequency of Monitoring and Analysis(<i>check each that applies</i>):
☒ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☒ Quarterly
☒ Quality Improvement Committee	☐ Annually
☐ Other Specify: 	☐ Other Specify:

b. System Design Changes

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

DDARS uses a centralized IT system to monitor its HCBS waiver programs and to identify systemic changes necessary for improving the quality of individuals' services and supports. DDARS management and OMPP representatives participate in the routine QIEC DDARS leadership meetings to review data collected from monitoring systems and to assess monitoring activities' effectiveness in producing positive changes for individuals receiving waiver services.

Different positions play a role and have a responsibility in the processes for monitoring and assessing effectiveness of system design changes. These include:

- Case managers have the front-line responsibility for overseeing the delivery of waiver services. They are responsible for conducting a minimum of four visits with the individual each year, coordinating and facilitating IST meetings as necessary, and identifying and resolving issues with service delivery. Case managers have the potential to identify the effectiveness of system design changes by how the waiver participants they work with are impacted.
- BDS-contracted complaint investigators are continually in the field following up on allegations that individuals' health and welfare may be in jeopardy. Aggregated information and analysis compared from one quarter to the next is shared in BDS's quarterly reports and is discussed in DDARS leadership meetings.
- BDS-contracted incident management staff are responsible for reviewing and coding all incident reports as they are submitted into the State's web-based system. Similar to information on complaint investigations, incident data is aggregated and analyzed in BDS's quarterly reports and discussed in QIEC and DDARS leadership meetings.
- The division will review service requests and make a determination based on the person-centered plan and the individualized needs of the individual on a case-by-case basis. Limitations may be set by the division if consistent with waiver, state, and federal authority. Data is aggregated and routinely discussed in QIEC meetings.

- ii. Describe the process to periodically evaluate, as appropriate, the quality improvement strategy.

Quality improvement strategies are living documents that result from an ongoing process of review and refinement. Necessary changes to DDARS's monitoring systems are identified through the continual review and analysis of data in QIEC and DDARS leadership meetings. Over the past few years DDARS has focused its resources on ensuring that we have the processes in place to collect data on our most basic assurances and that these processes are working effectively.

As needed, DDARS will submit modifications to the quality improvement strategy annually with the 372 report.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months (*Select one*):

- ☐ No
- ☒ Yes (*Complete item H.2b*)

b. Specify the type of survey tool the state uses:

- ☐ HCBS CAHPS Survey :
- ☒ NCI Survey :
- ☐ NCI AD Survey :
- ☐ Other (*Please provide a description of the survey tool used*):

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

FSSA PI has an agreement with the FSSA Audit Unit to investigate allegations of potential HCBS waiver provider fraud, waste, and abuse. PI and FSSA Audit maintain a natural level of collaboration and cooperation between the two groups. FSSA Audit's staff are knowledgeable of the different HCBS definitions, documentation standards, provider qualifications, and any required staffing ratios so it makes sense for them to audit allegations of wrongdoing in the waiver programs. The state does not require providers to secure an independent audit of their financial statements.

Select analytics are periodically rerun in an attempt to identify if provider billing patterns have changed/improved based on previous audit and/or provider education. Additional audit action may be taken for providers who continue to be identified as potential issues in these algorithms. If providers are again selected for audit, a similar audit process as previously described would occur.

Process for Conducting Audits:

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

FSSA Audit may decide to conduct a statistically valid random sample of consumers and then PI's Fraud & Abuse Detection System (FADS) vendor will pull a sample for their audit. The size of a random sample audit is dependent on the universe(s) size, claim/claim line payments, and other statistical criteria. The sample size is ultimately determined utilizing a tool developed by FADS contractors as well as their statistical consultants. Depending on the concerns identified during the risk assessment FADS will recommend an approach and/or scope for the audit:

Targeted Probe Audit Sample - A sample of sufficiently small size designed to focus on specific services, members, time frames, or other scenarios that have been identified as higher risk for fraud, waste, and/or abuse to determine potential outcomes of audit findings or payment error issues. If the probe identifies material issues, statistical sampling is used to expand the testing and quantify overpayments.

Random Sample Audit - The goal of the random sample is to identify potential payment errors and extrapolate those errors to the entire universe of claims.

FSSA Audits are performed onsite and include a review of:

- *Providers' source documents.* This include documents that supports paid claims (e.g. employee signed service notes, logs, etc.).
- *Payroll records.* Dates/times/locations of service per claims are compared to related time cards and payroll registers.
- *Employee background and qualifications.* Personnel files are reviewed for documentation of criminal background checks, licenses (if applicable), and search of the HHS/OIG exclusions list.

FSSA Audit conducts its audit activities and develops a findings report containing accuracy-related issues, missing documentation, internal control deficiencies, and training issues. Providers submit corrective action plans. Any overpayments are set up for recoupment. Audit reports are distributed to provider leadership and appropriate FSSA

executives. Periodically, PI is advised of any systemic issues identified. FSSA Audit Services seeks PI's advice on audit reporting and direction on technical questions.

For audits performed based on referrals such as incorrect billing, the reporting varies. If the audit finds the provider made unintentional errors, the typical audit reporting process is followed. However, if the referred audit identifies potential, intentional errors that may be credible allegations of fraud, the provider is referred to PI for further action.

The FSSA PI section utilizes a Provider Peer Comparison Tool (J-SURS) which compares providers to peers of like specialty to identify outliers to conduct on-going monitoring of IHCP providers. At a minimum, all provider types are profiled yearly, while higher-risk provider types are profiled on a quarterly basis. The results of the profiles are reviewed by PI staff to determine which providers may need further investigation and these results are discussed in weekly team meetings with PI's Fraud Abuse and Detection (FADS) group.

PI regularly utilize random-sampling and extrapolation in conducting audits of IHCP providers; however, the approach and sampling is determined by the allegation necessitating the audit. The frequency of utilizing this approach is fluid, based upon the providers in queue for audit as well as the proposed audits included in the yearly FADS Audit Workplans. If the audit has a narrow scope the review will be conducted on all identified claims. If the issue involves a large number of claims, or if the review is a provider-focused, comprehensive review, PI has the ability to utilize statistically-valid random sampling and extrapolation to determine any potential overpayments from the IHCP.

PI audits include a review of provider records to ensure compliance with applicable state and federal guidelines, as well as policies published by the IHCP. Review scope may vary depending on provider type/specialty and/or concerns/allegations identified. At a minimum, the review includes:

- Compliance with applicable documentation requirements. This may include documents such as reconciliation of the records to timesheet and/or other payroll records, vehicle insurance (e.g., transportation providers), etc.
- Employee background and qualifications. This may include a review of personnel files for documentation of licenses (if applicable), TB test records, etc.

For each review, PI prepares a detailed claim-level review checklist that lists all claims included in the review, outlines the scope of the review, and identifies all findings or educational items noted during the review. FADS investigations/audits can be initiated based on referrals received from different sources/agencies. PI receives information from the following sources which could potentially lead to additional action including audit action:

1. IHCP Provider and Member Concerns Line;
2. Other agencies (MFCU);
3. Analyses/Analytics performed by the PI Investigations team
4. Analytics performed by FADS contractors.

Depending on the allegations/information received regarding the provider(s), PI may conduct a Preliminary Investigation, utilizing the Credible Allegation of Fraud (CAF) tool developed by FADS contractors to determine next steps.

In certain instances, PI refers the provider(s) in question to FADS contractors for additional analysis which may include performing a Risk Assessment. The Risk Assessment tool, developed by FADS contractors, is utilized to gather information on a specific provider's background as well as billing patterns utilizing claims data and other research databases, focusing on any potential issues identified during the referral process. FADS contractors utilize this tool to assist in the decision making process when recommending the next appropriate action to be taken for the provider(s) in question.

There are differences in post-payment review methods, scope and frequency based upon audit type, provider type/specialty, background information, and state rules/regulations. PI can audit IHCP providers either through a narrow scope in which all identified claims are reviewed or a provider-specific full review. PI has the ability to utilize statistically-valid random sampling and extrapolation to determine any potential overpayments from the IHCP.

The providers are notified of the potential errors upon receipt of the Draft Audit Findings letter, where no medical records are reviewed prior to identification of the problematic claims. If PI decides to conduct a more comprehensive review of an IHCP provider, PI request a full medical record review. The audit can be conducted through a medical record request desk audit, or as an on-site review. The on-site audit can be announced or unannounced, based upon the circumstances behind the audit recommendation.

Depending on multiple factors, risk assessments typically result in one of the following recommended actions (dependent upon the severity of the allegations and other information uncovered during the risk assessment):

- No further action - No issues uncovered warranting further action.*
- Provider education - No major issues identified that would result in patient harm or overpayments; however, it may be apparent that the provider as well as the Medicaid Program would benefit from additional education for the provider on proper/best billing practices.*
- Provider self-audit - Specific concern(s) were identified resulting in a recommended limited-scope audit; however, the concern(s) are in an area which the State is comfortable with the provider conducting the audit to ensure compliance. FADS contractors subsequently perform validation review of the provider self-audit results. If FADS contractors determine they are not in agreement with a high percentage of the provider's self-audit results during the validation review, they will recommend the audit be escalated to a desk review and all records within the provider self- audit sample are evaluated by the contractor.*
- Provider desk audit - Concern(s) were identified resulting in the need for medical record review (could be full or limited scope). However, the severity of the concerns do not currently warrant an on-site review. Certain provider records, including medical records, are requested for selected claims and clinical staff (if necessary) conduct a review of the services billed to ensure compliance with IHCP guidelines. Providers are allowed thirty (30) days to submit the requested information.*
- Provider on-site audit (announced or unannounced) - Severity of the concern(s) has resulted in a recommendation of an on-site audit. Providers are generally given shorter notice (or no notice if warranted) of the pending on-site audit. If notice is provided, it can range from a few days to a few weeks depending on several factors (i.e., type of facility, audit concerns, etc.). Requested information is collected on-site. A facility tour as well as provider/staff interviews are also conducted during on-site reviews. FADS contractors, including clinical staff, are included in on-site reviews and assist with conducting interviews. State Program Integrity personnel often also participate in on-site reviews.*
- Referral to MFCU - Payment suspension recommended as the potential intent of fraudulent behavior was identified. Depending on the allegations/information received regarding the provider(s), the SUR Unit may conduct a Preliminary Investigation, utilizing the Credible Allegation of Fraud (CAF) tool developed by FADS contractors to determine the appropriate next steps, if any.*

Under the provisions of the Single Audit Act as amended by the Single Audit Act Amendments of 1996, the State of Indiana utilizes the Indiana State Board of Accounts to conduct the independent audit of state agencies, including the Indiana FSSA Compliance office. FSSA Compliance routinely monitors audit resolution and provides annual status updates to SBOA.

APPENDIX I-1: FINANCIAL INTEGRITY AND ACCOUNTABILITY IS CONTINUED IN THE MAIN MODULE:
ADDITIONAL NEEDED INFORMATION (OPTIONAL)

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:

The state must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program.

i. Sub-Assurances:

a. Sub-assurance: The state provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

Performance Measures

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

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

Performance Measure:

I.1 Number and percent of claims paid for individuals enrolled in the waiver on the date the service was delivered. Numerator: Number of claims paid for individuals enrolled in the waiver on the date the service was delivered. Denominator: Total number of claims submitted.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Medicaid Management Information System claims data

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

		Confidence Interval =
☒ Other Specify: Fiscal Agent	☐ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

Performance Measure:

I.2 Number and percent of claims paid for services that are specified in the individual's approved PCISP. Numerator: Number of claims paid during review period due to service having been identified on the approved PCISP. Denominator: Total number of claims submitted during the review period.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Medicaid Management Information System claims data

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

Data Aggregation and Analysis:

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

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

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

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

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

Performance Measure:

I.3 Number and percent of rates for waiver services adhering to reimbursement methodology in the approved waiver. Numerator: Number of waiver rates that follow the approved methodology. Denominator: Total number of waiver rates.

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

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

		Sample Confidence Interval =
☒ Other Specify: Fiscal Agent	☐ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

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

The State assures financial accountability through a systematic approach to the review and approval of services that are specifically coded as waiver services within the waiver case management system and the MMIS. The MMIS links to the waiver case management system in order to ensure that only properly coded services, that are approved in an individual's plan of care, are processed for reimbursement to providers who are enrolled Medicaid Community Integration and Habilitation Waiver providers.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

I.1 and I.2 Claims reimbursement issues may be identified by a case manager, the public, a provider, contractor, or FSSA staff.

For individual cases, FSSA's Operations division and/or the Medicaid Fiscal Agent, FSSA's Provider Relations staff, or FSSA's Office of Compliance, address the problem to resolution. This may include individual provider training, recoupment of inappropriately paid monies and if warranted, placing the provider on prepayment review monitoring for future claims submissions. If there is a billing issue involving multiple providers, FSSA will work with the Medicaid Fiscal Agent and/or FSSA's SUR unit within the Office of Compliance, to produce an educational clarification bulletin and/or conduct training to resolve billing issues.

If the issue is identified as a systems issue, the FSSA's Division of Healthcare Strategies and Technology will extract pertinent claims data to verify the problem and determine correction needed.

If the problem indicates a larger systemic issue, it is referred to the Change Control Board for a systems fix.

Each party responsible for addressing individual problems maintains documentation of the issue and the individual resolution. Meeting minutes are maintained as applicable. Depending on the magnitude of the issue, it may be resolved directly with the provider or the individual.

I.3 Financial records will be used to verify that reimbursement for services is paid at the approved rate, and therefore, using the approved rate methodology.

FSSA uses a centralized IT system to aggregate data and to identify systemic deficiencies. The Quality Improvement Executive Committee (QIEC) meets on a quarterly basis to review data collected from the performance measures for the waivers and identify systemic improvements needed (if any). The QIEC then follows up on the status of recommended systemic improvements at the next QIEC meeting until implementation is completed.

ii. Remediation Data Aggregation

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

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

☒ **No**

☐ **Yes**

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The state will review rates every five years. The last review occurred during SFY 2023 and included robust stakeholder engagement and analysis to understand underlying costs for current services, and to assess and assure access and quality. For most services, a traditional cost model build-up was used, while for others listed in Appendix I-2-a, a market-based approach was used. After the review, proposed rate increases were approved by the legislature and implemented July 1, 2023.

In state fiscal year (SFY) 2023, Indiana's Family and Social Services Administration (FSSA) completed a rate review (rate study) for the Community Integration and Habilitation (CIH) waiver. FSSA conducted a provider survey to capture the current provider experience of delivering the applicable waiver services, service specific work groups, and all provider meetings. The SFY 2023 rate review process was conducted by FSSA in partnership with a contractor (Milliman, Inc.). Milliman's analysis and stakeholder engagement activities were reviewed and approved by FSSA at each step of the process. All analysis was reviewed by FSSA, and proposed rates were developed with their input and guidance. Proposed rates were presented for legislative review and approval and exposed for public notice and tribal review.

Data sources: To develop revised payment rates, FSSA used the following primary data sources:

- **Bureau of Labor Statistics (BLS) data** - Data elements from the BLS incorporated in the rates include Indiana wage data for applicable occupation codes, healthcare industry benefits, and healthcare wages, which were used to project the costs out to the effective rate period.
- **Provider survey data** - Data collected from providers informed public source gaps and provided corroborating support for key BLS inputs. FSSA collected provider surveys related to provider costs (for employee salaries, benefits, administration and program support), average wages per hour, staffing information (such as number of employees relative to individuals served, and the average number of service hours per employee), mileage, and operational structure.
- **Service specific workgroups** - Service specific stakeholder meetings were held to contextualize provider survey information and to further capture the provider experience with hiring/retaining staff, delivering services, and sufficiency of current payment rates.
- **Other public and proprietary data sources** - Other data sources were used to develop assumptions in the rate models, including but not limited to, transportation mileage reimbursement, fleet vehicle costs, and food costs (limited to adult day).

Methodologies: To develop prospective payment rate methodologies for the Division of Disability Aging and Rehabilitative Services (DDARS) waiver program services, FSSA selected the following approaches:

- **Traditional cost model build-up** - This approach reflects the program-related cost per unit of providing each covered service. The foundation of this model is the labor cost per unit, which includes projected wages and benefits costs, allocated to the service unit level. Administration and program support costs are calculated as a percentage of the labor cost per unit component. Self-directed and non-agency service rates follow the cost model build up but do not include a supervisory component. Select services also include "other" cost components for unique requirements such as food for adult day services or on-call expenses for behavior management services. All services using this build-up approach have supporting rate models.

Key default rate inputs under this approach were as follows:

- **Direct care staff and supervisory wages:** based on BLS Indiana wages and percentiles, but were also informed by provider surveys and stakeholder feedback
- **Wage inflation:** based on changes in Consumer Price Index (CPI) for employment earnings of medical professionals
- **Training and Paid Time Off (PTO) factors:** training and PTO ranges between 60 and 70 hours per employee per year
- **Benefits factor ("employee related expenses" or ERE):** varies by wages and is based on BLS national benchmarks for insurance costs as well as federal and state taxes
- **Administration and program support factor:** 15% combined administration and program support factor
- **Indirect service time:** ranges between 1 minute and 3 minutes per 15-minute unit for timed individual services
- **Staffing ratios:** group services vary by staffing ratios that align with group service standards; group services include structured day program and adult day

- Caseload size: case management services reflect a waiver specific caseload size
- Transportation: some services include mileage for onsite staff travel or reimbursement for a fleet

CIH services for which the state's traditional cost model build-up methodology applies as of 07/01/2024:

- Adult Day Services
- Behavioral Support Services
- Career Exploration and Planning
- Case Management
- Day Habilitation
- Extended Services
- Facility Based Supports
- Home Modification Assessment
- Benefits Counseling
- Remote Supports (was Electronic Monitoring)
- Music Therapy
- Occupational Therapy
- Physical Therapy
- Prevocational Services
- Psychological Therapy
- Recreational Therapy
- Residential Habilitation & Support (hourly)
- Residential Habilitation & Support-Daily (RHS Daily)
- Respite
- Speech/Language Therapy
- Structured Family Caregiving
- Transportation
- Wellness Coordination
- Workplace Assistance

• Market-based approach - Based on market prices (up to an annual or lifetime limit) or commercial benchmarks for Community Transition, Home Modifications, Family and Caregiver Training, Personal Emergency Response System, Rent and Food for Unrelated Live-in Caregiver, Specialized Medical Equipment and Supplies (SMES) , and Vehicle Modifications (VMODs). Requested items/units under VMODs and SMES continue to be presented to DDARS for prior approval accompanied by three bids prepared by DDARS-approved vendors specializing in provision of the requested item(s) and representing current market costs. Home Modifications exceeding \$1000 require two bids prepared by DDARS-approved vendors specializing in provision of these modifications and representing current market costs be presented to DDARS for prior approval.

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

Additionally, the Medicaid agency now solicits public input on rate determination methods through collaboration with industry leaders in the collection and review of costs associated with the various service components. At any time, public comments may be received via the BDS Helpline at BDSHelp@fssa.in.gov.

*Information about payment rates is made available to waiver participants by their Case Manager. Current rates are continuously posted in the IHCP module located on the OMPP website at:
<http://www.in.gov/medicaid/providers/files/modules/ddrs-hcbs-waivers.pdf>*

Prior to any rate changes, a bulletin of the rates is posted to IndianaMedicaid.com to advise providers of the rate changes. Once the changes occur, manuals are updated regularly to reflect the changed rates.

At CMS' request, the Home Modification Assessment Service and the Home Modification service have been combined into one service line in the waiver filing. However, the service components are performed by different providers (the assessor is independent of the contractor who does the actual modification), and therefore payment for the service is remitted in two separate components: 1) the independent assessment continues to be paid using a flat fee developed using a traditional cost model build-up, and 2) the modification itself continues to use a market based approach. The payment

for the combined service is the sum of these two components.

The Benefits Counseling Service rate of \$50 per hour aligns with the rate paid outside of the waiver for the same service by the FSSA Vocational Rehabilitation program.

- b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Claims for waiver services flow directly from the providers to the Indiana Medicaid Management Information System and payments are made via Medicaid's contracted fiscal agent.

The State implemented an Electronic Visit Verification (EVV) system, known as the Sandata EVV System, that complies with the requirements of the federal 21st Century Cures Act. The IHCP CoreMMIS claim-processing system has been configured to integrate with the Sandata EVV system.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

- c. Certifying Public Expenditures (select one):**

- ☒ **No. state or local government agencies do not certify expenditures for waiver services.**
- ☐ **Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.**

Select at least one:

- ☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b). (Indicate source of revenue for CPEs in Item I-4-a.)

- ☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

a) and b) As explained in Appendix D the Person-Centered Individualized Support Plan (PCISP) contains only those services that are available under the Community Integration and Habilitation Waiver.

FSSA/DDARS Waiver Services Unit approves a individual's PCISP within the State's case management application database ensuring that only those services which are necessary and reimbursable under the Community Integration and Habilitation Waiver and that appear on the PCISP. The PCISP is sent to the state's fiscal agent and entered into the MMIS serving as the prior authorization for all Community Integration and Habilitation Waiver services. The case management data system will not allow the addition of services beyond those services offered under the Community Integration and Habilitation Waiver. The case management data system has been programmed to alert the DDARS waiver services staff when a PCISP is being reviewed for an individual whose Medicaid eligibility status is not currently open within an acceptable category as was discussed under Appendix B-4-b. When the appropriate Medicaid eligibility status is in place, and the PCISP is approved, the system generates a Service Authorization/Notice of Action (SA/NOA), which is sent to each authorized provider of services on the Plan. The SA/NOA identifies the individual service recipient (the waiver participant), the service that each provider is approved to deliver, and the rate at which the provider may bill for the service.

The case management database transmits data (typically each business night) containing all new or modified PCISP service and rate information to the Indiana MMIS. The PCISP data is utilized by the MMIS as the basis to create or modify Prior Authorization fields for billing of services against Medicaid waiver participants.

Providers submit electronic (or paper) claims directly to the MMIS. Claims are submitted with date(s) of service, service code, and billing amount. Reimbursements are only authorized and made in accordance with the Prior Authorization data. The MMIS also confirms that the waiver participant had the necessary Level of Care and Medicaid eligibility for all dates of service being claimed against.

c) Documentation and verification of service delivery consistent with paid claims is reviewed during the look behind efforts of the FSSA's BDS as well as by the FSSA's Operations and FSSA's SUR Unit when executing Surveillance Utilization (SUR) activities.

In summary, the waiver participants eligibility for Medicaid and eligibility for approved dates of service are controlled through the electronic case management database system which is linked to Medicaid's claims system. All services are approved within these systems by FSSA's DDARS. As part of the 90 day review, the case manager verifies with the individual the appropriateness of services and monitors for delivery of service as prescribed in the plan of care.

Modifications to the plan of care are made as necessary.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR § 92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS (select one):

- ☒ **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- ☐ **Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal

funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- **Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):

- ☐ **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- ☒ **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- ☐ **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

- ☐ **Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:

- ☒ **No. The state does not make supplemental or enhanced payments for waiver services.**
- ☐ **Yes. The state makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. Specify whether state or local government providers receive payment for the provision of waiver services.

- ☒ **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- ☐ **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

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

- ☐ **The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.**
- ☐ **The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**

- **The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:

- **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. Select one:

- **No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR § 447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. Select one:

- **No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR § 447.10.**
- **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR § 447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not

voluntarily agree to contract with a designated OHCDs; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDs arrangement is employed, including the selection of providers not affiliated with the OHCDs; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDs meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDs contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDs arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

- **The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- **The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of section 1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- **This waiver is a part of a concurrent section 1915(b)/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**
- **This waiver is a part of a concurrent section 1115/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1115 waiver specifies the types of health plans that are used and how payments to these plans are made.**
- **If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.**

In the text box below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of section 1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

- a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:

☒ **Appropriation of State Tax Revenues to the State Medicaid Agency**

☐ **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

☐ **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:

☒ **Not Applicable.** There are no local government level sources of funds utilized as the non-federal share.

☐ **Applicable**

Check each that applies:

☐ **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability**I-4: Non-Federal Matching Funds (3 of 3)**

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:

- ☒ **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- ☐ **The following source(s) are used**
Check each that applies:
 - ☐ **Health care-related taxes or fees**
 - ☐ **Provider-related donations**
 - ☐ **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability**I-5: Exclusion of Medicaid Payment for Room and Board**

a. Services Furnished in Residential Settings. Select one:

- ☐ **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- ☒ **As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.**

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:

The State of Indiana excludes Medicaid payment for room and board for individuals receiving services under the waiver. Waiver participants are responsible for all room and board costs.

There is no consideration of the cost of room and board in developing the rates. Waiver service providers are paid a fee for each type of direct service provided; no room and board costs are included in these fees.

Based on the method for establishing the fee for each waiver service, the State of Indiana assures that no room and board costs are paid through Medicaid. Indiana provider audit procedures also review provider billing and all allowable costs to further assure no room and board payments are made.

Appendix I: Financial Accountability**I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver**

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. Select one:

- ☒ **No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who**

resides in the same household as the participant.

- **Yes. Per 42 CFR § 441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

a) The State uses the following method to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver.

- Room and board expenses of non-related, live-in caregivers are based on an estimate of the cost of food and housing in typical two and three bedroom apartments. The amount paid for live-in caregiver will be up to the federal benefit level under SSI for an individual living in the home of another, or actual expenses, whichever is the lesser amount

b) This service must be an approved service and included in the Person Centered Individualized Support Plan (PCISP) in order to be reimbursed through the Medicaid MMIS.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:

- **No. The state does not impose a co-payment or similar charge upon participants for waiver services.**
- **Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

- ☐ **Nominal deductible**
- ☐ **Coinurance**
- ☐ **Co-Payment**
- ☐ **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)**a. Co-Payment Requirements.****ii. Participants Subject to Co-pay Charges for Waiver Services.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)**a. Co-Payment Requirements.****iii. Amount of Co-Pay Charges for Waiver Services.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)**a. Co-Payment Requirements.****iv. Cumulative Maximum Charges.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)**b. Other State Requirement for Cost Sharing.** Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:

- ☐ **No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ☒ **Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

MEDWorks members with income between 150% - 350% FPL are responsible for paying a premium based on family size and income; the income standard includes a 50% earned income disregard for all MEDWorks members. Premiums vary from \$0 to \$254.

The included groups are the MEDWorks members with HCBS waivers with income over 150% FPL.

For 2023, the MEDWorks premiums are:

Family Size 1:

Income standard \$1216 - \$1822: Premium \$0

Income standard \$1823 - \$2127: Premium \$48

Income standard \$2128 - \$2430: Premium \$69

Income standard \$2431 - \$3038: Premium \$107

Income standard \$3039 - \$3645: Premium \$134

Income standard \$3646 - \$4253: Premium \$161

Income standard \$4254 and over: Premium \$187

Family size 2:

Income standard \$1644 - \$2465: Premium \$0

Income standard \$2465 - \$2876: Premium \$65

Income standard \$2877 - \$3287: Premium \$93

Income standard \$3288 - \$4109: Premium \$145

Income standard \$4110 - \$4930: Premium \$182

Income standard \$4931 - \$5752: Premium \$218

Income standard \$5753 and over: Premium \$254

**Income of the non-MEDWorks member is not budgeted in the eligibility determination but does apply to the premium calculation.*

Every month, the Premium Vendor sends a bill to MEDWorks members with a premium. The member has 60 days to pay the premium; failure to pay within 60 days can result in the closure of the MEDWorks Medicaid. This results in

a 2 year lock out for MEDWorks members. If the member pays the premium in full, the lock out is removed.

MEDWorks members between 101-149% FPL are excluded as are other Medicaid categories with HCBS waivers.

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	102495.47	11066.05	113561.52	185441.39	11424.27	196865.66	83304.14
2	100253.91	11309.50	111563.41	191190.07	11675.60	202865.67	91302.26
3	100547.64	11558.31	112105.95	197116.96	11932.47	209049.43	96943.48
4	100234.11	11812.59	112046.70	203227.59	12194.98	215422.57	103375.87
5	100240.56	12072.47	112313.03	209527.65	12463.27	221990.92	109677.89

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		ICF/IID	
Year 1	9438		9438
Year 2	9451		9451
Year 3	9475		9475
Year 4	9499		9499
Year 5	9523		9523

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

Projected average length of stay was developed based on slot projections. Slot projections reflect actual experience through September 2024 in WY 5 of the fourth renewal. They also assume approximately 37 new entrants and 35 lapses per month. Lapses are estimated using a 0.39% monthly historical lapse rate.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:

Base Year data reflects experience from Waiver Year (WY) 4 of the fourth renewal: July 16, 2023 - July 15, 2024. The base year data was projected to WY 1 through WY 5 of the fifth renewal in the following manner:

- The number of users of each service was adjusted based on projected slots.
- Average units per user were projected to vary with average length of stay.
- Home modification assessment was added as a new service effective July 1, 2024. It is assumed that 55% of assessments lead to home modification, at a cost of \$628 per assessment.
- Career Exploration and Planning was added as a new service effective July 1, 2024. This service is offered to members age 18-24 for a duration of six months and will replace Pre-Vocational services for these members.
- Home Modification, Home Modification - Assessment, Home Modification - Equipment/Assessment/Inspection and Home Modification - Maintain lines were combined into one line now titled 'Home Modifications and Assessments' on the Appendix J.
- The following changes are proposed to be effective December 31, 2025:
 - o For Pre-Vocational services - the number of users and average cost per unit were adjusted to reflect elimination of the facility-based Pre-Vocational services. In addition, it was assumed that those members will be receiving Day Habilitation services instead.
 - o For Behavior Management Basic - the average units per user were adjusted to reflect the limitation of the service to 12 hours per month.
 - o For Music Therapy - the average units per user were adjusted to reflect the limitation of the service to 6 hours per month.
 - o For Recreational Therapy - the average units per user were adjusted to reflect the limitation of the service to 6 hours per month.
 - o Benefits Counseling - a new service being offered to members age 18-59 to provide counseling to members in order to vocational rehabilitation or other employment supports. It is assumed that 10% of CIHW members age 18-59 will utilize the service for 5 hours per year with an average cost per unit of \$50.
 - o Self-directions - proposed to be implemented and will impact Respite Care, Residential Habilitation (hourly services only) and Workplace Assistance. It is assumed that 2% of members will participate in self-direction of the services and this will reduce their budget by 10%. The average cost per unit was adjusted to decrease by 0.2% for the services listed above.
 - o Home Modification, Home Modification - Assessment, Home Modification - Equipment/Assessment/Inspection and Home Modification - Maintain lines were combined into one line now titled 'Home Modifications and Assessments' on the Appendix J.
 - o Intensive Behavioral Intervention services will be rolled into the Behavior Management services and are no longer projected for WY 2 - WY 5.
- Average cost per unit is projected to remain unchanged.

Cost per unit trend of 0.0% is utilized as the state does not expect the rates to change after rate review during the renewal period. Estimates of Factor D for each waiver year are illustrated in the cost neutrality summary in Appendix J-1: Composite Overview and Demonstration of Cost-Neutrality Formula.

- The following changes are proposed to be effective August 1, 2026:
 - Specialized Medical Equipment and Supplies (SMES): The proposal is to adopt a 30 percent markup cap over acquisition cost for Specialized Medical Equipment and Supplies. The estimated impact is reflected as an average unit cost adjustment for SMES. Service definitions and utilization assumptions remain unchanged.
 - Residential Habilitation Services (RHS): For eligible members meeting the amendment criteria, services are furnished under daily Residential Habilitation Services consistent with the existing service definitions and rate schedule. In Appendix J, this is a change in the number of users between hourly Residential Habilitation (over and under) and daily Residential Habilitation services (all tiers). There are no changes to average units per user and no changes to average cost per unit at either service level based on this proposed change. Proration is applied for partial-year effects, as applicable. Base data remains unchanged.

- Remote Supports (Residential Habilitation Services (RHS): For clinically appropriate populations, the estimated impact reflects utilization-based substitution where a portion of in-person hours is replaced with remote supports. In Appendix J, this is presented as a downward adjustment to expected Residential Habilitation Over and Under units per utilizer, with an offsetting adjustment to remote supports units for the affected services.

- ii. Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Base Year data reflects experience from Waiver Year 4 of the fourth renewal: July 16, 2023 - July 15, 2024.

Base year data was trended at 2.2% per year to reflect Medical CPI-U over the most recent 5 complete years (rounded).

Estimates of Factor D' for each waiver year are illustrated in the cost neutrality summary in Appendix J-1: Composite Overview and Demonstration of Cost-Neutrality Formula.

- iii. Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Base Year data reflects experience from Waiver Year 4 of the fourth renewal: July 16, 2023 - July 15, 2024, for individuals receiving care in the following ICF/IID settings:

- Comprehensive Rehabilitative Needs Facilities (CRMNFs)
- Extensive Support Needs Homes (ESNs)
- Extensive Medical Needs Homes (EMNs)

Factor G from WY 4 was inflated by 5.5% to WY 5 to reflect emerging experience and the start of modernization efforts. Future year cost factors were trended at 3.1% per year. The 3.1% trend was estimated using the average of Medical CPI-U and CPI-U over the most recent 5 complete years (rounded). This trend was applied to the WY 5 Factor G to estimate WY 1 and throughout the renewal period.

Estimates of Factor G for each waiver year are illustrated in the cost neutrality summary in Appendix J-1: Composite Overview and Demonstration of Cost-Neutrality Formula.

- iv. Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Base Year data reflects experience from Waiver Year 4 of the fourth renewal: July 16, 2023 - July 15, 2024, for individuals receiving care in the following ICF/IID settings:

- Comprehensive Rehabilitative Needs Facilities (CRMNFs)
- Extensive Support Needs Homes (ESNs)
- Extensive Medical Needs Homes (EMNs)

Base year data was trended at 2.2% per year to reflect Medical CPI-U over the most recent 5 complete years (rounded).

Estimates of Factor G' for each waiver year are illustrated in the cost neutrality summary in Appendix J-1: Composite Overview and Demonstration of Cost-Neutrality Formula.

The information provided in the filing is the same as for the initial renewal of this waiver. During RAI for that renewal, the information was reviewed and confirmed to be aligned with recent historical experience. Based on analysis of the state plan costs that are utilized for the D' and G' calculations, it was observed that those in the institutional setting have materially higher state plan costs for Prescription Drugs and Outpatient hospital services than those residing in the community. These appear to be the main drivers behind factor D' being less than factor G' for this waiver.

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “manage components” to add these components.

Waiver Services	
Adult Day Services	
Case Management	
Day Habilitation	
Prevocational Services	
Rent and Food for Unrelated Live-in Caregiver	
Residential Habilitation and Support (hourly)	
Respite	
Occupational Therapy	
Physical Therapy	
Psychological Therapy	
Speech /Language Therapy	
Behavioral Support Services (BSS)	
Benefits Counseling (Effective 12/31/2025)	
Career Exploration and Planning	
Community Transition	
Extended Employment Services	
Facility Based Support Services	
Family and Caregiver Training	
Home Modification Assessment (Terminated as of 12/30/2025)	
Home Modifications (Terminated as of 12/30/2025)	
Home Modifications and Assessments (Effective 12/31/2025)	
Intensive Behavioral Intervention (Terminated as of 12/30/2025)	
Music Therapy	
Personal Emergency Response System	
Recreational Therapy	
Remote Supports	
Residential Habilitation and Support - Daily (RHS Daily)	
Specialized Medical Equipment and Supplies	
Structured Family Caregiving	
Transportation	
Vehicle Modifications	
Wellness Coordination	
Workplace Assistance	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component

Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services Total:							2310192.96
Adult Day Service - half day - Level 3	☐	half day	78	233.70	54.71	997286.71	
Adult Day Service - 1/4 hour - Level 3	☐	1/4 hour	1	1.00	4.20	4.20	
Adult Day Service - 1/4 hour - Level 1	☐	1/4 hour	1	1.00	2.93	2.93	
Adult Day Service - 1/4 hour - Level 2	☐	1/4 hour	1	1.00	3.30	3.30	
Adult Day Service - half day - Level 2	☐	half day	69	209.30	43.66	630524.62	
Adult Day Service - half day - Level 1	☐	half day	70	262.40	37.15	682371.20	
Case Management Total:							20349550.52
Case Management	☐	month	9406	11.40	189.52	20321926.37	
Transitional Case Management	☐	month	45	3.40	180.55	27624.15	
Day Habilitation Total:							57002544.64
Day Habilitation - Medium	☐	hour	3066	418.60	6.52	8367947.95	
Day Habilitation - Large	☐	hour	1549	78.20	4.19	507542.24	
Day Habilitation - Individual	☐	hour	4597	182.20	36.58	30638434.97	
Day Habilitation - Small	☐	hour	3489	380.60	13.17	17488619.48	
Prevocational Services Total:							2432931.39
Prevocational Services-Medium Group	☐	hour	818	383.50	5.61	1759873.83	
Prevocational Services-Large Group	☐	hour	544	84.20	3.72	170393.86	
Prevocational Services-Small Group	☐	hour	673	70.00	10.67	502663.70	
Rent and Food for Unrelated Live-in Caregiver Total:							12535.00
Rent and Food for Unrelated Live-in Caregiver	☐	month				12535.00	

GRAND TOTAL: 967352251.57

Total: Services included in capitation:

Total: Services not included in capitation: 967352251.57

Total Estimated Unduplicated Participants: 9438

Factor D (Divide total by number of participants): 102495.47

Services included in capitation:

Services not included in capitation: 102495.47

Average Length of Stay on the Waiver:

348

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
			2	11.50	545.00		
Residential Habilitation and Support (hourly) Total:							392682661.60
Level 2 Residential Habilitation and Support - more than 35 hours/week	☐	hour	4298	2850.50	29.82	365338209.18	
Level 1 Residential Habilitation and Support - 35 hours or less/week	☐	hour	1074	731.20	34.82	27344452.42	
Respite Total:							13594033.06
Respite Nursing Care (LPN)	☐	1/4 hour	4	2034.90	13.68	111349.73	
Respite	☐	hour	703	440.20	43.13	13347035.68	
Respite Nursing Care (RN)	☐	1/4 hour	3	2647.30	17.08	135647.65	
Occupational Therapy Total:							5181.12
Occupational Therapy	☐	1/4 hour	3	96.00	17.99	5181.12	
Physical Therapy Total:							18.12
Physical Therapy	☐	1/4 hour	1	1.00	18.12	18.12	
Psychological Therapy Total:							2123.28
Psychological Therapy - Group	☐	1/4 hour	1	1.00	4.81	4.81	
Psychological Therapy - Individual	☐	1/4 hour	1	136.00	15.45	2101.20	
Psychological Therapy - Family	☐	1/4 hour	1	1.00	17.27	17.27	
Speech /Language Therapy Total:							60575.16
Speech /Language Therapy	☐	1/4 hour	10	334.30	18.12	60575.16	
Behavioral Support Services (BSS) Total:							41774682.82
Behavior Support Services - Level 2	☐	1/4 hour	6726	327.90	18.56	40933252.22	
Behavior Support Services - Level 1	☐	1/4 hour	5597	8.10	18.56	841430.59	
Benefits Counseling (Effective 12/31/2025) Total:							89875.00
Benefits Counseling (Effective 12/31/2025)	☐	hour	719	2.50	50.00	89875.00	
GRAND TOTAL: 967352251.57 Total: Services included in capitation: Total: Services not included in capitation: 967352251.57 Total Estimated Unduplicated Participants: 9438 Factor D (Divide total by number of participants): 102495.47 Services included in capitation: Services not included in capitation: 102495.47 Average Length of Stay on the Waiver: 348							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Career Exploration and Planning Total:							107666.40
Career Exploration and Planning - individual	☐	hour	22	120.00	37.06	97838.40	
Career Exploration and Planning - group	☐	hour	6	120.00	13.65	9828.00	
Community Transition Total:							212015.34
Community Transition	☐	unit	67	1.30	2434.16	212015.34	
Extended Employment Services Total:							1318138.08
Extended Employment Services	☐	hour	571	44.30	52.11	1318138.08	
Facility Based Support Services Total:							2.51
Facility Based Support Services	☐	hour	1	1.00	2.51	2.51	
Family and Caregiver Training Total:							30508.93
Family and Caregiver Training	☐	unit	16	11.60	164.38	30508.93	
Home Modification Assessment (Terminated as of 12/30/2025) Total:							21980.00
Home Modification Assessment (Terminated as of 12/30/2025)	☐	unit	35	1.00	628.00	21980.00	
Home Modifications (Terminated as of 12/30/2025) Total:							209746.48
Home Modifications - Install	☐	unit	3	1.00	893.63	2680.89	
Home Modifications-Maintain	☐	unit	20	1.10	9411.23	207047.06	
Home Modifications - Equipment/Assessment/Inspection	☐	unit	1	1.00	18.53	18.53	
Home Modifications and Assessments (Effective 12/31/2025) Total:							223659.90
Home Modifications and Assessments (Effective 12/31/2025)	☐	unit	35	1.70	3758.99	223659.90	
Intensive Behavioral Intervention (Terminated as of 12/30/2025) Total:							144.13
Intensive Behavior Intervention - Level 1	☐	hour	1	1.00	104.60	104.60	
Intensive Behavior Intervention - Level 2 direct care staff	☐	hour	1	1.00	39.53	39.53	
GRAND TOTAL: 967352251.57 Total: Services included in capitation: Total: Services not included in capitation: 967352251.57 Total Estimated Unduplicated Participants: 9438 Factor D (Divide total by number of participants): 102495.47 Services included in capitation: Services not included in capitation: 102495.47 Average Length of Stay on the Waiver: 348							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Music Therapy Total:							5273657.44
Music Therapy	☐	1/4 hour	1691	186.30	16.74	5273657.44	
Personal Emergency Response System Total:							64597.54
Personal Emergency Response System-Install	☐	unit	10	1.00	54.41	544.10	
Personal Emergency Response System-Maintain	☐	unit	124	11.00	46.96	64053.44	
Recreational Therapy Total:							5529884.90
Recreational Therapy	☐	1/4 hour	1314	251.10	16.76	5529884.90	
Remote Supports Total:							5685354.53
Remote Supports	☐	hour	235	1078.60	22.43	5685354.53	
Residential Habilitation and Support - Daily (RHS Daily) Total:							376796873.44
RHS Daily - Algo 3, 3-person	☐	day	611	256.40	233.51	36581770.00	
RHS Daily - Algo 3, 4-person	☐	day	252	256.20	220.82	14256669.17	
RHS Daily - Algo 4, 2-person	☐	day	831	230.90	331.12	63534610.25	
RHS Daily - Algo 3, 2-person	☐	day	421	216.60	237.37	21645437.98	
RHS Daily - Algo 4, 3-person	☐	day	1223	266.30	302.97	98672754.15	
RHS Daily - Algo 4, 4-person	☐	day	544	274.30	280.04	41787344.77	
RHS Daily - Algo 5, 2-person	☐	day	447	232.80	357.38	37189534.61	
RHS Daily - Algo 5, 4-person	☐	day	225	229.70	298.60	15432394.50	
RHS Daily - Algo 5, 3-person	☐	day	561	255.80	332.37	47696358.01	
Specialized Medical Equipment and Supplies Total:							74945.47
Specialized Medical Equipment and Supplies	☐	unit	56	1.20	1115.26	74945.47	
Structured Family Caregiving Total:							10213819.38
Level 3 Structured Family Caregiving (formerly Adult Foster Care Level 3)	☐	day	219	313.10	133.25	9136805.92	
GRAND TOTAL: 967352251.57 Total: Services included in capitation: Total: Services not included in capitation: 967352251.57 Total Estimated Unduplicated Participants: 9438 Factor D (Divide total by number of participants): 102495.47 Services included in capitation: Services not included in capitation: 102495.47 Average Length of Stay on the Waiver: 348							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Level 1 Structured Family Caregiving (formerly Adult Foster Care Level 1)	☐	day	9	280.00	77.54	195400.80	
Level 2 Structured Family Caregiving (formerly Adult Foster Care Level 2)	☐	day	34	263.30	98.48	881612.66	
Transportation Total:							25157048.18
Level 2 Transportation	☐	trip	484	143.10	25.71	1780684.88	
Level 1 Transportation	☐	trip	6120	256.60	14.87	23351729.04	
Level 3 Transportation	☐	trip	5	102.90	47.88	24634.26	
Vehicle Modifications Total:							71725.50
Vehicle Modifications	☐	unit	9	1.00	7969.50	71725.50	
Wellness Coordination Total:							5998912.96
Wellness Coordination - Tier II	☐	month	2635	9.60	162.34	4106552.64	
Wellness Coordination - Tier III	☐	month	381	8.80	251.71	843933.29	
Wellness Coordination - Tier I	☐	month	931	9.50	118.54	1048427.03	
Workplace Assistance Total:							44665.79
Workplace Assistance	☐	hour	4	291.40	38.32	44665.79	

GRAND TOTAL: 967352251.57
 Total: Services included in capitation:
 Total: Services not included in capitation: 967352251.57
Total Estimated Unduplicated Participants: 9438
Factor D (Divide total by number of participants): 102495.47
 Services included in capitation:
 Services not included in capitation: 102495.47
Average Length of Stay on the Waiver: 348

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services Total:							2310192.96
Adult Day Service - half day - Level 3	☐	half day	78	233.70	54.71	997286.71	
Adult Day Service - 1/4 hour - Level 3	☐	1/4 hour	1	1.00	4.20	4.20	
Adult Day Service - 1/4 hour - Level 1	☐	1/4 hour	1	1.00	2.93	2.93	
Adult Day Service - 1/4 hour - Level 2	☐	1/4 hour	1	1.00	3.30	3.30	
Adult Day Service - half day - Level 2	☐	half day	69	209.30	43.66	630524.62	
Adult Day Service - half day - Level 1	☐	half day	70	262.40	37.15	682371.20	
Case Management Total:							20377637.38
Case Management	☐	month	9419	11.40	189.52	20350013.23	
Transitional Case Management	☐	month	45	3.40	180.55	27624.15	
Day Habilitation Total:							58827169.54
Day Habilitation - Medium	☐	hour	3070	488.10	6.52	9770004.84	
Day Habilitation - Large	☐	hour	1552	93.40	4.19	607368.99	
Day Habilitation - Individual	☐	hour	4603	182.20	36.58	30678424.23	
Day Habilitation - Small	☐	hour	3494	386.20	13.17	17771371.48	
Prevocational Services Total:							932199.18
Prevocational Services-Medium Group	☐	hour	155	644.70	5.61	560598.88	
Prevocational Services-Large Group	☐	hour	173	127.80	3.72	82246.97	
Prevocational Services-Small Group	☐	hour	272	99.70	10.67	289353.33	
Rent and Food for Unrelated Live-in Caregiver Total:							12535.00
Rent and Food for Unrelated Live-in Caregiver	☐	month	2	11.50	545.00	12535.00	
Residential Habilitation and Support (hourly) Total:							294732502.73
Level 2 Residential Habilitation and Support - more than 35 hours/week	☐	hour	3188	2842.20	29.79	269925211.94	
GRAND TOTAL: 947499696.84 Total: Services included in capitation: Total: Services not included in capitation: 947499696.84 Total Estimated Unduplicated Participants: 9451 Factor D (Divide total by number of participants): 100253.91 Services included in capitation: Services not included in capitation: 100253.91 Average Length of Stay on the Waiver: 348							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Level 1 Residential Habilitation and Support - 35 hours or less/week	☐	hour	978	731.20	34.69	24807290.78	
Respite Total:							13597281.63
Respite Nursing Care (LPN)	☐	1/4 hour	4	2034.90	13.66	111186.94	
Respite	☐	hour	704	440.20	43.08	13350526.46	
Respite Nursing Care (RN)	☐	1/4 hour	3	2647.30	17.07	135568.23	
Occupational Therapy Total:							5181.12
Occupational Therapy	☐	1/4 hour	3	96.00	17.99	5181.12	
Physical Therapy Total:							18.12
Physical Therapy	☐	1/4 hour	1	1.00	18.12	18.12	
Psychological Therapy Total:							2123.28
Psychological Therapy - Group	☐	1/4 hour	1	1.00	4.81	4.81	
Psychological Therapy - Individual	☐	1/4 hour	1	136.00	15.45	2101.20	
Psychological Therapy - Family	☐	1/4 hour	1	1.00	17.27	17.27	
Speech /Language Therapy Total:							60575.16
Speech /Language Therapy	☐	1/4 hour	10	334.30	18.12	60575.16	
Behavioral Support Services (BSS) Total:							38748595.46
Behavior Support Services - Level 2	☐	1/4 hour	6736	303.20	18.56	37906112.51	
Behavior Support Services - Level 1	☐	1/4 hour	5604	8.10	18.56	842482.94	
Benefits Counseling (Effective 12/31/2025) Total:							179750.00
Benefits Counseling (Effective 12/31/2025)	☐	hour	719	5.00	50.00	179750.00	
Career Exploration and Planning Total:							107666.40
Career Exploration and Planning - individual	☐	hour	22	120.00	37.06	97838.40	
Career Exploration and Planning - group	☐	hour	6	120.00	13.65	9828.00	
GRAND TOTAL: 947499696.84 Total: Services included in capitation: Total: Services not included in capitation: 947499696.84 Total Estimated Unduplicated Participants: 9451 Factor D (Divide total by number of participants): 100253.91 Services included in capitation: Services not included in capitation: 100253.91 Average Length of Stay on the Waiver: 348							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Transition Total:							212015.34
Community Transition	☐	unit	67	1.30	2434.16	212015.34	
Extended Employment Services Total:							1320446.56
Extended Employment Services	☐	hour	572	44.30	52.11	1320446.56	
Facility Based Support Services Total:							2.51
Facility Based Support Services	☐	hour	1	1.00	2.51	2.51	
Family and Caregiver Training Total:							30508.93
Family and Caregiver Training	☐	unit	16	11.60	164.38	30508.93	
Home Modification Assessment (Terminated as of 12/30/2025) Total:							0.00
Home Modification Assessment (Terminated as of 12/30/2025)	☐	unit	0	0.00	0.01	0.00	
Home Modifications (Terminated as of 12/30/2025) Total:							0.00
Home Modifications - Install	☐	unit	0	0.00	0.01	0.00	
Home Modifications-Maintain	☐	unit	0	0.00	0.01	0.00	
Home Modifications - Equipment/Assessment/Inspection	☐	unit	0	0.00	0.01	0.00	
Home Modifications and Assessments (Effective 12/31/2025) Total:							453710.09
Home Modifications and Assessments (Effective 12/31/2025)	☐	unit	71	1.70	3758.99	453710.09	
Intensive Behavioral Intervention (Terminated as of 12/30/2025) Total:							144.13
Intensive Behavior Intervention - Level 1	☐	hour	1	1.00	104.60	104.60	
Intensive Behavior Intervention - Level 2 direct care staff	☐	hour	1	1.00	39.53	39.53	
Music Therapy Total:							4798099.15
Music Therapy	☐	1/4 hour	1694	169.20	16.74	4798099.15	
Personal Emergency Response System Total:							65114.10
GRAND TOTAL: 947499696.84 Total: Services included in capitation: Total: Services not included in capitation: 947499696.84 Total Estimated Unduplicated Participants: 9451 Factor D (Divide total by number of participants): 100253.91 Services included in capitation: Services not included in capitation: 100253.91 Average Length of Stay on the Waiver: 348							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Emergency Response System-Install	☐	unit	10	1.00	54.41	544.10	
Personal Emergency Response System-Maintain	☐	unit	125	11.00	46.96	64570.00	
Recreational Therapy Total:							2975375.98
Recreational Therapy	☐	1/4 hour	1316	134.90	16.76	2975375.98	
Remote Supports Total:							6383241.55
Remote Supports	☐	hour	235	1211.00	22.43	6383241.55	
Residential Habilitation and Support - Daily (RHS Daily) Total:							459770323.18
RHS Daily - Algo 3, 3-person	☐	day	887	256.40	233.51	53106432.07	
RHS Daily - Algo 3, 4-person	☐	day	488	256.20	220.82	27608152.99	
RHS Daily - Algo 4, 2-person	☐	day	937	230.90	331.12	71638904.70	
RHS Daily - Algo 3, 2-person	☐	day	520	216.60	237.37	26735457.84	
RHS Daily - Algo 4, 3-person	☐	day	1444	266.30	302.97	116503235.48	
RHS Daily - Algo 4, 4-person	☐	day	712	274.30	280.04	54692260.06	
RHS Daily - Algo 5, 2-person	☐	day	466	232.80	357.38	38770297.82	
RHS Daily - Algo 5, 4-person	☐	day	260	229.70	298.60	17832989.20	
RHS Daily - Algo 5, 3-person	☐	day	622	255.80	332.37	52882593.01	
Specialized Medical Equipment and Supplies Total:							67246.37
Specialized Medical Equipment and Supplies	☐	unit	56	1.20	1000.69	67246.37	
Structured Family Caregiving Total:							10213819.38
Level 3 Structured Family Caregiving (formerly Adult Foster Care Level 3)	☐	day	219	313.10	133.25	9136805.92	
Level 1 Structured Family Caregiving (formerly Adult Foster Care Level 1)	☐	day	9	280.00	77.54	195400.80	
Level 2 Structured Family Caregiving (formerly Adult Foster Care Level 2)	☐	day	34	263.30	98.48	881612.66	
GRAND TOTAL: 947499696.84 Total: Services included in capitation: Total: Services not included in capitation: 947499696.84 Total Estimated Unduplicated Participants: 9451 Factor D (Divide total by number of participants): 100253.91 Services included in capitation: Services not included in capitation: 100253.91 Average Length of Stay on the Waiver: 348							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transportation Total:							25191388.96
Level 2 Transportation	☐	trip	484	143.10	25.71	1780684.88	
Level 1 Transportation	☐	trip	6129	256.60	14.87	23386069.82	
Level 3 Transportation	☐	trip	5	102.90	47.88	24634.26	
Vehicle Modifications Total:							71725.50
Vehicle Modifications	☐	unit	9	1.00	7969.50	71725.50	
Wellness Coordination Total:							6008487.99
Wellness Coordination - Tier II	☐	month	2639	9.60	162.34	4112786.50	
Wellness Coordination - Tier III	☐	month	382	8.80	251.71	846148.34	
Wellness Coordination - Tier I	☐	month	932	9.50	118.54	1049553.16	
Workplace Assistance Total:							44619.17
Workplace Assistance	☐	hour	4	291.40	38.28	44619.17	
GRAND TOTAL: 947499696.84 Total: Services included in capitation: Total: Services not included in capitation: 947499696.84 Total Estimated Unduplicated Participants: 9451 Factor D (Divide total by number of participants): 100253.91 Services included in capitation: Services not included in capitation: 100253.91 Average Length of Stay on the Waiver: 348							

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services Total:							2329632.02
Adult Day Service - half day - Level 3	☐	half day	79	234.40	54.71	1013097.90	
Adult Day Service - 1/4 hour - Level 3	☐	1/4 hour	1	1.00	4.20	4.20	
Adult Day Service - 1/4 hour - Level 1	☐	1/4 hour	1	1.00	2.93	2.93	
Adult Day Service - 1/4 hour - Level 2	☐	1/4 hour	1	1.00	3.30	3.30	
Adult Day Service - half day - Level 2	☐	half day	69	209.90	43.66	632332.15	
Adult Day Service - half day - Level 1	☐	half day	70	263.10	37.15	684191.55	
Case Management Total:							20429490.05
Case Management	☐	month	9443	11.40	189.52	20401865.90	
Transitional Case Management	☐	month	45	3.40	180.55	27624.15	
Day Habilitation Total:							59145157.20
Day Habilitation - Medium	☐	hour	3078	489.50	6.52	9823560.12	
Day Habilitation - Large	☐	hour	1556	93.70	4.19	610890.27	
Day Habilitation - Individual	☐	hour	4615	182.70	36.58	30842811.09	
Day Habilitation - Small	☐	hour	3503	387.30	13.17	17867895.72	
Prevocational Services Total:							940150.75
Prevocational Services-Medium Group	☐	hour	156	646.60	5.61	565878.46	
Prevocational Services-Large Group	☐	hour	174	128.20	3.72	82981.30	
Prevocational Services-Small Group	☐	hour	273	100.00	10.67	291291.00	
Rent and Food for Unrelated Live-in Caregiver Total:							12644.00
Rent and Food for Unrelated Live-in Caregiver	☐	month	2	11.60	545.00	12644.00	
Residential Habilitation and Support (hourly) Total:							296338129.17
Level 2 Residential Habilitation and Support - more than 35 hours/week	☐	hour	3196	2850.40	29.79	271383277.54	
GRAND TOTAL: 952688919.70 Total: Services included in capitation: Total: Services not included in capitation: 952688919.70 Total Estimated Unduplicated Participants: 9475 Factor D (Divide total by number of participants): 100547.64 Services included in capitation: Services not included in capitation: 100547.64 Average Length of Stay on the Waiver: 349							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Level 1 Residential Habilitation and Support - 35 hours or less/week	☐	hour	981	733.30	34.69	24954851.64	
Respite Total:							13675454.20
Respite Nursing Care (LPN)	☐	1/4 hour	4	2040.70	13.66	111503.85	
Respite	☐	hour	706	441.50	43.08	13427992.92	
Respite Nursing Care (RN)	☐	1/4 hour	3	2654.90	17.07	135957.43	
Occupational Therapy Total:							5197.31
Occupational Therapy	☐	1/4 hour	3	96.30	17.99	5197.31	
Physical Therapy Total:							18.12
Physical Therapy	☐	1/4 hour	1	1.00	18.12	18.12	
Psychological Therapy Total:							2129.46
Psychological Therapy - Group	☐	1/4 hour	1	1.00	4.81	4.81	
Psychological Therapy - Individual	☐	1/4 hour	1	136.40	15.45	2107.38	
Psychological Therapy - Family	☐	1/4 hour	1	1.00	17.27	17.27	
Speech /Language Therapy Total:							60756.36
Speech /Language Therapy	☐	1/4 hour	10	335.30	18.12	60756.36	
Behavioral Support Services (BSS) Total:							38969747.14
Behavior Support Services - Level 2	☐	1/4 hour	6753	304.10	18.56	38114580.29	
Behavior Support Services - Level 1	☐	1/4 hour	5619	8.20	18.56	855166.85	
Benefits Counseling (Effective 12/31/2025) Total:							180250.00
Benefits Counseling (Effective 12/31/2025)	☐	hour	721	5.00	50.00	180250.00	
Career Exploration and Planning Total:							107935.57
Career Exploration and Planning - individual	☐	hour	22	120.30	37.06	98083.00	
Career Exploration and Planning - group	☐	hour	6	120.30	13.65	9852.57	
GRAND TOTAL: 952688919.70 Total: Services included in capitation: Total: Services not included in capitation: 952688919.70 Total Estimated Unduplicated Participants: 9475 Factor D (Divide total by number of participants): 100547.64 Services included in capitation: Services not included in capitation: 100547.64 Average Length of Stay on the Waiver: 349							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Transition Total:							212015.34
Community Transition	☐	unit	67	1.30	2434.16	212015.34	
Extended Employment Services Total:							1325740.93
Extended Employment Services	☐	hour	573	44.40	52.11	1325740.93	
Facility Based Support Services Total:							2.51
Facility Based Support Services	☐	hour	1	1.00	2.51	2.51	
Family and Caregiver Training Total:							30771.94
Family and Caregiver Training	☐	unit	16	11.70	164.38	30771.94	
Home Modification Assessment (Terminated as of 12/30/2025) Total:							0.00
Home Modification Assessment (Terminated as of 12/30/2025)	☐	unit	0	0.00	0.01	0.00	
Home Modifications (Terminated as of 12/30/2025) Total:							0.00
Home Modifications - Install	☐	unit	0	0.00	0.01	0.00	
Home Modifications-Maintain	☐	unit	0	0.00	0.01	0.00	
Home Modifications - Equipment/Assessment/Inspection	☐	unit	0	0.00	0.01	0.00	
Home Modifications and Assessments (Effective 12/31/2025) Total:							453710.09
Home Modifications and Assessments (Effective 12/31/2025)	☐	unit	71	1.70	3758.99	453710.09	
Intensive Behavioral Intervention (Terminated as of 12/30/2025) Total:							144.13
Intensive Behavior Intervention - Level 1	☐	hour	1	1.00	104.60	104.60	
Intensive Behavior Intervention - Level 2 direct care staff	☐	hour	1	1.00	39.53	39.53	
Music Therapy Total:							4823641.04
Music Therapy	☐	1/4 hour	1698	169.70	16.74	4823641.04	
Personal Emergency Response System Total:							65114.10
GRAND TOTAL: 952688919.70 Total: Services included in capitation: Total: Services not included in capitation: 952688919.70 Total Estimated Unduplicated Participants: 9475 Factor D (Divide total by number of participants): 100547.64 Services included in capitation: Services not included in capitation: 100547.64 Average Length of Stay on the Waiver: 349							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Emergency Response System-Install	☐	unit	10	1.00	54.41	544.10	
Personal Emergency Response System-Maintain	☐	unit	125	11.00	46.96	64570.00	
Recreational Therapy Total:							2991001.33
Recreational Therapy	☐	1/4 hour	1319	135.30	16.76	2991001.33	
Remote Supports Total:							6428931.46
Remote Supports	☐	hour	236	1214.50	22.43	6428931.46	
Residential Habilitation and Support - Daily (RHS Daily) Total:							462303005.24
RHS Daily - Algo 3, 3-person	☐	day	889	257.20	233.51	53392248.31	
RHS Daily - Algo 3, 4-person	☐	day	490	256.90	220.82	27797042.42	
RHS Daily - Algo 4, 2-person	☐	day	939	231.60	331.12	72009461.09	
RHS Daily - Algo 3, 2-person	☐	day	521	217.30	237.37	26873441.02	
RHS Daily - Algo 4, 3-person	☐	day	1447	267.10	302.97	117095996.29	
RHS Daily - Algo 4, 4-person	☐	day	715	275.10	280.04	55082887.86	
RHS Daily - Algo 5, 2-person	☐	day	467	233.50	357.38	38970323.41	
RHS Daily - Algo 5, 4-person	☐	day	261	230.30	298.60	17948338.38	
RHS Daily - Algo 5, 3-person	☐	day	623	256.60	332.37	53133266.47	
Specialized Medical Equipment and Supplies Total:							67246.37
Specialized Medical Equipment and Supplies	☐	unit	56	1.20	1000.69	67246.37	
Structured Family Caregiving Total:							10285160.40
Level 3 Structured Family Caregiving (formerly Adult Foster Care Level 3)	☐	day	220	314.00	133.25	9204910.00	
Level 1 Structured Family Caregiving (formerly Adult Foster Care Level 1)	☐	day	9	280.80	77.54	195959.09	
Level 2 Structured Family Caregiving (formerly Adult Foster Care Level 2)	☐	day	34	264.10	98.48	884291.31	
GRAND TOTAL: 952688919.70 Total: Services included in capitation: Total: Services not included in capitation: 952688919.70 Total Estimated Unduplicated Participants: 9475 Factor D (Divide total by number of participants): 100547.64 Services included in capitation: Services not included in capitation: 100547.64 Average Length of Stay on the Waiver: 349							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transportation Total:							25321315.15
Level 2 Transportation	☐	trip	485	143.50	25.71	1789351.72	
Level 1 Transportation	☐	trip	6144	257.30	14.87	23507257.34	
Level 3 Transportation	☐	trip	5	103.20	47.88	24706.08	
Vehicle Modifications Total:							71725.50
Vehicle Modifications	☐	unit	9	1.00	7969.50	71725.50	
Wellness Coordination Total:							6067945.84
Wellness Coordination - Tier II	☐	Month	2646	9.70	162.34	4166650.91	
Wellness Coordination - Tier III	☐	Month	383	8.80	251.71	848363.38	
Wellness Coordination - Tier I	☐	Month	935	9.50	118.54	1052931.55	
Workplace Assistance Total:							44756.98
Workplace Assistance	☐	hour	4	292.30	38.28	44756.98	
GRAND TOTAL: 952688919.70 Total: Services included in capitation: Total: Services not included in capitation: 952688919.70 Total Estimated Unduplicated Participants: 9475 Factor D (Divide total by number of participants): 100547.64 Services included in capitation: Services not included in capitation: 100547.64 Average Length of Stay on the Waiver: 349							

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services Total:							2341864.88
Adult Day Service - half day - Level 3	☐	half day	79	233.70	54.71	1010072.43	
Adult Day Service - 1/4 hour - Level 3	☐	1/4 hour	1	1.00	4.20	4.20	
Adult Day Service - 1/4 hour - Level 1	☐	1/4 hour	1	1.00	2.93	2.93	
Adult Day Service - 1/4 hour - Level 2	☐	1/4 hour	1	1.00	3.30	3.30	
Adult Day Service - half day - Level 2	☐	half day	70	209.30	43.66	639662.66	
Adult Day Service - half day - Level 1	☐	half day	71	262.40	37.15	692119.36	
Case Management Total:							20481342.73
Case Management	☐	month	9467	11.40	189.52	20453718.58	
Transitional Case Management	☐	month	45	3.40	180.55	27624.15	
Day Habilitation Total:							59125672.27
Day Habilitation - Medium	☐	hour	3086	488.10	6.52	9820923.43	
Day Habilitation - Large	☐	hour	1559	93.40	4.19	610108.41	
Day Habilitation - Individual	☐	hour	4626	182.20	36.58	30831716.38	
Day Habilitation - Small	☐	hour	3512	386.20	13.17	17862924.05	
Prevocational Services Total:							937355.16
Prevocational Services-Medium Group	☐	hour	156	644.70	5.61	564215.65	
Prevocational Services-Large Group	☐	hour	174	127.80	3.72	82722.38	
Prevocational Services-Small Group	☐	hour	273	99.70	10.67	290417.13	
Rent and Food for Unrelated Live-in Caregiver Total:							12535.00
Rent and Food for Unrelated Live-in Caregiver	☐	month	2	11.50	545.00	12535.00	
Residential Habilitation and Support (hourly) Total:							296264349.45
Level 2 Residential Habilitation and Support - more than 35 hours/week	☐	hour	3204	2842.20	29.79	271279918.15	
GRAND TOTAL: 952123836.17 Total: Services included in capitation: Total: Services not included in capitation: 952123836.17 Total Estimated Unduplicated Participants: 9499 Factor D (Divide total by number of participants): 100234.11 Services included in capitation: Services not included in capitation: 100234.11 Average Length of Stay on the Waiver: 348							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Level 1 Residential Habilitation and Support - 35 hours or less/week	☐	hour	983	731.20	34.76	24984431.30	
Respite Total:							13673136.90
Respite Nursing Care (LPN)	☐	1/4 hour	4	2034.90	13.66	111186.94	
Respite	☐	hour	708	440.20	43.08	13426381.73	
Respite Nursing Care (RN)	☐	1/4 hour	3	2647.30	17.07	135568.23	
Occupational Therapy Total:							5181.12
Occupational Therapy	☐	1/4 hour	3	96.00	17.99	5181.12	
Physical Therapy Total:							18.12
Physical Therapy	☐	1/4 hour	1	1.00	18.12	18.12	
Psychological Therapy Total:							2123.28
Psychological Therapy - Group	☐	1/4 hour	1	1.00	4.81	4.81	
Psychological Therapy - Individual	☐	1/4 hour	1	136.00	15.45	2101.20	
Psychological Therapy - Family	☐	1/4 hour	1	1.00	17.27	17.27	
Speech /Language Therapy Total:							60575.16
Speech /Language Therapy	☐	1/4 hour	10	334.30	18.12	60575.16	
Behavioral Support Services (BSS) Total:							38944286.53
Behavior Support Services - Level 2	☐	1/4 hour	6770	303.20	18.56	38097443.84	
Behavior Support Services - Level 1	☐	1/4 hour	5633	8.10	18.56	846842.69	
Benefits Counseling (Effective 12/31/2025) Total:							180500.00
Benefits Counseling (Effective 12/31/2025)	☐	hour	722	5.00	50.00	180500.00	
Career Exploration and Planning Total:							112113.60
Career Exploration and Planning - individual	☐	hour	23	120.00	37.06	102285.60	
Career Exploration and Planning - group	☐	hour	6	120.00	13.65	9828.00	
GRAND TOTAL: 952123836.17 Total: Services included in capitation: Total: Services not included in capitation: 952123836.17 Total Estimated Unduplicated Participants: 9499 Factor D (Divide total by number of participants): 100234.11 Services included in capitation: Services not included in capitation: 100234.11 Average Length of Stay on the Waiver: 348							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Transition Total:							215179.74
Community Transition	☐	unit	68	1.30	2434.16	215179.74	
Extended Employment Services Total:							1327371.98
Extended Employment Services	☐	hour	575	44.30	52.11	1327371.98	
Facility Based Support Services Total:							2.51
Facility Based Support Services	☐	hour	1	1.00	2.51	2.51	
Family and Caregiver Training Total:							30508.93
Family and Caregiver Training	☐	unit	16	11.60	164.38	30508.93	
Home Modification Assessment (Terminated as of 12/30/2025) Total:							0.00
Home Modification Assessment (Terminated as of 12/30/2025)	☐	unit	0	0.00	0.01	0.00	
Home Modifications (Terminated as of 12/30/2025) Total:							0.00
Home Modifications - Install	☐	unit	0	0.00	0.01	0.00	
Home Modifications-Maintain	☐	unit	0	0.00	0.01	0.00	
Home Modifications - Equipment/Assessment/Inspection	☐	unit	0	0.00	0.01	0.00	
Home Modifications and Assessments (Effective 12/31/2025) Total:							453710.09
Home Modifications and Assessments (Effective 12/31/2025)	☐	unit	71	1.70	3758.99	453710.09	
Intensive Behavioral Intervention (Terminated as of 12/30/2025) Total:							144.13
Intensive Behavior Intervention - Level 1	☐	hour	1	1.00	104.60	104.60	
Intensive Behavior Intervention - Level 2 direct care staff	☐	hour	1	1.00	39.53	39.53	
Music Therapy Total:							4820758.42
Music Therapy	☐	1/4 hour	1702	169.20	16.74	4820758.42	
Personal Emergency Response System Total:							65114.10
GRAND TOTAL: 952123836.17 Total: Services included in capitation: Total: Services not included in capitation: 952123836.17 Total Estimated Unduplicated Participants: 9499 Factor D (Divide total by number of participants): 100234.11 Services included in capitation: Services not included in capitation: 100234.11 Average Length of Stay on the Waiver: 348							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Emergency Response System-Install	☐	unit	10	1.00	54.41	544.10	
Personal Emergency Response System-Maintain	☐	unit	125	11.00	46.96	64570.00	
Recreational Therapy Total:							2991202.45
Recreational Therapy	☐	1/4 hour	1323	134.90	16.76	2991202.45	
Remote Supports Total:							6410404.28
Remote Supports	☐	hour	236	1211.00	22.43	6410404.28	
Residential Habilitation and Support - Daily (RHS Daily) Total:							461868533.59
RHS Daily - Algo 3, 3-person	☐	day	892	256.40	233.51	53405791.89	
RHS Daily - Algo 3, 4-person	☐	day	490	256.20	220.82	27721301.16	
RHS Daily - Algo 4, 2-person	☐	day	941	230.90	331.12	71944727.13	
RHS Daily - Algo 3, 2-person	☐	day	522	216.60	237.37	26838286.52	
RHS Daily - Algo 4, 3-person	☐	day	1451	266.30	302.97	117068001.86	
RHS Daily - Algo 4, 4-person	☐	day	716	274.30	280.04	54999519.95	
RHS Daily - Algo 5, 2-person	☐	day	468	232.80	357.38	38936693.95	
RHS Daily - Algo 5, 4-person	☐	day	261	229.70	298.60	17901577.62	
RHS Daily - Algo 5, 3-person	☐	day	624	255.80	332.37	53052633.50	
Specialized Medical Equipment and Supplies Total:							68447.20
Specialized Medical Equipment and Supplies	☐	unit	57	1.20	1000.69	68447.20	
Structured Family Caregiving Total:							10255539.96
Level 3 Structured Family Caregiving (formerly Adult Foster Care Level 3)	☐	day	220	313.10	133.25	9178526.50	
Level 1 Structured Family Caregiving (formerly Adult Foster Care Level 1)	☐	day	9	280.00	77.54	195400.80	
Level 2 Structured Family Caregiving (formerly Adult Foster Care Level 2)	☐	day	34	263.30	98.48	881612.66	
GRAND TOTAL: 952123836.17 Total: Services included in capitation: Total: Services not included in capitation: 952123836.17 Total Estimated Unduplicated Participants: 9499 Factor D (Divide total by number of participants): 100234.11 Services included in capitation: Services not included in capitation: 100234.11 Average Length of Stay on the Waiver: 348							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transportation Total:							25320711.17
Level 2 Transportation	☐	trip	487	143.10	25.71	1791722.19	
Level 1 Transportation	☐	trip	6160	256.60	14.87	23504354.72	
Level 3 Transportation	☐	trip	5	102.90	47.88	24634.26	
Vehicle Modifications Total:							71725.50
Vehicle Modifications	☐	unit	9	1.00	7969.50	71725.50	
Wellness Coordination Total:							6038808.77
Wellness Coordination - Tier II	☐	month	2652	9.60	162.34	4133046.53	
Wellness Coordination - Tier III	☐	month	384	8.80	251.71	850578.43	
Wellness Coordination - Tier I	☐	month	937	9.50	118.54	1055183.81	
Workplace Assistance Total:							44619.17
Workplace Assistance	☐	hour	4	291.40	38.28	44619.17	
GRAND TOTAL: 952123836.17 Total: Services included in capitation: Total: Services not included in capitation: 952123836.17 Total Estimated Unduplicated Participants: 9499 Factor D (Divide total by number of participants): 100234.11 Services included in capitation: Services not included in capitation: 100234.11 Average Length of Stay on the Waiver: 348							

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services Total:							2341864.88
Adult Day Service - half day - Level 3	☐	half day	79	233.70	54.71	1010072.43	
Adult Day Service - 1/4 hour - Level 3	☐	1/4 hour	1	1.00	4.20	4.20	
Adult Day Service - 1/4 hour - Level 1	☐	1/4 hour	1	1.00	2.93	2.93	
Adult Day Service - 1/4 hour - Level 2	☐	1/4 hour	1	1.00	3.30	3.30	
Adult Day Service - half day - Level 2	☐	half day	70	209.30	43.66	639662.66	
Adult Day Service - half day - Level 1	☐	half day	71	262.40	37.15	692119.36	
Case Management Total:							20533809.27
Case Management	☐	month	9491	11.40	189.52	20505571.25	
Transitional Case Management	☐	month	46	3.40	180.55	28238.02	
Day Habilitation Total:							59278451.75
Day Habilitation - Medium	☐	hour	3094	488.10	6.52	9846382.73	
Day Habilitation - Large	☐	hour	1563	93.40	4.19	611673.80	
Day Habilitation - Individual	☐	hour	4638	182.20	36.58	30911694.89	
Day Habilitation - Small	☐	hour	3521	386.20	13.17	17908700.33	
Prevocational Services Total:							938894.38
Prevocational Services-Medium Group	☐	hour	156	644.70	5.61	564215.65	
Prevocational Services-Large Group	☐	hour	175	127.80	3.72	83197.80	
Prevocational Services-Small Group	☐	hour	274	99.70	10.67	291480.93	
Rent and Food for Unrelated Live-in Caregiver Total:							12535.00
Rent and Food for Unrelated Live-in Caregiver	☐	month	2	11.50	545.00	12535.00	
Residential Habilitation and Support (hourly) Total:							296967484.66
Level 2 Residential Habilitation and Support - more than 35 hours/week	☐	hour	3212	2842.20	29.79	271957271.26	
GRAND TOTAL: 954590829.62 Total: Services included in capitation: Total: Services not included in capitation: 954590829.62 Total Estimated Unduplicated Participants: 9523 Factor D (Divide total by number of participants): 100240.56 Services included in capitation: Services not included in capitation: 100240.56 Average Length of Stay on the Waiver: 348							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Level 1 Residential Habilitation and Support - 35 hours or less/week	☐	hour	986	731.20	34.69	25010213.41	
Respite Total:							13711064.53
Respite Nursing Care (LPN)	☐	1/4 hour	4	2034.90	13.66	111186.94	
Respite	☐	hour	710	440.20	43.08	13464309.36	
Respite Nursing Care (RN)	☐	1/4 hour	3	2647.30	17.07	135568.23	
Occupational Therapy Total:							5181.12
Occupational Therapy	☐	1/4 hour	3	96.00	17.99	5181.12	
Physical Therapy Total:							18.12
Physical Therapy	☐	1/4 hour	1	1.00	18.12	18.12	
Psychological Therapy Total:							2123.28
Psychological Therapy - Group	☐	1/4 hour	1	1.00	4.81	4.81	
Psychological Therapy - Individual	☐	1/4 hour	1	136.00	15.45	2101.20	
Psychological Therapy - Family	☐	1/4 hour	1	1.00	17.27	17.27	
Speech /Language Therapy Total:							60575.16
Speech /Language Therapy	☐	1/4 hour	10	334.30	18.12	60575.16	
Behavioral Support Services (BSS) Total:							39042056.90
Behavior Support Services - Level 2	☐	1/4 hour	6787	303.20	18.56	38193109.50	
Behavior Support Services - Level 1	☐	1/4 hour	5647	8.10	18.56	848947.39	
Benefits Counseling (Effective 12/31/2025) Total:							181000.00
Benefits Counseling (Effective 12/31/2025)	☐	hour	724	5.00	50.00	181000.00	
Career Exploration and Planning Total:							112113.60
Career Exploration and Planning - individual	☐	hour	23	120.00	37.06	102285.60	
Career Exploration and Planning - group	☐	hour	6	120.00	13.65	9828.00	
GRAND TOTAL: 954590829.62 Total: Services included in capitation: Total: Services not included in capitation: 954590829.62 Total Estimated Unduplicated Participants: 9523 Factor D (Divide total by number of participants): 100240.56 Services included in capitation: Services not included in capitation: 100240.56 Average Length of Stay on the Waiver: 348							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Transition Total:							215179.74
Community Transition	☐	unit	68	1.30	2434.16	215179.74	
Extended Employment Services Total:							1329680.45
Extended Employment Services	☐	hour	576	44.30	52.11	1329680.45	
Facility Based Support Services Total:							2.51
Facility Based Support Services	☐	hour	1	1.00	2.51	2.51	
Family and Caregiver Training Total:							30508.93
Family and Caregiver Training	☐	unit	16	11.60	164.38	30508.93	
Home Modification Assessment (Terminated as of 12/30/2025) Total:							0.00
Home Modification Assessment (Terminated as of 12/30/2025)	☐	unit	0	0.00	628.00	0.00	
Home Modifications (Terminated as of 12/30/2025) Total:							0.00
Home Modifications - Install	☐	unit	0	0.00	0.01	0.00	
Home Modifications-Maintain	☐	unit	0	0.00	0.01	0.00	
Home Modifications - Equipment/Assessment/Inspection	☐	unit	0	0.00	0.01	0.00	
Home Modifications and Assessments (Effective 12/31/2025) Total:							453710.09
Home Modifications and Assessments (Effective 12/31/2025)	☐	unit	71	1.70	3758.99	453710.09	
Intensive Behavioral Intervention (Terminated as of 12/30/2025) Total:							144.13
Intensive Behavior Intervention - Level 1	☐	hour	1	1.00	104.60	104.60	
Intensive Behavior Intervention - Level 2 direct care staff	☐	hour	1	1.00	39.53	39.53	
Music Therapy Total:							4834920.46
Music Therapy	☐	1/4 hour	1707	169.20	16.74	4834920.46	
Personal Emergency Response System Total:							65630.66
GRAND TOTAL: 954590829.62 Total: Services included in capitation: Total: Services not included in capitation: 954590829.62 Total Estimated Unduplicated Participants: 9523 Factor D (Divide total by number of participants): 100240.56 Services included in capitation: Services not included in capitation: 100240.56 Average Length of Stay on the Waiver: 348							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Emergency Response System-Install	☐	unit	10	1.00	54.41	544.10	
Personal Emergency Response System-Maintain	☐	unit	126	11.00	46.96	65086.56	
Recreational Therapy Total:							2997985.22
Recreational Therapy	☐	1/4 hour	1326	134.90	16.76	2997985.22	
Remote Supports Total:							6437567.01
Remote Supports	☐	hour	237	1211.00	22.43	6437567.01	
Residential Habilitation and Support - Daily (RHS Daily) Total:							463116649.51
RHS Daily - Algo 3, 3-person	☐	day	893	256.40	233.51	53465663.85	
RHS Daily - Algo 3, 4-person	☐	day	492	256.20	220.82	27834449.33	
RHS Daily - Algo 4, 2-person	☐	day	944	230.90	331.12	72174093.95	
RHS Daily - Algo 3, 2-person	☐	day	523	216.60	237.37	26889700.87	
RHS Daily - Algo 4, 3-person	☐	day	1454	266.30	302.97	117310044.59	
RHS Daily - Algo 4, 4-person	☐	day	719	274.30	280.04	55229964.87	
RHS Daily - Algo 5, 2-person	☐	day	469	232.80	357.38	39019892.02	
RHS Daily - Algo 5, 4-person	☐	day	262	229.70	298.60	17970166.04	
RHS Daily - Algo 5, 3-person	☐	day	626	255.80	332.37	53222674.00	
Specialized Medical Equipment and Supplies Total:							68447.20
Specialized Medical Equipment and Supplies	☐	unit	57	1.20	1000.69	68447.20	
Structured Family Caregiving Total:							10297260.53
Level 3 Structured Family Caregiving (formerly Adult Foster Care Level 3)	☐	day	221	313.10	133.25	9220247.08	
Level 1 Structured Family Caregiving (formerly Adult Foster Care Level 1)	☐	day	9	280.00	77.54	195400.80	
Level 2 Structured Family Caregiving (formerly Adult Foster Care Level 2)	☐	day	34	263.30	98.48	881612.66	
GRAND TOTAL: 954590829.62 Total: Services included in capitation: Total: Services not included in capitation: 954590829.62 Total Estimated Unduplicated Participants: 9523 Factor D (Divide total by number of participants): 100240.56 Services included in capitation: Services not included in capitation: 100240.56 Average Length of Stay on the Waiver: 348							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transportation Total:							25385440.54
Level 2 Transportation	☐	trip	488	143.10	25.71	1795401.29	
Level 1 Transportation	☐	trip	6176	256.60	14.87	23565404.99	
Level 3 Transportation	☐	trip	5	102.90	47.88	24634.26	
Vehicle Modifications Total:							71725.50
Vehicle Modifications	☐	unit	9	1.00	7969.50	71725.50	
Wellness Coordination Total:							6054185.33
Wellness Coordination - Tier II	☐	Month	2659	9.60	162.34	4143955.78	
Wellness Coordination - Tier III	☐	Month	385	8.80	251.71	852793.48	
Wellness Coordination - Tier I	☐	Month	939	9.50	118.54	1057436.07	
Workplace Assistance Total:							44619.17
Workplace Assistance	☐	hour	4	291.40	38.28	44619.17	
GRAND TOTAL: 954590829.62 Total: Services included in capitation: Total: Services not included in capitation: 954590829.62 Total Estimated Unduplicated Participants: 9523 Factor D (Divide total by number of participants): 100240.56 Services included in capitation: Services not included in capitation: 100240.56 Average Length of Stay on the Waiver: 348							