2016

DDRS Waiver Manual

Our Mission: To develop, finance and compassionately administer programs to provide healthcare and other social services to Hoosiers in need in order to enable them to achieve healthy, self-sufficient and productive lives.

[DDRS]

State of Indiana
Summer 2016

Division of Disability and Rehabilitative Services

Waiver Manual

As of Summer 2016

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QUICK LINKS

- DDRS' website: http://www.in.gov/fssa/ddrs/3341.htm
  - Announcements
    - Register to receive DDRS updates by email
  - BDDS webpage
    - Local BDDS offices
  - BQIS webpage:
  - BQIS's Incident Reporting
  - DDRS Policies
  - Forms
  - Statistics webpage

- Family Supports Waiver and Community Integration and Habilitation Waiver documents http://www.in.gov/fssa/ddrs/2639.htm

- This document serves as an accessible resource for participants and families. Providers should primarily reference the Indiana Health Coverage Programs Provider Reference Module titled **Division of Disability and Rehabilitation Services Home and Community-Based Services Waivers** at http://provider.indianamedicaid.com/general-provider-services/manuals.aspx

- Indiana Health Coverage Programs Provider Information http://www.indianamedicaid.com/ and by calling 1-800-577-1278 or 1-877-707-5750

- If you have additional questions that cannot be answered by this manual or by the resources found above, please contact the BQIS Helpline at BQIS.Help@fssa.in.gov

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Section 1: Roles and Responsibilities

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

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

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

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

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

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

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

As a division of the Indiana Family and Social Services Administration (FSSA), the Division of Disability and Rehabilitative Services (DDRS) assists people with disabilities and their families who need support to attain employment, self-sufficiency, or independence. The DDRS/Bureau of Developmental Disabilities Services (BDDS) and the DDRS/Bureau of Quality Improvement Services (BQIS) are under the DDRS. The FSSA/DDRS administers the Family Supports Waiver (FSW) and the Community Integration and Habilitation (CIH) Waiver programs for persons requiring the level of care for admission to Intermediate Care Facilities for Individuals with Intellectual/Developmental Disabilities (ICF/IID), as well as other services for people with intellectual and developmental disabilities.

Additional information about DDRS is available at http://www.in.gov/fssa/2328.htm

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

Within the FSSA's DDRS, BDDS administers a variety of services for persons with intellectual/developmental disabilities, including the Family Supports Waiver (FSW) and the Community Integration and Habilitation Waiver (CIH Waiver) programs. There are eight District Offices of BDDS, each serving specific counties. The BDDS Service Coordinators determine eligibility for intellectual/developmental disabilities' services and facilitate the determination of Level of Care for ICF/IID services.

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

Additional information about BDDS is available at http://www.in.gov/fssa/ddrs/2639.htm

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

Within the FSSA's DDRS, BQIS is responsible for assuring the quality of services delivered to persons in the FSW and the CIH Waiver programs. Oversight activities include managing the state's system for reporting instances of abuse, neglect, and exploitation, assuring compliance with Indiana waiver regulations, researching best practices, and analyzing quality data.

Additional information about BQIS is found at http://www.in.gov/fssa/ddrs/2635.htm

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

The FSSA's Office of Medicaid Policy and Planning (OMPP), a division under the single state Medicaid Agency, has been appointed by the Secretary to serve as the administrative authority for Medicaid HCBS programs and is responsible for monitoring DDRS's administration of the waivers for compliance with CMS requirements.

FSSA's OMPP is responsible for oversight of all waiver activities, including level of care (LOC) determinations, plan of care reviews, identification of trends and outcomes, and initiating action to achieve desired outcomes, and retaining final authority for approval of level of care and plans of care.

FSSA's OMPP develops Medicaid policy for the State of Indiana and, on an ongoing and as needed basis, works collaboratively with DDRS to formulate policies specific to the waiver or that have a substantial impact on waiver participants. The OMPP seeks and reviews comment from DDRS before the adoption of

rules or standards that may affect the services, programs, or providers of medical assistance services for individuals with intellectual disabilities who receive Medicaid services. The OMPP and DDRS collaborate to revise and develop the waiver application to reflect current FSSA goals and policy programs. The OMPP reviews and approves all waiver manuals, bulletins, communications regarding waiver policy, and quality assurance/improvement plans prior to implementation or release to providers, participants, families or any other entity.

Additional information about the FSSA's OMPP may be found at the OMPP section of the FSSA website or at in.gov/fssa. For Medicaid eligibility requirements, see the Eligibility Guide on the member website at indianamedicaid.com.

Additional information about OMPP may be found at http://www.in.gov/fssa/2408.htm and for Medicaid eligibility requirements: http://member.indianamedicaid.com/am-i-eligible.aspx l

Section 1.6: Case Management Agencies

DDRS-approved Case Management agencies are waiver service providers that provide no other services except Case Management to waiver participants. These services include implementing the Person-Centered Planning (PCP) process, helping the participant identify members of the Individual Support Team (IST), and developing an Individualized Support Plan (ISP) before developing and submitting to the State, the service plan known as the Plan of Care/Cost Comparison Budget (POC/CCB). Specific responsibilities of the Case Management provider, including monitoring activities, are described in **Section 10:5: Case Management.**

Section 1.7: Division of Family Resources (DFR)

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

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

DFR's Indiana Manpower and Comprehensive Training (IMPACT) program assists SNAP and TANF recipient to achieve economic self-sufficiency through education, training, job search and job placement activities.

DFR's Bureau of Child Care (BCC) provides Hoosier families who have low incomes with child care resources, including day care quality ratings; and employment and training services to some SNAP and

TANF recipients. Also, DFR's Head Start program provides federal grants to local public and private non-profit and for-profit agencies to provide comprehensive child development services to economically disadvantaged children and families, with a special focus on helping preschoolers develop the early reading and math skills they need to be successful in school.

The division's overarching focus is the support and preservation of families by emphasizing self-sufficiency and personal responsibility. Information about DFR and DFR programs is available online at http://www.in.gov/fssa/2407.htm or you may call 1-800-403-0864.

Section 1.8: Waiver Service Providers

Waiver Service Providers are agencies, companies, and individuals that the Division of Disability and Rehabilitative Services (DDRS) has approved and that are paid by Medicaid to provide direct services to Medicaid waiver program participants. All waiver participants must have Case Management services. Waiver participants are provided a choice from among all Case Management Companies (CMCOs) that have been approved by DDRS/BDDS. After the CMCO has been chosen, the waiver participant will then chose a permanent case manager. The waiver participant's chosen case manager provides a list of available service providers at any time that the participant desires to select or change service providers, which includes changing providers of Case Management services upon request. See **Section 1.11: Helpful Hints for Participants and Guardians on How to Select Waiver Providers**.

Section 1.9: Hearings and Appeals

Hearings and Appeals is an administrative section within FSSA that receives and processes appeals from people receiving services within any FSSA program and many others. Administrative hearings are held throughout the State of Indiana, usually at county Division of Family Resources locations, at which time all parties have the opportunity to present their case to an Administrative Law Judge.

Section 1.10: Participants and Guardians

It is the policy of the DDRS' Bureau of Developmental Disabilities (BDDS) that individuals, or their legal representative when indicated, participate actively and responsibly in the administration and management of their Medicaid waiver-funded services.

BDDS supports and encourages individual choice in the selection of the participant's Case Management service provider, in the development of an Individualized Support Plan (ISP) and in the selection of all other service providers. Successful service delivery is dependent upon the collaboration of the Individual Support Team (IST) and entities with oversight responsibilities, including the Bureau of Quality Improvement Services (BQIS). The individual receiving services is the most prominent member of the IST, making their participation and cooperation in waiver service planning and administration essential.

Information Sharing
The Individual (or the Individual's legal representative when indicated) must upon request from BDDS, BQIS or any Division of Disability and Rehabilitative Services (DDRS) contracted vendor, provide information for the purpose of administration and/or management of waiver services.

Selecting or Changing Providers
When selecting a Case Management provider, the individual/participant (or the individual's legal representative when indicated) shall participate in:

- Choosing a Case Management Company (provider agency) from a pick list of approved Case Management Companies
  - For newly approved applicants preparing to enter into waiver services, the Case Management pick list is generated by the DDRS/BDDS
  - For individuals already active on the waiver, the Case Management pick list may be generated by the DDRS/BDDS or by their current provider of Case Management services
- Interviewing and choosing a permanent case manager
- Completing the service planning process

The individual (or the individual's legal representative when indicated) shall complete all actions as requested by BDDS to secure any replacement provider within:
- Sixty calendar days from the date the change is requested; *or*
- Sixty calendar days from when the provider gives notice of terminating services to the individual.

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

See **Section 1.11** (below) for Helpful Hints for Participants and Guardians on How to Select Waiver Providers

Participating in Risk Plan Development and Implementation
The individual (or the individual's legal representative when indicated) shall participate in:
- the development of risk plans for the individual, per current BDDS and/or BQIS procedures; *and* the
- implementation of risk plans developed for the individual, in lieu of documented risk negotiation with the individual's Individual Support Team, and a signed risk non-agreement document.

Allowing Representatives of the State into the Individual's Home
The individual (or the individual's legal representative when indicated) shall allow representatives from BDDS, BQIS, the selected Case Management agency and/or any DDRS-contracted vendor into the individual's home for visits scheduled at least 72 hours prior.

Consequences for Non-Participation
Should an individual (or their legal representative when indicated) choose not to participate actively and

responsibly in the administration and management of their Medicaid waiver-funded services, BDDS may terminate the individual's waiver services. If BDDS decides to terminate the individual's waiver services pursuant to this policy, BDDS must provide the individual (or the individual's legal representative when indicated) with written notice of intent to terminate the individual's waiver services.

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

Additional information regarding DDRS' policy on this issue can be found here:
http://www.in.gov/fssa/files/Individual_and_Guardian_Responsibilities.pdf

Section 1.11: Helpful Hints for Participants and Guardians on How to Select Waiver Providers

Here are some tips on selecting a provider:

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

General Topics to Discuss with Service Providers

Here are some tips on what to discuss with a service provider:

1. Discuss all areas of service that are absolute requirements for you and your family member, such as medications being administered on time, direct supervision, sign-language training, and so on.
2. What makes you and your family member happy? What causes pain? How will the provider maximize opportunities for happiness, and minimize or eliminate the things that cause pain?
3. What do you/your family member want to happen? To find a job? To attend or become a member of a church or local group? To live within a half-hour drive of family? How many housemates would you/ your family member like? Anything else? Are these wishes or requirements?
4. What are the risks for you/your family member? Examples might include daily seizures, a lack of street-safety skills, the inability to talk or use sign language, forgetfulness, a tendency to hit others when angry, and so on. How will the provider deal with those risks?

Questions to Ask Prospective Service Providers

The following are good questions to ask a prospective service provider:

1. What is the provider's mission? (Does it match the intent you are seeking?)
2. Is the provider certified, accredited, or licensed? What are the standards of service?
3. What kind of safety measures does the provider have in place to protect and assure treatment?
4. How does the provider assure compliance with the person's rights? Did you (and family members and advocates) receive copies of your rights as a consumer of services, as well as have these rights explained?
5. What is the provider's experience working with children and adults with disabilities, or adults who are elderly?
6. How would the provider ensure the implementation of the person-centered plan?
7. What connections has the provider established in the community? How would the provider assist in building a support system in the community?
8. Is the provider interested in what you/your family member want or dream about?
9. Is the provider connected to other programs that you may need, such as day support, local school and education services, or work programs? How is the provider connected? Ask for specific contacts.
10. If you are to live in a home shared with other people, can families drop in whenever they wish?
11. How are birthdays, vacations, and special events handled?
12. How would family money issues be handled? What is the policy on personal finances of the waiver participant?
13. How would minor illnesses and injuries be handled? What about major illnesses and injuries?
14. What information is routinely reported to families?
15. Can you get a copy of the provider's complaint policies and procedures? Is there someone else whom family members can talk to if there is a disagreement?

16. How are behavior problems handled? Are staff allowed to contact a behavioral support provider? How are new staff trained on the behavior support plan? Are they trained before working with waiver participants? What is the relationship between residential provider and behavioral provider?

17. How is medication handled? What happens if medication is refused?

18. What is the smoking policy?

19. How are planning meetings scheduled and conducted, and who attends? Can a family member call a meeting? How does the provider assure that what is agreed on in the meeting is actually provided?

20. Who would be the provider's contact person, how will that contact occur, and how often? Is someone available 24 hours a day in case of emergencies?

21. How many people with disabilities has the agency terminated or discontinued from services? Why? What happened to them?

22. Has the agency received any abuse or neglect allegations? Who made these allegations? What were the outcomes? What is the process for addressing allegations of abuse or neglect?

23. What challenges does the provider think the waiver participant will create for him or her?

24. As a provider of waiver services, what are the provider's strengths and weaknesses?

25. What is the process for hiring staff? Are background checks conducted and training given? What happens to the waiver participant while a new staff person is hired and trained?

26. How is direct staff supervised? What training does the staff receive? What is the average experience or education of staff?

27. How is staffing covered if regular staff is ill? What happens if staff does not show up for the scheduled time? How often does it happen?

28. What is the staff turnover rate? How are staff's respite needs handled?

29. What kind of support does staff have? Who can staff call if a problem develops?

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

Consider these issues when looking for a supported living setting:

1. How do the staff and housemates interact? Do they seem to respect and like each other?

2. Does the environment look comfortable? Is there enough to do? Are there regular activities happening in the home?

3. What kind of food is available and who selects it? Are choices encouraged and available? Are diets supervised?

4. Do people have access to banks, shops, restaurants, and so on? How is transportation handled? Are trips to access these resources planned or do they occur as needed?

5. Is there a telephone available to housemates (with privacy)? Is the telephone accessible (equipped with large buttons, volume control, other access features) if needed?

6. Does each person have his or her own bedroom? Is each person allowed to individually decorate the bedroom?

7. Do housemates seem to get along well? What happens when they don't?

8. Are there restrictions on personal belongings? What are the procedures for lost personal items? Are personal items labeled? Are lost items replaced?

9. Are pets allowed? What are the rules regarding pets?

10. How much time is spent in active learning (neighborhood, home, or community) and leisure activities? Is there a good balance with unstructured time?

11. Is there evidence that personal hygiene and good grooming (hair, teeth, nails, and so on) are encouraged?

12. How are personal items, clothing, and so on, paid for?

13. Does each person have privacy when he or she wants to be alone or with a special friend?

14. Does each person have the opportunity to belong to a church, club, community group, and so on?

15. Do staff knock on doors and wait for a response before entering a private room?

16. What kind of rules are there within the living situation? What are the consequences for breaking rules?

17. Does each housemate have opportunities to pursue his or her own individual interests, or do they travel in a group with everyone doing the same thing, attending the same movie, and so on?

Section 2: Provider Information

Section 2.1: Resources and references

Providers and prospective providers should register here to receive DDRS updates and announcements, and refer to the following resources for further information:

- Bureau of Developmental Disabilities (BDDS) Provider Relations webpage
- Current DDRS Policies
- Indiana Health Coverage Programs, Provider Reference Module titled Division of Disability and Rehabilitation Services Home and Community-Based Services Waivers

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Section 3.1: Other Program Information

Information about the variety of healthcare programs offered through the Indiana Health Coverage Programs (IHCP), including Hoosier Healthwise, Hoosier Care Connect, the Healthy Indiana Plan (HIP), and Traditional Medicaid (Fee-for-Service), is available on About Indiana Medicaid at indianamedicaid.com. See the *Indiana Health Coverage Programs' Provider Reference Module* titled ***Member Eligibility and Benefit Coverage*** for detailed information about member eligibility and services.

Individuals enrolled in Medicare, and those residing in an institution or receiving services through a home and community-based services (HCBS) waiver, will not be eligible for managed care programs such as Hoosier Care Connect.

If an individual is a Hoosier Healthwise or Medicaid managed care program participant, the Case Manager must contact the local FSSA/DFR caseworker to coordinate the managed care program stop date and waiver services start date.

DDRS' BDDS Service Coordinators and DDRS-approved Case Managers and Providers of other waiver-funded services may review the Indiana Health Coverage Programs' Provider Reference Module titled ***Member Eligibility and Benefit Coverage*** for detailed information about member eligibility and services in order to assist applicants and waiver participants.

Section 3.2: Hospice Services

Individuals who receive Medicaid HCBS waiver services and elect to use the Indiana Health Care Program Hospice benefit do not have to terminate their waiver program. However, the hospice provider will coordinate the direct care for those services held in common by both programs, so there is no duplication of services. In short, the individual receiving waiver services, who elects the hospice benefit, may still receive waiver services that are not related to the terminal condition and do not replicate hospice care. The hospice provider and the waiver case manager must collaborate and communicate regularly to ensure the best possible overall care to the individual waiver participant/hospice member. If applicable, the waiver case manager and managed care benefit advocate must inform the individual and individual's parent or guardian of his or her options to ensure he or she makes an informed choice. Additional information is available in the Indiana Health Coverage Programs' Provider Reference Modules, under the Service- and Provider-Specific Module titled ***Hospice Services*.**

Section 3.3: Medicaid Prior Authorization and Funding Streams

CMS requires that a HCBS waiver participant exhaust all services on the State Plan before utilizing

HCBS waiver services. HCBS waiver programs are considered funding of last resort and have a closed funding stream.

The following list provides the hierarchy of funding streams for HCBS waiver programs.

1. Private Insurance/Medicare
2. Medicaid State Plan Services
3. HCBS Waiver Programs
   - As a funding stream of last resort, teams must ensure that all other revenue streams are exhausted before utilizing waiver services.
   - Medicaid Home Health Prior Authorization (PA) Requests must specify if there are other caregiving services received by the member (waiver participant), including, but not limited to services provided by Medicare, Medicaid waiver programs, CHOICE, vocational rehabilitation, and private insurance programs. The number of hours per day and the days per week for each service must be listed.

State Plan services that must be accessed prior to the use of waiver-funded services include but are not limited to Home Health, Medical Transportation, Occupational Therapy, Physical Therapy, Speech/Language Therapy, and Medicaid Rehabilitation Option (MRO).

Participants and families may search for PA services at
http://www.indianamedicaid.com/ihcp/ProviderServices/ProviderSearch.aspx

For additional information please visit Indiana Medicaid at
http://provider.indianamedicaid.com/general-provider-services/providing-services/prior-authorization.aspx

Section 4: Intellectual/Developmental Disabilities Services Waivers

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Section 4.1: Medicaid Waiver Overview

The Medicaid Waiver program began in 1981, in response to the national trend toward providing Home and Community-Based Services (HCBS). In the past, Medicaid paid only for institutionally based long term care services, such as nursing facilities and group homes.

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waivers' target population.

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

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

Indiana applies for permission to offer Medicaid Waivers from the Centers for Medicare and Medicaid Services (CMS). The Medicaid Waivers make use of federal Medicaid funds (plus state matching funds) for Home and Community-Based Services (HCBS), as an alternative to institutional care, under the condition that the overall cost of supporting a group of people in the home or community is no more than the institutional cost for supporting that same group of people.

The goals of Waiver services are to provide to the person meaningful and necessary services and supports, to respect the person's personal beliefs and customs, and to ensure that services are cost-effective.

Specifically, waivers for individuals with an intellectual/developmental disability assist a person to:

- Become integrated in the community where he/she lives and works
- Develop social relationships in the person's home and work communities
- Develop skills to make decisions about how and where the person wants to live
- Become as independent as possible

DDRS oversees the following Indiana Medicaid Home and Community-Based Services waiver programs:

- Family Supports Waiver
- Community Integration and Habilitation Waiver

Section 4.2: State Definition of Developmental Disability

Individuals meeting the state criteria for an intellectual/developmental disability and meeting the criteria for an ICF/IID level of care determination are eligible to receive waiver services when approved by the state.

Per Indiana Code [IC 12-7-2-61], “developmental disability" means a severe, chronic disability of an individual that meets all of the following conditions:

- Is attributable to:
  - intellectual disability, cerebral palsy, epilepsy, or autism; or
  - any other condition (other than a sole diagnosis of mental illness) found to be closely related to intellectual disability, because this 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.
- Is manifested before the individual is twenty-two (22) years of age.
- Is likely to continue indefinitely.
- Results in substantial functional limitations in at least three (3) of the following areas of major life activities:
  - Self-care.
  - Understanding and use of language.
  - Learning.
  - Mobility.
  - Self-direction.
  - Capacity for independent living.
  - Economic self-sufficiency.

An individual with an intellectual/developmental disability must also be found to meet the federal level of care requirements for admission into an ICF/IID and be approved for entrance into the waiver program prior to receiving waiver-funded services through an Indiana Medicaid Home and Community Based Services waiver program administered by the Division of Disability and Rehabilitative Services. See **Section 5.3: Initial Level of Care Evaluation** for details.

Section 4.3: Cost Neutrality

Indiana must demonstrate that average per capita expenditure for the Family Supports Waiver and the Community Integration and Habilitation Waiver program participants are equal to or less than the average per capita expenditures of institutionalization for the same population. Indiana must demonstrate this cost neutrality for each waiver separately.

Section 4.4: Coordination with Medicaid State Plan Services

CMS **requires** that a HCBS waiver member exhaust all services on the State Plan before utilizing HCBS waiver services. **HCBS waiver programs are considered funding of last resort and have a closed funding stream.** Please reference **Section 3.3** for more specific information.

Section 4.5: Family Supports Waiver (FSW)

PURPOSE:
The Family Supports Waiver (FSW) program provides Medicaid Home and Community-Based Services (HCBS) to participants residing in a range of community settings as an alternative to care in an intermediate care facility for individuals with intellectual disability (known as an ICF/IID) or related conditions. The FSW serves persons with an intellectual/developmental disability, intellectual disability or autism and who have substantial functional limitations, as defined in 42 CFR 435.1010. Participants may choose to live in their own home, family home, or community setting appropriate to their needs.

Participants develop an Individualized Support Plan (ISP) using a person-centered planning process guided by an Individual Support Team (IST). The IST consists of the participant, the participant's case manager and anyone else of the participant's choosing but typically family and/or friends. The participant, with the IST, selects services, chooses service providers and develops a Plan of Care/Cost Comparison Budget (POC/CCB). **The POC/CCB is subject to an annual waiver services cost cap of $16,545.**

GOALS and OBJECTIVES:
The FSW provides access to meaningful and necessary home and community-based services and supports, seeks to implement services and supports in a manner that respects the participant's personal beliefs and customs, ensures that services are cost-effective, facilitates the participant's involvement in the community where he/she lives and works, facilitates the participant's development of social relationships in his/her home and work communities, and facilitates the participant's independent living.

LIST OF SERVICES CURRENTLY AVAILABLE UNDER THE FSW:

- Adult Day Services
- Behavioral Support Services
- Case Management
- Community Based Habilitation - Group
- Community Based Habilitation – Individual
- Extended Services
- Facility Based Habilitation - Group
- Facility Based Habilitation - Individual
- Facility Based Support Services

- Family and Caregiver Training
- Intensive Behavioral Intervention
- Music Therapy
- Occupational Therapy
- Participant Assistance and Care
- Personal Emergency Response System
- Physical Therapy
- Psychological Therapy
- Prevocational Services
- Recreational Therapy
- Respite
- Specialized Medical Equipment and Supplies
- Speech /Language Therapy
- Transportation
- Workplace Assistance

Section 4.6: Community Integration and Habilitation (CIH) Waiver

PURPOSE:
The **Community Integration and Habilitation (CIH) Waiver** program provides Medicaid Home and Community-Based Services (HCBS) to participants residing in a range of community settings as an alternative to care in an intermediate care facility for individuals with intellectual disabilities (known as an ICF/IID) or related conditions. The CIH Waiver serves individuals with an intellectual/developmental disability or autism who have substantial functional limitations, as defined in 42 CFR 435.1010. However, entrance into services under the CIH Waiver occurs only when an applicant has been determined by the Division of Disability and Rehabilitative Services (DDRS) to meet priority criteria of one or more federally approved reserved waiver capacity categories, a funded slot is available and DDRS also determines that other placement options are neither appropriate nor available.

When priority access has been deemed appropriate and a priority waiver slot in the specific reserved waiver capacity category met by the applicant remains open, participants may choose to live in their own home, family home, or community setting appropriate to their needs. Participants develop an Individualized Support Plan (ISP) using a person-centered planning process guided by an Individual Support Team (IST). The IST consists of the waiver participant, the participant's Case Manager, and anyone else of the participant's choosing, but typically family and/or friends. The participant, with the IST, selects services, chooses service providers, and develops a Plan of Care/Cost Comparison Budget (POC/CCB).

GOALS and OBJECTIVES:
The CIH Waiver provides access to meaningful and necessary home and community-based services and supports, seeks to implement services and supports in a manner that respects the participant's

personal beliefs and customs, ensures that services are cost-effective, facilitates the participant's involvement in the community where he/she lives and works, facilitates the participant's development of social relationships in his/her home and work communities, and facilitates the participant's independent living.

LIST OF SERVICES CURRENTLY AVAILABLE UNDER THE CIH Waiver:

- Adult Day Services
- Behavioral Support Services
- Case Management
- Community Based Habilitation - Group
- Community Based Habilitation - Individual
- Community Transition
- Electronic Monitoring
- Environmental Modifications
- Extended Services
- Facility Based Habilitation - Group
- Facility Based Habilitation - Individual
- Facility Based Support Services
- Family and Caregiver Training
- Intensive Behavioral Intervention
- Music Therapy
- Occupational Therapy
- Personal Emergency Response System
- Physical Therapy
- Psychological Therapy
- Prevocational Services
- Recreational Therapy
- Rent and Food for Unrelated Live-in Caregiver
- Residential Habilitation and Support (provided hourly)
- Residential Habilitation and Support – Daily (RHS Daily)
- Respite
- Specialized Medical Equipment and Supplies
- Speech /Language Therapy
- Structured Family Caregiving
- Transportation
- Wellness Coordination
- Workplace Assistance

Section 5: Application and Start of Waiver Services

Sections 5.1 – 5.8

Section 5.1: Request for Application

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Section 5.3: Initial Level of Care Evaluation

Section 5.4: Waiting List for the Family Supports Waiver Program

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

Section 5.8: State Authorization of the Initial Plan of Care/Cost Comparison Budget (POC/CCB)

Section 5.9: Initial Plan of Care Implementation

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Section 5.1: Request for Application

An individual or his/her guardian may apply for the Family Supports Waiver (FSW) or Community Integration and Habilitation (CIH) Waiver program through the local Division of Disability and Rehabilitative Services (DDRS)/Bureau of Developmental Disabilities Services (BDDS) office. An individual (or his or her guardians) has the right to apply without questions or delay.

To apply for the FSW or CIH Waiver, the individual or guardian must complete, sign, and date an *Application for Long Term Care Services* (State Form 4594) including the time of day that the application is signed. An individual who has not already applied for waiver services may also need to complete, sign, and date a DDRS Referral and Application (State Form 10057) located at http://www.in.gov/fssa/ddrs/3349.htm. Other individual or agency representatives may assist the individual or guardian in completing the application form and forward it to the DDRS/BDDS office serving the county in which the individual currently resides. The application may be submitted in person, by mail or by fax.

Please see the BDDS District Offices for the location of the BDDS offices, counties served and contact information for each office.

Upon receiving the waiver application, the DDRS/BDDS staff must contact the individual and his or her guardian (if applicable) and discuss the process for determining eligibility for the waiver (documentation of an intellectual/developmental disability, Medicaid eligibility, and level of care). If the applicant is not a Medicaid recipient, he or she will be referred to the local Division of Family Resources (DFR) to apply for Medicaid.

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

Section 5.2: Medicaid Eligibility: How to Apply for Medicaid

Medicaid eligibility is required prior to the start of waiver services. For individuals who have never applied at the Social Security Administration (SSA), Indiana Medicaid may require these applicants to apply for benefits with the SSA as part of the Medicaid application process. An application to SSA will need to be filed for Indiana Medicaid to complete the eligibility process.

For individuals who have an SSA disability determination the state will use this determination for Medicaid eligibility purposes. Individuals considered disabled by SSA will be considered disabled by Indiana Medicaid.

Otherwise, the Family and Social Services Administration (FSSA) Division of Family Resources (DFR) is responsible for processing applications and establishing eligibility for state benefits including:

- Medicaid / Indiana health coverage plans
- Supplemental Nutrition Assistance Program (SNAP) / food assistance
- Temporary Assistance for Needy Families (TANF) / cash assistance
- IMPACT (Job Training)
- Early Learning/Child Care
- How do I know if I qualify?
- A assessment tool that will help you see if you qualify for Medicaid and other benefits is available online at https://www.ifcem.com/CitizenPortal/application.do# .

NOTE: Individuals may also apply for Medicaid based on disability. Applications to the Social Security Administration for Supplemental Security Income are treated as applications for Medicaid under 1634 status. See http://www.in.gov/fssa/ddrs/4861.htm#Post for more information.

Where do I apply?

To apply for Medicaid and other DFR benefits, you will need to fill out and submit an application. You may apply online at or in person at a local office, or call **1-800-403-0864** to request an application be mailed to you.

- **To apply online,** go to the Division of Family Resources Benefits Portal at https://www.ifcem.com/CitizenPortal/application to apply for benefits and complete your application. The online application is available 24 hours a day, 7 days a week.
- **To apply in person,** go to your local DFR office, Monday through Friday, 8:00 a.m. to 4:30 p.m. A DFR office is located in every county in Indiana; with multiple offices located in Marion, Lake and St. Joseph counties.
- **To apply by mail,** call toll free **1-800-403-0864** Monday through Friday between 8:00 a.m. and 4:30 p.m. to request an application be mailed to you. Complete the application and return it in the mail, FAX it toll free to 1-800-403-0864, or bring it into the DFR office in the county where you reside.

DFR office locations

To find a DFR office near you, go online to http://www.DFRBenefits.IN.gov. Enter your ZIP code in the search box provided, or click on the name of the county where you live in the table shown. This will take you to a page listing the address and other information about your local office. If you do not have

Internet access, call toll free 1-800-403-0864 and an operator will provide you with this information.

Information required to complete a Medicaid application

- ❑ Go to the **http://www.DFRBenefits.IN.gov** web site to learn what information is required to complete a Medicaid application.

- ❑ To get started, the following information for all of your household members may help you complete the application
  - Names, date of birth and social security numbers
  - Employer and income information
  - Tax filing status and tax dependent information
  - Current health insurance information including policy numbers

- ❑ DFR may contact you by phone or by mail if additional information or documentation is required to complete your application.

- ❑ **Applicants under the age of 18 *should* submit the Plan of Care/Cost Comparison Budget (POC/CCB) approval letter (described under Section 5.8) to the Division of Family Resources (DFR) when submitting an application for Medicaid benefits or when requesting for a change of Medicaid Aid Category in order to qualify for waiver eligibility.**

NOTE: Medicaid eligibility is required prior to the start of waiver services.

Section 5.3: Initial Level of Care Evaluation

An individual targeted for the Family Supports Waiver (FSW) or meeting reserved waiver capacity (priority) criteria and approved for entrance to the FSW or Community Integration and Habilitation (CIH) Waiver must meet the level of care required for placement in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).

- Initial Level of Care determinations are made by a Family and Social Services Administration (FSSA)/Division of Disability and Rehabilitative Services (DDRS)/Bureau of Developmental Disabilities Services (BDDS) Service Coordinator

- Reevaluations are performed by the selected provider of Case Management services.

- For those applicants whose initial Level of Care (LOC) evaluation was unfavorable, an independent third party contractor conducts a subsequent LOC evaluation and makes a recommendation to the State Medicaid Agency, the Family and Social Services Administration (FSSA), and FSSA makes the final determination of eligibility.

Qualifications of Individuals Performing Initial Evaluation: Only individuals (FSSA employees/contractors) who are Qualified Intellectual Disability Professionals (QIDP) as specified by the federal standard within 42 CFR §483.430(a), may perform initial Level of Care determinations.

Level of Care Criteria: If collateral records are not available or are not a valid reflection of the individual, additional assessments may be obtained from contracted psychologists, physicians, nurses and licensed social workers. Following review of the collateral records, the LOC assessment tool is completed, applicable to individuals with intellectual disability and other related conditions, in order to ascertain if the individual meets ICF/IID LOC.

The LOC assessment tool is used for:

- Reviewing and referencing documentation related to the intellectual/developmental disabilities of the applicant/participant as well as any psychiatric diagnosis and results of the individual's intellectual assessment
- Recording age of onset
- Identifying areas of major life activity within which the individual may exhibit a substantial functional limitation, including the areas of mobility, understanding and use of language, self-care, capacity for independent learning, self-direction, and, for the state definition of developmental disability found in Indiana Code [IC 12-7-2-61], economic self-sufficiency.

The BDDS Service Coordinator/contractor (initial LOC) or selected provider of Case Manager (re-evaluations) reviews the LOC assessment tool and collateral material, applicable to individuals with intellectual/developmental disability and other related conditions, in order to ascertain if the individual meets ICF/IID LOC. An applicant/participant must meet each of four basic conditions and three of six substantial functional limitations in order to meet LOC.

The basic conditions are:

- intellectual disability, cerebral palsy, epilepsy, autism, or other condition (other than a sole diagnosis of mental illness) similar to intellectual disability
- the ID, DD or other related condition is expected to continue indefinitely,
- the ID, DD or other related condition had an age of onset prior to age 22, and
- the ID, DD or other related condition results in substantial functional limitations in at least three (3) major life activities.

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

- are: self-care,
- learning,
- self-direction,
- capacity for independent living,
-
-

understanding and use of language, and
mobility.

Section 5.4: Waiting List for the Family Supports Waiver

It is the policy of the Bureau of Developmental Disabilities Services (BDDS) that individuals may be placed on a single statewide waiting list after applying for waiver services and meeting specified criteria. Individuals are responsible for maintaining current collateral and contact information with their local DDRS/BDDS office.

For initial Placement on a single, statewide Home and Community Based Services (HCBS) Waiver Waiting List, the following requirements must be met:

- Individuals or their legal representative must complete an application and submit the application to their local BDDS office to apply for HCBS waiver services.
- The individual or their legal representative is expected to participate in the completion of the following:
    - Application
    - Collateral Information, including the following:
        - Level of Care (LOC) assessment tool
        - Supporting documents:
            - Diagnostic Evaluation(s)
            - Functional Evaluation(s)
            - Psychological Report(s)
            - Individualized Education Program from schools
            - School records
            - Physician's diagnosis and remarks
            - Existing evaluation done by Supplemental Security Income (SSI) or Vocational Rehabilitation
            - Intelligence Quotient (IQ) testing done at any time
    - Medicaid application for individuals over eighteen years of age
    - SSI application, if applicable
- Level of Care (LOC) must be assessed for all individuals

An individual must meet:

- the State definition of a developmental disability found in *IC 12-7-2-61(a);* and
- Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) Level of Care (LOC) with substantial functional limitations as defined in *42 CFR §435.1010*.

- If an individual completes the application and meets the LOC criteria listed in Section 5.3 above, they will be placed on a waiting list using the individual's application date.

Waiting List Targeting for a Waiver Slot

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

Note that entrance into services under the Community Integration and Habilitation Waiver now occurs only by meeting and being approved for certain priority criteria known as reserved waiver capacity.

Responsibilities of Individuals on a Waiting List

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

Section 5.5: Targeting Process for the Family Supports Waiver

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

- Accept or decline the waiver slot within 30 calendar days and apply for Medicaid if he or she hasn't already done so
- Provide or obtain confirmation of their diagnosis from a physician on the DDRS form known as the 450B.

A response accepting or declining the waiver slot must be received by the State within 30 calendar days.

Individuals ages 18 through 24 who have aged out of, graduated from or have permanently separated from their school setting may be able to enter waiver services under the FSW upon that separation if funded slots are available.

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

If an individual accepts the offer for a FSW slot:

- An intake meeting with a service coordinator from the local BDDS District Office is scheduled for the BDDS to complete the following:
    - Collateral information, provided by the individual, is reviewed and level of care must again be established
    - The LOC assessment tool is completed
- The individual or any legal guardian must obtain confirmation of their diagnosis on a 450B form signed by their physician within 21 calendar days from date of letter
- The individual or any legal guardian has 60 calendar days to apply for and obtain Medicaid if the individual does not yet have Medicaid coverage
- If the individual already has Medicaid coverage, but the Aid Category to which the individual's Medicaid eligibility has been assigned is not compatible with waiver program requirements, he or she has 30 calendar days from the date on the contact letter from DDRS/BDDS to request that the FSSA/DFR process the needed change in Medicaid aid category
- The individual or any legal guardian must cooperate fully with requests related to the application for Medicaid eligibility and any needed change in Medicaid aid category

After all assessments have been made, applicants under the age of 18 and their legal guardians are given a pick list by the DDRS/BDDS containing providers of Case Management services that are approved by DDRS to provide service in the applicant's county of residency.

Due to the disregard of parental income for minors receiving waiver services, proof of an approved Plan of Care/Cost Comparison Budget (POC/CCB) may be required before some minors can obtain Medicaid eligibility. For that reason, the BDDS service coordinator creates an Initial POC/CCB, although selection of a Case Manager is still required. The Case Manager is cited on the Initial POC/CCB if the selection has been finalized, but may also be added at a later date if necessary.

For adults, generation of the Case Management agency pick list by DDRS/BDDS and selection of a Case Management agency will not occur until after all eligibility criteria are met, including establishment of Medicaid eligibility in a waiver-compatible aid category. Thereafter, the applicant or guardian (if applicable) completes the service planning process, chooses a service provider(s), and the Case Manager submits a POC/CCB for waiver service.

After the pick list is provided by BDDS, the individual (consumer) and/or legal guardian has:

- Five calendar days to interview and choose a permanent Case Manager
- Fourteen calendar days to interview and choose, at minimum, one provider

From the date a provider is chosen, the individual (consumer) and/or legal guardian has:

- Fourteen calendar days to complete the service planning process enabling the POC/CCB to be
- created.

  Three calendar days to review and sign all service planning documents after the POC/CCB is completed

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

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

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

Effective September 1, 2012, entering the Home and Community Based Services (HCBS) waiver program known as the Community Integration and Habilitation (CIH) Waiver requires the individual to meet and be approved for certain federally approved priority criteria technically known as *reserved waiver capacity categories* within the CIH Waiver.

- To move onto the needs-based CIH Waiver, an individual must meet and be approved for the specific priority criteria of at least one of the following categories:
  - Eligible individuals transitioning to the community from NF, ESN and SOF
  - Eligible individuals determined to no longer need/receive active treatment in Supervised Group Living (SGL)
  - Eligible individuals transitioning from 100% state-funded services
  - Eligible individuals aging out of Department of Education (DOE), Department of Child Services (DCS), or SGL
  - Eligible individuals requesting to leave a Large Private ICF/IID
  - Eligible individuals meeting the following emergency placement criteria:
    - Death of a Primary Caregiver where there is no other caregiver available, or
    - Caregiver over 80 years of age where there is no other caregiver available, or
    - Evidence of abuse or neglect in the current institutional or SGL placement, or
    - Extraordinary health and safety risk as reviewed and approved by the division director

- Individuals, their legal representative or other persons acting on their behalf must request a priority

waiver slot when it appears that the individual meets the specific criteria of one or more reserved waiver capacity categories

- It is necessary to complete an application and submit the application to their local DDRS/BDDS office to apply for HCBS waiver services.
- The Individual and/or any legal guardian are expected to participate in the completion of the following:
  - Application
  - Collateral Information, including the following:
    - Level of Care assessment tool
    - Supporting documents:
      - Diagnostic Evaluation(s)
      - Functional Evaluation(s)
      - Psychological Report(s)
      - Individualized Education Program from schools
      - School records
      - Physician diagnosis and remarks
      - Existing evaluation done by Supplemental Security Income or Vocational Rehabilitation
      - IQ testing done at any time
  - Medicaid application for individuals over eighteen (18) years of age
  - Supplemental Security Income application, if applicable

- Level of Care (LOC) must be assessed for all individuals
- An individual must meet:
  - the State definition of a developmental disability found in *IC 12-7-2-61(a)*; and
  - Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) Level of Care (LOC) with substantial functional limitations as defined in *42 CFR §435.1010*.
- Additionally, if an individual meets the LOC criteria listed in Section 5.3 above, and a funded priority slot is available in the reserved waiver capacity category met by the individual, the DDRS/BDDS Office will first determine whether or not other potential placement options have been exhausted before offering the slot to the individual
- Individuals are responsible for maintaining current collateral and contact information with their local BDDS office.

Application for a CIH Waiver Priority Slot

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

Responsibilities of Individuals Applying for a CIH Waiver Priority Slot

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

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

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

If an individual or an individual's legal representative accepts placement through the offer of a funded CIH Waiver priority slot:

- An intake meeting with a service coordinator from the local DDRS/BDDS District Office is scheduled to complete the following:
    - Collateral information, provided by the individual, is reviewed and level of care, again, established
    - LOC assessment tool is completed
    - The allocation is recorded into system
- The individual/guardian must obtain confirmation of their diagnosis on a 450B form signed by their physician within 21 calendar days from date of letter
- The individual/guardian has 60 calendar days to apply for/obtain Medicaid when the individual does not yet have Medicaid coverage
- If the individual already has Medicaid coverage, but the aid category to which the individual's Medicaid eligibility has been assigned is not compatible with waiver program requirements, he or she has 30 calendar days from the date on the contact letter from BDDS to request that the DFR process the needed change in Medicaid aid category
- The individual or guardian must cooperate fully with requests related to the application for Medicaid eligibility and/or any needed change in Medicaid aid category

After all assessments have been made, BDDS applicants younger than the age of 18 and their legal guardians are given a list of Case Management service providers approved by the DDRS/BDDS to provide service in the applicant's county of residency. Due to the disregard of parental income for minors receiving waiver services, proof of an approved Plan of Care/Cost Comparison Budget (POC/CCB) may be required before some minors can obtain Medicaid eligibility. In those situations, the BDDS creates the POC/CCB, enabling the minor to obtain Medicaid. Otherwise, selection of a Case Manager is required before the POC/CCB can be created. For adults, generating the BDDS Case Management agency list and selecting a Case Management agency does not occur until after all eligibility criteria are met, including establishing Medicaid eligibility in a waiver-compatible aid category. Thereafter, the applicant or guardian (if applicable) completes the service planning process and chooses service providers, and the Case Manager submits a POC/CCB for waiver service.

After the BDDS provides the pick list, the individual or guardian has:

- Five calendar days to interview and choose a permanent case manager
- Fourteen calendar days to interview and choose, at minimum, one provider

From the date a provider is chosen, the individual or guardian has 14 calendar days to complete the service planning process, enabling the POC/CCB to be created. After the POC/CCB is completed, the individual or guardian (consumer) has three calendar days to review and sign service-planning documents.

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

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

The State monitors its Person-Centered Planning (PCP) process to ensure compliance with *CMS 2249-F* and *CMS 2296-F*. The Plan of Care/Cost Comparison Budget (POC/CCB) is developed based upon the outcomes of the initial, annual or subsequent meeting of the Individual Support Team (IST) during which the Person-Centered Plan (PCP) and the Individualized Support Plan (ISP) are developed, reviewed, and/or updated. Person-centered plans document the options based on the individual's needs and preferences, and, for residential settings, an individual's resources. This entire process is driven by the individual/participant and is designed to recognize the participant's needs and desires. The Case Manager holds a series of structured conversations, beginning with the participant/ guardian and with other individuals, identified by the participant that know them well and can provide pertinent information about them, to gather initial information to support the person-centered planning process. The overall emphasis of the conversations will be to derive what is important to and what is important for the participant, with a goal of presenting a good balance of the two. The participant-chosen facilitator, typically the Case Manager, facilitates the IST meeting, reviews the participant's desired outcomes, their health and safety needs and their preferences, and reviews covered services, other sources of services and support (paid and unpaid) and the budget development process for waiver services. The case manager then finalizes the ISP and completes the POC/CCB. (See ***Section 1.11: Helpful Hints for Participants and Guardians on How to Select Waiver Providers***.)

Although the Family Supports Waiver is already capped at $16,545 annually, budgeted amounts for POC/CCBs developed under the Community Integration and Habilitation Waiver use the objective based allocation process described in **Section 6**.

Coordination of waiver services and other services is completed by the Case Manager. Within 30 calendar days of implementation of the plan, the Case Manager is responsible for ensuring that all identified services and supports have been implemented as identified in the Individualized Support Plan and the POC/CCB. The Case Manager is responsible for monitoring and coordinating services on an ongoing basis and is required to record a case note for each encounter with the participant. A formal 90 day review is

also completed by the Case Manager with the participant and includes the IST.

Most waiver service providers are required to submit a quarterly report summarizing the level of support provided to the participant based upon the identified supports and services in the ISP and the POC/CCB. As part of the 90 day review process, the Case Manager reviews these reports for consistency with the ISP and POC/CCB and works with providers as needed to address findings from this review.

Section 5.8: State Authorization of the Initial POC/CCB

The Case Manager transmits the Plan of Care/Cost Comparison Budget (POC/CCB) electronically to the State's waiver specialist who reviews the POC/CCB and confirms the following:

- The individual is a current Medicaid recipient within one of the following categories:
  - Aged **(MA A)**
  - Blind **(MA B)**
  - Low Income Families **(MA GF)**
  - Disabled **(MA D)**
  - Disabled Worker **(MA DW, MA DI)**
  - Children receiving Adoption Assistance or Children receiving Federal Foster Care Payments under Title IV E - Sec. 1902(a)(10)(A)(i)(I) of the Act **(MA 4 & MA 8)**
  - Children receiving adoption assistance under a state adoption agreement - Sec 1902(a)(10)(A)(ii)(VIII) **(MA 8)**
  - Independent Foster Care Adolescents – Sec 1902(a)(10)(A)(ii)(XVII) **(MA 14)**
  - Children Under Age 1 – Sec 1902(a)(10)(A)(i)(IV) **(MA Y)**
  - Children Age 1-5 - Sec 1902(a)(10)(A)(i)(VI) **(MA Z)**
  - Children Age 1 through 18 - Sec 1902(a)(10)(A)(i)(VII) **(MA 9 & MA 2)**
  - Transitional Medical Assistance – Sec 1925 of the Act **(MA F)**
  - Aged, blind or disabled in 1634 states:
    - Supplemental Security Income (SSI)-eligible individuals will be automatically enrolled in the Indiana Health Coverage Programs (IHCP) and will not need to file a separate *Indiana Application for Health Coverage*. Members with SSI will be assigned to the new Modified Adjusted Gross Income (MAGI) eligibility aid category. Individuals deemed disabled by the Social Security Administration and who are receiving SSI based on that determination, will not be required to undergo a separate determination of disability from Indiana's Medical Review Team (MRT).
    - Individuals who receive Social Security Disability Income (SSDI) will not be required to undergo a separate determination of disability from Indiana's Medical Review Team (MRT). A financial eligibility review will still be required, so these individuals will need to complete the *Indiana Application for Health Coverage*.

- The individual has a current ICF/IID level of care approval

- The individual has been targeted for an available waiver slot;

- The individual's identified needs are addressed with a plan to assure his or her health, safety and welfare;

- The individual or guardian has signed, indicating acceptance of, the POC/CCB; signed that he or she has been offered choice of certified waiver service providers; and signed that he or she has chosen waiver services over services in an institution.

The Waiver Specialist may request additional information from the Case Manager to assist in reviewing the POC/CCB.

If the Waiver Specialist approves the Initial POC/CCB, the Initial approval letter and *Notice of Action (NOA)* are electronically transmitted to the Case Manager, DDRS/BDDS district office (for Initial POC/CCBs only), and Service Providers. Within three calendar days of receiving the Initial POC/CCB approval letter, the Case Manager must print an *NOA* form (*HCBS Form 5*) and sign it. The Case Manager must provide copies of the approval letter, the signed *NOA* form and addendum (containing information from the POC/CCB) to the individual participant/guardian. The participant's chosen waiver service providers are required to register so that they receive the *NOA*s and the addendums electronically.

The Notice of Action (*NOA*)

The *Notice of Action (NOA)* serves as the official authorization for service delivery and reimbursement.

If the Waiver Specialist approves the POC/CCB pending Medicaid eligibility or change of Aid Category (for minors only), disenrollment of a child from Hoosier Healthwise, facility discharge, or other reasons, the pending approval letter is to be transmitted to the Case Manager, DDRS/BDDS district office, and service providers. The Case Manager must notify the individual or guardian within three calendar days of receipt of the pending approval and provide a copy of the Initial approval letter naming the pending conditions. No *NOA* is generated until all pending issues are resolved and a final approval letter is released.

If the Waiver Specialist denies the Initial POC/CCB, a denial letter must be transmitted to the Case Manager, DDRS/BDDS (for Initials only), and Service Providers. Within three calendar days of receipt of the denial the Case Manager must complete and provide a copy of an *NOA* (HCBS Form 5), the Appeal Rights as an HCBS waiver services recipient, and an explanation of the decision to deny to the individual participant and/or guardian. The case manager will discuss other service options with the individual and guardian. If the denial pertains to the Family Supports Waiver, the individual's name should be removed from a single statewide waiting list, unless the individual participant or guardian files an appeal.

NOTE: *Once waiver services begin, waiver participants are sometimes referred to as consumers, or "members" for Medicaid purposes.*

Section 5.9: Initial Service Plan Implementation

An individual cannot begin waiver services under the Family Supports Waiver program or the Community Integration and Habilitation Waiver program prior to the approval of the Initial Plan of Care/Cost Comparison Budget (POC/CCB) by the State's Waiver Specialist. The Initial POC/CCB

represents the service plan identified for the individual as the result of the person-centered planning process and the individualized support plan development. If the waiver specialist issues an Initial approval letter pending certain conditions being met, those conditions must be resolved prior to the start of the individual's waiver services. For applicants under the age of 18, if the individual's Medicaid eligibility is approved pending waiver approval, the Case Manager notifies the local FSSA/DFR caseworker when the waiver has been approved. The FSSA/DFR caseworker and waiver Case Manager coordinate the Medicaid eligibility date and waiver start date. If Medicaid eligibility depends on eligibility for the waiver, the Medicaid start date is usually the first day of the month following approval of the POC/CCB.

If an individual is a Hoosier Healthwise, Hoosier Care Connect, or Medicaid managed care program participant the Case Manager must contact the local FSSA/DFR caseworker to coordinate the managed care program stop date and waiver services start date. Individuals receiving the Indiana Health Coverage Program's Hospice benefit do not have to dis-enroll from this benefit to receive waiver services that are not related to the terminal condition and are not duplicative of hospice care. If applicable, the Case Manager and managed care benefit advocate must inform the individual and individual's parent or guardian of his or her options to assure he or she makes an informed choice.

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

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

For all waiver starts, when the Case Manager completes the *Confirmation of Waiver Start* form in the Insite database and electronically transmits it to the DDRS database, the Family and Social Services Administration (FSSA)'s Office of Medicaid Policy and Planning (OMPP) is also electronically notified to enter the individual's waiver start information in the Indiana AIM database.

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

Within three calendar days of receiving the Initial POC/CCB approval letter, the Case Manager must print a *Notice of Action* form *(HCBS Form 5)* and sign it. The Case Manager must provide copies of the signed *NOA* form and Addendum (containing information from the POC/CCB) to the individual or guardian. The individual's chosen waiver service providers are required to register so that they receive the *Notices of Action* and the *Addendums* electronically.

There is no reimbursement for services delivered prior to receipt of the *NOA*.

Section 6: Objective Based Allocation (OBA)

Sections 6.1 – 6.7

Section 6.1: OBA Overview and Development

Section 6.2: ICAP Assessment and Algo Level Development

Section 6.3: Algo Level Descriptors per 460 IAC 13

Section 6.4: Translating Algo Level into a Budget Allocation

Section 6.5: Budget Review Questionnaire (BRQ) and Budget Modification Review (BMR)

Section 6.6: Implementation of Objective-Based Allocations

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

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Section 6.1: OBA Overview and Development

The objective-based allocation (OBA) is the method the State uses to determine the level of supports an individual needs to live in a community setting while receiving services under the Community Integration and Habilitation Waiver.

In 2007, the Division of Disability and Rehabilitative Services (DDRS) and an external group of stakeholders consisting of advocates, providers, and industry professionals began the research and development of an objective-based allocation method.

The development included baseline research, provider cost reporting, modeling, assessment validation, pilots, and best practices. Modeling was used to determine the parameters for Algorithm development (Algos). As is further explained in the following section, Section 6.2, the OBA is determined by combining the overall Algo (determined by the Inventory for Client and Agency Planning or ICAP, and the ICAP addendum), age, employment, and living arrangement.

Note: The OBA methodology is not used with the already-capped Family Supports Waiver.

Section 6.2: ICAP Assessment and Algo Level Development

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

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

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

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

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

The OBA is then determined by combining the overall Algo (determined by the ICAP and ICAP addendum), age, employment, and living arrangement.
It should be noted that for any individual who is living alone, the OBA is based on a shared living model. Section 6.5: Budget Review Questionnaire (BRQ) and Budget Modification Review (BMR) addresses potential

adjustments to the allocation amount.

Section 6.3: Algo Level Descriptors per 460 IAC 13

Table 6.1 – Algo Level Descriptors

Level	Descriptor
0 (Low)	Algo level zero (0): (A) high level of independence with few supports needed; (B) no significant behavioral issues; and (C) requires minimal residential habilitation services.
1 (Basic)	Algo level one (1): (A) moderately high level of independence with few supports needed; (B) behavioral needs, if any, can be met with medication or informal direction by caregivers through the Medicaid State Plan services; and (C) likely a need for day programming and light residential habilitation services to assist with certain tasks, but the individual can be unsupervised for much of the day and night.
2 (Regu lar)	Algo level two (2): (A) moderate level of independence with frequent supports needed; (B) behavioral needs, if any, can be met with medication or light therapy, or both, every one (1) to two (2) weeks; (C) does not require twenty-four (24) hours a day supervision; and (D) generally able to sleep unsupervised, but needs structure and routine throughout the day.
3 (Mod erate)	Algo level three (3): (A) requires access to full-time supervision for medical or behavioral, or both, needs; (B) twenty-four (24) hours a day, seven (7) days a week staff availability; (C) behavioral and medical supports are not generally intense; and (D) behavioral and medical supports can be provided in a shared staff setting.
4 (High)	Algo level four (4): (A) requires access to full-time supervision for medical or behavioral, or both, needs: (i) twenty-four (24) hours a day, seven (7) days a week frequent staff interaction; and (ii) requires line of sight support; and (B) has moderately intense needs that can generally be provided in a shared staff setting.
5 (Inte nsive)	Algo level five (5): (A) requires access to full-time supervision with twenty-four (24) hours a day, seven (7) days a week absolute line of sight support; (B) needs are intense; (C) needs require the full attention of a caregiver with a one-to-one staff to individual ratio; and (D) typically only needed by those with intense behavioral needs, not medical needs alone.
6 (High	Algo level six (6): (A) requires access to full-time supervision: (i) twenty-four (24) hours a day, seven (7) days a week; and

Level	Descriptor
Intensive)	(ii) more than a one-to-one staff to individual ratio; (B) needs are exceptional; (C) needs require more than one (1) caregiver exclusively devoted to the individual for at least part of each day; and (D) imminent risk of individual harming self or others, or both, without vigilant supervision.

Section 6.4: Translating Algo Level into a Budget Allocation

Based on the Algo, age, and living arrangement, budget allocations have been established by taking a predetermined baseline from that Algo level group to calculate a dollar amount for each of the three potentially required buckets of budgeted funds (Other/RHS*, BMAN, and DAYS).

After the ICAP and ICAP addendum assessments (described in Section 6.2) are completed and the information is received by the State, participants in the Community Integration and Habilitation Waiver program and their support teams are required to review the information and ensure that it accurately reflects them. On completion of their review, participants and their support teams are notified of their OBA through their Case Managers.

Individual teams may request a formal review of their allocations through their Case Managers. Teams are asked to review the ICAP and ICAP addendum and provide supporting documentation to substantiate an individual's need for placement in a different Algorithm level. The supporting documentation is reviewed, as well as the person-centered planning document, individualized service plans, behavior-support plans, high-risk plans, and any other collateral documentation needed to analyze the individual's Algorithm level.

*NOTE: RHS funding comes from the budget bucket referred to as "Other," because that bucket must also cover all other (non-BMAN and non-DAYS) services, such as Environmental Modifications, Vehicle Modifications, Specialized Medical Equipment and Supplies, Personal Emergency Response Systems, Family & Caregiver Training, Electronic Monitoring, etc. when and if these other services are selected by the individual and his or her support team.

Table 6.2 shows an **example** of a budget allocation for an individual over the age of 25 using the service hours defined in *460 IAC 13-5-2* and the rates that were in effect as of December 1, 2014. The example below shows the allocation amounts for all 25-year-old individuals, but the combination of his or her living arrangement and Algo level determines which budget amount (Total Allocation) the individual may use when selecting the services that are required to meet his or her needs.

Table 6.2 – Algo to Budget - ***Example***

Annual OBA for Adults Ages 25 and Older (Using Rates Effective January 2014) and for Young Adults Ages 19-24 NOT Attending School

Living Arrangement	Overall Algo 0	Overall Algo 1	Overall Algo 2	Overall Algo 3	Overall Algo 4	Overall Algo 5	Overall Algo 6*
Living with Family Example							

BMAN Reserve	$0	$0	$2,620.80	$5,241.60	$7,862.40	$10,483.20	$10,483.20
DAYS Reserve	$10,500.00	$10,500.00	$10,500.00	$10,500.00	$10,500.00	$18,000.00	$18,000.00
Other/RHS Services	$1,730.10	$17,301.00	$25,951.50	$43,252.50	$50,870.05	$58,137.20	$58,137.20
Total Allocation	$12,230.10	$27,801.00	$39,072.30	$58,994.10	$69,232.45	$86,620.40	$86,620.40

Living Alone or Not Sharing RHS Staff with Others Example

BMAN Reserve	$0	$0	$2,620.80	$5,241.60	$7,862.40	$10,483.20	$10,483.20
DAYS Reserve	$10,500.00	$10,500.00	$10,500.00	$10,500.00	$10,500.00	$18,000.00	$18,000.00
Other/RHS Services	$1,730.10	$22,491.30	$39,792.30	$56,683.77	$73,398.22	$79,938.65	$79,938.65
Total Allocation	$12,230.10	$32,991.30	$52,913.10	$72,425.37	$91,760.62	$108,421.85	$108,421.85

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

BMAN Reserve	$0	$0	$2,620.80	$5,241.60	$7,862.40	$10,483.20	$10,483.20
DAYS Reserve	$10,500.00	$10,500.00	$10,500.00	$10,500.00	$10,500.00	$18,000.00	$18,000.00
Other/RHS Services	$1,730.10	$22,491.30	$38,515.90	$56,683.77	$79,938.65	$87,205.80	$87,205.80
Total Allocation	$12,230.10	$32,991.30	$51,636.70	$72,425.37	$98,301.05	$115,689.00	$115,689.00

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

BMAN Reserve	$0	$0	$2,620.80	$5,241.60	$7,862.40	$10,483.20	$10,483.20
DAYS Reserve	$10,500.00	$10,500.00	$10,500.00	$10,500.00	$10,500.00	$18,000.00	$18,000.00
Other/RHS Services	$1,730.10	$22,491.30	$39,792.30	$56,683.77	$73,398.22	$79,938.65	$79,938.65
Total Allocation	$12,230.10	$32,991.30	$52,913.10	$72,425.37	$91,760.62	$108,421.85	$108,421.85

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

BMAN Reserve	$0	$0	$2,620.80	$5,241.60	$7,862.40	$ 10,483.20	$10,483.20
DAYS Reserve	$10,500.00	$10,500.00	$10,500.00	$10,500.00	$10,500.00	$18,000.00	$18,000.00
Other/RHS Services	$1,730.10	$20,761.20	$37,197.15	$53,050.20	$68,311.21	$72,671.50	$72,671.50
Total Allocation	$12,230.10	$31,261.20	$50,317.95	$68,791.80	$86,673.61	$101,154.70	$101,154.70

Structured Family Caregiving Example

BMAN Reserve	$0	$0	$2,620.80	$5,241.60	$7,862.40	$ 10,483.20	$10,483.20
DAYS Reserve	$10,500.00	$10,500.00	$10,500.00	$10,500.00	$10,500.00	$10,500.00	$10,500.00
Other/SFC Services	$18,932.55	$18,932.55	$27,619.55	$37,547.55	$37,547.55	$37,547.55	$37,547.55
Total Allocation	$29,432.55	$29,432.55	$40,740.35	$53,289.15	$55,909.95	$58,530.75	$58,530.75

Note: The Behavior Management (BMAN) Reserve is reduced to $0.00 and the Total Allocation is reduced by the corresponding BMAN Reserve amount when the ICAP Addendum indicates there are NO Behavioral Challenges.

*Algo 6 Designations

Individuals who receive an Algo 6 designation are calculated at an Algo 5 base allocation. Algo 6 indicates a significant behavior, high-risk event, or health need that requires additional support in the form of additional funds for service needs and frequent interaction by agents of the State. Algo 6 individuals will receive monthly face-to-face interaction with their Case Managers. Their complete case files and budgets are reviewed annually through the high cost BRQ process.

Section 6.5: Budget Review Questionnaire (BRQ) and Budget Modification Review (BMR)

The BRQ

Applicable only to the Community Integration and Habilitation Waiver (CIH Waiver) program, a Budget Review Questionnaire (BRQ) is a set of qualifying questions, responses and supporting documentation used to determine why a budget review is necessary. The Budget Review Questionnaire and responses are submitted by the individual's Case Manager based on information provided by the Individual Support Team (IST).

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

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

(a) The IST identified that the individual's needs are not being met through shared staffing.
(b) The individual has completed his or her education.
(c) The IST believes the Algo level is incorrect.
(d) Health or medical condition prevents the individual from attending Day Programs.
(e) The IST believes that the Wellness Coordination Health score is inaccurate and needs reviewed.
(f) An individual's behavior conditions have changed.
(g) The IST believes the ICAP assessment has significant errors.
(h) The IST believes the ICAP addenda (behavioral and health factors) are incorrect.
(i) The individual has a High Cost Allocation.

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

The waiver Case Manager must submit the BRQ to the Bureau of Developmental Disabilities Services (BDDS) with the following documentation based on the specific qualifying event.

a. <u>The IST identified that the individual's needs are not being met through shared staffing:</u>
   i. An explanation of why it is not feasible for the individual to share staffing or live with housemates.
b. <u>The individual completes his or her education:</u>
   i. A copy of certificate of completion or other documentation from school noting the final date for attendance.
c. <u>The IST believes the ALGO level is incorrect:</u>
   i. The IST's review of the ICAP assessment with detailed notes on areas needing reviewed; and ii. The medical and behavioral documentation needed to update the addendum.
d. <u>Health or medical condition prevents the individual from attending day programs:</u>
   i. Documentation from a medical professional outlining why the condition negates a day program, the duration of the condition, and risk factors to consider.
e. <u>The IST believes that the Wellness Coordination Health score is inaccurate and needs to be reviewed:</u>
   i. Documentation from a medical professional outlining the change in condition or diagnosis, with an anticipated duration of the condition, risk factors to consider and any other special considerations. f.

An individual's behavioral conditions change: i. A copy of the behavioral support plan;
ii. Monthly documentation supporting the change in condition(s); and
iii. Incident reports.

g. The IST believes the ICAP assessment has significant errors:
i. The IST's review of the ICAP assessment with detailed notes on areas needing reviewed; and ii. The medical and behavior documentation needed to update the addendum

h. The IST believes the ICAP addenda (behavioral and health factors) are incorrect:
i. Documentation from a medical professional outlining the change in condition or diagnosis, with an anticipated duration of the condition, risk factors to consider and any other special considerations
ii. A copy of the behavioral support plan;
iii. Monthly documentation supporting the change in condition(s); and
iv. Incident reports.

i. The individual has a High Cost Allocation:
i. A completed high budget/needs assessment;
ii. Behavior Support Plan with data from the last 90 calendar days;
iii. Any medical documentation that supports the extraordinary health needs; and
iv. Documentation and information to substantiate that the standard OBA determination cannot meet the individual's health and safety needs.

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

For High Cost Allocations, the PAR unit will automatically notify the waiver Case Manager of the budget allocations of individuals who have High Cost Allocations annually.

BDDS sends the waiver Case Manager a notification to submit a High Cost BRQ and supporting documentation 90 calendar days before the start of an individual's new budget year if the Individual Support Team (IST) determines the individual requires a budget above the standard OBA.

If the waiver Case Manager fails to provide BDDS the High Cost BRQ and supporting documentation before the new budget year:

- The individual shall receive the budget allocation based upon the standard OBA
- BDDS shall send a *Notice of Action (NOA)* based upon the standard OBA with appeal rights

The BMR

The Budget Modification Review (BMR) allows participants on the Community Integration and Habilitation (CIH) Waiver to obtain additional funds for a short-term when the individual experiences an unanticipated event that

requires a higher budget to meet his or her needs.

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

Unanticipated events are defined as:

a. Loss of a housemate due to:
    i. death;
    ii. extended hospitalization of fourteen (14) or more calendar days;
    iii. nursing facility respite stay of fourteen (14) or more calendar days;
    iv. incarceration of fourteen (14) or more calendar days;
    v. substantiated abuse, neglect, or exploitation;
    vi. needed intervention for behavioral needs;
    vii. needed intervention for health or medical needs; or
    viii. inability to share staffing
b. Loss of employment.
c. State substantiated abuse, neglect, or exploitation.
d. Behavioral needs requiring intervention.
e. Extraordinary Health or medical needs requiring intervention.

Documentation requirements for Budget Modification Requests include, but are not limited to, the following:

- For BMRs resulting from needed intervention for behavior needs, documentation shall include:
    - Documentation of behavior data for past 30 to 90 calendar days;
    - Documentation regarding changes to the individual's behavior plan that have already occurred prior to the submission of the BMR; and
    - If the IST anticipates that the behaviors will last longer than 90 calendar days, the waiver Case Manager should complete a Budget Review Questionnaire (BRQ) instead of the BMR.
- For BMRs resulting from a loss of a housemate, the IST shall provide documentation that includes:
    - A schedule identifying when each service is being used, including non-Residential Habilitation and Support (RHS) services activities; and
    - A plan with strategies that IST will use to find a new housemate.
- The documentation must demonstrate the alternative support options the IST considered before making the submission. The following is a non-exhaustive list of potential alternative support options:
    - Shared staffing with housemates;
    - Electronic monitoring services;
    - Medicaid prior authorization services; and
    - Family and community supports

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

The DDRS/Bureau of Developmental Disabilities Services (BDDS) responds to new BMRs within seven business days of submission. Final decisions on BMRs are not made until Case Managers respond to all inquiries from the DDRS/BDDS.

An individual or the individual's legal representative may appeal the Algo if he or she feels the Algo is inaccurate. The consumer or legal guardian has the right to appeal any waiver-related decision of the State within 33 calendar days of *Notice of Action (NOA)*. A *NOA* is issued with the release of each State decision pertaining to a Plan of Care/Cost Comparison Budget (POC/CCB). Each *NOA* contains the consumer's appeal rights, as well as instructions for filing an appeal.

Note: The BRQ and BMR processes are not used with the already capped Family Supports Waiver

Section 6.6: Implementation of Objective Based Allocations

The Case Manager for each individual participating in the Community Integration and Habilitation (CIH) Waiver program receives the new OBA three months before the participant's annual renewal date. The Case Manager must review the OBA with the participant and his or her Individual Support Team (IST) prior to the development of a new annual service plan. If there has been a significant change in the life of the participant, with agreement of the IST, the Case Manager is responsible for requesting a Budget Review Questionnaire (BRQ) (see Section 6.5).

Note that the OBA is not used with the Family Supports Waiver.

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

Applicable only to participants in the Community Integration and Habilitation Waiver program, an IST may request a PAR (personal allocation review) through the Case Manager via a BRQ. The BRQ states the reason for allocation review. The full list of acceptable reasons for allocation review is found in Section 6.5, but examples include:

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

The BRQ is submitted by the Case Manager to the Bureau of Developmental Disabilities Services (BDDS). The BRQ and supporting documentation and information are reviewed by the Personal Allocation Review (PAR) unit within the DDRS. The PAR unit determines whether an individual's Algo score is supported based on the provided information. BDDS reviews the BRQ within seven business days of submission.

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

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

The PAR unit will notify the waiver Case Manager of any changes in the Algo or allocation. If a change in the Algo

score is appropriate, an Update POC/CCB must be submitted at the correct allocation level so that a *Notice of Action (NOA)* with appeal rights may be generated by BDDS and distributed to the participant through the waiver Case Manager.

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

Note: PAR reviews are not available under the Family Supports Waiver.

The appeal process is explained on the back pages of the *NOA* as is seen on the following page, **Your Appeal Right as an Applicant for HCBS Benefits.**

Note: On receiving an official notice of appeal, the budget is locked by the PAR unit. Please carefully read "The Right to Appeal and Have a Fair Hearing." If your benefits are continued during the appeal process and you lose the appeal, you may be at risk of being required to repay assistance paid in your behalf during the appeal process.

Your Appeal Right as an Applicant for HCBS Benefits

If you question the indicated decision, you should discuss this matter with your Case Manager.

Your Right to Appeal and Have a Fair Hearing:

The *Notice of Action* provides an explanation of the decision made on your application for services or changes in your services. If you disagree with the decision, you have the right to appeal by submitting a request for a Fair Hearing. Your Home and Community-Based Services (HCBS) benefits will continue if your appeal is received within the required time frame described below under "How to Request an Appeal". If you appeal and your benefits are continued and you lose the appeal, you may be required to repay assistance paid on your behalf pending the release of the appeal hearing decision.

How to Request an Appeal:

1) If you wish to appeal this decision, the appeal request must be received by close of business not later than:

(1) 33 calendar days following the effective date of the action being appealed; or
(2) 33 calendar days from the date of the notice of agency action, whichever is later.

To file an appeal, please sign, date and return the Hearings & Appeals copy of this form to:

Indiana Family and Social Services Administration
Office of Hearings and Appeals
MS 04
402 W. Washington St., Room W392
Indianapolis, IN 46204

or via facsimile to 317-232-4412

If you are unable to sign, date, and return this form to the above mentioned address, you may have someone assist you in requesting the appeal.

2) You will be notified in writing by the Indiana Family and Social Services Administration, Hearings and Appeals office of the date, time, and location for the hearing. Prior to, or at the hearing, you have the right to examine the entire contents of your case record maintained by the Case Manager.

3) You may represent yourself at the hearing or you may authorize a person to represent you, such as an attorney, relative, or other spokesperson. At the hearing you will have full opportunity to bring witnesses, establish all pertinent facts and circumstances, advance any arguments without interference and question, or refute any testimony or evidence presented.

Section 7: Monitoring and Continuation of Waiver Services

Sections 7.1 – 7.9

Section 7.1: Level of Care Re-Evaluation

Section 7.2: Medicaid Eligibility Re-Determination

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

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

Section 7.5: State Authorization of the Annual/Update Cost Comparison Budget

Section 7.6: Service Plan implementation and Monitoring

Section 7.7: Interruption/Termination of Waiver Services

Section 7.8: Waiver Slot Retention after Termination and Re-Entry

Section 7.9: Parents, Guardians & Relatives Providing Waiver Services

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Section 7.1: Level of Care Re-Evaluation

The process for re-evaluation of level of care is the same as the initial evaluation process, except that a new confirmation of diagnosis form is no longer required for each re-evaluation. The re-evaluation is typically performed by the waiver Case Management agency as opposed to being performed by the Division of Disability and Rehabilitative Services (DDRS)/Bureau of Developmental Disabilities Services (BDDS) staff. However, under specific circumstances, such as with potential denials of level of care, re-evaluations may be completed either by DDRS/BDDS Staff or by the DDRS Central Office. Re-evaluation is required at least annually, or as needed.

Per federal guidelines, Family Supports Waiver (FSW) and Community Integration and Habilitation (CIH) Waiver program participants must be re-evaluated each year to meet intermediate care facility for individuals with intellectual disabilities (ICF/IID) level of care.

Only individuals who are Qualified Intellectual Disability Professionals (QIDP) as specified by the federal standard within 42 CFR §483.430(a), may perform initial Level of Care (LOC) determinations.

The local DDRS/BDDS office completes the initial level of care evaluation for these waivers. Annual level of care re-evaluations are completed by the Case Manager, who must be a QIDP.

Section 7.2: Medicaid Eligibility Re-Determination

The Family and Social Services Administration's (FSSA) Division of Family Resources (DFR) is the group that determines eligibility for all Indiana social services programs. The FSSA/DFR will assist you in determining which programs are right for you and your family. You can learn more about the application process by going to Apply for Medicaid at http://member.indianamedicaid.com/apply-for-medicaid.aspx .

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

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

All individuals/participants (also known as consumers, or members for Medicaid purposes) receiving waiver services must have a new Plan of Care/Cost Comparison Budget (POC/CCB) approved at least annually. The Person-Centered Plan (PCP) must also be updated at least annually. The Annual POC/CCB represents the service plan identified for the individual during the required review/update of the Individualized Support Plan (ISP). **Annual POC/CCBs are to start the date following the expiration of the previous POC/CCB and cover a 12 month period.**

If an Annual POC/CCB is not submitted or cannot be approved in a timely manner, the most recently

approved POC/CCB is automatically converted to a new annual POC/CCB. The total cost/amount of services on the "auto-converted", or "default", POC/CCB is determined by the cost of services and supports appearing on the most recently approved but expiring POC/CCB. The auto-converted, or default POC/CCB ensures that there is no loss of services for the participant. The Case Manager is subsequently contacted and required to complete the annual planning process, ISP, and POC/CCB revision.

The plan is developed by the Individual Support Team (IST) identified by the participant. The participant has the right and power to command the entire process. The Case Manager, participant and others of the participant's choosing form the IST. The POC/CCB is developed a minimum of six weeks prior to the initial start date of services or six weeks prior to the end date of the current annual service plan. The POC/CCB is routinely developed to cover a timeframe of 12 consecutive months.

The POC/CCB is driven by a person-centered planning process, coordinated in conjunction with the participant, his or her guardian or legal representative, and members of the individual's support team. Case Managers are responsible for the facilitation and development of the participant's Person-Centered Plan (PCP), which must include the following five key components:

1. Personal priorities, which includes the personal priority statements and personal priority narratives;
2. Relationships;
3. Communication;
4. Outcomes; and
5. Historical narrative.

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

A state-approved risk assessment tool is completed by the case manager to help identify risks related to health**, behavior, safety and support needs for waiver participants.

** For the CIH Waiver, note that, when participants have State-assessed health scores of 5 or higher and opt to utilize the waiver's Wellness Coordination services, healthcare needs and associated risks are separately assessed and monitored by a registered nurse (RN) or licensed practical nurse (LPN) employed by their chosen Wellness Coordination provider agency. The

RN/LPN, who must be actively involved in all IST meetings, develops a Wellness Coordination Plan specific to the assessed healthcare needs and risks, sharing the plan with the IST. As described in the service definition for Wellness Coordination services in Appendix C-1/C-3 of the CIH Waiver, the Wellness Coordinator's healthcare related coordination and monitoring responsibilities vary according to the specified tier of Wellness Coordination services. However, as is true of all other waiver-funded services, it is ultimately the responsibility of the waiver Case Manager to monitor and ensure that the Wellness Coordination activities occur as specified within the ISP and POC/CCB.

The participant is informed of available waiver services at the time of application, during enrollment and development of the PCP, ISP and POC/CCB and on an ongoing basis throughout the year as needed. The participant's Case Manager is knowledgeable in all services available on the waiver and is responsible for providing the participant with information about each covered service, its definition, scope and limitations.

The POC/CCB is developed based upon the outcomes of the initial, annual, or subsequent meeting of the Individual Support Team during which the Person-Centered Plan and the Individualized Support Plan are developed, reviewed, and/or updated.

This entire process is driven by the participant and is designed to recognize the participant's needs and desires. The Case Manager holds a series of structured conversations, beginning with the participant/ guardian, and with other individuals identified by the participant, that know them well and can provide pertinent information about them, to gather initial information to support the person-centered planning process. The overall emphasis of the conversations will be to derive what is important to and what is important for the participant, with a goal of presenting a good balance of the two. The participant-chosen facilitator, typically the case manager, facilitates the IST meeting, reviews the participant's desired outcomes, health and safety needs (including any risk plans), 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 ISP and completes the POC/CCB. (See *Helpful Hints for Participants and Guardians on How to Select Waiver Providers* in **Section 1.11**)

Although the Family Supports Waiver is already capped at $16,545 annually, budgeted amounts for POC/CCBs developed under the Community Integration and Habilitation Waiver use the objective based allocation process described under **Section 6: Objective Based Allocation (OBA).**

The Case Manager coordinates waiver services and other services. Within 30 calendar days of implementation of the plan, the Case Manager is responsible for ensuring that all identified services and supports have been implemented as identified in the Individualized Support Plan and the POC/CCB. The Case Manager is responsible for monitoring and coordinating services on an ongoing basis and is required to record at least one monthly case note for each participant. At least once every 90 calendar days, the Case Manager also completes a formal 90-day review with the participant and includes the IST. Most waiver service providers are required to submit a monthly or quarterly report summarizing the level of support provided to the participant based on the identified supports and services in the ISP and

the POC/CCB. The Case Manager reviews these reports for consistency with the ISP and POC/CCB and works with providers as needed to address findings from this review.

The ISP identifies the services needed by the participant to pursue their desired outcomes and to address their health and safety needs. Each outcome in the ISP has an associated proposed strategy/activity designed to address potential barriers or maintenance needs in relation to the desired outcomes and the support and services needed to facilitate the outcomes. The proposed strategy/activity also identifies all paid and unpaid responsible parties and, includes the name of the provider agency, the service, and the staffing position(s) within the agency that are responsible for the strategy/activity. The participant may be the responsible party for a strategy/activity if he or she so determines. In addition, each strategy/activity has a specific timeframe identified, including a minimum timeframe for review.

The Plan of Care/Cost Comparison Budget (POC/CCB) identifies the name of the waiver service, the name of the participant-chosen provider of that service, the cost of the service per unit, the number of units of service and the start and end dates for each waiver service identified on the POC/CCB.

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

The ISP and POC/CCB are reviewed a minimum of every 90 calendar days and updated a minimum of every 365 calendar days. The participant can request a change to the POC/CCB at any point, be it a new service provider, or a change in the type or amount of service. If a change to the ISP and/or the POC/CCB is determined necessary during that time, the participant and/or family or legal representative and IST will meet to discuss the change. The actual updating of the POC/CCB is completed by the Case Manager based on the participant and the IST discussion and determination.

Section 7.5: State Authorization of the Annual/Update Cost Comparison Budget

The Case Manager will transmit the Plan of Care/Cost Comparison Budget (POC/CCB) electronically to the State's waiver specialist who will review the POC/CCB and confirm the following:

- The individual is a current Medicaid recipient within one of the following categories:
    - Aged **(MA A)**
    - Blind (MA B)
    - Low-income families (MA GF)
    - Disabled (MA D)
    - Disabled worker (MA DW, MA DI)

- Children receiving adoption assistance or children receiving federal foster care payments under Title IV E - Sec 1902(a)(10)(A)(i)(I) of the Act (MA 4 & MA 8)
- Children receiving adoption assistance under a state adoption agreement – Sec 1902(a)(10)(A)(ii)(VIII) (MA 8)
- Independent foster care adolescents – Sec 1902(a)(10)(A)(ii)(XVII) (MA 14)
- Children under age one – Sec 1902(a)(10)(A)(i)(IV) (MA Y)
- Children age one to five – Sec 1902(a)(10)(A)(i)(VI) (MA Z)
- Children age 1 through 18 – Sec 1902(a)(10)(A)(i)(VII) (MA 9 & MA 2)
- Transitional medical assistance – Sec 1925 of the Act (MA F)
- Aged, blind or disabled in 1634 states:
  - Supplemental Security Income (SSI)-eligible individuals will be automatically enrolled in the Indiana Health Coverage Programs (IHCP) and will not need to file a separate Indiana Application for Health Coverage. Members with SSI will be assigned to the new Modified Adjusted Gross Income (MAGI) eligibility aid category. Individuals deemed disabled by the Social Security Administration and who are receiving SSI based on that determination, will not be required to undergo a separate determination of disability from Indiana's Medical Review Team (MRT).
  - Individuals who receive Social Security Disability Income (SSDI) will not be required to undergo a separate determination of disability from Indiana's Medical Review Team (MRT). A financial eligibility review will still be required, so these individuals will need to complete the Indiana Application for Health Coverage.

- The individual has a current ICF/IID level of care approval
- The individual's identified needs are addressed with a plan to assure his or her health, safety and welfare;
- The individual or guardian has signed, indicating acceptance of, the POC/CCB; signed that he or she has been offered choice of certified waiver service providers; and signed that he or she has chosen waiver services over services in an institution.

The Waiver Specialist may request additional information from the Case Manager to assist in reviewing the packet.

If the Waiver Specialist approves the POC/CCB, the approval letter and *NOA* are transmitted to the Case Manager and Service Providers. The Case Manager notifies the individual or guardian within three calendar days of receipt of the approval and provides a copy of the approval letter.

If the Waiver Specialist denies the POC/CCB, a denial letter must be transmitted to the Case Manager and Service Providers. Within three calendar days of receipt of the denial the Case Manager must complete and provide a copy of a *Notice of Action (NOA) (HCBS Form 5),* the Appeal Rights as an HCBS Waiver Services Recipient, and an explanation of the decision to deny to the individual/guardian.

Section 7.6: Service Plan implementation and Monitoring

Case Managers are responsible for the implementation and monitoring of the service plan (inclusive of the Individualized Support Plan (ISP), Cost Comparison Budget POC/CCB) and, often, other non-funded services) and participant health and welfare.

A minimum of one face-to-face contact between the case manager and the participant is required at least every 90 calendar days in the home of the participant, and as frequently as needed to support the participant. In each meeting, the participant's Individual Support Team (IST) will review current concerns, progress and implementation of the service plan (plan of care).

A 90-Day Checklist is utilized by the Case Manager and IST in order to systematically review the status of the POC/CCB, the ISP, any behavioral support program, choice and rights, medical needs, medications, including psychotropic medications (if applicable), seizure management (if applicable), nutritional/dining needs, incident review, staffing issues, fiscal issues, risk plans and any other issues which may be identified in regard to the satisfaction and health and welfare of the participant. The checklist is also used to verify that emergency contact information is in place in the home, including the telephone numbers for Adult Protective Services or Child Protective Services and the Bureau of Quality Improvement Services. Case Managers educate the participant by offering examples of when the emergency contact numbers should be called.

The case manager is required to enter a case note for each encounter (at least one per month) with the participant indicating the progress and implementation of the service plan. The Case Manager also maintains regular contact with the participant, family/guardian and the provider(s) of services through home and community visits or by phone to coordinate care, monitor progress and address any immediate needs. During each of these contacts the Case Manager assesses the service plan implementation as well as monitors the participant's needs.

The monitoring and follow up method used by the Case Manager include conversations with the participant, the parent/guardian, and providers to monitor the frequency and effectiveness of the services through team meetings and regular face-to-face and phone contacts. The case manager asks:

- Are the services being rendered in accordance with the plan of care?
- Are the service needs of the participant being met?
- Do participants exercise freedom of choice of providers?
- What is the effectiveness of the crisis and back up plans?
- Is the participant's health and welfare being ensured?
- Do participants have access to non-waiver services identified in the plan of care including access to health services?

The implementation and effectiveness of the plan of care is reviewed at least once every 90 calendar days in the 90-Day meetings of the IST meetings.

At all times, full, immediate and unrestricted access to the individual data is available to the State,

including the DDRS Case Management Liaison position as well as other members of the DDRS Executive Management Team and FSSA's Office of Medicaid Policy and Planning (OMPP).

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

- Case Managers conduct a face-to-face visit with each participant at least every 90 calendar days to review and update the 90 Day Checklist with the IST.
- Case Managers investigate the quality of participant services and indicate whether there are any problems related to participant services not being in place. This is recorded on the 90-Day Checklist. For each identified problem, they 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 Manager supervisors, directors, or other identified executive management staff within each case management provider organization monitor each problem quarterly via a report from the State's case management system to ensure that Case Managers are following up on, and closing out, any pending corrective actions for identified problems.

At least every 90 calendar days, in conjunction with the 90 Day Checklist, Case Managers update the participant's Individualized Support Plan (ISP) progress notes, to indicate if all providers and other team members are current and accurate in their implementation of plan activities on behalf of the participant. Any lack of compliance on the part of provider entities or other team members is noted within participant-specific case notes, flagged for follow-up and communicated to the noncompliant entity for resolution.

Section 7.7: Interruption/Termination of Waiver Services

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

- Voluntarily withdrawals
- Chooses institutional placement/entering Medicaid-funded long-term care facility
- Dies
- Needs services so substantial that the total cost of Medicaid services for the individual would jeopardize the waiver program's cost-effectiveness
- No longer meets ICF/IID level of care criteria
- Is no longer eligible for Medicaid services
- No longer requires Home and Community-Based Services, or
- Is no longer intellectually or developmentally disabled

Other examples of circumstances appropriate for interruption/termination may include a participant being arrested, in jail, awaiting trial, convicted/sentenced.

For waiver terminations due to institutionalization or death, the termination Data Entry Worksheet (DEW) entered by the Case Manager and accepted by the State auto-generates the Notice of Action (NOA). For all other reasons, the termination DEW is reviewed by a Waiver Specialist who determines the appropriate next action.

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

Section 7.8: Waiver Slot Retention after Termination and Re-Entry

The following situations related to waiver slot retention after Termination are contingent upon review and approval by the State.

Upon review and approval of the State, if an individual who has been terminated from waiver services wishes to return to the program, he or she may do so within the same waiver year of his or her termination, if otherwise eligible. The individual shall return to the waiver without going on a waiting list. "Within the same waiver year" is considered as follows:

- Community Integration and Habilitation Waiver (CIH): October 1 through September 30
- Family Supports Waiver (FSW): April 1 through March 31

An individual who has been interrupted from the waiver program within the past 30 calendar days may resume the waiver with the same level of care approval date and Cost Comparison Budget (POC/CCB) if the individual's condition has not significantly changed and the POC/CCB continues to meet his or her needs.

- The Case Manager must certify that the individual continues to meet level of care criteria
- The Case Manager must complete a "Re-Start" Data Entry Worksheet (DEW), enter it in the INsite database, and submit it electronically to the FSSA/DDRS case management database. The information will be reviewed by a Waiver Specialist and automatically transmitted to the FSSA/Office of Medicaid Policy and Planning (OMPP) to enter into the Indiana*AIM* database.

If an individual who has been terminated from the waiver program longer than 30 calendar days wishes to return to the program and is otherwise eligible,

- The Case Manager is responsible for developing the level of care packet and POC/CCB following the same processes described in **Section 7.1: Level of Care Re-Evaluation** and **Section 5.7: Initial Plan of Care/Cost Comparison Budget (POC/CCB) Development**, minus the need for a new *Confirmation of Waiver Start* form.
- The Case Manager is to indicate a "Re-Entry" POC/CCB when electronically transmitting them to the State waiver specialist via the FSSA/DDRS case management database (INsite).

- When the individual "Re-Enters" waiver services, the Case Manager must enter a *Confirmation of Waiver Start* form in the INsite database and electronically transmits it to the FSSA/DDRS case management database. The information will be automatically transmitted to the FSSA/Office of Medicaid Policy and Planning (OMPP) to enter in the Indiana*AIM* database.

- When the *Confirmation of Waiver Start* form is received electronically by the DDRS, it is reviewed. When it's accepted, a *Notice of Action (NOA)* form will be automatically transmitted to the Case Manager and to all of the individual's waiver service providers.

- Within three calendar days of receiving the Re-Entry POC/CCB approval letter, the Case Manager must print a *Notice of Action (HCBS Form 5)*. The Case Manager must provide copies of the *NOA* form and Addendum (containing information from the POC/CCB) to the individual/guardian.

When an individual "re-enters" waiver services:

- If within 30 calendar days of terminating waiver services, the annual level of care and POC/CCB dates remain the same dates as they were prior to the termination of waiver services,

- If more than 30 calendar days since terminating waiver services, the new level of care and POC/CCB dates are used for determining when future annual level of care determinations and POC/CCBs are due.

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

Section 7.9: Parents, Guardians & Relatives Providing Waiver Services

Parents, step-parents and legal guardians of waiver participants who are minors (under the age of 18) may not receive payment for the delivery of any waiver-funded service to the minor waiver participant(s). Per Section 4442.3.B.1 of the *State Medicaid Manual,* the *Version 3.5 Instructions, Technical Guide and Review Criteria* and the *Code of Federal Regulations [42 CFR §440.167]*, all of which are published by the Center for Medicare and Medicaid (CMS), this prohibition is based on the presumption that legally responsible individuals may not be paid for supports that they are ordinarily obligated to provide.

Other relatives* (excluding spouses) may provide waiver service(s) to waiver participants when that relative is employed by or a contractor of a Division of Disability and Rehabilitative Services (DDRS)-approved provider.

*** For all purposes pertaining to waiver-funded programs administered by FSSA's DDRS,**

"related/relative" implies any of the following natural, adoptive and/or step relationships, whether by blood or by marriage, inclusive of half and/or in-law status:

1) Aunt (natural, step, adopted)
2) Brother (natural, step, half, adopted, in-law)
3) Child (natural, step, adopted)
4) First cousin (natural, step, adopted)
5) Grandchild (natural, step, adopted)
6) Grandparent (natural, step, adopted)
7) Nephew (natural, step, adopted)
8) Niece (natural, step, adopted)
9) Parent (natural, step, adopted, in-law)
10) Sister (natural, step, half, adopted, in-law)
11) Spouse (husband or wife)
12) Uncle (natural, step, adopted)

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

- The relative must be at least 18 years of age;
- The relative is employed by or a contractor of an agency that is approved by FSSA/DDRS to provide care under the waiver;
- The relative meets the appropriate provider standards (per 460 IAC 6) for the service(s) being provided;
- The decision for the relative to provide services to a waiver participant is part of the person-centered planning process, which indicates that the relative is the best choice of persons to provide services from the DDRS-approved provider agency, and this decision is recorded and explained in the Individualized Support Plan (ISP);
- There is detailed justification as to why the relative is providing service;
- The decision for a relative to provide service(s) is evaluated periodically (for example, at least annually) to determine if it continues to be in the best interest of the waiver participant;
- Payment is made only to the DDRS-approved Medicaid enrolled waiver provider agency in return for specific services rendered; and
- The services must be rendered one-on-one with the participant or in shared settings with group sizes allowable per specified waiver service definitions and documented as acceptable by all relevant Individual Support Teams. Authorization for shared or group services must be reflected on and documented via the approved *NOA* for each group participant. With the exception of groups of waiver participants as noted above, the relative may not be responsible for others (including their other children or family members) nor engaged in other activities while providing services.

NOTES: Regarding Participant Assistance and Care (PAC) and to Residential Habilitation and Supports

(RHS) under the Community Integration & Habilitation Waiver, the weekly total of reimbursable waiver-funded services furnished to a waiver participant by any combination of relative(s) and/or legal guardian(s) may not exceed 40 hours per week.

Section 8: Appeal Process

Sections 8.1 – 8.18

Section 8.1: Appeal Request

Section 8.2: Group Appeals

Section 8.3: Time Limits for Requesting Appeals

Section 8.4: The Hearing Notice

Section 8.5: Request for Continuance from the Appellant

Section 8.6: Review of Action

Section 8.7: Disposal of Appeal without a Fair Hearing

Section 8.8: The Fair Hearing

Section 8.9: Preparation for Hearing by Appellant

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

Section 8.11: Conduct of the Hearing

Section 8.12: Continuance of Hearing

Section 8.13: The Hearing Record

Section 8.14: The Fair Hearing Decision

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

Section 8.16: Agency Review

Section 8.17: Judicial Review

Section 8.18: Lawsuit

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Section 8.1: Appeal Request

The following pertain to requests for appeal:

- An appeal is a request for a hearing before an administrative law judge with the Family and Social Services Administration (FSSA)/Office of General Counsel or Office of Hearings and Appeals. The purpose of an appeal is to determine whether a decision made by a service coordinator, Case Manager, waiver specialist, or the Division of Disability and Rehabilitative Services (DDRS) Central Office affecting the waiver applicant or waiver participant, was correct. An appeal request must be in writing and forwarded to the hearing authority.
- *State Form 46015 Form HCBS 5* is used to notify each Medicaid Home and Community-Based Services (HCBS) waiver applicant or participant of any action that affects the applicant's, participant's, or prospective participant's:
  - Choice of home and community-based services as an alternative to institutional care
  - Medicaid benefits related to HCBS waivers, including determinations regarding level of care
  - HCBS waiver service actions, including reduction, termination, or denial of a service
  - Authorized services and service providers
- Providers can find an explanation regarding a waiver service applicant/participant or prospective participant's appeal rights and the opportunity for a fair hearing on the back of the Notice of Action (NOA). *Part 2 – "Your Right to Appeal and Have a Fair Hearing"* advises the applicant/participant or prospective participant of his/her right to appeal and the timeliness requirements association with the right to appeal. *Part 3 – "How to Request an Appeal"* provides instructions regarding the procedures that are necessary in the appeal process, including the right of the appellant to authorize representation by an attorney, relative, or other spokesperson on behalf of the appellant.
- HCBS waiver participants are advised of the right to appeal and request a fair hearing by the Case Manager. The Case Manager provides each participant and eligible prospective participant (as well as his or her guardian or advocate, as appropriate) with a copy of the NOA.
- For HCBS waiver participants, an NOA is generated and sent to a participant when the Case Manager generates the Plan of Care/Cost Comparison Budget (POC/CCB) and the POC/CCB is authorized by the Division of Disability and Rehabilitative Services (DDRS)/Bureau of Developmental Disabilities Services (BDDS). The NOA specifies any adverse determination (when he or she is denied the services or the providers of his or her choice, or when actions are taken to deny, suspend, reduce, or terminate services). The NOA informs the participant (and the participant's guardian or advocate, as appropriate) of his or her right to appeal the determination and also advises the participant that services will be continued if he or she files the appeal in a timely manner. Appeals must be received by the FSSA within 33 calendar days of the decision date noted on the NOA.
- When a request for entrance to the Community Integration and Habilitation (CIH) waiver program is denied, the denial letter advises the applicant of his or her right to file an appeal with the Office of General Counsel.

- Additionally, participants of the CIH waiver have the right to appeal the assessment used to determine the objective-based allocation amount.
- On request, the Case Manager may advise the participant on how to prepare the written request for appeal and fair hearing. The Case Manager may advise the participant of the required time frames, the address for submission of the appeal, and provide an opportunity to discuss the issue being appealed, but due to conflict free Case Management requirements, the Case Manager may not file an appeal or appear on behalf of a participant at an appeal hearing unless they are the Medicaid Authorized representative noted on the participant's record with the Division of Family Resources (DFR), as doing so could result in a conflict of interest. The request for an appeal and a fair hearing is recorded in a case note by the Case Manager as well as recorded at the FSSA's Hearing and Appeals office.

Section 8.2: Group Appeals

The following pertain to group appeals:

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

Section 8.3: Time Limits for Requesting Appeals

The following are time limits for requesting appeals:

- Plan of Care/Cost Comparison Budget (POC/CCB): The applicant, participant, or his or her legal guardian/authorized representative has the right to appeal any waiver-related decision of the State. An NOA is issued with the release of each State decision pertaining to a POC/CCB. Each NOA contains the appeal rights of the applicant/participant, as well as instructions for filing an appeal. The appeal must be received by FSSA within 33 calendar days of NOA.

- Objective-based allocation (OBA): The participant, or his or her legal guardian/authorized representative, has the right to appeal the OBA within 30 calendar days of the NOA. Each NOA contains the appeal rights of the participant, as well as instructions for filing an appeal.
- Developmentally Disabled (DD) eligibility: The applicant, participant, or his or her legal guardian/authorized representative has the right to appeal DD eligibility within 15 calendar days of the decision. The decision letter will contain the appeal rights of the applicant/participant, as well as instructions for filing an appeal.
- Individuals with Intellectual Disabilities (IID) level of care (LOC): The applicant, participant, or his or her legal guardian/authorized representative has the right to appeal level of care within 15 calendar days of the decision. The decision letter contains the appeal rights of the applicant/participant, as well as instructions for filing an appeal.
- Reserved Waiver Capacity (priority criteria): The applicant, participant, or his or her legal guardian/authorized representative has the right to appeal a denial for entrance to the waiver via priority criteria within 18 calendar days of the decision. The decision letter will contain the appeal rights of the applicant/participant, as well as instructions for filing an appeal.

Section 8.4: The Hearing Notice

The FSSA's Office of General Counsel or Office of Hearings and Appeals sends a notice acknowledging the appeal to the individual filing the appeal.

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

The Notice of Scheduled Hearing

The Notice of Scheduled Hearing contains the following:

- Includes a statement of the date, time, place, and nature of the hearing, which,
- For budget-related issues, is always conducted in the appellant's county of residency or by phone; and
- For DD and/or waiver eligibility-related issues, is conducted by phone.
- Advises the appellant of the name, address, and telephone number of the person to notify in the event it is not possible for him or her to attend.
- Specifies that the hearing request will be dismissed if the appellant fails to appear for the hearing without good cause.
- Specifies that the appellant may request a continuance of the hearing if good cause is shown.
- Includes the appellant's rights, information, and procedures to provide the appellant or representative with an understanding of the hearing process.
- Explains that the appellant may examine the case record prior to the hearing.

- The notice of scheduled hearing is sent out so that it reaches the appellant at least 10 calendar days before the hearing.

Note: Please contact the Administrative Law Judge (ALJ) from FSSA's Office of General Counsel or the Office of Hearings and Appeals for all questions and issues related to scheduling a hearing. The DDRS and the BDDS cannot schedule hearings. Neither party should contact the ALJ prior to the scheduled hearing date to discuss case-specific information without the other party being included/notified.

Section 8.5: Request for Continuance from the Appellant

A written request for a continuance is to be directed to the Office of Hearings and Appeals or the Office of General Counsel's Administrative Law Judge (ALJ). Good cause must exist for a continuance to be granted. "Good cause" is defined as a valid reason for the appellant's inability to be present at the scheduled hearing, such as being unable to attend the hearing because of

- A serious physical or mental condition
- An incapacitating injury
- A death in the family
- Severe weather conditions that make it impossible to travel to the hearing
- Unavailability of a witness whose evidence cannot be obtained otherwise
- Other similar causes

If good cause exists and a continuance is granted, the hearing will be rescheduled.

Note: *Please contact the Office of Hearings and Appeals for all questions or issues related to scheduling a hearing, or the Office of General Counsel's Administrative Law Judge (ALJ) regarding continuances. The DDRS and BDDS cannot reschedule hearings. Neither party should contact the ALJ prior to the scheduled hearing date to discuss specific information without the other party being included/notified.*

Section 8.6: Review of Action

When an appeal request is received, a designated State staff within the appropriate units (BDDS Service Coordinator or District representative, DDRS Central Office or DDRS/BDDS Waiver Unit) should review the proposed action to determine whether the proposed action is appropriate.

Upon request, the designated State staff provides the individual (or representative) the opportunity for an informal conference and an opportunity to review the evidence prior to the hearing. Individuals should be advised that an informal conference prior to the hearing is optional and in no way delays or replaces the administrative hearing. The conference may lead to an informal resolution of the dispute. An

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

Section 8.7: Disposal of Appeal without a Fair Hearing

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

- If, after review of the appellant's situation, the BDDS Service Coordinator and/or the DDRS Central Office realizes that the proposed action or action taken is incorrect, adjusting action may be taken.
- If the appellant wishes to withdraw the appeal, he/she is to be assisted by the BDDS Service Coordinator and/or the DDRS Central Office in promptly notifying the Office of Hearings and Appeals or Office of General Counsel's Administrative Law Judge in writing of the decision. No pressure is to be exerted on the appellant to withdraw the appeal. The withdrawal must be acknowledged in writing and it is only with the receipt of a signed voluntary withdrawal statement from the appellant that the appeal is to be dismissed.
- An appeal is abandoned when the appellant (or representative), without good cause, does not appear at a scheduled hearing. The appeal will be dismissed and both parties will be notified.

Section 8.8: The Fair Hearing

An administrative hearing is a review of actions of a BDDS Service Coordinator, Case Manager, DDRS Central Office, or DDRS/BDDS Waiver Unit regarding issues relating to the Family Supports Waiver or the Community Integration and Habilitation Waiver. An Administrative Law Judge, who is an employee of the Family and Social Services Administration, Office of Hearings and Appeals or Office of General Counsel, is designated to hold the hearing and to issue findings of fact, conclusions of law, and a decision related to the appeal request.

A hearing allows the dissatisfied appellant an opportunity to present his or her grievance and to describe the circumstance and needs in his or her own words. An attorney or another individual of his choice may represent the individual. A designated State staff within the appropriate units (BDDS Service Coordinator or District representative, DDRS Central Office or DDRS/BDDS Waiver Unit) will attend the hearing and present evidence supporting the action under appeal.

Section 8.9: Preparation for Hearing by Appellant

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

- Have an informal meeting to discuss the issue being appealed with the DDRS/BDDS Service Coordinator or other District representative, DDRS/BDDS Waiver Unit (or representative), or the DDRS Central Office representative.
- Upon request, examine the entire case file and all documents and records that will be used by the DDRS/BDDS District representative, DDRS/BDDS Waiver Unit representative, or the DDRS Central Office representative at the hearing, noting that the State's appeal-related evidence is sent to the appellant free of charge prior to the hearing.
- The appeal notice informs the appellant of his or her right be represented by legal counsel at the appeal hearing.

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

Additionally, the appellant may submit their own exhibits to the State prior to the hearing. It is expected that appellants who are submitting exhibits will bring copies of their own exhibits to the hearing for the Administrative Law Judge (ALJ) and for the State.

For budget-related appeals, the appellant submits their exhibits to the Bureau of Developmental Disabilities Services (DDRS/BDDS) Appeal Coordinator, who will distribute the copies to the ALJ. The appellant should submit his or her exhibits to:

BDDS Appeals Coordinator
MS 18
402 W. Washington Street, Room W453
Indianapolis, IN 46204

The appeal must be received by FSSA within 33 calendar days of the NOA decision date.

For eligibility-related appeals, the appellant submits their exhibits to:

Office of General Counsel
MS 27
402 W. Washington Street, Room W451
Indianapolis, IN 46204

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

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

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

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

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

- Review all factors and issues that led to the action being appealed.
- Discuss the issue being appealed with the appellant (or representative) if at all possible, and definitely if a discussion is requested by the appellant. If requested, allow the appellant (or representative) to examine the entire case record.
- Identify and label all documents that are pertinent to the issue under appeal. The exhibits should be labeled in the lower right hand corner, with the State's Exhibit beginning with Exhibit A. If more than one page is in an exhibit, the pages are labeled (for the first page) State's Exhibit A, page 1 of 2; and (for page2) State's Exhibit A, page 2 of 2. The next numbers continue for each page in the exhibit being presented. The subsequent exhibit would be labeled Exhibit B and the pages according to the number of pages. For example, if three pages are in an exhibit, the third page would be labeled:

  State's Exhibit A Page 3 of 3

- Make one copy of labeled exhibits for the ALJ and one copy for the appellant (unless already given to the appellant). A duplicate copy of the notice sent to the appellant advising of the proposed action should be included as part of the documentation.
- Prepare a written outline that can be used as a tool in presenting the testimony at the hearing. Bear in mind when preparing the outline that the ALJ knows nothing about the situation. The outline should focus on:
  - Identification of the staff representative by name and position
  - The period of time the representative worked directly or indirectly with the appellant
  - A one-sentence explanation of the issue under appeal
  - The important information concerning how it was determined that the action proposed or taken was appropriate, *and*
  - Federal and State laws and regulations that were the basis for the action
- Include the labeled exhibits at the appropriate point in the presentation outline.

Section 8.11: Conduct of the Hearing

The Administrative Law Judge conducts the hearing. The appellant and the appropriate State representative have the opportunity to:

- Present the case or have it presented by legal counsel or another person
- Present testimony of witnesses

- Introduce relevant documentary evidence
- Establish all pertinent facts and circumstances
- Present any arguments without interference
- Question or refute any testimony or evidence presented by the other party, including the opportunity to confront and cross-examine any adverse witnesses
- Examine the appellant's entire case record and all documents and records used by the DDRS/BDDS Service Coordinator or other District representative, the DDRS Central Office, or DDRS/BDDS Waiver Unit at the hearing

The parties are advised at the close of the hearing that they will be informed in writing of the Administrative Law Judge's decision.

Note: See *Section 8.9* and *Section 8.10* of this manual. The State shall ensure that the appellant receives the State's exhibits and the appellant shall ensure that the State receives any exhibits submitted by the appellant prior to the day of the hearing.

Section 8.12: Continuance of Hearing

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

Section 8.13: The Hearing Record

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

Section 8.14: The Fair Hearing Decision

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

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

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

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

Unless an Agency Review is requested, the decision of the Administrative Law Judge shall be binding upon the DDRS or the Office of Medicaid Policy and Planning and is to be enacted.

Section 8.16: Agency Review

Any party may request an Agency Review if dissatisfied with the decision made by the Administrative Law Judge. The Agency Review request must be made in writing to the FSSA's Office of Hearings and Appeals (OHA) or the ultimate agency authority, within 10 calendar days following receipt of the hearing decision.

- After an Agency Review is requested, the OHA or the ultimate agency authority will write to all parties to acknowledge receipt of the request and to provide information concerning the review.
- No new evidence will be considered during the Agency Review; however, any party may submit a written Memorandum of Law, citing evidence in the record, for consideration.
- The Secretary of the FSSA or the Secretary's designee shall complete the agency review. The decision made at Agency Review will be sent to all appropriate parties.

Section 8.17: Judicial Review

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

Section 8.18: Lawsuit

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

Section 9: Bureau of Quality Improvement Services

Sections 9.1 – 9.6

Section 9.1: Overview

Section 9.2: Provider Compliance Reviews

Section 9.3: Incident Reports

Section 9.4: Complaints

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Section 9.1: Overview

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

Section 9.2: Provider Compliance Reviews

The DDRS/BQIS is responsible for assuring that the providers of Supportive Living Services are in compliance with Indiana Administrative Code and DDRS Policies, and therefore continue to meet the waivers' qualifications to provide services. The DDRS/BQIS fulfills this oversight function by conducting provider compliance reviews.

The Compliance Evaluation and Review Tool (CERT) is designed to capture provider compliance with Indiana Administrative Code and DDRS Policies in the following focus areas:

- The provider meets qualifications for waiver services being delivered;
- The provider has policies and procedures to ensure the rights of individuals, to direct appropriate services, and to support and manage employees;
- The provider maintains employee information confirming key health, welfare and training issues (this includes validating that the provider conducts criminal background checks) ; and
- Quality assurance and quality improvement.

All providers are required to go through a provider compliance review within 12 months of being approved to provide waiver services. Depending on providers' accreditation status specific to Indiana programs, providers may be required to go through subsequent provider compliance reviews at least once every three years.

Provider compliance reviews take place onsite. Following the review, providers receive a report of findings and a request to develop a corrective action plan. The DDRS/BQIS validates that the corrective action plan is being implemented.

There are two different versions of the CERT – one for non-direct, ancillary service providers, and another for all other types of providers. As DDRS continues to issue new policies the CERT will be updated accordingly.

Copies of the CERT Guides, findings templates, and a process map are available on the DDRS/BQIS web page DDRS/BQIS web page under the Compliance Evaluation and Review Tool category.

Indiana Code requires all residential habilitation, day program, and case management providers to be accredited (specific to Indiana programs) by any of the following accreditation entities:

- The Commission on Accreditation of Rehabilitation Facilities (CARF), or its successor
- The Council on Quality and Leadership in Supports for People with Disabilities (CQL), or its successor
- The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or its successor
- The ISO-9001 Quality Management System
- An independent national accreditation organization approved by the secretary

Residential and day program providers may choose to obtain accreditation for other waiver services that they are approved to provide, however this is not required.

Some accreditation entities accredit the organization, whereas others allow providers to select the services they wish to accredit. The DDRS/BQIS will not conduct compliance reviews on any accredited services. This means if a provider chooses to accredit only some of its services, BQIS will continue to conduct provider compliance reviews on all of the provider's non-accredited services.

All services are reviewed at least once every three years, by BQIS or the accreditation entity of the provider's choosing.

Section 9.3: Incident Reports

Incident Reporting

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

- Alleged, suspected, or actual abuse, neglect, or exploitation of an individual. This includes physical, sexual, emotional/verbal, and domestic abuse. An incident in this category shall also be reported to Adult Protective Services or Child Protection Services as applicable. The provider shall suspend staff involved in an incident from duty pending investigation by the provider.
- Peer to peer aggression that results in significant injury.
- Death of an individual. A death shall also be reported to Adult Protective Services or Child Protection Services as applicable. If death is a result of alleged criminal activity, the death must be reported to law enforcement.

- Structural or environmental issues with a service delivery site that compromise the health and safety of an individual. Fire that jeopardizes or compromises the health or welfare of an individual
- Elopement of an individual that results in evasion of required supervision as described in the ISP as necessary for the individual's health and welfare.
- Missing person when an individual wanders away and no one knows where they are.
- Alleged, suspected or actual criminal activity by: a staff member, employee, or agent of a provider; or an individual receiving services.
- An emergency intervention for an individual resulting from a physical symptom, a medical or psychiatric condition, or any other event.
- Injury to an individual when the origin or cause of the injury is unknown and the injury requires medical evaluation or treatment.
- A significant injury to an individual, including but not limited to:
    - a fracture,
    - a burn greater than first degree,
    - choking that requires intervention,
    - bruises or contusions larger than three inches or lacerations requiring more than basic first aid,
    - any puncture wound penetrating the skin,
    - any pica ingestion requiring more than first aid
- A fall resulting in injury, regardless of severity of the injury.
- A medication error, except for refusal to take medications, including the following:
    - Medication given that was not prescribed or ordered for the individual, or wrong medication.
    - Failure to administer medication as prescribed, including: incorrect dosage, missed medication, wrong route, and failure to give medication at the appropriate time.
    - Medication error that jeopardizes an individual's health and welfare and requires medical attention.
- Use of any aversive technique including but not limited to:
    - Seclusion,
    - Painful or noxious stimuli,
    - Denial of a health related necessity,
    - Other aversive technique identified by DDRS Policy.
- Use of any PRN (as needed/when necessary) medication related to an individual's behavior.
- Use of any physical or mechanical restraint regardless of whether it was planned, was approved by a Human Rights Committee, or if there was informed consent.

View the full incident reporting policy at
http://www.in.gov/fssa/files/Incident_Reporting_and_Management.pdf

Additional information about incident reporting is available on the BQIS Incident Reporting web page: http://www.in.gov/fssa/ddrs/3838.htm

Section 9.4: Complaints

The DDRS/BQIS Quality Vendor is responsible for operating the DDRS Complaint System for consumers receiving Supportive Living Services from the Family Support Waiver (FSW) or Community Integration and Habilitation (CIH) Waiver.

By definition, complaints are broad in type and scope and can be specific to either one individual, a group of individuals, or a provider. DDRS does not intend for complaints to replace any of the waivers' primary systems established to routinely monitor and assure individuals' health and welfare, specifically the state's case management and incident reporting systems. Instead, the complaint system is meant to provide individuals, their families/guardians, providers, and community members an additional venue for identifying and addressing issues when day-to-day monitoring activities have been, or appear to be, ineffective in assuring an individual's health and safety.

In order to give the system an opportunity to work, the DDRS/BQIS encourages complainants with individual-specific issues, who have not already done so, to approach their Case Managers to try and resolve the issue first. If this has not produced the desired outcome, the complainant can contact BQIS again to file a complaint. When requested, complainants can choose to be anonymous.

The DDRS/BQIS's Quality Vendor reviews and categorizes all initial complaints as urgent, critical, or non-critical and assigns a complaint investigator to investigate the case within specified time parameters. Certain circumstances may require the DDRS/BQIS to contact Adult Protective Services, Child Protective Services, local law enforcement, and/or the provider to take immediate measures to assure the individual's health and welfare.

It should be noted that the DDRS/BQIS's Quality Vendor conducts all activities related to complaint investigations on an unannounced basis. Some activities, such as interviews with individuals who may have information regarding the issue but are not directly employed by the entity the complaint is against, sometimes require advanced scheduling in order to ensure those individual are available. Depending on the nature of the complaint, investigation activities may include:

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

When complaint allegations are substantiated, the DDRS/BQIS's Quality Vendor will request the provider to develop a corrective action plan (CAP). The DDRS/BQIS will later validate the provider is implementing the CAP. In rare cases where the issue was already discovered and corrected by the provider prior to any investigation by the Quality Vendor, a CAP may not be required. In these cases, the Quality Vendor would verify the implementation of the corrective action plan the provider

implemented in order to ensure that the issue is appropriately resolved. To obtain specific information related to the investigation process you may refer to the BQIS Complaint Policy at http://www.in.gov/fssa/files/BQIS_Complaints.pdf.

Currently, complaints can be filed via email - BQIS.Help@fssa.in.gov or through the BQIS toll free phone number 1-866-296-8322.

Section 9.5: Mortality Reviews

The DDRS/BQIS is responsible for conducting mortality reviews for all deaths of individuals that received DDRS-funded services, regardless of service setting. Providers are required to report all deaths through the Incident Reporting System.

The DDRS/BQIS's Quality Vendor is responsible for conducting the mortality review process which begins when BQIS's Mortality Review Triage Team (MRTT) requests and reviews medical history and other related documentation for all deceased individuals. Reviews involve discussion of events prior to the death, supports/services in place at the time of death, documentation received, whether additional documentation is needed for review, and whether the death should be presented to the Mortality Review Committee (MRC) as a focus case for further review and discussion. Any death can be brought before the MRC for discussion at the request of the members, the DDRS/BQIS Director, or other DDRS staff that has a concern.

The MRC is facilitated by the DDRS/BQIS Quality Vendor. Committee members include representatives from Adult Protective Services, the Department of Health, the Office of Medicaid Policy and Planning, the Statewide Waiver Ombudsman, DDRS/BDDS field service staff, and community advocates.

Based on their discussion, the MRC makes recommendations for systemic improvements such as developing new DDRS policy, revising policy, training, or sharing key information through the posting of quarterly data reports to the BQIS web page. The MRC also makes provider-specific recommendations that are included in the closure letter from the MRC.

The MRTT and/or the MRC can refer a case to DDRS/BQIS for a mortality investigation to review key areas of a provider's system that appear to have not been in place or to have been ineffective at the time of an individual's death. Providers may be required to develop corrective action plans to address identified issues and to prevent other individuals from experiencing negative outcomes.

An annual Mortality Report is posted on the BQIS web page that analyzes the data from all deaths reviewed by the MRC during the calendar year. The annual report also includes comparisons with national data.

See the Policy on Mortality Review at http://www.in.gov/fssa/files/Mortality_Review(1).pdf for further information regarding mortality reviews and the Mortality Review Committee.

Section 9.6 National Core Indicator (NCI) Project

At the beginning of fiscal year 2013, DDRS began participating in the National Core Indicator (NCI) Project. This national research project, administered through the Human Services Research Institute and the National Association of Developmental Disabilities Directors, was developed to obtain a standardized set of consumer outcome measures for community based services. NCI Project information is designed to be captured through face-to-face consumer satisfaction interviews. The DDRS/BQIS complaint investigators conduct these interviews across the state with individuals selected based on representative random samples from each of DDRS's waivers. Participation in this project allows DDRS to make comparisons with other states providing waiver services across the country.

Section 9.7: Statewide Waiver Ombudsman

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

Complaints may be received via the toll free number 1-800-622-4484, via e-mail, in hard copy format or by referral.

Types of complaints received include complaints initiated by families and/or participants, complaints involving rights or issues of participant choice, and complaints requiring coordination between legal services, the administrating agency services and provider services.

The ombudsman is expected to initiate contact with the complainant as soon as possible once the complaint is received. However, precise timelines for the final resolution of each complaint are not established. While it is expected that the ombudsman diligently and persistently pursue the resolution of each complaint determined to require investigation, it is recognized that circumstances surrounding each investigation vary.

Timeframes for complaint resolution vary in accordance with the required research, in the collection of evidence and in the numbers and availability of persons who must be contacted, interviewed, or brought together to resolve the complaint. Although the statewide waiver ombudsman is considered "independent" by statute, the DDRS Director is responsible for oversight of the ombudsman.

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

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

A state or local government agency or entity that has records relevant to a complaint or an investigation

conducted by the ombudsman must also provide the ombudsman with access to the records. The statewide waiver ombudsman coordinates his or her activities among the programs that provide legal services for individuals with an intellectual/developmental disability, the administrative agency, providers of waiver services, and providers of other necessary or appropriate services, and ensure that the identity of the participant will not be disclosed without either the participant's written consent or a court order.

At the conclusion of an investigation of a complaint, the ombudsman reports the ombudsman's findings to the complainant. If the ombudsman does not investigate a complaint, the ombudsman notifies the complainant of the decision not to investigate and the reasons for the decision.

The statewide waiver ombudsman prepares a report at least annually (or upon request) describing the operations of the program. A copy of the report is provided to the governor, the legislative council, and the director of the Division of Disability and Rehabilitative Services. Trends are identified so that recommendations for needed changes in the service delivery system can be implemented.

The administrative agency is required to maintain a statewide toll free telephone line continuously open to receive complaints regarding waiver participants with intellectual/developmental disabilities. All complaints received from the toll free line must be forwarded to the statewide waiver ombudsman, who will advise the participant that the complaint process is not a pre-requisite or a substitute for a Medicaid Fair Hearing when the problem falls under the scope of the Medicaid Fair Hearing process.

A person who intentionally prevents the work of the ombudsman; knowingly offers compensation to the ombudsman in an effort to affect the outcome of an investigation; or a potential investigation; or knowingly or intentionally retaliates against a participant, a client, an employee, or another person who files a complaint or provides information to the ombudsman; commits a Class B misdemeanor.

Section 10: Service Definitions and Requirements

Sections 10.1 – 10.34

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Section 10.1: Service Definition Overview

This section of the manual lists service definitions for the services currently approved for the Home and Community Based Services (HCBS) waiver programs administered by the Division of Disability and Rehabilitative Services (DDRS). Each service definition includes the following information:

- A definition of the service.
- A list of reimbursable (allowable) activities for the service.
- Service standards
- Documentation standards
- Limitations
- A list of activities not allowed
- And in some cases, additional information or clarifications that are unique to the service

Note that some services are not available under both waivers. Please refer to **Sections 4.5 and 4.6** for the lists of available waiver services unique to each waiver.

A chart (Table 10.2) containing procedure (billing) codes and modifiers as well as unit rates is found in **Section 10.2**.

Additional Information

- Facility settings are defined as non-residential, non-integrated 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 non-residential, integrated settings that are primarily out in the community where services are not rendered within the same building(s) alongside other non-integrated participants.

By March 17, 2019, all services will be compliant with the HCBS Final Rule settings requirements as outlined in Indiana's Statewide Transition Plan.

Section 10.2: Medicaid Waiver Services, Codes, and Rates

Table 10.2 – Medicaid Waiver Services, Codes, and Rates for Community Integration and Habilitation Waiver (CIH Waiver) and Family Supports Waiver (FSW)

Effective July 2016

See the Rate Charts at www.in.gov/fssa/ for the most recent information.

Medicaid Waiver Services, Codes, and Rates, Effective July 1, 2016

For Family Supports (FSW) Waiver and Community Integration and Habilitation (CIH) Waiver And Money Follows the Person – Community Integration and Habilitation (MFP-CIH) Grant

Waiver Type			INsite Code	Service Description	Natl. Code	Modifiers				Rate	Unit/ Size	Unit/$ Limit
FSW	CIH	MFP-CIH				1	2	3	4			
■	■	■	ADS1	Adult Day Services, Level 1	S5101	U7	U5	U1		$21.95	.50/Day	2 Units/ Day
■	■	■	ADS2	Adult Day Services, Level 2	S5101	U7	U5	U2		$28.80	.50/Day	2 Units/ Day
■	■	■	ADS3	Adult Day Services, Level 3	S5101	U7	U5	U3		$34.29	.50/Day	2 Units/ Day
■	■	■	AS14	Adult Day Services, ¼ Hour, Level 1	S5100	U7	U5	U1		$1.38	.25/Hour	12 Units/Day
■	■	■	AS24	Adult Day Services, ¼ Hour, Level 2	S5100	U7	U5	U2		$1.80	.25/Hour	12 Units/Day
■	■	■	AS34	Adult Day Services, ¼ Hour, Level 3	S5100	U7	U5	U3		$2.14	.25/Hour	12 Units/Day
■	■	■	BMGO	Behavior Management, Basic	H0004	U7	U5	U2		$18.20	.25/Hour	
■	■	■	BG1O	Behavior Management, Level 1	H0004	U7	U5	U1		$18.20	.25/Hour	
	■	■	CMGT	Case Management	T2022	U7	U5			$131.25	1.00/Month	1 Unit/Month
■			CMGT	Case Management	T2022	U7	U5			$125.00	1.00/Month	1 Unit/Month
■	■	■	CHIO	Community Habilitation, Individual	T2020	U7	U5			$23.67	1.00/Hour	
■	■	■	CHG2	Community Habilitation, Group (2:1)	T2020	U7	U5	U2		$8.48	1.00/Hour	
■	■	■	CHG3	Community Habilitation, Group (3:1)	T2020	U7	U5	U3		$8.48	1.00/Hour	
■	■	■	CHG4	Community Habilitation, Group (4:1)	T2020	U7	U5	U4		$8.48	1.00/Hour	
■	■	■	CHG6	Community Habilitation, Group (6:1)	T2020	U7	U5	U6		$4.72	1.00/Hour	
■	■	■	CHG8	Community Habilitation, Group (8:1)	T2020	U7	U5	U8		$4.72	1.00/Hour	
■	■	■	CHGB	Community Habilitation, Group (10:1)	T2020	U7	U5	UB		$4.72	1.00/Hour	
	■	■	CT	Community Transition	T2038	U7	U5			Individual	1.00/Unit	$1,000 Lifetime
	■	■	EM1	Electronic Monitoring, 1 Participant	A9279	U7	U5	UA		$13.62	1.00/Hour	
	■	■	EM2	Electronic Monitoring, 2 Participants	A9279	U7	U5	U2		$6.81	1.00/Hour	
	■	■	EM3	Electronic Monitoring, 3 Participants	A9279	U7	U5	U3		$4.54	1.00/Hour	
	■	■	EM4	Electronic Monitoring, 4 Participants	A9279	U7	U5	U4		$3.41	1.00/Hour	
	■	■	EMOI	Environmental Modification, Install	S5165	U7	U5	NU		Individual	1.00/Unit	$15,000 Lifetime
	■	■	EMOM	Environmental Modification, Maintain	S5165	U7	U5	U8		Individual	1.00/Unit	$500/Year
■	■	■	INSP	Equipment – Assess/Inspect/Train	T1028	U7	U5			$17.99	.25/Hour	
■	■	■	EXTS	Extended Services	T2025	U7	U5	UA		$35.20	1.00/Hour	
■	■	■	FBS	Facility Based Support	T1020	U7	U5	UA		$1.85	1.00/Hour	
■	■	■	FHIO	Facility Habilitation, Individual	T2020	U7	U5	UA		$23.67	1.00/Hour	
■	■	■	FHG2	Facility Habilitation, Group (2:1)	T2020	U7	U5	UA	U2	$8.48	1.00/Hour	
■	■	■	FHG4	Facility Habilitation, Group (4:1)	T2020	U7	U5	UA	U4	$8.48	1.00/Hour	
■	■	■	FHG6	Facility Habilitation, Group (6:1)	T2020	U7	U5	UA	U6	$4.72	1.00/Hour	
■	■	■	FHG8	Facility Habilitation, Group (8:1)	T2020	U7	U5	UA	U8	$4.72	1.00/Hour	
■	■	■	FHGB	Facility Habilitation, Group (10:1)	T2020	U7	U5	UA	UB	$4.72	1.00/Hour	
■	■	■	FHGC	Facility Habilitation, Group (12:1)	T2020	U7	U5	UA	UC	$3.00	1.00/Hour	
■	■	■	FHGD	Facility Habilitation, Group (14:1)	T2020	U7	U5	UA	UD	$3.00	1.00/Hour	
■	■	■	FHG9	Facility Habilitation, Group (16:1)	T2020	U7	U5	UA	U9	$3.00	1.00/Hour	
■	■	■	FCAR	Family & Caregiver Training, Family	S5111	U7	U5			Individual	1.00/Unit	$2,000/Year
■	■	■	FCNF	Family & Caregiver Training, Non-Family	S5116	U7	U5			Individual	1.00/Unit	$2,000/Year
■	■	■	IBI1	Intensive Behavioral Intervention, Level 1	H2020	U7	U5	U1		$104.60	1.00/Hour	
■	■	■	IBI2	Intensive Behavioral Intervention, Level 2	H2020	U7	U5	U2		$25.00	1.00/Hour	
■	■	■	MUTH	Music Therapy	H2032	U7	U5	U1		$10.78	.25/Hour	
■	■	■	OCTH	Occupational Therapy	G0152	U7	U5	UA		$17.99	.25/Hour	
■			PAC	Participant Assistance and Care	T2033	U7	U5			$23.24	1.00/Hour	
■	■	■	PRSI	Personal Response System, Install	S5160	U7	U5			$52.07	1.00/Unit	2 Units/CCB

FSW	CIH	MFP-CIH	INsite Code	Service Description	Natl. Code	1	2	3	4	Rate	Unit/ Size	Unit/$ Limit
■	■	■	PRSM	Personal Response System, Maintain	S5161	U7	U5			$52.07	1.00/Unit	1 Unit/Month
■	■	■	PHTH	Physical Therapy	G0151	U7	U5	UA		$18.12	.25/Hour	
■	■	■	PV02	Pre-Vocational (2:1)	T2015	U7	U5	U2		$8.48	1.00/Hour	
■	■	■	PV04	Pre-Vocational (4:1)	T2015	U7	U5	U4		$8.48	1.00/Hour	
■	■	■	PV06	Pre-Vocational (6:1)	T2015	U7	U5	U6		$4.72	1.00/Hour	
■	■	■	PVO8	Pre-Vocational (8:1)	T2015	U7	U5	UA		$4.72	1.00/Hour	
■	■	■	PV10	Pre-Vocational (10:1)	T2015	U7	U5	UB		$4.72	1.00/Hour	
■	■	■	PV12	Pre-Vocational (12:1)	T2015	U7	U5	UC		$3.00	1.00/Hour	
■	■	■	PV14	Pre-Vocational (14:1)	T2015	U7	U5	UD		$3.00	1.00/Hour	
■	■	■	PV16	Pre-Vocational (16:1)	T2015	U7	U5	U9		$3.00	1.00/Hour	
■	■	■	PSTF	Psychological Therapy, Family	90846	U7	U5			$17.27	.25/Hour	
■	■	■	PSTG	Psychological Therapy, Group	90853	U7	U5			$4.81	.25/Hour	
■	■	■	PSTI	Psychological Therapy, Individual	H0004	U7	U5	U3		$15.45	.25/Hour	
■	■	■	RETH	Recreational Therapy	H2032	U7	U5	U2		$10.78	.25/Hour	
	■	■	R&F	Rent & Food for Unrelated Live-In Caregiver	T2025	U7	U5			$545.00	1.00/Month	
	■	■	RH1O	Residential Habilitation Services, Level 1 (35 or fewer Hrs/Week)	T2016	U7	U5	UA		$24.90	1.00/Hour	
	■	■	RH2O	Residential Habilitation Services, Level 2 (Over 35 Hrs/Week)	T2016	U7	U5			$20.92	1.00/Hour	
	■	■	RD1	RHD Daily Level 1 (2 Person Setting, Algo Level 3)	T2016	U7	U5	UN	UA	$163.17	1.0/Day	1 Unit/Day
	■	■	RD2	RHD Daily Level 2 (2 Person Setting, Algo Level 4)	T2016	U7	U5	UN	UB	$230.12	1.0/Day	1 Unit/Day
	■	■	RD3	RHD Daily Level 3 (2 Person Setting, Algo Level 5)	T2016	U7	U5	UN	UC	$251.04	1.0/Day	1 Unit/Day
	■	■	RD4	RHD Daily Level 4 (3 Person Setting, Algo Level 3)	T2016	U7	U5	UP	UA	$163.17	1.0/Day	1 Unit/Day
	■	■	RD5	RHD Daily Level 5 (3 Person Setting, Algo Level 4)	T2016	U7	U5	UP	UB	$211.29	1.0/Day	1 Unit/Day
	■	■	RD6	RHD Daily Level 6 (3 Person Setting, Algo Level 5)	T2016	U7	U5	UP	UC	$230.12	1.0/Day	1 Unit/Day
	■	■	RD7	RHD Daily Level 7 (4 Person Setting, Algo Level 3)	T2016	U7	U5	UQ	UA	$152.71	1.0/Day	1 Unit/Day
	■	■	RD8	RHD Daily Level 8 (4 Person Setting, Algo Level 4)	T2016	U7	U5	UQ	UB	$196.64	1.0/Day	1 Unit/Day
	■	■	RD9	RHD Daily Level 9 (4 Person Setting, Algo Level 5)	T2016	U7	U5	UQ	UC	$209.20	1.0/Day	1 Unit/Day
■	■	■	RNUR	Respite Nursing Care, RN	T1005	U7	U5	TD		$7.79	.25/Hour	
■	■	■	RNUR	Respite Nursing Care, LPN	T1005	U7	U5	TE		$5.91	.25/Hour	
■	■	■	RSPO	Respite Care Services	S5151	U7	U5			$24.90	1.00/Hour	
	■	■	ATCH	Specialized Medical Equip/Supply, Install	T2029	U7	U5	NU		Individual	1.00/Unit	
■			ATCH	Specialized Medical Equip/Supply, Install	T2029	U7	U5	NU		Individual	1.00/Unit	$7,500 Lifetime
■	■	■	ATCM	Specialized Medical Equip/Supply, Maintain	T2029	U7	U5	U8		Individual	1.00/Unit	$500/Year
■	■	■	SPTH	Speech Therapy	92507	U7	U5	UA		$18.12	.25/Hour	
	■	■	AF01	Structured Family Caregiving, Level 1	T2033	U7	U5	U1		$51.87	1.00/Day	1 Unit/Day
	■	■	AF02	Structured Family Caregiving, Level 2	T2033	U7	U5	U2		$75.67	1.00/Day	1 Unit/Day
	■	■	AF03	Structured Family Caregiving, Level 3	T2033	U7	U5	U3		$102.87	1.00/Day	1 Unit/Day
■			TRNO	Transportation	T2002	U7	U5			$5.00	1.00/Trip	2 Trips/Day
	■	■	TRNO	Transportation, Level 1	T2002	U7	U5			$5.00	1.00/Trip	2 Trips/Day,$2500/Year

FSW	CIH	MFP-CIH	INsite Code	Service Description	Natl. Code	1	2	3	4	Rate	Unit/ Size	Unit/$ Limit
	■	■	TRN2	Transportation, Level 2	T2002	U7	U5	U2		$20.00	1.00/Trip	2 Trips/Day,$5000/Year
	■	■	TRN3	Transportation, Level 3	T2002	U7	U5	U3		$40.00	1.00/Trip	2 Trips/Day,$7500/Year
	■	■	VMOD	Vehicle Modification, Install	T2039	U7	U5			Individual	1.00/Unit	$15,000 Lifetime
■			VMOD	Vehicle Modification, Install	T2039	U7	U5			Individual	1.00/Unit	$7,500 Lifetime
■	■	■	VMOM	Vehicle Modification, Maintain	T2039	U7	U5	U8		Individual	1.00/Unit	$500/Year
	■	■	WEL1	Wellness Coordination Tier 1	T2022	U7	U5	U1		$52.77	1.00/Month	1 Unit/Month
	■	■	WEL2	Wellness Coordination Tier 2	T2022	U7	U5	U2		$111.96	1.00/Month	1 Unit/Month
	■	■	WEL3	Wellness Coordination Tier 3	T2022	U7	U5	U3		$223.92	1.00/Month	1 Unit/Month
■	■	■	WPA	Workplace Assistance	T1020	U7	U5			$26.37	1.00/Hour	

Section 10.3: Adult Day Services

Service Definition

Adult Day Services (ADS) are community-based group programs designed to meet the needs of adults with impairments through individual plans of care. These structured, comprehensive, non-residential programs provide health, social, recreational, and therapeutic activities, supervision, support services, and personal care. Meals and/or nutritious snacks are required. The meals need not constitute the full daily nutritional regimen. However, each meal must meet one-third of the daily Recommended Dietary Allowance. These services must be provided in a congregate, protective setting in one of three available levels of service: Basic, Enhanced, or Intensive.

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

A half-day unit is defined as one unit of three hours to a maximum of five hours per day. Two units is more than five hours to a maximum of eight hours per day. A maximum of two half-units per day is allowed.

A quarter-hour unit is defined as 15 minutes. It is billable only if fewer than three hours or more than eight hours of ADS have been provided on the same day. A maximum of 16 quarter-hour units per day are allowed.

Reimbursable Activities

Adult Day Services may be used in conjunction with Transportation Services.

Basic Adult Day (Level 1) includes:

- Monitor and/or supervise all activities of daily living (ADLs) defined as dressing, bathing, grooming, eating, walking, and toileting with hands-on assistance provided as needed.
- Comprehensive, therapeutic activities.
- Health assessment and intermittent monitoring of health status.
- Monitor medication or medication administration.

- Appropriate structure and supervision for those with mild cognitive impairment.
- Minimum staff ratio: One staff for each eight individuals.

Enhanced Adult Day Services (Level 2) includes Level 1 service requirements must be met. Additional services include:

- Hands-on assistance with two or more ADLs or hands-on assistance with bathing or other personal care.
- Health assessment with regular monitoring or intervention with health status.
- Dispense or supervise the dispensing of medication to individuals.
- Psychosocial needs assessed and addressed, including counseling as needed for individuals and caregivers.
- Therapeutic structure, supervision, and intervention for those with mild to moderate cognitive impairments.
- Minimum staff ratio: One staff for each six individuals.

Intensive Adult Day Services (Level 3) includes Level 1 and Level 2 service requirements must be met. Additional services include:

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

Service Standards

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

Documentation Standards

The following are required documentation for Adult Day Services:

- Services outlined in the individualized support plan (ISP)
- Evidence that level of service provided is required by the individual
- Attendance record documenting the date of service and the number of units of service delivered that day
- Completed Adult Day Service Level of Service Evaluation form

- The Case Manager should give the completed Adult Day Service Level of Service Evaluation form to the provider.

As applicable, monthly/quarterly reports must be uploaded to Advocare by the chosen service provider on or before the fifteenth day of the following month

Limitations

The following limitations apply to Adult Day Service:

- Therapies provided through Adult Day Services will not duplicate therapies provided under any other service.

Activities Not Allowed

Any activity that is not described under Reimbursable Activities is not included in Adult Day Services.

Section 10.4: Behavioral Support Services

Service Definition

Behavioral Support Services means training, supervision, or assistance in appropriate expression of emotions and desires, compliance, assertiveness, acquisition of socially appropriate behaviors, and the reduction of inappropriate behaviors.

Reimbursable Activities

Reimbursable activities of Behavioral Support Services include

- Observation of the individual and environment for purposes of development of a plan and to determine baseline
- Development of a behavioral support plan and subsequent revisions
- Obtain consensus of the Individual Support Team (IST) that the behavioral support plan is feasible for implementation
- Training in assertiveness
- Training in stress reduction techniques
- Training in the acquisition of socially accepted behaviors
- Training staff, family members, roommates, and other appropriate individuals on the implementation of the behavioral support plan
- Consultation with team members

Service Standards

Behavioral Support Services must be reflected in the ISP:

- Services must address needs identified in the person-centered planning process and be outlined in the ISP.

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

Documentation Standards

At minimum, documentation will include:

- Services outlined in the ISP. The ISP identifies the services needed by the participant to pursue their desired outcomes and to address their health and safety needs. Each outcome within the ISP has at least one associated proposed strategy/activity designed to address potential barriers or maintenance needs in relation to the desired outcomes and the support and services needed to facilitate the outcomes. The proposed strategy/activity also identifies all paid and unpaid responsible parties and includes the name of the provider, the service, and the staffing positions within the agency that are responsible for the strategy/activity. The participant may be the responsible party for a strategy/activity initiative if they so determine. In addition, each proposed strategy/activity has a specific timeframe identified, including a minimum timeframe for review. The Plan of Care/Cost Comparison Budget (POC/CCB) identifies the name of the waiver-funded service, the name of the participant-chosen provider of that service, the cost of the service per unit, the number of units of service, and the start and end dates for each waiver service identified on the POC/CCB.
- Documentation in compliance with *460 IAC 6-18-4* Documentation Standards.

As applicable, monthly/quarterly reports must be uploaded to Advocare by the chosen service provider on or before the fifteenth day of the following month

Limitations

The following limitations apply to Behavioral Support Services:

- See *Activities Not Allowed*.

Activities Not Allowed

The following activities are not allowed:

- Aversive techniques – any techniques not approved by the individual's person-centered planning team and the provider's HRC.
- Therapy services furnished to the participant within the educational/school setting or as a component of the participant's school day.
- Services furnished to a minor by parent(s), stepparent(s), or legal guardian.
- Services furnished to a participant by the participant's spouse.
- In the event that a Level 1 clinician performs Level 2 clinician activities, billing for Level 1 services is not allowed. In this situation, billing for Level 2 services only is allowed.
- Simultaneous receipt of facility-based support services or other Medicaid-billable services and intensive behavior supports.

Section 10.5: Case Management

Service Definition

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

Reimbursable Activities

Reimbursable activities under Case Management services include the following:

- Developing, updating, and reviewing the ISP using the person-centered planning process.
- Convening team meetings at least every 90 calendar days and as needed to discuss the ISP and any other issues needing consideration in relation to the participant.
- Completion of a DDRS-approved risk assessment tool during service plan development, initially, annually, and when there is a change in the participant's status.
- Monitoring of service delivery and utilization (via telephone calls, home visits, and team meetings) to ensure that services are being delivered in accordance with the ISP.
- Completing and processing the annual level of care determination.
- Compiling case notes for each encounter with the participant.
- Conducting face-to-face contacts with the individual (and family members, as appropriate) at least once every 90 calendar days in the home of the waiver participant and as needed to ensure health and welfare and to address any reported problems or concerns.
- Completing and processing the 90-Day Checklist

- Developing initial, annual, and update Cost Comparison Budgets using the State-approved process.
- Disseminating information including all Notices of Action and forms to the participant and the Individual Support Team (IST) within five business days of the IST meeting.
- Completing, submitting, and following up on incident reports in a timely fashion using the State-approved process, including notifying the family/guardian of the incident outcome, all of which must be verifiable by documented supervisory oversight and monitoring of the Case Management agency.
- Monitoring participants' health and welfare.
- Monitoring participants' satisfaction and service outcomes.
- Monitoring claims reimbursed through the approved Medicaid Management Information System (MMIS) and pertaining to waiver-funded services.
- Maintaining files in accordance with State standards.
- Cultivating and strengthening informal and natural supports for each participant.
- Identifying resources and negotiating the best solutions to meet identified needs.

Limitations

The following limitations apply to Case Management services:

- Case Management services are required under both the Family Supports Waiver and the Community Integration and Habilitation Waiver.
- In addition, Indiana maintains a conflict-free Case Management policy. This covers conflict of interest in terms of provision of services as well as in relationship to the participant being served. Conflict-free means
  - Case Management agencies may not be an approved provider of any other waiver service.
  - The owners of one Case Management agency may not own multiple Case Management agencies.
  - The owners of one Case Management agency may not be a stakeholder of any other waiver service agency.
  - There may be no financial relationship between the referring Case Management agency, its staff, and the provider of other waiver services.
- In addition, Case Managers must not be
  - Related by blood or marriage to the participant
  - Related by blood or marriage to any paid caregiver of the participant
  - Financially responsible for the participant *or*
  - Authorized to make financial or health-related decisions on behalf of the participant.

Activities Not Allowed

The Case Management services agency may not own or operate another waiver service agency, nor may the Case Management agency be an approved provider of any other waiver service.

Reimbursement is not available through Case Management services for the following activities or any other activities that do not fall under the previously listed definition:

- Services delivered to persons who do not meet eligibility requirements established by DDRS/BDDS.
- Counseling services related to legal issues. Such issues shall be directed to the Indiana Advocacy Services, the designated Protection and Advocacy agency under the Developmental Disabilities Act and Bill of Rights Act, P.L. 100-146.
- Case Management conducted by a person related through blood or marriage to any degree to the waiver participant.

Service Standards

The following service standards apply to Case Management services:

- Case Managers must understand, maintain, and assert that the Medicaid program functions as the payer of last resort. The role of the Case Manager includes care planning, service monitoring, working to cultivate and strengthen informal and natural supports for each participant, 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 participant'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 DDRS/BDDS-approved training entity or person; observed a facilitation; and participated in a person-centered planning meeting prior to leading an IST.
- Participate in developing, updating, and reviewing the ISP using the person-centered planning process that is used as the basis for care planning.
- Monitor participant outcomes using a State-approved standardized tool.
- Convene team meetings at least quarterly and as needed.
- Complete and process the annual level of care determination within specified time frames.
- Maintain case notes for each participant on no less than a monthly basis.
- Complete the DDRS-approved risk assessment tool during initial assessment, annually, and any time there is a change in the participant's status.
- Monitor service delivery and utilization (via telephone calls, home visits, and team meetings) to ensure that services are being delivered in accordance with the ISP.
- Conduct face-to-face contacts with the individual (and family members, as appropriate) at least once every 90 calendar days in the home of the participant and as needed to ensure health and welfare and to address any reported problems or concerns.
- Complete and process the 90-Day Checklist in a timely fashion. (Completion must be face-to-face.)
- Develop the annual Cost Comparison Budgets using the State-approved process.
- Develop updated Cost Comparison Budgets, as needed, using the State-approved process.
- Disseminate information, including all Notices of Action and forms, to the participant and the IST within specified time frames.

- Complete, submit, and follow up on incident reports in a timely fashion using the State-approved process, including notifying the family/guardian of the incident outcome, all of which must be verifiable by documented supervisory oversight and monitoring of the Case Management agency.
- Monitor participants' health and welfare.
- Monitor participants' satisfaction and service outcomes.
- Monitor claims submitted through the approved Medicaid Management Information System (MMIS) and pertaining to waiver-funded services.
- At minimum, the Case Management agency must provide a 60-day notice to the participant (and to his or her legal guardian, if applicable) prior to the termination of Case Management services.
- Upon request of the participant and/or his or her legal guardian, if applicable, the participant's most recently selected Case Management agency must provide a pick list of alternate DDRS-approved Case Management provider agencies and assist the participant in selecting a new provider of Case Management.

Noting the participants' have right to select and transition to a new provider of Case Management services at any time, only one Case Management provider agency may bill for the authorized monthly unit of Case Management services during any given month. With the state's approval of the participant's POC/CCB, a single prior authorization of the monthly Case Management service unit will be sent from the administrative agency (DDRS) to the contractor of the MMIS. Therefore, it is *recommended* that transitions from one Case Management agency to another occur on the first day of the month. When transitions occur on other days of the month, the two providers of Case Management services must determine which provider agency will bill and whether one agency owes the other a portion of the monthly fee. Providers will handle any such transactions and/or arrangements amongst themselves, with both (or all) provider agencies being held responsible for documenting these transactions in regard to future financial audits.

Documentation Standards
Case Managers must perform and document at least one meaningful activity on behalf of the individual waiver participant each calendar month.

Preferred practice calls for activity to be documented via case note within 48 hours of a Case Management activity or event. At a minimum, a case note must be completed within seven calendar days of an activity or event.

Section 10.6: Community Based Habilitation – Group

Service Definition
Community-Based Habilitation Services - Group are services provided outside of the participant's home that support learning and assistance in the areas of self-care, sensory/motor development, socialization, daily living skills, communication, community living, and social skills. Community-based activities are intended to build relationships and natural supports.
Community settings are defined as non-residential, integrated settings that are primarily in the community

where services are not rendered within the same buildings with non-integrated (segregated) participants.

Reimbursable Activities
Reimbursable activities include the following:

- Monitoring, training, education, demonstration, or support to assist with the acquisition and retention of skills in the following areas:
- Leisure activities and community/public events (for example, integrated camp settings)
- Educational activities
- Hobbies
- Unpaid work experiences (for example, volunteer opportunities)
- Maintaining contact with family and friends
- Training and education in self-direction designed to help participants achieve one or more of the following outcomes:
- Develop self-advocacy skills
- Exercise civil rights
- Acquire skills that enable self-control and responsibility for services and supports received or needed
- Acquire skills that enable the participant to become more independent, integrated, or productive in the community

Service Standards
Community-Based Habilitation Services must be reflected in the ISP. Services must address needs identified in the person-centered planning process and be outlined in the ISP.

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

- Name of participant served
- Recipient identification (RID) number
- Name of provider
- Service rendered
- Time frame of service (include a.m. or p.m.)
- Date of service, including the year
- Notation of the primary location of service delivery
- A brief activity summary of service rendered
- In addition to the brief activity summary of service rendered, a description* should be provided by the direct care staff of any issue or circumstance concerning the participant including, but not limited to, significant medical or behavioral incidents or any other situation that may be uncommon for the participant.

- Signature that includes at least the last name and first initial of the direct care staff person making the entry.
- Electronic signatures are permissible when in compliance with the *Uniform Electronic Transactions Act (IC 26-2-8)*.
- Upon request, all data elements must be made available to auditors, quality monitors, Case Managers, and any other government entity.

*The data may reside in multiple locations but must be clearly and easily linked to the participant or the standard will not be met.

As applicable, monthly/quarterly reports must be uploaded to Advocare by the chosen service provider on or before the fifteenth day of the following month

For Group Services

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

Limitations

The following limitations apply to Community-Based Habilitation-Group Services:

- The following are limitations on group sizes:
  - Small groups (4:1 or smaller)
  - Medium groups (5:1 to 10:1)
- Habilitation services reimbursement does not include reimbursement for the cost of the activities in which the individual is participating when they receive skills training, such as the cost to attend a community event.

Activities Not Allowed

The following activities are not allowed under Community-Based Habilitation Services – Group:

- Services that are available under the *Rehabilitation Act of 1973* or *PL 94-142.*
- Skills training for any activity that is not identified as directly related to an individual habilitation outcome.
- Activities that do not foster the acquisition and retention of skills.
- Services furnished to a minor by parent(s), stepparent(s), or legal guardian.
- Services furnished to a participant by the participant's spouse.
- Services rendered in a facility.
- Group size in excess of 10:1.

Section 10.7: Community Based Habilitation – Individual

Service Definition
Community-Based Habilitation Services − Individual services are services provided outside of the Participant's home that support learning and assistance in the areas of self-care, sensory/motor development, socialization, daily living skills, communication, community living, and social skills. Community-based activities are intended to build relationships and natural supports.

Note: Community settings are defined as non-residential, integrated settings that are primarily out in the community where services are not rendered within the same buildings alongside other non-integrated participants Reimbursable Activities.

Reimbursable Activities
Reimbursable activities include the following:

- Monitoring, training, education, demonstration, or support to assist with the acquisition and retention of skills in the following areas:
- Leisure activities and community/public events (for example, integrated camp settings)
- Educational activities
- Hobbies
- Unpaid work experiences (for example, volunteer opportunities)
- Maintaining contact with family and friends
- Training and education in self-direction designed to help participants achieve one or more of the following outcomes:
- Develop self-advocacy skills
- Exercise civil rights
- Acquire skills that enable self-control and responsibility for services and supports received or needed
- Acquire skills that enable the participant to become more independent, integrated, or productive in the community

Service Standards
Community-Based Habilitation Services must be reflected in the ISP. Services must address needs identified in the person-centered planning process and be outlined in the ISP.

Documentation Standards
Community-Based Habilitation Services – Individual documentation must include services outlined in the ISP:

- Need for service continuation and justification of goals is to be evaluated annually and reflected in the ISP
- In addition to compliance with documentation requirements outlined in *460 IAC 6*, the following data elements are required for each service rendered:
- Name of participant served

- RID of the participant
- Name of provider
- Service rendered
- Time frame of service (include a.m. or p.m.)
- Date of service including the year
- Notation of the primary location of service delivery
- A brief activity summary of service rendered
- In addition to the brief activity summary of service rendered, provide a description* by direct care staff of any issue or circumstance concerning the participant including, but not limited to, significant medical or behavioral incidents or any other situation that may be uncommon for the participant
- Signature that includes at least the last name and first initial of the direct care staff person making the entry

Electronic signatures are permissible when in compliance with the *Uniform Electronic Transactions Act* (*IC 26-2-8*).

Upon request, all data elements must be made available to auditors, quality monitors, Case Managers, and any other government entity.

* The data may reside in multiple locations, but must be clearly and easily linked to the participant or the standard will not be met.

As applicable, monthly/quarterly reports must be uploaded to Advocare by the chosen service provider on or before the fifteenth day of the following month

Limitations
The following limitations apply to Community-Based Habilitation - Individual services:

- The allowable participant/staff ratio is 1:1.
- Habilitation services reimbursement does not include reimbursement for the cost of the activities in which the individual is participating when they receive skills training, such as the cost to attend a community event.

Note: Effective July 1, 2015, Community Based Habilitation - Individual is limited to ten hours per month from their RHS Daily provider for participants who also utilize RHS Daily services under the Community Integration and Habilitation (CIH) Waiver.

Activities Not Allowed
The following activities are not allowed under Community-Based Habilitation Services – Individual:

- Services that are available under the *Rehabilitation Act of 1973* or *PL 94-142*.
- Skills training for any activity that is not identified as directly related to an individual habilitation outcome.

- Activities that do not foster the acquisition and retention of skills.
- Services furnished to a minor by parent(s), stepparent(s) or legal guardian.
- Services furnished to a participant by the participant's spouse.
- Services rendered in a facility.

Section 10.8: Community Transition *(currently under CIHW only)*

Service Definition

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

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

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

Reimbursable Activities
Reimbursable activities include the following:

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

When the individual is receiving Residential Habilitation and Support, Structured Family Caregiving services, or Community-Based Habilitation - Individual services under the CIH Waiver, the Community Transition Supports service is included in the Cost Comparison Budget.

Service Standards
Community Transition services must be reflected in the ISP and the Cost Comparison Budget (POC/CCB) of the individual.

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

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

Limitations
The following limitations apply to Community Transition Services:

- Community Transition Services are limited to one-time set-up expenses, up to $1,000.

Activities Not Allowed
The following activities are not allowed under Community Transition services:

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

Section 10.9: Electronic Monitoring *(currently under CIHW only)*

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

Reimbursable Activities
Reimbursable activities include the following:

- Electronic Monitoring/Surveillance System and On-Site Response may be installed in residential settings in which all residing adult participants, their guardians, and their support teams request such surveillance and monitoring in place of on-site staffing.
- Use of the system may be restricted to certain hours through the ISPs of the participants involved.

Service Standards
To be reimbursed for operating an electronic monitoring and surveillance system, a provider must adhere to the following:

- The system to be installed must be reviewed and approved by the Director of the DDRS.
- The Electronic Monitoring/Surveillance System and On-Site Response system must be designed and implemented to ensure the health and welfare of the participant in his or her own home/apartment and achieve this outcome in a cost-neutral manner.

Note: The Case Manager and/or the DDRS/BDDS Service Coordinator will review the use of the system at seven calendar days, and again at 14 calendar days post-installation.

- Services provided to waiver participants or otherwise reimbursed by the Medicaid program is subject to oversight/approval from the FSSA/OMPP.
- Retention of written documentation is required for seven years
- Retention of video/audio records, including computer vision, audio, and sensor information, shall be retained for seven years if an incident report is filed.

Assessment and Informed Consent

The following are key points regarding assessment and informed consent:

- Initial assessment: Participants requesting this service must be preliminarily assessed by the IST for appropriateness in ensuring the health and welfare of the participants and have written approval by HRC. These actions must be documented in the ISP and the DDRS Case Management system.
- Informed consent: Each participant, guardian, and IST must be made aware of both the benefits and risks of the operating parameters and limitations. Informed consent documents must be acknowledged in writing, signed and dated by the participant, guardian, Case Manager, and provider agency representative, as appropriate. A copy of the consent shall be maintained by the local DDRS/BDDS office, the guardian (if applicable), and in the home file.
- Annual assessment updates: At least annually, the IST must assess and determine that continued usage of the electronic monitoring system will ensure the health and welfare of the participant. The results of this assessment must be documented in the ISP and in the DDRS Case Management system. A review of all incident reports and other relevant documentation must be part of this assessment.

System Design

The following are requirements of an electronic monitoring system design:

- The provider must have safeguards and/or backup system such as battery and generator for the electronic devices in place at the monitoring base and the participant'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, participant medical issue, or personal emergency in place and detailed in writing for each site utilizing the system as well as in each participant's ISP. This plan should specify the staff person or persons to be contacted by monitoring base staff who will be responsible for responding to these situations and traveling to the participant's living sites.
- The electronic monitoring system must receive notification of smoke/heat alarm activation at each participant's residential living site.

- The electronic monitoring system must have two-way (at minimum, full duplex) audio communication capabilities to allow monitoring base staff to effectively interact with and address the needs of participants in each living site, including emergency situations when the participant may not be able to use the telephone.
- The electronic monitoring system must allow the monitoring base staff to have visual (video) oversight of areas in participant's residential living sites deemed necessary by the IST.
- A monitoring base may not be located in a participant's residential living site.
- A secure (compliant with the *Health Insurance Portability and Accountability Act* – HIPAA) network system requiring authentication, authorization, and encryption of data must be in place to ensure access to computer vision, audio, sensor or written information is limited to authorized staff including the parent/guardian, provider agency, Family and Social Services Administration (FSSA), the DDRS, the BDDS, the Bureau of Quality Improvement Services (BQIS), the Qualified Intellectual Disability Professional (QIDP), Case Manager, and participant.
- The equipment must include a visual indicator to the participant that the system is on and operating.
- Situations involving electronic monitoring of participants needing 24 hour support. If a participant indicates that he or she wants the electronic monitoring system to be turned off, the following protocol will be implemented:
- The electronic caregiver will notify the provider to request an on-site staff.
- The system would be left operating until the on-site staff arrives.
- The electronic caregiver would turn off the system at that site after it has been relieved by an on-site staff.
- A visible light on the control box would signal when the system is on and when it is off.

Monitoring Base Staff

The following are requirements for monitoring base staff:

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

- The monitoring base staff must have detailed and current written protocols for responding to the needs of each participant at each remote living site, including contact information for staff to supply on-site support at the participant's residential living site, when necessary.

The following are requirements for stand-by intervention staff (float staff):

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

Documentation Standards

Documentation must include the following:

Services outlined in the ISP:

- To be reimbursed, the provider must prepare and be able to produce the following:
- Status as a DDRS/BDDS-approved provider
- Approval of the specific electronic monitoring/surveillance system by the Director of the DDRS.
- Case notes regarding the assessment and approval by both the IST of each participant and the HRC, documented within both the DDRS system and the ISP.
- Informed consent documents written, signed and dated by the participant, guardian, Case Manager, and provider agency representative, as appropriate. Copies of consent documents maintained by the local DDRS/BDDS office, the Case Manager, the guardian (if applicable) and in the home file.
- Proof of utilization of the electronic monitoring device outlined in the ISPs, and budgets of *each* participant in a setting, including typical hours of electronic monitoring
- Each remote site will have a written policy and procedure approved by the DDRS (and available to the FSSA/OMPP for all providers serving waiver participants) that defines emergency situations and details how remote and float staff will respond to each. Examples include
- Fire, medical crises, stranger in the home, violence between participants, and any other situation that appears to threaten the health or welfare of the participant.
- Emergency response drills must be carried out once per quarter per shift in each home equipped with and capable of utilizing the electronic monitoring service. Documentation of the drills must be available for review upon request.
- The remote monitoring base staff shall generate a written report on each participant served in each participant's residential living site on a daily basis. This report will follow documentation standards of the Residential Habilitation Services. This report must be transmitted to the primary RHS provider daily.

- Each time an emergency response is generated, an incident report must be submitted to the State per the DDRS/BDDS and DDRS/BQIS procedures.
- At least every 90 calendar days, the appropriateness of continued use of the monitoring system must be reviewed by the IST; the results of these reviews must be documented in the DDRS Case Management system and/or the ISP. Areas to be reviewed include but are not limited to the number and nature of responses to the home as well as damage to the equipment.

As applicable, monthly/quarterly reports must be uploaded to Advocare by the chosen service provider on or before the fifteenth day of the following month

Limitations and Reimbursement Parameters

The following limitations apply to Electronic Monitoring services:

- The budget will be completed for each participant based upon the total number of participants residing within the residence. However, lower Tiers may also appear on the service plans to reflect reimbursement rates for situations where one or more participant is away from the home during service utilization.

- Reimbursement will then be the hourly rate of $13.62 divided by and among the number of participants who are at home during the hours of utilization. If only one participant from a four-participant setting is at home during service utilization, the solitary participant pays the full hourly rate of $13.62. If only two of the four participants are home, each pays $6.81 per hour of utilization, and if three of the four are home, each pays $4.54 per hour of utilization.

Table 4 – Reimbursement Rates by Tier

Tier	Number of Participants	Reimbursement
Tier 1	One participant in a home	$13.62
Tier 2	Two participants in a home	$6.81
Tier 3	Three participants in a home	$4.54
Tier 4	Four participants in a home	$3.41

Billing clarification: When all service standards are met, the service provider shall be reimbursed at the full unit rate for each hour that the Electronic Monitoring service is rendered. The unit rate for each hour of Electronic Monitoring 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. All participants present must be CIHW participants who have chosen to utilize this service.

Activities Not Allowed

The following activities are not allowed under Electronic Monitoring:

- Electronic monitoring and surveillance systems that have not received specific approval by the DDRS.

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

Section 10.10: Environmental Modifications *(currently under CIHW only)*

Service Definition
Those physical adaptations to the home, required by the individual's plan of care (POC), that are necessary to ensure the health, welfare, and safety of the individual, or that enable the individual to function with greater independence in the home, and without which the individual would require institutionalization.
The FSSA/DDRS waiver specialist must approve all environmental modifications prior to service being rendered.

Reimbursable Activities
Reimbursable activities include the following:

- Installation of ramps and grab bars
- Widening doorways
- Modifying existing bathroom facilities
- Installation of specialized electric and plumbing systems necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the individual, including anti-scald devices
- Maintenance and repair of the items and modifications installed during the initial request
- Assessment and inspection

Service Standards

The following service standards apply to Environmental Modifications:

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

Documentation Standards

Documentation standards for Environmental Modifications include the following:

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

Limitations

The following limitations apply to Environmental Modifications:

- Reimbursement for Environmental Modification services has a lifetime cap of $15,000.
- Service and repair up to $500 per year, outside this cap, is permitted for maintenance and repair of prior modifications that were funded by a waiver service.
- If the lifetime cap is fully utilized, and a need is identified, the Case Manager will work with other available funding streams and community agencies to fulfill the need.

Activities Not Allowed

The following activities are not allowed under Environmental Modifications services:

- Adaptations to the home that are of general utility
- Adaptations that are not of direct medical or remedial benefit to the individual (such as carpeting, roof repair, or central air conditioning)
- Adaptations that add to the total square footage of the home
- Adaptations that are not included in the comprehensive plan of care (POC)
- Adaptations that have not been approved on a *Request for Approval to Authorize Services* form

- Adaptations to service provider-owned and -leased housing. Home accessibility modifications as a service under the waiver may not be furnished to individuals who receive residential habilitation and support services, except when such services are furnished in the participant's own home.
- Compensation for the costs of life safety code modifications and other accessibility modifications made with participant waiver funds to provider-owned housing.

Section 10.11: Extended Services

Service Definition

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

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

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

Reimbursable Activities

Reimbursable activities include the following:

- Ensuring that natural supports at the work site are secured through interaction with supervisors and staff. A tangible outcome of this activity would be a decrease in the number of hours of Extended Services an individual accessed over time.
- Training for the participant, and/or the participant's employer, supervisor or coworkers, to increase the participant's inclusion at the worksite.
- Regular observation or supervision of the participant to reinforce and stabilize the job placement.
- Job-specific or job-related safety training.
- Job-specific or job-related self-advocacy skills training.
- Reinforcement of work-related personal care and social skills.

- Training on use of public transportation and/or acquisition of appropriate transportation.
- Facilitating, but not funding, driver's education training.
- Coaching and training on job-related tasks such as computer skills or other job-specific tasks.

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

For Extended Services provided in a group setting, reimbursement equals the unit rate divided by the number of individuals served.

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

Additional Information

- Individuals may also utilize Workplace Assistance during any hours of competitive integrated employment in conjunction with their use of Extended Services.
- Extended Services are not time-limited.
- Community settings are defined as non-residential, integrated settings that are in the community. Services may not be rendered within the same building(s) alongside other non-integrated participants.
- Competitive integrated employment is defined as full or part-time work at minimum wage or higher, with wages and benefits similar to those without disabilities performing the same work, and fully integrated with co-workers without disabilities.
- Individuals may be self-employed, working from their own homes, and still receive Extended Services when the work is competitive and could also be performed in an integrated environment by and among persons without intellectual/developmental disabilities.

Service Standards

Extended Services are provided in integrated community settings where persons without disabilities are also employed. Reimbursement will only be made for the employment support services required by the individual receiving services as a result of their disability.
Extended Services do not include sheltered work or other similar types of vocational services furnished in specialized facilities or volunteer endeavors.

An individuals' ISP should be constructed in a manner that reflects individual informed choice and goals relating to employment and ensures provision of services in the most integrated setting possible. The Extended Services supports should be designed to support employment outcomes that lead to further

independence and are consistent with the individual's goals.

Documentation Standards
Individual informed choices and goals related to employment and the justification/need for Extended Services must be outlined in the Individualized Support Plan.

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

- Name of participant served
- RID number of the participant
- Name of provider
- Identified employment need
- Service rendered
- Expected outcome
- Date of service including the year
- Time frame of service (include a.m. or p.m.) (from/to)
- Notation of the primary location of service delivery
- A summary of services rendered to include the specific reimbursable activities that were performed and the outcomes realized from those activities.
- A description of any issue or circumstance concerning the participant including, but not limited to, significant medical or behavioral incidents or any other situation that may be uncommon for the individual
- Signature that includes at least the last name and first initial of the staff person making the entry
- Electronic signatures are permissible when in compliance with the Uniform Electronic Transactions Act (*IC 26-2-8*)
- Upon request, all data elements must be made available to auditors, quality monitors, case managers, and any other government entity.

*The data may reside in multiple locations but must be clearly and easily linked to the individual or the standard will not be met.

As applicable, monthly/quarterly reports must be uploaded to Advocare by the chosen service provider on or before the fifteenth day of the following month

Limitations
The following limitations apply to Extended Services:

- Only those waiver participants engaged in competitive community employment and actively utilizing a combination of Supported Employment Follow-Along (SEFA) and Prevocational services as of June 30, 2015 (as reflected in their ISP, approved POC/CCB and NOA) may utilize the combination of Extended Services and Prevocational services on or after July 1, 2015.

- Group services may only be rendered at the discretion of the IST and in group sizes no greater than four individuals to one staff. In addition, the provider must be able to provide appropriate documentation, as outlined in the Indiana Health Coverage Programs' Provider Reference Module titled ***Division of Disability and Rehabilitative Services Home and Community-Based Services Waivers***, demonstrating that the ratio for each claimed time frame of services did not exceed the maximum allowable ratio determined by the IST for each group participant, and provide documentation identifying other group participants, by using the individuals' HIPAA naming convention.

Activities Not Allowed

Reimbursement is not available under Extended Services for the following activities:

- Any non-community based setting where the majority (51% or more) of the individuals have an Intellectual or Developmental Disability.
- Sheltered work observation or participation.
- Volunteer endeavors.
- Any service that is otherwise available under the Rehabilitation Act of 1973 or Public Law 94-142.
- Public relations.
- Incentive payments made to an employer to subsidize the employer's participation in Extended Services.
- Payment for vocational training that is not directly related to the individual's Extended Service needs outlined in the ISP.
- Extended Services do not include payment for supervisory activities rendered as a normal part of the business setting.
- Extended Services provided to a minor by a parent(s), step-parent(s), or legal guardian, or spouse.
- Waiver funding is not available for the provision of vocational services delivered in facility based or sheltered work settings, where individuals are supervised for the primary purpose of producing goods or performing services.
- The provision of transportation is not a reimbursable activity within Extended Services.
- Only those waiver participants who were engaged in competitive community employment and actively utilizing a combination of Supported Employment Follow-Along (SEFA) and Prevocational services as of June 30, 2015 (as reflected in their ISP, approved POC/CCB and NOA) may utilize the combination of Extended Services and Prevocational services on or after July 1, 2015. Effective July 1, 2015, for all other waiver participants, there is no longer an option to utilize this service combination as Prevocational services and Extended Services are considered to be mutually exclusive and shall not overlap. The latter group of waiver participants includes all new enrollees to the waiver as well as other active participants not utilizing a combination of Extended Services and Prevocational services as of June 30, 2015, whether or not they are/were engaged in competitive community employment. Going forward, individuals from the latter group of waiver participants who engage competitive community employment are no longer eligible for Prevocational services.

- Group supports delivered to individuals who are utilizing different support options. For example, one individual in the group is using Extended Services and another individual in the same group setting is using Facility-Based Habilitation. This type of activity would not be allowed.

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

Section 10.12: Facility Based Habilitation – Group

Service Definition
Facility-Based Habilitation Services are services provided outside of the participant's home and within the facility of a DDRS-approved provider. These services support learning and assistance in the areas of self-care, sensory/motor development, socialization, daily living skills, communication, community living, and social skills.

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

Reimbursable Activities
Reimbursable activities include the following:

- Monitoring, training, education, demonstration, or support to assist with the acquisition and retention of skills in the following areas:
- Leisure activities (for example, segregated camp settings)
- Educational activities
- Hobbies
- Unpaid work experiences (that is, volunteer opportunities)
- Maintaining contact with family and friends
- Training and education in self-direction designed to help participants achieve one or more of the following outcomes:
- Develop self-advocacy skills
- Exercise civil rights
- Acquire skills that enable self-control and responsibility for services and supports received or needed
- Acquire skills that enable the participant to become more independent, integrated, or productive in the community

Service Standards
The following service standards apply to Facility-Based Habilitation – Group Services:

- Facility-Based Habilitation – Group Services must be reflected in the ISP.
- Services must address needs identified in the person-centered planning process and be outlined in the ISP.

Documentation Standards
Documentation standards for Facility-Based Habilitation - Group include the following:

- Services outlined in the ISP.
- In addition to compliance with documentation requirements outlined in *460 IAC 6*, the following data elements are required for each service rendered:
- Name of participant served.
- RID of the participant.
- Name of provider.
- Service rendered.
- Time frame of service (include a.m. or p.m.).
- Date of service including the year.
- Notation of the primary location of service delivery.
- A brief activity summary of service rendered.
- In addition to the brief activity summary of service rendered, provide a description* by direct care staff of any issue or circumstance concerning the participant including, but not limited to, significant medical or behavioral incidents or any other situation that may be uncommon for the participant.
- Signature that includes at least the last name and first initial of the direct care staff person making the entry. Electronic signatures are permissible when in compliance with the *Uniform Electronic Transactions Act* (*IC 26-2-8*).
- Upon request, all data elements must be made available to auditors, quality monitors, Case Managers, and any other government entity.

* The data may reside in multiple locations, but must be clearly and easily linked to the participant or the standard will not be met.

As applicable, monthly/quarterly reports must be uploaded to Advocare by the chosen service provider on or before the fifteenth day of the following month

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

Limitations
The following limitations apply to Facility-Based Habilitation – Group services:

- The following are limitations on group sizes:

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

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

Activities Not Allowed
The following activities are not allowed under Facility-Based Habilitation – Group:

- Services that are available under the *Rehabilitation Act of 1973* or *PL 94-142*
- Skills training for any activity that is not identified as directly related to an individual habilitation outcome
- Activities that do not foster the acquisition and retention of skills
- Activities that would normally be a component of a person's residential life or services, such as shopping, banking, household errands, medical appointments, and so forth
- Services furnished to a minor by parent(s), stepparent(s), or legal guardian
- Services furnished to a participant by the participant's spouse

Section 10.13: Facility Based Habilitation – Individual

Service Definition
Facility-Based Habilitation - Individual services are provided outside of the participant's home and within the facility of a DDRS-approved provider. These services support learning and assistance in the areas of self-care, sensory/motor development, socialization, daily living skills, communication, community living, and social skills.

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

Reimbursable Activities
Reimbursable activities include the following:

- Monitoring, training, education, demonstration, or support to assist with the acquisition and retention of skills in the following areas:
- Leisure activities (that is, segregated camp settings)
- Educational activities
- Hobbies

- Unpaid work experiences (that is, volunteer opportunities)
- Maintaining contact with family and friends
- Training and education in self-direction designed to help participants achieve one or more of the following outcomes:
- Develop self-advocacy skills
- Exercise civil rights
- Acquire skills that enable the ability to exercise self-control and responsibility over services and supports received or needed
- Acquire skills that enable the participant to become more independent, integrated, or productive in the community

Service Standards
The following service standards apply to Facility-Based Habilitation – Individual:

- Facility Based Habilitation - Individual services must be reflected in the ISP.
- Services must address needs identified in the person-centered planning process and be outlined in the ISP.

Documentation Standards
Documentation standards for Facility-Based Habilitation – Individual include the following:

- Services outlined in the ISP
- In addition to compliance with documentation requirements outlined in *460 IAC 6*, the following data elements are required for each service rendered:
- Name of participant served
- RID of the participant
- Name of provider
- Service rendered
- Time frame of service (include a.m. or p.m.)
- Date of service including the year
- Notation of the primary location of service delivery
- A brief activity summary of service rendered
- In addition to the brief activity summary of service rendered, provide a description* by direct care staff of any issue or circumstance concerning the participant including, but not limited to, significant medical or behavioral incidents or any other situation that may be uncommon for the participant.
- Signature that includes at least the last name and first initial of the direct care staff person making the entry. Electronic signatures are permissible when in compliance with the *Uniform Electronic Transactions Act* (*IC 26-2-8*).
- Upon request, all data elements must be made available to auditors, quality monitors, Case Managers, and any other government entity.

- The data may reside in multiple locations but must be clearly and easily linked to the participant or the standard will not be met.

As applicable, monthly/quarterly reports must be uploaded to Advocare by the chosen service provider on or before the fifteenth day of the following month

Limitations
The following are limitations on Facility-Based Habilitation – Individual services:

- The allowable staffing ratio is 1:1
- Habilitation services reimbursement does not include reimbursement for the cost of the activities in which the individual is participating when they receive skills training, such as the cost to attend a camp.

Activities Not Allowed
The following activities are not allowed under Facility-Based Habilitation – Individual:

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

Section 10.14: Facility Based Support Services

Service Definition
Facility-Based Support services are facility-based group programs designed to meet the needs of participants with impairments through individual POC. These structured, comprehensive, nonresidential programs provide health, social, recreational, therapeutic activities, supervision, support services, and personal care and may also include optional or non-work related educational and life skill opportunities. Participants attend on a planned basis.

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

Reimbursable Activities
Reimbursable activities include the following:

- Monitoring and/or supervision of activities of daily living (ADLs) defined as dressing, grooming, eating, walking, and toileting with hands-on assistance provided as needed
- Appropriate structure, supervision, and intervention

- Minimum staff ratio: 1 staff for each 16 participants
- Medication administration
- Optional or non-work related educational and life skill opportunities (such as how to use computers/computer programs/Internet, set an alarm clock, write a check, fill out a bank deposit slip, plant and care for vegetable/flower garden, and so on) may be offered and pursued

Service Standards
The following service standards apply to Facility-Based Support services:

- Facility-Based Support services must be reflected in the ISP.
- Facility-Based Support services must follow a written POC addressing specific needs as identified in the ISP.

Documentation Standards
Documentation standards for Facility-Based Support services include the following:

- Services outlined in the ISP
- In addition to compliance with documentation requirements outlined in *460 IAC 6*, the following data elements are required for each service rendered:
- Name of participant served.
- RID of the participant.
- Name of provider.
- Service rendered.
- Time frame of service (include a.m. or p.m.).
- Date of service including the year.
- Notation of the primary location of service delivery.
- A brief activity summary of service rendered.
- In addition to the brief activity summary of service rendered, provide a description* by direct care staff of any issue or circumstance concerning the participant including, but not limited to, significant medical or behavioral incidents or any other situation that may be uncommon for the participant.
- Signature that includes at least the last name and first initial of the direct care staff person making the entry. Electronic signatures are permissible when in compliance with the *Uniform Electronic Transactions Act* (*IC 26-2-8*).
- Upon request, all data elements must be made available to auditors, quality monitors, Case Managers, and any other government entity.

* The data may reside in multiple locations but must be clearly and easily linked to the participant, or the standard will not be met.

As applicable, monthly/quarterly reports must be uploaded to Advocare by the chosen service provider on or before the fifteenth day of the following month

For Group Services

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

Limitations
The following are limitations on Facility-Based Support services:

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

Activities Not Allowed
The following activities are not allowed under Facility-Based Support services:

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

Section 10.15: Family and Caregiver Training

Service Definition
Family and Caregiver Training services provide training and education in order to:

- Instruct a parent, other family member, or primary caregiver about the treatment regimens and use of equipment specified in the ISP and
- Improve the ability of the parent, family member, or primary caregiver to provide the care to or for the individual.

Reimbursable Activities
Reimbursable activities include the following:

- Treatment regimens and use of equipment
- Stress management
- Parenting training specific to the disability of the child
- Family dynamics training specific to the disability of the child
- Community integration
- Behavioral intervention strategies
- Mental health training specific to the disability of the child

- Caring for medically fragile individuals

Service Standards
The following service standards apply to Family and Caregiver Training services:

- Family and Caregiver Training services must be included in the ISP.
- The ISP shall be based on the person-centered planning process for that individual.

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

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

As applicable, monthly/quarterly reports must be uploaded to Advocare by the chosen service provider on or before the fifteenth day of the following month

Limitations
The following limitations apply to Family and Caregiver Training services:

- Reimbursement for this service is limited to $2,000 per year.

Activities Not Allowed
The following activities are not allowed under Family and Caregiver Training services:

- Training/instruction not pertinent to the caregiver's ability to give care to the individual
- Training provided to caregivers who receive training reimbursement within their Medicaid or State line item reimbursement rates
- Meals, accommodations, and so on, while attending the training

Section 10.16: Intensive Behavioral Intervention

Service Definition
Intensive Behavioral Intervention (IBI) is a highly specialized, individualized program of instruction and behavioral intervention. IBI is based upon a functional, behavioral and/or skills assessment of an individual's treatment needs. The primary goal of IBI is to reduce behavioral excesses, such as tantrums and acting-out behaviors, and to increase or teach replacement behaviors that have social value for the individual and increase access to their community. Program goals are accomplished by the application of research-based interventions.

Generally, IBI addresses manifestations that are amenable to change in response to specific, carefully

programmed, constructive interactions with the environment.

IBI must include:

- A detailed functional/behavioral assessment
- Reinforcement
- Specific and ongoing objective measurement of progress
- Family training and involvement so that skills can be generalized and communication promoted
- Emphasis on the acquisition, generalization, and maintenance of new behaviors across other environments and with other people
- Training of caregivers, IBI direct care staff, and providers of other waiver services
- Breaking down targeted skills into small, manageable, and attainable steps for behavior change
- Utilizing systematic instruction, comprehensible structure, and high consistency in all areas of programming
- Provision for one-on-one structured therapy
- Treatment approach tailored to address the specific needs of the individual
- Skills training under IBI must include
- Measurable goals and objectives (specific targets may include appropriate social interaction, negative or problem behavior, communication skills, and language skills)
- Heavy emphasis on skills that are prerequisites to language (attention, cooperation, imitation)

Reimbursable Activities

Reimbursable activities include the following:

- Preparation of an IBI support plan in accordance with the DDRS' Behavioral Support Plan Policy
- 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:
    - Antecedent: A directive or request for the individual to perform an action
    - Behavior: A response from the individual, including anything from successful performance, non-compliance, or no response
    - Consequence: A reaction from the therapist, including a range of responses from strong positive reinforcement, faint praise, or a negative (not aversive) reaction
    - A pause to separate trials from each other (inter-trial interval)
- Natural Environment Training (NET) is learner-directed training in which the learner engages in activities that are naturally motivating and reinforcing to him or her, rather than the more contrived reinforcement employed in ITT.

- Interventions that are supported by research in behavior analysis and that have been found to be effective in the treatment of individuals with intellectual/developmental disabilities, which may include but are not limited to:
    - Precision teaching: A type of programmed instruction that focuses heavily on frequency as its main datum. It is a precise and systematic method of evaluating instructional tactics. The program emphasizes learner fluency and data analysis is regularly reviewed to determine fluency and learning.
    - Direct instruction: A general term for the explicit teaching of a skill-set. The learner is usually provided with some element of frontal instruction of a concept or skill lesson followed by specific instruction on identified skills. Learner progress is regularly assessed and data analyzed.
    - Pivotal response training: This training identifies certain behaviors that are "pivotal" (that is, critical for learning other behaviors). The therapist focuses on these behaviors 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.

Service Standards

The following service standards apply to Intensive Behavioral Intervention services:

- An appropriate range of hours per week is generally between 20-30 hours of direct service. It is recommended that IBI services be delivered a minimum of 20 hours per week. When fewer than 20 hours per week will be delivered, justification must be submitted explaining why the IST feels a number fewer than the recommended minimum is acceptable.
- A detailed IBI support plan is required.
- At least quarterly, the IST must meet to review the IBI, consider the need for change, develop a new plan, or set new goals.
- IBI services must be reflected in the ISP.
- Services must address needs identified in the person-centered planning process and be outlined in the ISP.
- Services must be detailed in the IBI support plan.
- Services are usually direct and one-to-one, with the exception of time spent in training the caregivers and the family, performing ongoing data collection and analysis, and revising goals and plans.
- The IBI Case Supervisor will provide a narrative and graphical report to pertinent parties at least monthly. Pertinent parties include the individual, IBI Director, guardian, DDRS/BDDS service coordinator, waiver Case Manager, all service providers, and other entities.

- The IBI Director will provide a narrative and graphical report to pertinent parties at least quarterly. Pertinent parties include the individual, IBI Case Supervisor, guardian, DDRS/BDDS service coordinator, waiver Case Manager, all service providers, and other entities.

Documentation Standards
Documentation standards for Intensive Behavioral Intervention services include the following:

- Services outlined in the ISP.
- Documentation in compliance with *460 IAC 6*.
- The IBI Case Supervisor will provide a narrative and graphical report to pertinent parties at least monthly. Pertinent parties include the individual, IBI Director, guardian, DDRS/BDDS service coordinator, waiver Case Manager, all service providers, and other entities.
- The IBI Director will provide a narrative and graphical report to pertinent parties at least quarterly. Pertinent parties include the individual, IBI Case Supervisor, guardian, DDRS/BDDS service coordinator, waiver Case Manager, all service providers, and other entities.

As applicable, monthly/quarterly reports must be uploaded to Advocare by the chosen service provider on or before the fifteenth day of the following month

Limitations
The following limitations apply to Intensive Behavioral Intervention services:

- See *Activities Not Allowed*.

Activities Not Allowed
The following activities are not allowed under Intensive Behavioral Intervention services:

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

Section 10.17: Music Therapy

Service Definition
Music Therapy services are services provided for the systematic application of music in the treatment of the physiological and psychosocial aspects of an individual's disability and focusing on the acquisition of nonmusical skills and behaviors.

Reimbursable Activities
Reimbursable activities include the following:

Therapy to improve:

- Self-image and body awareness
- Fine and gross motor skills
- Auditory perception
- Therapy to increase
- Communication skills
- Ability to use energy purposefully
- Interaction with peers and others
- Attending behavior
- Independence and self-direction
- Therapy to reduce maladaptive (stereotypic, compulsive, self-abusive, assaultive, disruptive, perseverative, or impulsive) behaviors
- Therapy to enhance emotional expression and adjustment
- Therapy to stimulate creativity and imagination. The music therapist may provide services directly, or may demonstrate techniques to other service personnel or family members
- Planning, reporting, and write-up when in association with the actual one-on-one direct care/therapy service delivery with the waiver participant
- Individual
- Group services in group sizes no greater than four participants to one Music Therapist (Unit rate divided by number of participants served)

Service Standards
The following service standards apply to Music Therapy services:

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

Documentation Standards
Documentation standards for Music Therapy services include the following:

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

As applicable, monthly/quarterly reports must be uploaded to Advocare by the chosen service provider on or before the fifteenth day of the following month

Limitations
The following limitations apply to Music Therapy services:

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

Activities Not Allowed
The following activities are not allowed under Music Therapy services:

- Any services that are reimbursable through the Medicaid State Plan.
- Therapy services furnished to the participant within the educational/school setting or as a component of the participant's school day
- Specialized equipment needed for the provision of Music Therapy services should be purchased under "Specialized Medical Equipment and Supplies."
- Activities delivered in a nursing facility
- Group sizes greater than four participants to one Music Therapist or group sizes exceeding the maximum allowable group size determined by the IST for each group participant

Section 10.18: Occupational Therapy

Service Definition
Occupational Therapy services means services provided by a licensed/certified occupational therapist.

These services cannot be provided as a substitute for services offered under the Medicaid State Plan.

Reimbursable Activities
Reimbursable activities include the following:

- Evaluation and training services in the areas of gross and fine motor function, self-care, and sensory and perceptual motor function.
- Screening
- Assessments
- Planning, reporting, and write-up when in association with the actual one-on-one direct care/therapy service delivery with the waiver 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
The following service standards apply to Occupational Therapy services:

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

Documentation Standards
Documentation standards for Occupational Therapy services include the following:

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

As applicable, monthly/quarterly reports must be uploaded to Advocare by the chosen service provider on or before the fifteenth day of the following month

Limitations
The following limitations apply to Occupational Therapy services:

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

Activities Not Allowed
The following activities are not allowed under Occupational Therapy services:

- Therapy services furnished to the participant within the educational/school setting or as a component of the participant's school day
- Activities delivered in a nursing facility
- Services that are 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).

Section 10.19: Participant Assistance and Care (PAC) *(currently under FSW only)*

Service Definition
Participant Assistance and Care (PAC) services are provided in order to allow participants (consumers) with intellectual/developmental disabilities to remain and live successfully in their own homes, function and

participate in their communities, and avoid institutionalization. PAC services support and enable the participant in activities of daily living, self-care, and mobility with the hands-on assistance, prompting, reminders, supervision, and monitoring needed to ensure the health, safety, and welfare of the participant.

Reimbursable Activities
Reimbursable activities under Participant Assistance and Care services include the following:

- Activities may include any task or tasks of direct benefit to the participant that would generally be performed independently by persons without intellectual/developmental disabilities or by family members for or on behalf of persons with intellectual/developmental disabilities.
- Examples of activities include but are not limited to the following:
    - Assistance with personal care, meals, shopping, errands, scheduling appointments, chores, and leisure activities (excluding the provision of transportation)
    - Assistance with mobility – including but not limited to transfers, ambulation, use of assistive devices
    - Assistance with correspondence and bill-paying
    - Escorting the participant to community activities and appointments
    - Supervision and monitoring of the participant
    - Reinforcement of behavioral support
    - Adherence to risk plans
    - Reinforcement of principle of health and safety
    - Completion of task list
- Participating on the IST for the development or revision of the service plan (staff must attend the IST meeting in order to claim reimbursement)

Service Standards
The following service standards apply to Participant Assistance and Care services:

- PAC services must follow a written POC addressing the specific needs determined by the participant's assessment and identified in the ISP
- Ability to consult with a nurse as needed (on staff or on call for the provider)

Documentation Standards
Participant Assistance and Care services documentation must include:

- Recorded completion of tasks on a participant-specific Task List (created by the IST) that includes identification of the paid staff members as well as the date and start/stop time of each waiver-funded shift
- Documentation in compliance with *460 IAC 6*

As applicable, monthly/quarterly reports must be uploaded to Advocare by the chosen service provider on or before the fifteenth day of the following month

Limitations
The following limitations apply to Participant Assistance and Care services:

- Parent(s), stepparent(s) and legal guardians may not be paid to provide care to minor children while other relatives* or groups of relatives may provide a combined total of up to 40 hours per week in PAC services to a minor child.
- Spouses may not provide paid services at all, while reimbursable waiver-funded PAC services furnished to an adult waiver participant by any combination of relatives* and/or legal guardians may not exceed a combined total of 40 hours per week.
- Related/relative implies any of the following natural, adoptive and/or step relationships, whether by blood or by marriage, inclusive of half and/or in-law status:
    - Aunt (natural, step, adopted)
    - Brother (natural, step, half, adopted, in-law)
    - Child (natural, step, adopted)
    - First cousin (natural, step, adopted)
    - Grandchild (natural, step, adopted)
    - Grandparent (natural, step, adopted)
    - Nephew (natural, step, adopted)
    - Niece (natural, step, adopted)
    - Parent (natural, step, adopted, in-law)
    - Sister (natural, step, half, adopted, in-law)
    - Spouse (husband or wife)
    - Uncle (natural, step, adopted)

Available individually or as a shared service:

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

Activities Not Allowed

PAC services will not be provided to household members other than to the waiver participants.

Reimbursement is not available through PAC in the following circumstances:

- When services are furnished to a *minor* by the parents, stepparents, or legal guardians
- When services are furnished to a participant by the participant's spouse
- When services furnished to a minor by relatives* other than parents, stepparents, or legal guardians exceed a combined total of 40 hours per week
- When services furnished to an adult by any combination of relatives* exceed a combined total of 40 hours per week
- When Indiana Medicaid State Plan services are available for the same tasks
- When services provided are available under the Rehabilitation Act of 1973 or section 602(16) & (17) of the Individuals with Disabilities Education Act

- Homeschooling, special education, and related activities
- When the participant is admitted to an institutional facility (for example, Acute Hospital, Nursing Facility, ICF/IID)
- For homemaker or maid service
- As a substitute for care provided by a registered nurse, licensed practical nurse, licensed physician, behaviorist, licensed therapist, or other health professional.
- Transportation costs are not included

Section 10.20: Personal Emergency Response System (PERS)

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

Reimbursable Activities
Reimbursable activities include the following:

- Device installation service
- Ongoing monthly maintenance of the device

Service Standards
Service standards require that Personal Emergency Response System must be included in the ISP.

Documentation Standards
Documentation standards for a Personal Emergency Response System include the following:

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

Limitations
The following limitations apply to Personal Emergency Response System services:

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

Activities Not Allowed
Reimbursement is not available for PERS supports when the individual requires constant supervision to maintain health and safety.

Section 10.21: Physical Therapy

Service Definition
Physical Therapy services means services provided by a licensed physical therapist.

These services cannot be provided as a substitute for services offered under the Medicaid State Plan.

Reimbursable Activities
Reimbursable activities include the following:

- Screening and assessment
- Treatment and training programs designed to preserve and improve abilities for independent functioning, such as gross and fine motor skills, range of motion, strength, muscle tone, and activities of daily living
- Planning, reporting, and write-up when in association with the actual one-on-one direct care/therapy service delivery with the waiver 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
The following service standards apply to Physical Therapy services:

- Individual Physical Therapy Services must be reflected in the ISP regardless of the funding source.
- The need for such services must be documented by an appropriate assessment and authorized in the ISP.

Documentation Standards
Physical Therapy services documentation must include

- Documentation by appropriate assessment
- Services provided both under the Medicaid State Plan and the waiver must be outlined in the ISP
- Appropriate credentials for service providers
- Attendance record, therapist logs, and chart detailing services provided, dates, and times
- Documentation in compliance with *460 IAC 6* Supported Living Services and Supports requirements
- Documentation of this service being requested on Medicaid State Plan shall be included in the ISP

As applicable, monthly/quarterly reports must be uploaded to Advocare by the chosen service provider on

or before the fifteenth day of the following month

Limitations
The following limitations apply to Physical Therapy services:

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

Activities Not Allowed
The following activities are not allowed under Physical Therapy services:

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

Section 10.22: Prevocational Services

Service Definition
Prevocational Services are services that prepare a participant for paid or unpaid employment. Prevocational Services include teaching concepts such as compliance, attendance, task completion, problem-solving, and safety. Services are not job-task oriented, but instead, aimed at generalized results. Services are habilitative in nature and not explicit employment objectives.

Reimbursable Activities
Reimbursable activities under Prevocational Services include the following:

- Monitoring, training, education, demonstration, or support provided to assist with the acquisition and retention of skills in the following areas:
- Paid and unpaid training compensated at less than 50% of the federal minimum wage
- Generalized and transferrable employment skills acquisition
- These activities may be provided using off-site enclave or mobile community work crew models.
- Until the June 30, 2015, end of Supported Employment Follow-Along (SEFA), participants could choose to utilize SEFA Services and Prevocational Services during the same service plan year

Service Standards
The following service standards apply to Prevocational Services:

- Prevocational Services must be reflected in the ISP.
- All Prevocational Services will be reflected in the participant's plan of care as directed to habilitative rather than explicit employment objectives.

- Participant is not expected to be able to join the general workforce or participate in sheltered employment within one year (excluding Supported Employment).

Documentation Standards
Prevocational Services documentation must include:

- Services outlined in the ISP
- In addition to compliance with documentation requirements outlined in *460 IAC 6*, the following data elements are required for each service rendered:
- Name of participant served
- RID of the participant
- Name of provider
- Service rendered
- Time frame of service (include a.m. or p.m.)
- Date of service including the year
- Notation of the primary location of service delivery
- A brief activity summary of service rendered
- In addition to the brief activity summary of service rendered, provide a description* by direct care staff of any issue or circumstance concerning the participant including, but not limited to, significant medical or behavioral incidents or any other situation that may be uncommon for the participant
- Signature that includes at least the last name and first initial of the direct care staff person making the entry. Electronic signatures are permissible when in compliance with the *Uniform Electronic Transactions Act* (*IC 26-2-8*)
- Upon request, all data elements must be made available to auditors, quality monitors, Case Managers, and any other government entity.

* The data may reside in multiple locations, but must be clearly and easily linked to the participant or the standard will not be met.

As applicable, monthly/quarterly reports must be uploaded to Advocare by the chosen service provider on or before the fifteenth day of the following month

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

Limitations
The following limitations apply to Prevocational Services:

- The following are limitations on group sizes:
  - Small (4:1 or smaller)

- Medium (5:1 to 10:1)
- Larger (larger than 10:1 but no larger than 16:1)

- Monitoring of prevocational services occurs on a quarterly basis. The objectives of monitoring include assessment of the participant's progress toward achieving the outcomes identified on the participant's ISP related to employment and to verify the continued need for prevocational services. The appropriateness of Prevocational services is determined by dividing the previous quarter's gross earnings by the hours of attendance. If the hourly wage falls below 50% of the Federal minimum wage, Prevocational services may be continued. If the average wage exceeds 50% of the Federal minimum wage, Prevocational services should be discontinued for the next quarter.

Note: Beginning July 1, 2015, outside of the following noted exception, Prevocational services may not be utilized by an individual who is receiving Extended Services. (Individuals in competitive community employment are no longer eligible for Prevocational services.) Prevocational services and Extended Services are mutually exclusive and shall not overlap.

Exception: Only those waiver participants engaged in competitive community employment and actively utilizing a combination of Supported Employment Follow-Along (SEFA) and Prevocational services as of June 30, 2015 (as reflected in their ISP, approved POC/CCB, and NOA) may utilize the combination of Extended Services and Prevocational services on or after July 1, 2015.

Activities Not Allowed

The following activities are not allowed under Prevocational Services:

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

Note: Effective July 1, 2015, Prevocational services may not be utilized by an individual who is receiving Extended Services unless that individual waiver participant was engaged in competitive community employment and actively utilizing a combination of Supported Employment Follow-Along (SEFA) and Prevocational services as of June 30, 2015 (as reflected in their ISP, approved POC/CCB and NOA). Effective July 1, 2015, for all other waiver participants, there is no longer an option to utilize this service combination as Prevocational services and Extended Services are considered to be mutually exclusive and shall not overlap. The latter group of waiver participants includes all new enrollees to the waiver as well as other active participants not utilizing a combination of Extended Services and Prevocational services as of June 30, 2015, whether or not they are/were engaged in competitive community employment. Going forward, individuals from the latter group of waiver participants who engage competitive community employment are no longer eligible for Prevocational services.

Additional Information

- Available under the Family Supports Waiver and the Community Integration and Habilitation Waiver.
- Facility settings are defined as non-residential, non-integrated 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 non-residential, integrated settings that are primarily out in the community where services are not rendered within the same building(s) alongside other non-integrated participants.

Section 10.23: Psychological Therapy

Service Definition
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.

These services cannot be provided as a substitute for services offered under the Medicaid State Plan.

Reimbursable Activities
Reimbursable activities under Psychological Therapy services include the following:

- Individual counseling
- Biofeedback
- Individual-centered therapy
- Cognitive behavioral therapy
- Psychiatric services
- Crisis counseling
- Family counseling
- Group counseling
- Substance abuse counseling and intervention
- Planning, reporting, and write-up when in association with the actual one-on-one direct care/therapy service delivery with the waiver participant

Service Standards
The following service standards apply to Psychological Therapy services:

- Therapy services should be reflected in the ISP of the individual regardless of the funding source.

- Services must address needs identified in the person-centered planning process and be outlined in the ISP.
- Services must complement other services the individual receives and enhance increasing independence for the individual.

Documentation Standards
Psychological Therapy services documentation must include

- Documentation by appropriate assessment
- Services outlined in the ISP
- Appropriate credentials for service provider
- Attendance record, therapist logs, and/or charts detailing services provided, dates, and times
- Documentation in compliance with *460 IAC 6* Supported Living Services and Supports requirements
- Documentation of this service being requested on Medicaid State Plan shall be included in the ISP

As applicable, monthly/quarterly reports must be uploaded to Advocare by the chosen service provider on or before the fifteenth day of the following month

Limitations
The following limitations apply to Psychological Therapy services:

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

Activities Not Allowed
The following activities are not allowed under Psychological Therapy services:

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

Additional Information

- Therapies provided through this service will not duplicate therapies provided under any other service.
- Available under the Family Supports Waiver and the Community Integration and Habilitation Waiver.

Section 10.24: Recreational Therapy

Service Definition
Recreational Therapy services are services provided under this article and consisting of a medically approved

recreational program to restore, remediate, or rehabilitate an individual in order to

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

Reimbursable Activities
Reimbursable activities under Recreational Therapy services include the following:

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

Service Standards
The following service standards apply to Recreational Therapy services:

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

Documentation Standards
Recreational Therapy services documentation must include

- Documentation by appropriate assessment
- Services provided under both the Medicaid State Plan and the waiver must be outlined in ISP
- Appropriate credentials for service provider
- Attendance record, therapist logs, and/or charts detailing services provided, dates, and times
- Documentation in compliance with *460 IAC 6* Supported Living Services and Supports requirements
- Documentation of this service being requested on Medicaid State Plan shall be included in the ISP

As applicable, monthly/quarterly reports must be uploaded to Advocare by the chosen service provider on or before the fifteenth day of the following month

Limitations
The following limitations apply to Recreational Therapy services:

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

Activities Not Allowed

The following activities are not allowed as part of Recreational Therapy services:

- Payment for the cost of the recreational activities, registrations, memberships, or admission fees associated with the activities being planned, organized, or directed
- Any services that are reimbursable through the Medicaid State Plan
- Therapy services furnished to the participant within the educational/school setting or as a component of the participant's school day.
- Group sizes greater than four participants to one Recreational Therapist or group sizes exceeding the maximum allowable group size determined by the IST for each group participant
- Group services when group settings were not determined to be appropriate by the IST for each group participant

Section 10.25: Rent and Food for Unrelated Live-in Caregiver *(currently under CIHW only)*

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

Reimbursable Activities
Reimbursable activities under Rent and Food for Unrelated Live-in Caregiver Services include the following:

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

Service Standards
The following service standards apply to Rent and Food for Unrelated Live-in Caregiver Services:

- Rent and Food for an Unrelated Live-in Caregiver should be reflected in the ISP.
- Services must address needs identified in the person-centered planning process and be outlined in the ISP.
- Services must complement other services the participant receives and enhance increasing independence for the participant.
- 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 participant and the type of support needed.

Documentation Standards
Rent and Food for Unrelated Live-in Caregiver services documentation must include:

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

As applicable, monthly/quarterly reports must be uploaded to Advocare by the chosen service provider on or before the fifteenth day of the following month

Limitations
The following limitations apply to Rent and Food for Unrelated Live-In Caregiver services:

- See *Activities Not Allowed*.

Activities Not Allowed
The following activities are not allowed under Rent and Food for Unrelated Live-in Caregiver services:

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

Section 10.26: Residential Habilitation and Support-Daily (RHS-Daily) *(currently under CIHW only)*

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

maintaining natural supports, physical, intellectual, emotional, and social functioning, and full community participation.

Individuals Eligible for RHS Daily Services

Individuals who choose Residential Habilitation and Support (RHS) and meet all of the following criteria are eligible for and will utilize RHS Daily Services:

- Individuals who have an ALGO score of 3, 4, or 5 on their Objective Based Allocation (OBA).
- Individuals who are living with housemates and are utilizing a shared staffing model.
- Individuals who are living outside of their family home.

ALGO LEVEL DESCRIPTORS/ICAP/OBA

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

Level: 0 (low)

Descriptor: Algo level zero:

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

(B) no significant behavioral issues; and

(C) requires minimal residential habilitation services.

Level: 1 (Basic)

Descriptor: Algo level one :

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

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

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

Level: 2 (Regular)

Descriptor: Algo level two :

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

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

(C) does not require twenty-four hours a day supervision; and

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

Level: 3 (Moderate)

Descriptor: Algo level three:

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

(B) twenty-four hours a day, seven days a week staff availability;

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

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

Level: 4 (High)

Descriptor: Algo level four :

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

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

(ii) requires line of sight support; and

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

Level: 5 (Intensive)

Descriptor: Algo level five :

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

(B) needs are intense;

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

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

Level: 6 (High Intensive)

Descriptor: Algo level six :

(A) requires access to full-time supervision:

(i) twenty-four hours a day, seven days a week; and

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

(B) needs are exceptional;

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

(D) imminent risk of individual harming self or others, or both, without vigilant supervision.

The nationally recognized Inventory for Client and Agency Planning, or ICAP, was selected to be the primary

tool for individual assessment.

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

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

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

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

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

Reimbursable Activities

Reimbursable activities include the following:

- Assistance with acquiring, enhancing and building natural supports. For example, a measureable outcome would be increased hours of natural supports and a decrease in the number of hours needed for paid staff. Another measurable outcome would be the number of activities an individual participates in with non-paid (natural support) supports versus paid staff.
- Working with the participant to meet the goals they have set for themselves on their Individualized Support Plan (ISP).
- Training the participant to enhance their home-making skills; meal preparation; household chores; money management; shopping; communication skills; social skills and positive behavior.
- Provision of transportation to fully participate in social and recreational activities in the community. For example, transportation to church, the park, the library, the YMCA, classes.
- Provision of transportation to community employment and/or volunteer activities.
- Coordination and facilitation of medical and wellness services to meet the healthcare and wellness needs, including physician consults, medications, implementation of risk plans, dining plans and wellness plans. Maintenance of each participant's health record.
- The individual must be present and receive RHS Daily services for at least a portion of any day the provider bills as a day of RHS Daily service.

- Electronic Monitoring (only when billed as a component of RHS Daily and may not be billed concurrently with RHS Daily)

Service Standards

- Services must address needs identified in the person-centered planning process and be outlined in the Individualized Support Plan (ISP).
- RHS Daily should complement but not duplicate habilitation services provided in other settings.

Documentation Standards

A minimum of one daily note for each day the individual is present and receiving RHS Daily services, with appropriate elements, documenting one or more distinct actions or behaviors as outlined in "Reimbursable Activities" per individual served is required to support the billing of RHS Daily Services. The RHS Daily Service provider must able to demonstrate through relevant time keeping records or other similar documentation which staff members were working during the RHS Daily Service provided upon audit, or upon request by the State of Indiana or its contracted agents.

RHS Daily Documentation must include:

- Documentation of Services rendered as outlined in the Individualized Support Plan
- Data record of service delivered documenting the complete date and time entry (including a.m. or p.m.). If the person providing the service is required to be professionally licensed, the title of that individual must also be included. For example, if a nurse provides RHS Daily services, the nurse's title should be included.
- Any significant issues involving the participant requiring intervention by a Health Care Professional, Case Manager, or BDDS staff member are also to be documented.
- Documentation must be in compliance with 460 IAC 6.
- Quarterly summaries as specified by BDDS and monthly, quarterly and/or annual outcome data as specified by BDDS.

As applicable, monthly/quarterly reports must be uploaded to Advocare by the chosen service provider on or before the fifteenth day of the following month

Limitations

The following limitations apply to Residential Habilitation and Support-Daily (RHS-Daily) 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.

- Reimbursable waiver-funded services furnished to an adult waiver participant by any combination of relative(s)* and/or legal guardian(s) may not exceed a total of 40 hours per week. (See "Activities Not Allowed" for definition of relative)

- Additionally,

- Individuals receiving RHS Daily Services cannot receive more than 10 hours per month of Community Habilitation Individual (CHIO) services from their RHS Daily provider.
- Providers will not be reimbursed separately for Electronic Monitoring Services for individuals receiving RHS Daily Services. Electronic Monitoring is built into the daily rate of RHS Daily services. Providers must adhere to all Electronic Monitoring Service Standards as defined within the Electronic Monitoring Service Definition.
- Providers may not bill for RHS Daily reimbursement for time when staff/paid caregiver is asleep. Only awake, engaged staff can be counted in reimbursement.
- Providers may not bill for RHS Daily reimbursement during the time when a participant is admitted to a hospital. (The care and support of a participant who is admitted to a hospital is a non-billable RHS Daily activity.)
- RHS Daily Services can be billed the day of a hospital admission and the day of discharge from a hospital if services are provided on these days; however, RHS Daily cannot be billed for other days the individual is hospitalized, even if the RHS Daily provider provided services in the hospital setting such as "sitter" services.

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

Activities Not Allowed

The following activities are not allowed under RHS Daily:

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

*** Related/relative implies any of the following natural, adoptive and/or step relationships, whether by blood or by marriage, inclusive of half and/or in-law status:

- Aunt (natural, step, adopted)
- Brother (natural, step, half, adopted, in-law)
- Child (natural, step, adopted)
- First cousin (natural, step, adopted)
- Grandchild (natural, step, adopted)

- Grandparent (natural, step, adopted)
- Niece (natural, step, adopted)
- Nephew (natural, step, adopted)
- Parent (natural, step, adopted, in-law)
- Sister (natural, step, half, adopted, in-law)
- Spouse (husband or wife)
- Uncle (natural, step, adopted)

Section 10.27: Residential Habilitation and Support - Hourly *(currently under CIHW only)*

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

*** FROM 7/01/2015 FORWARD ***
Residential Habilitation and Support (RHS-Hourly) Level 1 and Level 2 services provide up to a full day (24-hour basis) of services and/or supports for participants designated as Algo 0, 1, or 2*, or individuals at any Algo level not meeting criterion for RHS Daily Rate, which are designed to ensure the health, safety and welfare of the participant, and assist in the acquisition, improvement, and retention of skills necessary to support participants to live successfully in their own homes

Billable either as

- RH1O – for Level 1 with 35 hours or less per week of RHS-Hourly, or
- RH2O – for Level 2 with greater than 35 hours per week of RHS-Hourly

***Participants designated as Algo 3, 4 or 5 and meeting criteria for RHS Daily services will utilize RHS Daily effective July 1, 2015.**

ALGO LEVEL DESCRIPTORS/ICAP/OBA

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

Level: 0 (low)
Descriptor: Algo level zero (0):
(A) high level of independence with few supports needed;
(B) no significant behavioral issues; and

(C) requires minimal residential habilitation services.

Level: 1 (Basic)
Descriptor: Algo level one (1):
(A) moderately high level of independence with few supports needed;
(B) behavioral needs, if any, can be met with medication or informal direction by caregivers through the Medicaid state plan services; and
(C) likely a need for day programming and light residential habilitation services to assist with certain tasks, but the individual can be unsupervised for much of the day and night.

Level: 2 (Regular)
Descriptor: Algo level two (2):
(A) moderate level of independence with frequent supports needed;
(B) behavioral needs, if any, can be met with medication or light therapy, or both, every one (1) to two (2) weeks;
(C) does not require twenty-four (24) hours a day supervision; and
(D) generally able to sleep unsupervised, but needs structure and routine throughout the day.

Level: 3 (Moderate)
Descriptor: Algo level three (3):
(A) requires access to full-time supervision for medical or behavioral, or both, needs;
(B) twenty-four (24) hours a day, seven (7) days a week staff availability;
(C) behavioral and medical supports are not generally intense; and
(D) behavioral and medical supports can be provided in a shared staff setting.

Level: 4 (High)
Descriptor: Algo level four (4):
(A) requires access to full-time supervision for medical or behavioral, or both, needs:
(i) twenty-four (24) hours a day, seven (7) days a week frequent staff interaction; and
(ii) requires line of sight support; and
(B) has moderately intense needs that can generally be provided in a shared staff setting.

Level: 5 (Intensive)
Descriptor: Algo level five (5):
(A) requires access to full-time supervision with twenty-four (24) hours a day, seven (7) days a week absolute line of sight support;
(B) needs are intense;
(C) needs require the full attention of a caregiver with a one-to-one staff to individual ratio; and
(D) typically only needed by those with intense behavioral needs, not medical needs alone.

Level: 6 (High Intensive)
Descriptor: Algo level six (6):
(A) requires access to full-time supervision:
(i) twenty-four (24) hours a day, seven (7) days a week; and
(ii) more than a one-to-one staff to individual ratio;
(B) needs are exceptional;

(C) needs require more than one (1) caregiver exclusively devoted to the individual for at least part of each day; and
(D) imminent risk of individual harming self or others, or both, without vigilant supervision.

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

The ICAP assessment determines an individual's level of functioning for broad independence and general maladaptive factors.

The ICAP addendum, commonly referred to as the behavior and health factors, determines an individual's level of functioning on behavior and health factors.

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

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

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

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

Reimbursable Activities
RHS-Hourly includes the following reimbursable activities:

- Direct supervision, monitoring, and training to implement the ISP outcomes for the participant through the following:
    - Assistance with personal care, meals, shopping, errands, chore and leisure activities, and transportation (excluding transportation that is covered under the Medicaid State Plan)
    - Coordination and facilitation of medical and non-medical services to meet healthcare needs, including physician consults, medications, development and oversight of a health plan, utilization of available supports in a cost effective manner, and maintenance of each participant's health record
    - Assurance that direct service staff are aware and active individuals in the development and implementation of ISP, Behavior Support Plans, and Risk Plans**
    - Collaboration and coordination with the wellness coordinator when the participant receiving RHS also utilizes Wellness Coordination services

**Note: When Wellness Coordination services are utilized in addition to RHS-Hourly services, the Wellness Coordinator is responsible for the development, oversight, and maintenance of a Wellness Coordination plan

as well the development, oversight, and maintenance of the health-related Risk Plan, which includes training of Direct Support Professionals to ensure implementation of the health-related Risk Plans.

Service Standards
The following service standards apply to Residential Habilitation and Support-Hourly services:

- Services must address needs identified in the person-centered planning process and be outlined in the ISP.
- Residential Habilitation and Support-Hourly services should complement but not duplicate habilitation services being provided in other settings.
- Services provided must be consistent with the participant's service plan.

Documentation Standards
RHS-Hourly documentation must include:

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

As applicable, monthly/quarterly reports must be uploaded to Advocare by the chosen service provider on or before the fifteenth day of the following month

Limitations
The following limitations apply to Residential Habilitation and Support-Hourly services:

- Reimbursable waiver-funded services furnished to a waiver participant by any combination of relatives* and/or legal guardians may not exceed a total of 40 hours per week. (See *Activities Not Allowed* for the definition of relative.)
- Additionally:

- Providers may not bill for RHS-Hourly reimbursement for time when staff/paid caregiver is asleep. Only awake, engaged staff can be counted in reimbursement. (A team may decide that a staff or contractor may sleep while with a participant, but this activity is not billable.)
- Providers may not bill for RHS-Hourly reimbursement during the time when a participant is admitted to a hospital. (The care and support of a participant who is admitted to a hospital is a non-billable RHS-Hourly activity.)
- RHS-Hourly and Electronic Monitoring services are not billable during the same time period.
- Level 1 RHS-Hourly may not exceed 35 hours of service per week.
- Group services/shared staffing is reimbursable at the unit rate divided by the number of participants sharing RHS staffing. Group services/shared staffing is not billable at a 1:1 ratio.

Activities Not Allowed

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

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

*Related/relative implies any of the following natural, adoptive and/or step relationships, whether by blood or by marriage, inclusive of half and/or in-law status:

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

Additional Information

- Available only under the Community Integration and Habilitation Waiver, Residential Habilitation and Support-Hourly is not available under the Family Supports Waiver.

Section 10.28: Respite

Service Definition
Respite care services are services provided to participants unable to care for themselves. Respite care services are furnished on a short-term basis in order to provide temporary relief to those unpaid persons normally providing care. Respite can be provided in the participant's home or place of residence, in the respite caregiver's home, in a camp setting, in a DDRS-approved day habilitation facility, or in a non-private residential setting (such as a respite home).

Reimbursable Activities
Reimbursable activities under Respite care services include the following:

- Assistance with toileting and feeding
- Assistance with daily living skills, including assistance with accessing the community and community activities
- Assistance with grooming and personal hygiene
- Meal preparation, serving, and cleanup
- Administration of medications
- Supervision
- Individual services
- Group services (unit rate divided by number of participants served)

Service Standards
The following service standards apply to Respite care services:

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

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

- Participant name
- RID
- Date of service

- Provider rendering service
- Primary location of services rendered

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

As applicable, monthly/quarterly reports must be uploaded to Advocare by the chosen service provider on or before the fifteenth day of the following month

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

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

Limitations
The following limitations apply to Respite services:
- Waiver-funded respite services may not be rendered in a nursing facility.

Activities Not Allowed
The following activities are not allowed under Respite services:

- Reimbursement for room and board
- Services provided to a participant living in a licensed facility-based setting
- The cost of registration fees or the cost of recreational activities (for example, camp)
- When the service of SFC is being furnished to the participant or when the participant is in Children's Foster Care with the Division of Child Services
- Other family members (such as siblings of the participant) may not receive care or supervision from the provider while Respite care is being provided/billed for the waiver participants
- Respite care shall not be used as day/child care
- Respite is not intended to be provided on a continuous, long-term basis as part of daily services that would enable the unpaid caregiver to go to work or to attend school
- Respite care shall not be used to provide service to a participant while the participant is attending school
- Respite care may not be used to replace skilled nursing services that should be provided under the Medicaid State Plan
- Respite care must not duplicate any other service being provided under the participant's POC/CCB

- Services furnished to a minor by a parent(s), stepparent(s), or legal guardian
- Services furnished to a participant by the participant's spouse

Additional Information

- Available under the Family Supports Waiver and the Community Integration and Habilitation Waiver.
- Respite may be used intermittently to cover those hours normally covered by an unpaid caregiver.

Section 10.29: Specialized Medical Equipment and Supplies

Service Definition
Specialized Medical Equipment and Supplies services are specialized medical equipment and supplies to include devices, controls, or appliances, specified in the POC, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live and without which the individual would require institutionalization.

The BDDS Waiver Unit must approve all specialized medical equipment and supplies prior to service being rendered.

Reimbursable Activities
Reimbursable activities under Specialized Medical Equipment and Supplies services include the following:

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

Service Standards
The following service standards apply to Specialized Medical Equipment and Supplies services:

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

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

Documentation Standards
Specialized Medical Equipment and Supplies services documentation must include:

- Identified need in ISP and the POC/CCB.
- Identified direct medical benefit for the individual.
- Documentation of the request for IHCP prior approval (denied PA).
- Documentation of the reason of denial of IHCP prior authorization.
- Receipts for purchases.
- Signed and approved *Request for Approval to Authorize Services* (State Form 45750)

Limitations
The following limitations apply to Specialized Medical Equipment and Supplies services:

- Service and repair up to $500 per year is permitted for maintenance and repair of previously obtained specialized medical equipment that was funded by a waiver service. If the need for maintenance exceeds $500, the Case Manager will work with other available funding streams and community agencies to fulfill the need.
- A lifetime cap of $15,000 is available for vehicle modifications. In addition to the $15,000 lifetime cap, $500 will be allowable annually for repair, replacement, or an adjustment to an existing modification that has been provided through the HCBS waiver. If the lifetime cap is fully utilized, and a need is identified, the Case Manager will work with other available funding streams and community agencies to fulfill the need.
- Vehicle Modifications have a cap of $7,500 under the Family Supports Waiver, but a cumulative lifetime cap of $15,000 across all HCBS waiver programs administered by the State.

Activities Not Allowed
The following activities are not allowed under Specialized Medical Equipment and Supplies services:

- Equipment and services that are available under the Medicaid State Plan
- Equipment and services that are not of direct medical or remedial benefit to the individual
- Equipment and services that are not included in the comprehensive POC
- Equipment and services that have not been approved on a Request for Approval to Authorize services (RFA)
- Equipment and services that are not reflected in the ISP
- Equipment and services that do not address needs identified in the person-centered planning process

Section 10.30: Speech/Language Therapy

Service Definition
Speech/Language Therapy services are services provided by a licensed speech pathologist under *460 IAC 6* Supported Living Services and Supports requirements.

These services cannot be provided as a substitute for services offered under the Medicaid State Plan.

Reimbursable Activities
Reimbursable activities under Speech/Language Therapy services include the following:

- Screening
- Assessment
- Direct therapeutic intervention and treatment for speech and hearing disabilities such as delayed speech, stuttering, spastic speech, aphasic disorders, injuries, lip reading or signing, or the use of hearing aids
- Evaluation and training services to improve the ability to use verbal or 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
The following service standards apply to Speech/Language Therapy services:

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

Documentation Standards
Speech/Language Therapy Services documentation must include:

- Documentation of an appropriate assessment
- Services provided both under the Medicaid State Plan and the waiver must be outlined in the ISP
- DDRS/BDDS-approved provider

- Appropriate credentials for service provider
- Attendance record, therapist logs, and/or chart detailing services provided, dates, and times
- Documentation in compliance with *460 IAC 6* Supported Living Services and Supports requirements
- Documentation of this service being requested on Medicaid State Plan shall be included in the ISP

As applicable, monthly/quarterly reports must be uploaded to Advocare by the chosen service provider on or before the fifteenth day of the following month

Limitations
The following limitations apply to Speech-Language Therapy services:

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

Activities Not Allowed
The following activities are not allowed under Speech/Language Therapy services:

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

Section 10.31: Structured Family Caregiving *(currently under CIHW only and ends 9/30/2016 if CIHW 2nd Amendment is approved)*

Service Definition
Structured Family Caregiving (SFC) is a living arrangement in which a participant lives in the private home of a principal caregiver who may be a non-family member (foster care) or a family member who is not the participant's spouse, the parent of the participant who is a minor, or the legal guardian of the minor participant.

Necessary support services are provided by the principal caregiver (family caregiver) as part of SFC. Only agencies may be SFC providers, with the SFC settings being approved, supervised, trained, and paid by the approved agency provider. The provider agency must conduct two visits per month to the home – one by a Registered Nurse and one by a SFC Home Manager. The provider agency must keep daily notes that can be accessed by the State.

Service Levels and Rates
There are three service levels of SFC, each with a unique rate. Beginning January 1, 2013, the Algo level assigned to the participant will drive and determine the appropriate level of SFC service and reimbursement

to be utilized in service plan development at the participant's next annual anniversary date. With the phase-in of this methodology, all participants will be served at or above their pre-existing level of SFC service.

- Level 1 – Appropriate for participants choosing SFC and having an Algo level of 0 or 1
- Level 2 – Appropriate for participants choosing SFC and having an Algo level of 2
- Level 3 – Appropriate for participants choosing SFC and having an Algo level of 3, 4, 5, or 6

Reimbursable Activities
Reimbursable activities under SFC services include the following:

- Personal care and services.
- Homemaker or chore services.
- Attendant care and companion care services.
- Medication oversight.
- Respite for the family caregiver (funding for this respite is included in the per diem paid to the service provider; the actual service of Respite care may not be billed in addition to the per diem).
- Other appropriate supports as described in the ISP.

Service Standards
The following service standards apply to SFC services:

- SFC services must be reflected in the ISP.
- Services must address the needs (for example, intellectual/developmental needs, vocational needs, and so forth) identified in the person-centered planning process and must be outlined in the ISP.
- Ten percent of the total per diem amount is intended for use by the provider for respite care as needed. It is the provider's responsibility to approve any providers of respite chosen by the family or the participant.
- The provider determines the total amount per month paid to the family caregiver.
- The agency's administrative/supervision fee comes from the remaining total amount and includes the following duties:
- Publish written policies and procedures regarding Structured Family Caregiver support services.
- Maintain financial and service records to document services provided to the individual.
- Establish a criteria for the acceptance of the family caregiver or foster parent, screen potential family caregivers/foster parents for qualities of stability, maturity, and experiences so as to ensure the safety and well-being of the individual, and obtain a criminal background and reference check.
- Coordinate/provide adequate initial training and ongoing training, consultation and supervision to the family caregiver/foster parent.
- Provide for the safety and well-being of the participant by inspection of environment for compliance with the DDRS policies and procedures, including, but not limited to, the provider and Case Management standards found in *460 IAC 6* Supported Living Services and Supports requirements.
- Reimburse family caregiver/foster parent.

Documentation Standards
SFC Services documentation must include:

- Written policies and procedures, including for screening and accepting family caregivers/foster parents
- Maintain financial and service records to document services provided to the participant
- Document provision of training to family caregivers according to agency policies/procedures
- Reimbursement of family caregiver/foster parent
- One entry per participant per week

As applicable, monthly/quarterly reports must be uploaded to Advocare by the chosen service provider on or before the fifteenth day of the following month

Documentation by Families
Under SFC services, families must provide the following documentation:

- One dated entry per day detailing an issue concerning the participant
- The entry should detail any outcome-oriented activities, tying those into measurable progress toward the participant's outcome (as identified in the ISP)
- The entry should also include any significant issues concerning the individual, including
- Health and safety management
- Intellectual/developmental challenges and experiences aimed at increasing an participant's ability to live a lifestyle that is compatible with the participant's interest and abilities
- Modification or improvement of functional skills
- Guidance and direction for social/emotional support
- Facilitation of both the physical and social integration of an participant into typical family routines and rhythms

Limitations
The following limitations apply to Structured Family Caregiving services:

- Separate payment will not be made for homemaker or chore services furnished to an individual receiving SFC because these services are integral to and inherent in the provision of SFC services.

Activities Not Allowed
SFC services will not be provided to household members other than to the waiver participants.

Reimbursement is not available through SFC in the following circumstances:

- Services provided by a caregiver who is the spouse of the participant or the parent of the minor participant.
- The service of Residential Habilitation and Supports (whether paid hourly or daily) is not available to participants receiving SFC services.

- Transportation services through the waiver may not be used in conjunction with SFC services.

Section 10.32A: Transportation – as specified in the Family Supports Waiver

Service Definition
Transportation services (as specified in the FSW) enable waiver participants to gain access to any non-medical community services, resources/destinations, or places of employment, maintain or improve their mobility within the community, increase independence and community participation, and prevent institutionalization as specified by the ISP and POC.

Reimbursable Activities
Reimbursable activities under Transportation services (as specified in the FSW) include the following:

- Two one-way trips per day to or from a non-medical community service, resource or place of employment as specified on the ISP and provided by an approved provider of Residential Habilitation and Support, Community-Based Habilitation, Facility-Based Habilitation, Adult Day Services, or Transportation services.
- Bus passes or alternate methods of transportation may be utilized.
- May be used in conjunction with other services, including Community-Based Habilitation, Facility-Based Habilitation, and Adult Day Services.

Service Standards
The following service standards apply to Transportation services (as specified in the FSW):

- Transportation service is offered in addition to medical transportation required under *42 CFR 431.53* and transportation services under the State Plan, defined at *42 CFR 440.170(a)* (if applicable), and shall not replace them.
- Transportation services under the waiver shall be offered in accordance with the ISP, and when unpaid transportation is not available.
- Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge will be utilized.

Documentation Standards
Transportation Services (as specified in the FSW) documentation must include:

- Service Notes: A service note can include multiple discrete services as long as discrete services are clearly identified. A service note entry for this service can be part of a comprehensive daily note with other services recorded, as long it is clearly separated from other services in the note.
- A service note must include
- Consumer name
- RID of the participant
- Date of service

- Provider rendering service
- Pick up point and destination
- If contract transportation is utilized, contractor must provide log and invoice support that includes dates of transportation provided.
- If bus passes or alternative methods of transportation are utilized, invoices and attendance logs must support calendar days for which round trips are billed to the waiver.

Limitations
The following limitations apply to Transportation services (under the Family Supports Waiver):

- Transportation services (as specified in the FSW) may not be used to meet medical transportation needs already available under the Indiana Medicaid State Plan.

Section 10.32B: Transportation - as specified in the Community Integration and Habilitation Waiver

Service Definition
Transportation services (as specified in the CIH) enable waiver participants to gain access to any non-medical community services, resources/destinations or places of employment, maintain or improve their mobility within the community, increase independence and community participation, and prevent institutionalization as specified by the ISP and POC.

Specific to the CIH Waiver only: Depending upon the needs of the participant, there are three levels of transportation. The level of transportation service needed must be documented in the ISP.

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

Reimbursable Activities
Reimbursable activities under Transportation services (as specified in the CIH Waiver) include the following:

- Two one-way trips per day to or from a non-medical community service or resource or place of employment as specified on the ISP and provided by an approved provider of Residential Habilitation and Support (a service available only under the Community Integration and Habilitation waiver), Community-Based Habilitation, Facility-Based Habilitation, Adult Day Services, or Transportation services.

- Bus passes or alternate methods of transportation may be utilized for Level 1 or Level 2. Bus passes may be purchased on a monthly basis or on a per-ride basis, whichever is most cost-effective in meeting the participant's transportation needs as outlined in the ISP.
- May be used in conjunction with other services, including Community-Based Habilitation, Facility-Based Habilitation, and Adult Day Services.

Note: Whenever possible, family, neighbors, friends, or community agencies that can provide Transportation Services without charge will be utilized.

Service Standards

The following service standards apply to Transportation services (as specified in the CIH Waiver):

- Transportation Services are offered in addition to medical transportation required under *42 CFR 431.53* and transportation services under the Medicaid State Plan, defined at *42 CFR 440.170(a)* (if applicable), and shall not replace them.
- Transportation services under the waiver shall be offered in accordance with the ISP, and when unpaid transportation is not available.
- Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge will be utilized.

Documentation Standards

Transportation services (as specified in the CIH Waiver) documentation must include:

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

Limitations

The following limitations apply to Transportation services (under the Community Integration and Habilitation Waiver):

- Annual limits have been added to this non-medical waiver Transportation service, the costs of which have been removed from the Day Services Building Block of the annual allocation for each participant and are now paid from a stand-alone but limited bucket outside of and in addition to the participants' annual allocation amount.

- The annual limits for each level of non-medical waiver Transportation are:
  - $2,500 for Level 1 Transportation
  - $5,000 for Level 2 Transportation
  - $7,500 for Level 3 Transportation

Activities Not Allowed
Reimbursement is not available under Transportation services (as Specified in the CIH Waiver) for the following activities:

- May not be used to meet medical transportation needs already available under the Indiana Medicaid State Plan
- May not be used in conjunction with Structured Family Care services

Section 10.33: Wellness Coordination *(currently under CIHW only)*

Service Definition
Wellness Coordination services means the development, maintenance, and routine monitoring of the waiver participant's Wellness Coordination plan and the medical services required to manage his or her health care needs.

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

- Tier I – Health care needs require at least weekly* consultation/review with RN or LPN, including face-to-face visits once a month.
- Tier II – Health care needs require at least weekly consultation/review with RN or LPN, including face-to-face visits at least twice monthly.
- Tier III – Health care needs require at least twice weekly consultation/review with RN or LPN, including face-to-face visits once a week.

*Weekly – a calendar week (Sunday through Saturday)

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

Service Standards
Reimbursement is available for Wellness Coordination services only when the following circumstances are present:

- The participant requires assistance in coordinating medical needs beyond what can be provided through routine doctor/health care visits
- Wellness Coordination services are specifically included in the participant's individualized support plan
- The participant has a wellness coordination plan

Reimbursable Activities
Coordination of Wellness services by the RN or LPN provider must include, but is not limited to, the following:

- Completion of the (medical/health care related section's needs and risks) State-approved risk assessment tool
- Development, oversight, and maintenance of a Wellness Coordination plan
- Development, oversight, and maintenance of the (medical/health care) Risk Plan, which includes
  - Training of Direct Support Professionals to ensure implementation of (medical/health care) Risk Plans
- Consultation with the individual's health care providers
- Face-to-face consultations with the individual as described in the support plan
- Consultation with the individual's support team
- Active involvement at all team meetings, reporting on the Wellness Coordination plan as it relates to the individual's full array of services as listed in the ISP.

Limitations
The following limitations apply to Wellness Coordination services:

- Participants assessed with health scores of 0-4 would not require assistance of an RN or LPN to coordinate medical needs.

Activities Not Allowed
Reimbursement for Wellness Coordination services is not available under the following circumstances:

- The individual does not require Wellness Coordination services.
- Wellness Coordination services are not specified in the Individualized Support Plan.
- Wellness Coordination services may not be provided by a provider of waiver-funded Case Management services.
- Residential, vocational, and/or educational services otherwise provided under other Supported Living Services cannot be billed as Wellness Coordination services.
- Services furnished to a minor by a parent(s), stepparent(s), or legal guardian.
- Services furnished to a participant by the participant's spouse.
- Nurses rendering waiver-funded services must obtain/maintain Indiana licensure.

Documentation Standards
Wellness Coordination services documentation standards are as follows:

- Wellness Coordination services must be documented in agency files.
- Weekly consultations/reviews.
- Face-to-face visits with the individual.
- Other activities, as appropriate.
- Services must address needs identified in the person-centered planning process and be outlined in the Individualized Support Plan.
- The provider of Wellness Coordination will provide a written report to pertinent parties at least quarterly. "Pertinent parties" includes the individual, guardian, BDDS service coordinator, and waiver Case Manager.

As applicable, monthly/quarterly reports must be uploaded to Advocare by the chosen service provider on or before the fifteenth day of the following month

Section 10.34: Workplace Assistance

Service Definition
Workplace Assistance services provide a range of personal care services and/or supports during paid competitive community employment hours and in a competitive community employment setting to enable waiver participants to accomplish tasks that they would normally do for themselves if they did not have a disability. Assistance may take the form of hands-on assistance (actually performing a personal care task for the participant) or prompting the participant to perform a personal care task. Workplace Assistance services may be provided on an episodic or on a continuous basis.

Workplace Assistance services are designed to ensure the health, safety, and welfare of the participant, thereby assisting in the retention of paid employment for the participant who is paid at or above the federal minimum wage.

Reimbursable Activities
Reimbursable activities under Workplace Assistance services include the following:

- Direct supervision, monitoring, training, education, demonstration, or support to assist with personal care while on the job or at the job site (may include assistance with meals, hygiene, toileting, transferring, maintaining continence, administration of medication, and so forth)
- May have been used in conjunction with SEFA (until June 30, 2015)/Extended Services (from July 1, 2015 forward)
- May be utilized with each hour the participant is engaged in paid competitive community employment

Service Standards
The following service standards apply to Workplace Assistance services:

- Workplace Assistance services must be reflected in the ISP
- Workplace Assistance services should complement but not duplicate community habilitation services being provided in other settings
- Workplace Assistance services may only be delivered in the employment setting. There is no requirement for a physician's prescription or authorization. The need for Workplace Assistance Services is determined entirely by the IST.

Documentation Standards
Workplace Assistance services documentation must include:

- Services outlined in the ISP
- In addition to compliance with documentation requirements outlined in *460 IAC 6*, the following data elements are required for each service rendered:
- Name of participant served.
- RID of the participant.
- Name of provider.
- Service rendered.
- Time frame of service (include a.m. or p.m.).
- Date of service including the year.
- Notation of the primary location of service delivery.
- A brief activity summary of service rendered.
- In addition to the brief activity summary of service rendered, provide a description* by direct care staff of any issue or circumstance concerning the participant including, but not limited to, significant medical or behavioral incidents or any other situation that may be uncommon for the participant.
- Signature that includes at least the last name and first initial of the direct care staff person making the entry. Electronic signatures are permissible when in compliance with the *Uniform Electronic Transactions Act* (*IC 26-2-8*).
- Upon request, all data elements must be made available to auditors, quality monitors, Case Managers, and any other government entity.

* The data may reside in multiple locations, but must be clearly and easily linked to the participant or the standard will not be met.

As applicable, monthly/quarterly reports must be uploaded to Advocare by the chosen service provider on or before the fifteenth day of the following month

Limitations
The following limitations apply to Workplace Assistance services:

- Allowed Ratio – Individual, one client to one staff.

- Reimbursement for Workplace Assistance services is available only during the participant's hours of paid, competitive community employment.
- Workplace Assistance is NOT to be used for observation or supervision of the participant for the purpose of teaching job tasks or to ascertain the success of the job placement.
- Workplace Assistance is NOT to be used for offsite monitoring when the monitoring directly relates to maintaining a job.
- Workplace Assistance is NOT to be used for the provision of skilled job trainers who accompany the participant for short-term job skill training at the work site to help maintain employment.
- Workplace Assistance is NOT to be used for regular contact and/or follow-up with the employers, participants, parents, family members, guardians, advocates or authorized representatives of the participants, or other appropriate professional or informed advisors, in order to reinforce and stabilize the job placement.
- Workplace Assistance is NOT to be used for the facilitation of natural supports at the work site.
- Workplace Assistance is NOT to be used for individual program development, writing tasks analyses, monthly reviews, termination reviews, or behavioral intervention programs.
- Workplace Assistance is NOT to be used for advocating for the participant.
- Workplace Assistance is NOT to be used for staff time in traveling to and from a work site.

Activities Not Allowed

Reimbursement is not available through Workplace Assistance services under the following circumstances:

- When services are furnished to a minor child by the parent(s), stepparent(s), or legal guardian
- When services are furnished to a participant by that participant's spouse
- Any service that is otherwise available under the Rehabilitation Act of 1973 or Public Law 94-142
- During volunteer activities
- In a facility setting
- In conjunction with sheltered employment
- During activities other than paid competitive community employment
- Workplace Assistance should complement but not duplicate services being provided under SEFA (until June 30, 2015)/Extended Service (from July 1, 2015 forward)

Section 11: Request for Approval (RFA) Policies

Sections 11.1 – 11.3

Section 11.1: Environmental Modification Policy

Section 11.2: Specialized Medical Equipment and Supplies

Section 11.3: Vehicle Modification

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Section 11.1: Environmental Modification Policy

Waiver Policy Notification

Authority: 42 CFR §441.302

Policy Topic: Environmental Modification Policy Clarification

Impacts the following Home and Community-Based Services (HCBS) Waivers:

Aged and Disabled (AD) – Division of Aging

Traumatic Brain Injury (TBI) – Division of Aging

Community Integration and Habilitation Waiver (CIH) – Division of Disability and Rehabilitative Services

Note: Not a covered service for the Family Supports Waiver – Division of Disability and Rehabilitative Services

Effective Date: December 1, 2007 and replaces all previous policies related to the authorization of Environmental Modifications.

Description

Environmental modifications are minor physical adaptations to the home, as required by the individual's Plan of Care/Cost Comparison Budget (POC/CCB), which are necessary to ensure the health, welfare and safety of the individual, which enable the individual to function with greater independence in the home, and without which the individual would require institutionalization.

A lifetime cap of $15,000 is available for environmental modifications. The cap represents a cost for basic modification of an individual's home for accessibility and safety and accommodates the individual's needs for housing modifications. The cost of an environmental modification includes all materials, equipment, labor, and permits to complete the project. No parts of an environmental modification may be billed separately as part of any other service category (e.g. Specialized Medical Equipment). In addition to the $15,000 lifetime cap, $500 is allowable annually for the repair, replacement, or an adjustment to an existing environmental modification that was funded by a Home and Community Based Services (HCBS) waiver.

Home Ownership

Environmental modifications shall be approved for the individual's own home or family owned home. Rented homes or apartments are allowed to be modified only when a signed agreement from the landlord is obtained. The signed agreement must be submitted along with all other required waiver documentation.

Choice of Provider

The individual chooses which approved/certified providers will submit bids or estimates for this service. The provider with the lowest bid will be chosen, unless there is a strong written justification from the case manager detailing why a provider with a higher bid should be selected.

Requirements

All environmental modifications must be approved by the waiver program prior to services being rendered.

Environmental modification requests must be provided in accordance with applicable State and/or local building codes and should be guided by Americans with Disability Act (ADA) or ADA Accessibility Guidelines (ADAAG) requirements when in the best interest of the individual and his/her specific situation.

Environmental modifications shall be authorized only when it is determined to be medically necessary and shall have direct medical or remedial benefit for the waiver individual. This determination includes the following considerations:

- The modification is the most cost effective or conservative means to meet the individual's need(s) for accessibility within the home;
- The environmental modification is individualized, specific, and consistent with, but not in excess of, the individual's need(s);
- Three (3) home modification bids must be obtained for all modifications over $1,000;
- If three (3) bids cannot be obtained, it must be documented to show what efforts were made to secure the three (3) bids and explain why fewer than three (3) bids were obtained (e.g. provider name, dates of contact, response received);
- For modifications under $1,000, one (1) bid is required and pricing must be consistent with the fair market price for such modification(s);
- Bids must be itemized to include the following:

Example:

Scope of work	Material	Related Labor
Ramp 15' long	$$	$$
Widen front door to 36"	$$	$$
Widen bathroom door to 36"	$$	$$
Install ADA toilet	$$	$$
Building permits (specify)	$$	$$
Total Cost	$$$$	$$$$

Requests for modifications at two or more locations may only be approved at the discretion of the State division director or State agency designee.

Requests for modifications may be denied if the State division director or State agency designee determines the documentation does not support residential stability and/or the service requested.

Service Standards

Environmental Modification must be of direct medical or remedial benefit to the individual;

To ensure that environmental modifications meet the needs of the individual and abide by established federal, state, local and FSSA standards, as well as ADA requirements, when applicable, approved environmental modifications will include:

- Assessment of the individual's specific needs, conducted by an approved, qualified individual who is independent of the entity providing the environmental modifications;
- Independent inspections during, as well as at the completion of, the modification process, prior to authorization for reimbursement;
- Modifications must meet applicable standards of manufacture, design and installation;
- Modifications must be compliant with applicable building codes.

Documentation Standards:

The identified direct benefit or need must be documented within:

- 1. POC/CCB; and
- 2. Physician prescription and/or clinical evaluation as deemed appropriate; and
- Individual Support Plan (ISP) if under the Community Integration and Habilitation Waiver .

Documentation/explanation of the service within the Request for Approval to Authorize Services (RFA) including the following:

- Property owner of the residence where the requested modification is proposed;
- Property owner's relationship to the individual;
- What, if any, relationship the property owner has to the waiver program;
- Length of time the individual has lived at this residence;
- If a rental property - length of lease;
- Written agreement of landlord for modification;
- Verification of individual's intent to remain in the setting; and
- Land survey may be required when exterior modification(s) approach property line.
- Signed and approved RFA;
- Signed and approved POC/CCB;
- Provider of services must maintain receipts for all incurred expenses related to the modification;
- Must be in compliance with FSSA and Division specific guidelines and/or policies.

Reimbursement
Reimbursement is available for modifications which satisfy each of the following:

- Service and documentation standards outlined within this policy;
- Allowable under current Medicaid waiver guidelines;
- Not available under the Rehabilitation Act of 1973, as amended;
- Included in the individual's approved POC/CCB;
- Authorized on the RFA and linked to the POC/CCB;
- Included on a State approved and signed Notice of Action (NOA);
- Completed by an approved Medicaid Waiver Service Provider (who is approved to perform this service);
- Completed in accordance with the applicable Building permits.

Modifications/Items – Covered
Justification and documentation is required to demonstrate that the modification is necessary in order to meet the individual's identified need (s).

Adaptive door openers and locks - limited to one (1) per individual primary residence for an individual living alone or who is alone without a caregiver for substantial periods of time but has a need to open, close or lock the doors and cannot do so without special adaptation.

- Bathroom Modification **-** limited to one (1) existing bathroom per individual primary residence when no other accessible bathroom is available. The bathroom modification may include:
  - removal of existing bathtub, toilet and/or sink;
  - installation of roll in shower, grab bars, ADA toilet and wall mounted sink;
  - installation of replacement flooring, if necessary due to bath modification.

- Environmental Control Units - Adaptive switches and buttons to operate medical equipment, communication devices, heat and air conditioning, and lights for an individual living alone or who is alone without a caregiver for a substantial portion of the day.

- Environmental safety devices limited to:
  - door alarms;
  - anti-scald devices;
  - hand held shower head;
  - grab bars for the bathroom.

- Fence - limited to 200 linear feet (individual must have a documented history of elopement);

- Ramp - limited to one per individual primary residence, and only when no other accessible ramp exists:
  - In accordance with the Americans with Disabilities Act (ADA) or ADA Accessibility Guidelines (ADAAG), unless this is not in the best interest of the client;
  - Portable - considered for rental property only;
  - Permanent;

Vertical lift - may be considered in lieu of a ramp if there is photographic and written documentation that shows it is not possible for a ramp to be used.

- Stair lift – if required for access to areas of the home necessary to meet the direct medical or remedial benefit of the individual per POC/CCB (and ISP under CIH Waiver);

- Single room air conditioner (s) / single room air purifier (s) – if required for access to areas of the home necessary to meet the direct medical or remedial benefit of the individual per POC/CCB (and ISP under CIH Waiver):
    - There is a documented medical reason for the individual's need to maintain a constant external temperature. The documentation necessary for this equipment includes a prescription from the primary care physician.
    - The room air conditioner size is consistent with the room size (square feet) capacity to be cooled.

- Widen doorway - to allow safe egress:
    - Exterior - modification limited to one per individual primary residence when no other accessible door exists;
    - Interior - modification of bedroom, bathroom, and/or kitchen door/doorway as needed to allow for access. (A pocket door may be appropriate when there is insufficient room to allow for the door swing).

- Windows - replacement of glass with Plexi-glass or other shatterproof material when there is a documented medical/behavioral reason (s);

- Upon the completion of the modification, painting, wall coverings, doors, trim, flooring etc. will be matched (to the degree possible) to the previous color/style/design;

- Maintenance - limited to $500 annually for the repair and service of environmental modifications that have been provided through a HCBS waiver:
    - Requests for service must detail parts cost and labor cost;
    - If the need for maintenance exceeds $500, the case manager will work with other available funding streams and community agencies to fulfill the need. If service costs exceed the annual limit, those parts and labor costs funded through the waiver must be itemized clearly to differentiate the waiver service provision from those parts and labor funded through a non-waiver funding source.

- Items requested which are not listed above, must be reviewed and decision rendered by the State division director or State agency designee.

Modifications/Items – Non-Covered

Examples/descriptions of modifications/items Not Covered include, but are not limited to the following, such as:

- Adaptations or improvements which are not of direct medical or remedial benefit to the individual:
    - central heating and air conditioning;
    - routine home maintenance;
    - installation of standard (non-ADA or ADAAG) home fixtures (e.g., sinks, commodes, tub, wall, window and door coverings, etc.) which replace existing standard (non-ADA or ADAAG) home fixtures;
    - roof repair;
    - structural repair;
    - garage doors;
    - elevators;
    - ceiling track lift systems;
    - driveways, decks, patios, sidewalks, household furnishings;
    - replacement of carpeting and other floor coverings;
    - storage (e.g., cabinets, shelving, closets), sheds;
    - swimming pools, spas or hot tubs;
    - video monitoring system;
    - adaptive switches or buttons to control devices intended for entertainment, employment, or education;
    - home security systems.

- Modifications that create living space or facilities where they did not previously exist (e.g. installation of a bathroom in a garage/basement, etc.);
- Modifications that duplicate existing accessibility (e.g., second accessible bathroom, a second means of egress from home, etc.);
- Modifications that will add square footage to the home;
- 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 environmental modifications rests with the facility owner or operator);
- Individuals living in a provider owned residence are not eligible to receive this service. (Note: The responsibility for environmental modifications rests with the facility owner or operator);
- 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.

Decision Making Authority:

Each Division, with approval from the Office of Medicaid Policy and Planning (OMPP), shall identify a designee(s) to render decisions based upon the articles within this policy.

- The designee(s) is responsible for preparing and presenting testimony for all Fair Hearings.

- The case management entity, working as an agent of the State, shall not attend Fair Hearings in opposition of the State, unless requested by the individual when there is no other advocate to represent the individual at the Hearing. If the case manager does attend the Hearing, working as an agent of the State, he/she must also uphold the established federal, state, local and FSSA standards and Division specific guidelines and/or policies. Additionally, the case manager must submit a letter, in writing to the Administrative Law Judge at the Fair Hearing, as to what his/her role is at the hearing.

- Each Division shall implement a Quality Assurance Plan. In the event of inappropriate authorizations being granted, any or all of the following actions may be required:
    - a corrective action plan;
    - reimbursement to Medicaid;
    - loss of decision making authority.

Section 11.2: Specialized Medical Equipment and Supplies

Waiver Policy Notification

Authority: 42 CFR §441.302

Policy Topic: Specialized Medical Equipment and Supplies Policy Clarification

Impacts the following Home and Community-Based Services (HCBS) Waivers:

Aged and Disabled (AD) – Division of Aging

Traumatic Brain Injury (TBI) – Division of Aging

Community Integration and Habilitation Waiver (CIHW)– Division of Disability and Rehabilitative Services

Family Supports Waiver (FSW)– Division of Disability and Rehabilitative Services

Effective Date: December 1, 2007 and replaces all previous policies related to the authorization of Specialized Medical Equipment and Supplies (SMES).

Description

Specialized Medical Equipment and Supplies are medically prescribed items required by the individual's Plan of Care/Cost Comparison Budget (POC/CCB) which are necessary to assure the health, welfare and safety of the individual, which enable the individual to function with greater independence in the home, and without which the individual would require institutionalization.

Under the FS Waiver, a lifetime cap of $7,500 is available for Specialized Medical Equipment and Supplies.

Choice of Provider

The individual chooses which approved/certified providers will submit bids or estimates for this service. The provider with the lowest bid will be chosen, unless there is strong written justification from the case manager detailing why a provider with a higher bid should be selected.

Requirements

All Specialized Medical Equipment and Supplies must be approved by the waiver program prior to the service being rendered.

Individuals requesting authorization for this service through utilization of Home and Community Based Services (HCBS) waivers must first exhaust eligibility of the desired equipment or supplies through Indiana Medicaid State Plan, which may require Prior Authorization (PA).

- There should be no duplication of services between HCBS waiver and Medicaid State Plan;
- The refusal of a Medicaid vendor to accept the Medicaid reimbursement through the Medicaid State Plan is not a justification for waiver purchase;
- Preference for a specific brand name is not a medically necessary justification for waiver purchase. Medicaid State Plan often covers like equipment but may not cover the specific brand requested. When this occurs, the individual is limited to the Medicaid State Plan covered service/brand;
- Reimbursement is limited to the Medicaid State Plan fee schedule, if the requested item is covered under Medicaid State Plan;

- Refer to 405 IAC 5-19 (attached) for additional information regarding Medicaid State Plan coverage. All requests for items to be purchased through a Medicaid waiver must be accompanied by documentation of Medicaid State Plan PA request and decision, if requested item is covered under State Plan.

Specialized Medical Equipment and Supplies shall be authorized only when it is determined to be medically necessary and shall have direct medical or remedial benefit for the waiver individual. This determination includes the following considerations:

- The request is the most cost effective or conservative means to meet the individual's specific need(s);
- The request is individualized, specific, and consistent with, but not in excess of, the individual's need(s);
- Three (3) bids must be obtained for items over $1,000;
- If three (3) bids cannot be obtained, it must be documented to show what efforts were made to secure the three (3) bids and explain why fewer than three (3) bids were obtained (e.g. provider name, dates of contact, response received);
- For requested items under $1,000, one (1) bid is required and pricing must be consistent with the fair market price;
- Bids must be itemized to include the following: picture of the product and detailed product information, including make/model number of the item.

Example:

Scope	**Make/Model #**	**Material**
Adapted plates/bowls		$$
Interpreter service		$$
Wheelchair		$$
Portable generator		$$

Total Cost		$$$$$

Requests will be denied if the State division director, or State agency designee determines the documentation does not support the service requested.

Service Standards

- Specialized Medical Equipment and Supplies must be of direct medical or remedial benefit to the individual;
- All items shall meet applicable standards of manufacture, design and service specifications;
- Under the FSW and CIHW, requests for items over $500 require that the individual first be evaluated by a qualified professional such as a physician, nurse, occupational therapist, physical therapist, speech and language therapist or rehabilitation engineer as required per the approved waiver.

Documentation Standards

Documentation standards include the following:

- The identified direct benefit or need must be documented within:
  - POC/CCB; and
  - Physician prescription and/or clinical evaluation as deemed appropriate; and
  - Individual Support Plan (ISP) under the FSW and CIHW
- Medicaid State Plan Prior Authorization request and the decision rendered, if applicable;
- Signed and approved Request for Approval to Authorize Services (RFA);
  Signed and approved POC/CCB;
  Provider of services must maintain receipts for all incurred expenses related to this service;
  Must be in compliance with FSSA and Division specific guidelines and/or policies.

Reimbursement

Reimbursement is available for Specialized Medical Equipment and Supplies which satisfy each of the following:

- Service and documentation standards outlined within this policy;
- Allowable under current Medicaid waiver guidelines;
- Not available under the Rehabilitation Act of 1973, as amended;
- Included in the individual's approved POC/CCB;
- Authorized on the RFA and linked to the POC/CCB;
- Included on a State approved and signed Notice of Action (NOA);
- Completed by an approved Medicaid Waiver Service Provider (who is approved to perform this service).

Items - Covered

Justification and documentation is required to demonstrate that the request is necessary in order to meet the individual's identified need(s).

- Communication Devices - computer adaptations for keyboard, picture boards, etc.

- RFA must be accompanied by documentation of Medicaid State Plan PA request and decision rendered under Medicaid State Plan;

- Generators (portable) - when either ventilator, daily use of oxygen via a concentrator, continuous infusion of nutrition (tube feeding), or medication through an electric pump are medical requirements of the individual. The generator is limited to the kilo-wattage necessary to provide power to the essential life-sustaining equipment, and is limited to one (1) generator per individual per ten (10) year period;

- Interpreter service - provided in circumstances where the interpreter assists the individual in communication during specified scheduled meetings for service planning(e.g. waiver case conferences, team meetings) and is not available to facilitate communication for other service provision;

- Self-help devices - including over the bed tables, reachers, adaptive plates, bowls, cups, drinking glasses and eating utensils that are prescribed by a physical therapist or occupational therapist;

- Strollers - when needed because individual's primary mobility device does not fit into the individual's vehicle/mode of transportation, or when the individual does not require the full time use of a mobility device, but a stroller is needed to meet the mobility needs of the individual outside of the home setting. RFA must be accompanied by documentation of Medicaid State Plan PA request and decision rendered under Medicaid State Plan;
- Manual wheelchairs - when required to facilitate safe mobility. RFA must be accompanied by documentation of Medicaid State Plan PA request and decision rendered under Medicaid State Plan;
- Maintenance - limited to $500 annually for the repair and service of items that have been provided through a HCBS waiver:

    - Requests for service must detail parts cost and labor cost;

    - If the need for maintenance exceeds $500, the case manager will work with other available funding streams and community agencies to fulfill the need. If service costs exceed the annual limit, those parts and labor costs funded through the waiver must be itemized clearly to differentiate the waiver service provision from those parts and labor provided through a non-waiver funding source.

- Posture chairs and feeding chairs - as prescribed by physician, occupational therapist, or physical therapist. RFA must be accompanied by documentation of Medicaid State Plan PA request and decision rendered under Medicaid State Plan;

- Vehicle Modifications **(**VMOD) - are administered under separate and independent waiver policy (Vehicle Modification Policy).

Items – Non-Covered
The following items and equipment:

- hospital beds, air fluidized suspension mattresses/beds;
- therapy mats;
- parallel bars;
- scales;
- activity streamers;
- paraffin machines or baths;
- therapy balls;
- books, games, toys;
- electronics – such as CD players, radios, cassette players, tape recorders, television, VCR/DVDs, cameras or film, videotapes and other similar items;
- computers and software;
- adaptive switches and buttons;
- exercise equipment such as treadmills or exercise bikes;
- furniture;
- appliances - such as refrigerator, stove, hot water heater;
- indoor and outdoor play equipment such as swing sets, swings, slides, bicycles adaptive tricycles, trampolines, play houses, merry-go-rounds;
- swimming pools, spas, hot tubs, portable whirlpool pumps;
- temperpedic mattresses, positioning devices, pillows;
- bathtub lifts;
- motorized scooters;
- barrier creams, lotions, personal cleaning cloths;
- totally enclosed cribs and barred enclosures used for restraint purposes; medication dispensers.
- Any equipment or items that can be authorized through Medicaid State Plan;
- Any equipment or items purchased or obtained by the individual, his/her family members, or other non-waiver providers.

Note: In rare circumstances, a new or unanticipated item may be presented for consideration as a covered item under this service. **Prior to submission** of an RFA for this item, a written proposal justifying the need for this item must be sent to the OMPP for submission to the FSSA Policy Governance Board for consideration and determination of appropriateness as a Covered Item. The written proposal should be directed to:

Director of Agency Coordination and Integration
Office of Medicaid Policy and Planning
402 W. Washington Street, Room W382
Indianapolis, IN 46204-2739.

These requests should be extremely rare and should not include items on the Non-Covered list, which have been previously vetted at the State, and determined to be Non-Covered items.

Decision Making Authority:

- Each Division, with approval from the Office of Medicaid Policy and Planning (OMPP), shall identify a designee(s) to render decisions based upon the articles within this policy.

- The designee(s) is responsible for preparing and presenting testimony for all Fair Hearings.

- The case management entity, working as an agent of the State, shall not attend Fair Hearings in opposition of the State, unless requested by the individual when there is no other advocate to represent the individual at the Hearing. If the case manager does attend the Hearing; working as an agent of the State, he/she must also uphold the established federal, state, local and FSSA standards and the Division specific guidelines and/or policies. Additionally, the case manager must submit a letter, in writing to the Administrative Law Judge at the Fair Hearing, as to what his/her role is at the hearing.

- Each Division shall implement a Quality Assurance Plan. In the event of inappropriate authorizations being granted, any or all of the following actions may be required:
    - a corrective action plan;
    - reimbursement to Medicaid;
    - loss of decision making authority.

Section 11.3: Vehicle Modification

Waiver Policy Notification

Authority: 42 CFR §441.302

Policy Topic: Vehicle Modification Policy Clarification

Impacts the following Home and Community-Based Services (HCBS) Waivers:

Aged and Disabled (AD) – Division of Aging

Traumatic Brain Injury (TBI) – Division of Aging

Community Integration and Habilitation (CIHW)– Division of Disability and Rehabilitative Services

Family Supports (FSW) – Division of Disability and Rehabilitative Services

Effective Date: December 1, 2007 and replaces all previous policies related to the authorization of Vehicle Modifications.

Description
Vehicle Modifications (VMOD) are the addition of adaptive equipment or structural changes to a motor vehicle that permit an individual with a disability to safely transport in a motor vehicle. Vehicle modifications, as specified in the Plan of Care/Cost Comparison Budget (POC/CCB), may be authorized when necessary to increase an individual's ability to function in a home and community based setting to ensure accessibility of the individual with mobility impairments. These services must be necessary to prevent or delay institutionalization. The necessity of such items must be documented in the plan of care by a physician's order. Vehicles necessary for an individual to attend post secondary education or job related services should be referred to Vocational Rehabilitation Services.

A lifetime cap of $15,000 is available for vehicle modifications under the AD, CIH, and TBI waivers. Under the FS Waiver, a lifetime cap of $7,500 is available for Specialized Medical Equipment, which includes vehicle modifications. In addition to the applicable lifetime cap, $500 will be allowable annually for repair, replacement, or an adjustment to an existing modification that was funded by a Home and Community Based Services (HCBS) waiver.

Vehicle Ownership
The vehicle to be modified must meet all of the following:

- The individual or primary caregiver is the titled owner;
- The vehicle is registered and/or licensed under state law;
- The vehicle has appropriate insurance as required by state law;
- The vehicle is the individual's sole or primary means of transportation;
- The vehicle is not registered to or titled by a Family and Social Services Administration (FSSA) approved provider agency.

Choice of Provider

The individual chooses which approved/certified providers will submit bids or estimates for this service. The provider with the lowest bid will be chosen, unless there is strong written justification from the case manager detailing why a provider with a higher bid should be selected.

Requirements

All vehicle modifications must be approved by the waiver program prior to services being rendered.

Vehicle modification requests must meet and abide by the following:

- The vehicle modification is based on, and designed to meet, the individual's specific need(s);
- Only one vehicle per an individual's household may be modified;
- The vehicle is less than ten (10) years old and has less than 100,000 miles on the odometer;
- If the vehicle is more than five years old, the individual must provide a signed statement from a qualified mechanic verifying that the vehicle is in sound condition.

All vehicle modification shall be authorized only when it is determined to be medically necessary and/or shall have direct medical or remedial benefit for the waiver individual. This determination includes the following considerations:

- The modification is the most cost effective or conservative means to meet the individual's specific need(s);
- The modification is individualized, specific, and consistent with, but not in excess of, the individual's need(s);
- Three (3) modification bids must be obtained for all modifications over $1,000;
- If three (3) bids cannot be obtained, it must be documented to show what efforts were made to secure the three (3) bids and explain why fewer than three (3) bids were obtained (e.g. provider name, dates of contact, response received);
- For modifications under $1,000, one (1) bid is required and pricing must be consistent with the fair market price for such modification (s);
- All bids must be itemized to include the following:

Example:

Make: Model: Mileage: Year:		
Scope of work	**Materials Cost**	**Related Labor**
Lift	$$	$$
Tie down	$$	$$
Total Cost:	$$$$$	

Many automobile manufacturers offer a rebate of up to $1,000 for individuals purchasing a new vehicle requiring modifications for accessibility. To obtain the rebate the individual is required to submit to the manufacturer documented expenditures of modifications. If the rebate is available it must be applied to the cost of the modifications.

Requests for modifications may be denied if the State division director or State agency designee determines the documentation does not support the service requested.

Service Standards

- Vehicle Modification must be of direct medical or remedial benefit to the individual;
- All items must meet applicable manufacturer, design and service standards.
- Under the FSW and CIHW, requests for items over $500 require that the individual first be evaluated by a qualified professional such as a physician, nurse, occupational therapist, physical therapist, speech and language therapist or rehabilitation engineer as required per the approved waiver.

Documentation Standards

The identified direct benefit or need must be documented within:

- POC/CCB; and
- Physician prescription and/or clinical evaluation as deemed appropriate; and
- Individual Support Plan (ISP) if under the FSW and CIHW.

Documentation/explanation of service within the Request for Approval to Authorize Services (RFA) must include:

- ownership of vehicle to be modified; or
- vehicle owner's relationship to the individual; and
- make, model, mileage, and year of vehicle to be modified.
  Signed and approved RFA;
  Signed and approved POC/CCB;
  Provider of services must maintain receipts for all incurred expenses related to the modification;
  Must be in compliance with FSSA and Division specific guidelines and/or policies.

Reimbursement

Reimbursement is available for modifications which satisfy each of the following:

- Service and documentation standards outlined within this policy;
  Allowable under current Medicaid Waiver Guidelines;
  Not available under the Rehabilitation Act of 1973, as amended;
  Included in the individual's approved POC/CCB;
  Authorized on the RFA and linked to the POC/CCB;
  Included on a State approved and signed Notice of Action (NOA);

Completed by an approved Medicaid Waiver Service Provider (who is approved to perform this service).

Modifications/Items - Covered

Justification and documentation is required to demonstrate that the modification is necessary in order to meet the individual's identified need (s).

- 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 (Excludes mobility base);

Maintenance is limited to $500 annually for repair and service of items that have been funded through a HCBS waiver:

- Requests for service must differentiate between parts and labor costs;
- If the need for maintenance exceeds $500, the case manager will work with other available funding streams and community agencies to fulfill the need. If service costs exceed the annual limit, those parts and labor costs funded through the waiver must be itemized clearly to differentiate the waiver service provision from those parts and labor provided through a non-waiver funding source.

Items requested which are not listed above, must be reviewed and decision rendered by the State division director or State agency designee.

Modifications/Items – Non-Covered

Examples/descriptions of modifications/items Not Covered include, but are not limited to the following:

- Lowered floor van conversions;
- Purchase, installation, or maintenance of CB radios, cellular phones, global positioning/tracking devices, or other mobile communication devices;
- Repair or replacement of modified equipment damaged or destroyed in an accident;
- Alarm systems;
- Auto loan payments;
- Insurance coverage;
- Drivers license, title registration, or license plates;
- Emergency road service;
- Routine maintenance and repairs related to the vehicle itself.

Decision Making Authority:

- Each Division, with approval from the Office of Medicaid Policy and Planning (OMPP), shall identify a designee(s) to render decisions based upon the articles within this policy.

- The designee(s) is responsible for preparing and presenting testimony for all Fair Hearings.

- The case management entity, working as an agent of the State, shall not attend Fair Hearings in opposition of the State, unless requested by the individual when there is no other advocate to represent the individual at the Hearing. If the case manager does attend the Hearing; working as an agent of the State, he/she must also uphold the established federal, state, local and FSSA standards and the Division specific guidelines and/or policies. Additionally, the case manager must submit a letter, in writing to the Administrative Law Judge at the Fair Hearing, as to what his/her role is at the hearing.

- Each Division shall implement a Quality Assurance Plan. In the event of inappropriate authorizations being granted, any or all of the following actions may be required:
    - a corrective action plan;
    - reimbursement to Medicaid;
    - loss of decision making authority.

Signature Page

Subject: **DDRS Waiver Manual**

My signature below is an acknowledgement that I have received a link to, or, upon my request, a hard copy of, the Division of Disability & Rehabilitative Services' **DDRS Waiver Manual**

_____

DDRS Waiver Manual delivery acknowledgement:

_____

Individual Waiver Participant's HIPAA Name (Print)

_____

Recipient's relationship to Individual Waiver Participant (Print)

_____

DDRS Waiver Manual Recipient's Name (Print)

_____

DDRS Waiver Manual Recipient's Signature