PROVIDER REVERIFICATION PROCESS

ANNUAL REVIEW/REVERIFICATION GUIDANCE

Bureau of Quality Improvement Services
402 W. Washington St., W 453, MS 46, Indianapolis, Indiana 46204

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I. PROVIDER REVERIFICATION PROCESS OVERVIEW

The Bureau of Developmental Disabilities Services (BDDS), or its designee, within the Division of Disability and Rehabilitative Services (DDRS) is required to re-verify all BDDS approved waiver providers. The Bureau of Quality Improvement Services (BQIS) has been designated to facilitate the provider reverification process. The purpose of the provider reverification process is to ensure, on an on-going basis, providers are 'fit for business' by validating basic compliance with statutes, rules, regulations, and requirements. In accordance with BDDS Policies, (Provider Reverification for Accredited Waiver Services (2020-01-R-001, eff. 2/9/2020) and Provider Reverification for Non-Accredited Waiver Services (2020-02-R-001, eff. 2/9/2020)), the reverification process consists of an annual review of provider documentation; and, at year two (2) for non-accredited providers or year four (4) for accredited providers, an additional review of the provider's data on incident reports, complaints, mortalities, outstanding corrective action plans, sanctions, as well as any other monitoring data deemed applicable.

ANNUAL REVIEW	VS.	REVERIFICATION DETERMINATION YEAR (YEAR 2 OR 4)
• Initiated by BQIS • Provider submits required annual documents to BQIS • BQIS reviews submitted documents • Identified issues are addressed by Provider • BQIS issues letter of annual completion		• Initiated by BQIS • Provider submits required annual documents to BQIS • Provider submits a signed provider agreement • BQIS reviews submitted documents • BQIS reviews Provider's data obtained from monitoring activities (e.g. incidents, complaints, mortalities, CAPs, sanctions, etc.) • Identified issues are addressed by Provider • BQIS issues Reverification Determination letter once all issues are addressed

II. ANNUAL REVIEW

The annual review consists of a review of the provider's documentation that verifies the provider's compliance with statutes, rules, regulations, and requirements. The annual review is initiated by BQIS through an electronic communication approximately sixty (60) calendar days from the annual expiration date. The provider submits the following documents to BQIS by the deadline established in the letter which is twenty-one (21) calendar days from the date of the letter. Further information regarding these documents is below.

1) BDDS waiver provider information (Attachment B);
2) Organizational chart;
3) Indiana Secretary of State documentation;
4) Financial information:
    a. financial status

b. current expenses and revenues;
c. projected budgets outlining future operations;
d. credit history and the ability to obtain credit; and
e. documented ability to deliver services without interruption for at least two (2) months without payment for services;

5) Provider's insurance documentation;
6) Annual satisfaction survey, including the following;
   a. blank copy of annual satisfaction survey;
   b. survey implementation date;
   c. survey response due date;
   d. record of findings (e.g. spreadsheet of responses with totals for each question, etc.); and
   e. documentation of efforts (or planned efforts) to improve service delivery (e.g. improvement plan, evidence of efforts, etc.);
7) All policies created or updated since its last reverification with substantive revisions since the previous year; and
8) Annual accreditation status report (if applicable).

III. DOCUMENTS

A. BDDS Waiver Provider Information (Attachment B) (460 IAC 6-10-3)

In the initial communication, the provider will receive the BDDS waiver provider information that is contained in the state's system. The provider should review the information for its accuracy and return it to BQIS with any changes and/or updates. An authorized representative (i.e. Executive Director, Chief Operating Officer, etc.) of the organization must sign and date the document prior to returning to BQIS regardless of whether changes were made. This information will be used to ensure the state's system has the most accurate information. [See Example A on the BQIS webpage (https://www.in.gov/fssa/ddrs/2635.htm)]

The provider will need to review and update, as needed, the following information:

- Address(es)
- Contact Name(s)
- Phone Number
- Fax Number
- Additional Contacts
- Additional Phone Numbers
- Additional Emails
- Counties
- Services

B. Organizational Chart (460 IAC 6-10-6)

The provider's organizational chart must include the parent organization, subsidiary organization(s) as well as familial relationships. The organizational chart should include the title of all positions and the names of the upper management. The provider will be required to address any identified issue(s) with the organizational chart. [See Example B on the BQIS webpage (https://www.in.gov/fssa/ddrs/2635.htm)]

C. Indiana Secretary of State documentation (460 IAC 6-10-3)

Medicaid waiver providers are required to maintain active registration with the Indiana Secretary of State (SOS) (https://inbiz.in.gov). To provide evidence of active registration, the provider will need to access the Indiana SOS website and print the agency's registration. The provider will be required to address any identified issue with the Indiana SOS. [See Example C on the BQIS webpage (https://www.in.gov/fssa/ddrs/2635.htm)]

D. Financial Information (460 IAC 6-11-2 and 6-11-3)

The state must ensure each BDDS waiver provider is financially solvent. This includes a review of the provider's financial status, current expenses and revenues, projected budgets outlining future operations, credit history and the ability to obtain credit, and the documented ability to deliver services without interruption for at least two (2) months without payment for services. Non-profit organizations should submit, in their entirety, the most recent annual audit and current operating budget. The necessary financial information should be contained within these two documents. For-profit organizations, depending on the type of legal entity, will fall under one of two different options. Organizations that conduct an annual audit would utilize Option 1. These organizations would submit, in their entirety, the most recent annual audit and current operating budget. If the organization does not conduct an annual audit, Option 2 should be utilized. Organizations utilizing Option 2 would submit the following: twelve (12) months of bank statements, prior year's tax return, and current operating budget. The FSSA financial department will assist BQIS in reviewing the documents to ensure compliance. BQIS will obtain the provider's Medicaid paid claims for comparison with the provider's financial information to ensure the provider has the ability to deliver services without interruption for at least two (2) months without payment for services. The tables below outline the acceptable documentation for Non-profit and For-profit organizations. The provider will be required to address any missing components in the financial documentation or the failure to have the required financial stability. [See Examples D through D-7 on the BQIS webpage (https://www.in.gov/fssa/ddrs/2635.htm)]

i. Non-profit Organizations

Non-profit Organizations		
Requirement	**Source Document**	**Necessary information**
Financial status (Example D-1)	Annual Audit	• Consolidated financial statements • Supplementary information
Current expenses and revenues (Example D-1)	Annual Audit	Consolidated statement of activities and changes in net assets (found in consolidated financial statement)
Projected budgets outlining future operations (Example D-2)	Operating Budget	In Full
Credit history and the ability to obtain credit (Example D-3)	Annual Audit	Found in notes of the consolidated financial statement
Documented ability to deliver services without interruption for at least two (2) months without payment for services (Example D-4)	Annual Audit	Found in notes of the consolidated financial statement

ii. For-profit Organizations

For-profit Organizations		
OPTION 1: Annual audit required		
Requirement	**Source Document**	**Necessary information**
Financial status (Example D-1)	Annual Audit	• Consolidated financial statements • Supplementary information
Current expenses and revenues (Example D-1)	Annual Audit	Consolidated statement of activities and changes in net assets (found in consolidated financial statement)
Projected budgets outlining future operations (Example D-2)	Operating Budget	In Full
Credit history and the ability to obtain credit (Example D-3)	Annual Audit	Found in notes of the consolidated financial statement
Documented ability to deliver services without interruption for at least two (2) months without payment for services (Example D-4)	Annual Audit	Found in notes of the consolidated financial statement

OPTION 2: Annual audit not required		
Requirement	**Source Document**	**Necessary information**
Financial status (Examples D-5 & D-6)	• Bank statements • Federal tax return	• Last twelve (12) months of bank statements • Prior year's federal tax return
Current expenses and revenues (Example D-5)	Bank statements	Last twelve (12) months of bank statements
Projected budgets outlining future operations (Example D-2)	Operating Budget	In Full
Credit history and the ability to obtain credit (Example D-7)	Line of Credit through a financial institution	Must be through a financial institution (a loan from a private source, credit card with an available balance and revolving credit arrangements are not acceptable). The required amount varies by type of provider service. • A minimum of $3,000.00 is required for providers of: music, recreational, physical, speech-language and occupational therapies, Environmental Modification, Specialized Medical Equipment and Supply, and Personal Response systems. • A minimum of $75,000 is required for providers of case management. • A minimum of $35,000.00 is required for providers of all other services.
Documented ability to deliver services without interruption for at least two (2) months without payment for services (Examples D-5 & D-6)	• Bank statements • Tax return	• Last twelve (12) months of bank statements • Prior year's tax return

E. INSURANCE DOCUMENTATION (460 IAC 6-12)

A BDDS waiver provider must have an active insurance policy that covers personal injury, loss of life, or property damage to an individual caused by fire, accident, or other casualty while receiving services from the provider. The provider must submit the insurance policy in its entirety. A letter from the insurance agency attesting that the provider's active insurance policy includes the required components may also be submitted in lieu of the policy. Insurance policies use a variety of phrases/language to indicate types of coverage. For example, the words 'loss of life' are not found in many policies; however, 'loss of life' is covered under 'Personal & Advertising Injury'. Personal injury and property damage may be listed as: building and personal property loss, personal injury, abuse or molestation liability, physical damage, etc. The provider will be required to address any missing

components in the policy or the failure to have an active policy. [See Example E on the BQIS webpage (https://www.in.gov/fssa/ddrs/2635.htm)]

F. Annual Satisfaction Survey (460 IAC 6-10-10(b)(1-3))

In an effort to assess an individual's satisfaction with service delivery, all BDDS waiver providers are required to conduct an annual individual satisfaction survey. The survey should be focused on the individual and appropriated for the services being provided. On an annual basis, the provider will submit a blank copy of the annual satisfaction survey, a record of findings including the survey timeframe (implementation date and response due date) (e.g. spreadsheet of responses with totals for each question, etc.), and documentation of efforts (or planned efforts) to improve service delivery (e.g. improvement plan, evidence of efforts, new training, data tracking, etc.). The provider will be required to address any missing components or the failure to administer and document the components of the survey. [See Examples F-1 through F-3 on the BQIS webpage (https://www.in.gov/fssa/ddrs/2635.htm)]

G. All policies created or updated since its last reverification with substantive revisions since the previous year

The policies referenced are only those that are applicable to waiver services and supports, not personnel. For example, the Centers for Medicare and Medicaid Services (CMS) issued the Home and Community-Based Services Settings Final Rule. Providers should have updated policies that reflect the requirements in the rule. It is anticipated that policies will only be submitted when BDDS makes a change in waiver services or there is a change in a statute, rule, code, regulation, or requirement that is associated with Home and Community Based Services provided by a BDDS approved waiver provider. If BQIS is expecting a particular policy to be submitted, the policy will be requested in the initial letter.

H. Annual Accreditation Status Report (if applicable) (460 IAC 6-10-3)

BDDS waiver providers who are accredited by a national accrediting body that requires an annual accreditation status report must submit the report as part of the annual review. The provider will be required to address any missing components or the failure to submit the report. See Examples G-1 through G-3 on the BQIS webpage (https://www.in.gov/fssa/ddrs/2635.htm)].

IV. REVERIFICATION DETERMINATION YEAR

A provider's reverification determination frequency is dependent upon whether the provider has one or more BDDS waiver services accredited by one of the national accreditation entities listed in Indiana Code 12-11-1.1.11:

- The Commission on Accreditation of Rehabilitation Facilitates (CARF)
- The Council on Quality and Leadership (CQL)

- The Joint Commission on Accreditation of Healthcare Organizations (JACHO)
- The National Committee on Quality Assurance (NCQA)
- The ISO-9001 human services Quality Assurance system
- The Council on Accreditation (COA)

BDDS Services Requiring Accreditation:

- Adult Day Services (all levels)
- Case Management
- Community Habilitation (Ind. & Group) – (*Note:* 2020 Waiver Renewal renamed as Day Services)
- Extended Services
- Facility Habilitation (Ind. & Group) – (*Note:* 2020 Waiver Renewal renamed as Day Services)
- Pre-Vocational (All levels)
- Residential Habilitation (All levels)

Agencies who choose to provide one or more of the services requiring accreditation will have the reverification determination at year four (4). If a provider chooses to have any other BDDS waiver service accredited by one of the accrediting entities in Indiana Code 12-11-1.1.11, it will also have the reverification determination at year four (4). For example, a provider may only have BDDS approval for behavior management which does not require accreditation. However, if that agency seeks or obtains accreditation through one of the entities in code, the provider will be recognized as 'accredited' and will have the reverification determination at year four (4). An agency seeking or obtaining accreditation for a service not requiring accreditation will be required to submit either a letter of intent from the accrediting body or the accreditation award letter.

Providers who do not have or are not seeking accreditation through one of the accrediting entities listed in code will have the reverification determination at year two (2).

During the reverification determination year, BQIS will initiate the process through an electronic communication to the provider approximately sixty (60) calendar days from the annual expiration date. The provider submits the following documents to BQIS by the deadline established in the letter which is twenty-one (21) calendar days from the date of the letter:

1. BDDS waiver provider information (Attachment B);
2. Organizational chart;
3. Indiana Secretary of State documentation;
4. Financial information:
    a. financial status
    b. current expenses and revenues;
    c. projected budgets outlining future operations;
    d. credit history and the ability to obtain credit, and
    e. documented ability to deliver services without interruption for at least two (2) months without payment for services;
5. Provider's insurance documentation;

6. Annual satisfaction survey, including the following;
    a. blank copy of annual satisfaction survey;
    b. survey implementation date;
    c. survey response due date;
    d. record of findings (e.g. spreadsheet of responses with totals for each question, etc.); and
    e. documentation of efforts (or planned efforts) to improve service delivery (e.g. improvement plan, evidence of efforts, etc.);
7. All policies created or updated since its last reverification with substantive revisions since the previous year;
8. Annual accreditation status report (if applicable); and
9. Signed DDRS Service Provider Agreement.

In addition to BQIS review of the annual documentation, BQIS will review the provider's data on incident reports, complaints, mortalities, any outstanding corrective action plans, sanctions, and any other monitoring data deemed applicable. The purpose of reviewing these data elements is to identify outliers that are unexplainable or have not been adequately addressed by the provider. The provider will be required to address any outstanding issues prior to issuance of the reverification determination.

Residential providers will continue to receive their comparative data during the reverification determination year.

V. DOCUMENT SUBMISSION

The annual documents are due on or before the due date noted in the initial letter and must be submitted in accordance with the Document Submission Guide (Attachment C) electronically to BQIS at BQISReporting@fssa.in.gov.