



# INDIANA HEALTH COVERAGE PROGRAMS

## PROVIDER REFERENCE MODULE

Division of Disability and  
Rehabilitative Services

# Home and Community-Based Services Waivers

LIBRARY REFERENCE NUMBER: PRPR10014  
PUBLISHED: DECEMBER 19, 2019  
POLICIES AND PROCEDURES AS OF JULY 1, 2019  
VERSION: 7.0



## **Revision History**

<b>Version</b>	<b>Date</b>	<b>Reason for Revisions</b>	<b>Completed By</b>
1.0	Policies and procedures as of November 1, 2012 Published: June 10, 2013	Initial release	FSSA
1.1	Policies and procedures as of December 1, 2013 Published: April 23, 2014	Scheduled review	FSSA and HP
2.0	Policies and procedures as of June 1, 2014 Published: November 6, 2014	Scheduled review	FSSA and HP
2.1	Policies and procedures as of December 1, 2014 Published: February 24, 2015	Scheduled review	FSSA and HP
2.2	Policies and procedures as of December 1, 2014 Published: May 12, 2015	Updates to Section 6, including updated tables	FSSA and HP
3.0	Policies and procedures as of June 1, 2015 Published: September 8, 2015	Scheduled review	FSSA and HP
3.1	Policies and procedures as of October 1, 2015 Published: February 25, 2016	Conversion to modular format, scheduled review	FSSA and HPE
4.0	Policies and procedures as of April 1, 2016 Published: June 21, 2016	Scheduled review	FSSA and HPE
4.1	Policies and procedures as of April 1, 2016 <i>CoreMMIS</i> updates as of: February 13, 2017 Published: April 13, 2017	<i>CoreMMIS</i> updates	FSSA and HPE
5.0	Policies and procedures as of April 1, 2017 <i>CoreMMIS</i> updates as of February 13, 2017 Published: August 24, 2017	Scheduled review	FSSA and DXC
6.0	Policies and procedures as of August 1, 2018 Published: January 3, 2019	Scheduled review	FSSA and DXC
6.0	Policies and Procedures as of August 1, 2018 Published: August 22, 2019	Correction	FSSA and DXC

Version	Date	Reason for Revisions	Completed By
7.0	Policies and procedures as of July 1, 2019 Published: December 19, 2019	Scheduled review: <ul style="list-style-type: none"> <li>• Edited text as needed for clarity</li> <li>• Added two oversight activities in <a href="#">Section 1.4: The Bureau of Quality Improvement Services (BOIS)</a></li> <li>• Updated <a href="#">Section 2.1: Provider Application Process</a></li> <li>• Added the <a href="#">Electronic Visit Verification System Required for Personal Care Services</a> section</li> <li>• Updated <a href="#">Section 5.3: Initial Level of Care Evaluation</a></li> <li>• Added clarification about Medicaid eligibility in <a href="#">Section 7.2: Medicaid Eligibility Redetermination</a></li> <li>• Added information about the transfer of property penalty in <a href="#">Section 10: Service Definitions and Requirements</a></li> <li>• Note added to clarify participants in <a href="#">Section 10.23: Residential Habilitation and Support (Hourly)</a></li> <li>• Added a documentation standard for the Wellness Coordination Plan in the <a href="#">Documentation Standards</a> section</li> <li>• Added travel to worksite as reimbursable for Extended Services in the <a href="#">Reimbursable Activities</a> section</li> <li>• Updated the <a href="#">Limitations</a> and <a href="#">Provider Qualifications</a> sections for RHS Daily services</li> </ul>	FSSA and DXC

# Table of Contents

<b>Section 1: Roles and Responsibilities</b> .....	<b>1</b>
Section 1.1: The Centers for Medicare & Medicaid Services (CMS) .....	1
Section 1.2: FSSA Division of Disability and Rehabilitative Services (DDRS).....	1
Section 1.3: The Bureau of Developmental Disabilities Services (BDDS).....	2
Section 1.4: The Bureau of Quality Improvement Services (BQIS) .....	2
Section 1.5: FSSA Office of Medicaid Policy and Planning (OMPP) .....	3
Section 1.6: FSSA Division of Family Resources .....	3
Section 1.7: Waiver Service Providers, Including Case Management Agencies .....	4
Section 1.8: Office of Hearings and Appeals .....	4
Section 1.9: Participants and Guardians.....	4
<b>Section 2: Provider Information</b> .....	<b>9</b>
Section 2.1: Provider Application Process .....	9
Section 2.2: Provider Reapproval .....	10
Section 2.3: Claims and Billing .....	11
Section 2.4: Financial Oversight – Waiver Audits .....	12
<b>Section 3: Additional Medicaid Information</b> .....	<b>15</b>
Section 3.1: Other Program Information.....	15
Section 3.2: Medicaid Prior Authorization and Funding Streams .....	15
<b>Section 4: Intellectual/Developmental Disabilities Services Waivers</b> .....	<b>17</b>
Section 4.1: Medicaid Waiver Overview .....	17
Section 4.2: State Definition of Intellectual/Developmental Disability .....	18
Section 4.3: Cost Neutrality .....	18
Section 4.4: Coordination with Medicaid State Plan Services .....	18
Section 4.5: Family Supports Waiver (FSW).....	19
Section 4.6: Community Integration and Habilitation (CIH) Waiver .....	20
<b>Section 5: Application and Start of Waiver Services</b> .....	<b>23</b>
Section 5.1: Request for Application .....	23
Section 5.2: Medicaid Eligibility .....	23
Section 5.3: Initial Level of Care Evaluation .....	23
Section 5.4: Waiting List for the Family Supports Waiver .....	24
Section 5.5: Targeting Process for the Family Supports Waiver .....	26
Section 5.6: Entrance into the Community Integration and Habilitation Waiver Program.....	27
Section 5.7: Initial Plan of Care/Cost Comparison Budget Development.....	30
Section 5.8: State Authorization of the Initial POC/CCB .....	30
Section 5.9: Initial Service Plan Implementation .....	32
<b>Section 6: Objective-Based Allocation</b> .....	<b>33</b>
Section 6.1: OBA Development.....	33
Section 6.2: ICAP Assessment and Algo Level Development.....	33
Section 6.3: Algo Level Descriptors .....	34
Section 6.4: Translating Algo Level into a Budget Allocation .....	35
Section 6.5: Budget Review Questionnaire and Budget Modification Request .....	37
Section 6.6: Implementation of Objective-Based Allocations .....	41
Section 6.7: Personal Allocation Review (PAR) and the Appeal Process .....	41
<b>Section 7: Monitoring and Continuation of Waiver Services</b> .....	<b>45</b>
Section 7.1: Level of Care Reevaluation.....	45
Section 7.2: Medicaid Eligibility Redetermination .....	45
Section 7.3: Annual Plan of Care/Cost Comparison Budget Development .....	45
Section 7.4: Plan of Care/Cost Comparison Budget Updates and Revisions .....	47

Section 7.5: State Authorization of the Annual/Update Cost Comparison Budget .....	47
Section 7.6: Service Plan Implementation and Monitoring.....	47
Section 7.7: Interruption/Termination of Waiver Services .....	49
Section 7.8: Waiver Slot Retention after Termination and Re-Entry .....	50
Section 7.9: Parents, Guardians, and Relatives Providing Waiver Services .....	51
<b>Section 8: Appeal Process .....</b>	<b>53</b>
Section 8.1: Appeal Request .....	53
Section 8.2: Group Appeals .....	54
Section 8.3: Time Limits for Requesting Appeals .....	54
Section 8.4: The Hearing Notice .....	55
Section 8.5: Request for Continuance from the Appellant.....	55
Section 8.6: Review of Action .....	56
Section 8.7: Disposal of Appeal without a Fair Hearing .....	56
Section 8.8: The Fair Hearing .....	56
Section 8.9: Preparation for Hearing by Appellant .....	57
Section 8.10: Preparation for Hearing by the BDDS Service Coordinator or District Representative, BDDS Waiver Unit, or the DDRS Central Office.....	57
Section 8.11: Conduct of the Hearing .....	58
Section 8.12: Continuance of Hearing .....	59
Section 8.13: The Hearing Record .....	59
Section 8.14: The Fair Hearing Decision .....	59
Section 8.15: Actions of the Administrative Law Judge’s Decision .....	59
Section 8.16: Agency Review .....	59
Section 8.17: Judicial Review .....	60
Section 8.18: Lawsuit.....	60
<b>Section 9: Bureau of Quality Improvement Services .....</b>	<b>61</b>
Section 9.1: Overview .....	61
Section 9.2: Provider Compliance Reviews .....	61
Section 9.3: Incident Reports .....	62
Section 9.4: Complaints .....	63
Section 9.5: Mortality Reviews .....	64
Section 9.6: National Core Indicator (NCI) Project .....	64
Section 9.7: Case Record Reviews.....	65
Section 9.8: Data Driven Reviews .....	65
Section 9.9: Statewide Waiver Ombudsman .....	65
<b>Section 10: Service Definitions and Requirements .....</b>	<b>67</b>
Section 10.1: Service Definition Overview.....	67
Section 10.2: Medicaid Waiver Services, Codes, and Rates .....	67
Section 10.3: Adult Day Services .....	71
Section 10.4: Behavioral Support Services .....	73
Section 10.5: Community-Based Habilitation – Group .....	76
Section 10.6: Community-Based Habilitation – Individual .....	78
Section 10.7: Community Transition .....	81
Section 10.8: Electronic Monitoring .....	82
Section 10.9: Environmental Modifications.....	87
Section 10.10: Facility-Based Habilitation – Group .....	90
Section 10.11: Facility-Based Habilitation – Individual .....	92
Section 10.12: Facility-Based Support.....	95
Section 10.13: Family and Caregiver Training .....	97
Section 10.14: Intensive Behavioral Intervention .....	99
Section 10.15: Music Therapy .....	102
Section 10.16: Occupational Therapy .....	104
Section 10.17: Personal Emergency Response System.....	106
Section 10.18: Physical Therapy.....	107

Section 10.19: Prevocational Services ..... 109

Section 10.20: Psychological Therapy ..... 112

Section 10.21: Recreational Therapy ..... 114

Section 10.22: Rent and Food for Unrelated Live-in Caregiver..... 116

Section 10.23: Residential Habilitation and Support (Hourly) ..... 117

Section 10.24: Respite Care ..... 121

Section 10.25: Specialized Medical Equipment and Supplies ..... 123

Section 10.26: Speech/Language Therapy ..... 126

Section 10.27A: Transportation (as Specified in the FSW) ..... 128

Section 10.27B: Transportation (as Specified in the CIH Waiver) ..... 130

Section 10.28: Workplace Assistance ..... 132

Section 10.29: Case Management ..... 135

Section 10.30: Participant Assistance and Care ..... 140

Section 10.31: Structured Family Caregiving ..... 143

Section 10.32: Wellness Coordination ..... 146

Section 10.33: Extended Services ..... 149

Section 10.34: Residential Habilitation and Support – Daily (RHS Daily) ..... 152

**Section 11: RFA Policies ..... 159**

Section 11.1: Environmental Modification Policy ..... 159

Section 11.2: Specialized Medical Equipment and Supplies ..... 164

Section 11.3: Vehicle Modification ..... 169





# **Section 1: Roles and Responsibilities**

---

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

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

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

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

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

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

Additional information about the CMS is available at the [CMS website](https://www.cms.gov) at cms.gov.

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

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

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

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

Additional information about the DDRS is available at the [DDRS section of the FSSA website](https://www.in.gov/fssa) at in.gov/fssa.

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

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

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

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

Eight BDDS district offices serve specific counties. The BDDS service coordinators determine initial eligibility for intellectual/developmental disability services, determining LOC for ICF/IID services.

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

Additional information about the BDDS is available on the [DDRS Bureau of Developmental Disabilities Services](http://in.gov/fssa/ddrs) page at [in.gov/fssa/ddrs](http://in.gov/fssa/ddrs).

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

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

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

Additional information about the BQIS is available on the [DDRS Bureau of Quality Improvement](http://in.gov/fssa/ddrs) page at [in.gov/fssa/ddrs](http://in.gov/fssa/ddrs).

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

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

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

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

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

## Section 1.6: FSSA Division of Family Resources

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

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

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

The division's overarching focus is the support and preservation of families by emphasizing self-sufficiency and personal responsibility. Information about the DFR and DFR programs is available online at the [DFR section of the FSSA website](#) at [in.gov/fssa](#) or by telephone at 1-800-403-0864.

## Section 1.7: Waiver Service Providers, Including Case Management Agencies

HCBS waiver provider applicants are agencies, companies, and individuals that have applied to provide waiver services and have been found to have the qualifications and business structures in place to seek enrollment as a Medicaid provider. After DDRS approval, the providers must then enroll in Medicaid as Indiana Health Coverage Programs (IHCP) providers. For more information on how to enroll in Medicaid, see the [Provider Enrollment](#) module at [in.gov/medicaid/providers](http://in.gov/medicaid/providers). After enrolling in Medicaid, the providers are paid by the IHCP to provide direct services to Medicaid HCBS Waiver program participants.

The DDRS-approved Case Management agencies are waiver service providers that provide only Case Management services to waiver participants. These services include the following:

- Implementing the recently enhanced person-centered planning process
- Helping the participant identify members of the Individual Support Team (IST)
- Developing a Person-Centered/Individualized Support Plan (PC/ISP) before developing and submitting to the State the service plan known as the Plan of Care/Cost Comparison Budget (POC/CCB)

Case Management agencies often refer to themselves as *Case Management Companies*, using the acronym CMCOs. Specific responsibilities of the Case Management provider, including monitoring activities, are described in [Section 10.29: Case Management](#).

All waiver participants must have Case Management services. Waiver participants are provided a choice from among all CMCOs that have been approved by the DDRS and IHCP. After the waiver participant chooses a CMCO, he or she chooses a Case Manager. The waiver participant's chosen Case Manager provides a list of available service providers at any time that the participant requests to select or change service providers, which includes changing providers of Case Management services.

## Section 1.8: Office of Hearings and Appeals

The FSSA Office of Hearings and Appeals (OHA) is an administrative section within the FSSA that receives and processes appeals from people receiving services within FSSA programs and many other programs. Administrative hearings are held throughout the state of Indiana, usually at county DFR locations, at which time all parties have the opportunity to present their cases to an administrative law judge. See [Section 8: Appeal Process](#) for additional information about the hearing and appeal process.

## Section 1.9: Participants and Guardians

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

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

The BDDS supports and encourages individual choice in selecting the participant's Case Management service provider, developing a PC/ISP, and selecting all other service providers. Successful service delivery is dependent on the collaboration of the IST and entities with oversight responsibilities, including the BQIS. The individual receiving services is the most prominent member of the IST, making his or her participation and cooperation in waiver service planning and administration essential.

For additional information, see [Individual/Guardian Responsibilities While Receiving Waiver Funded Services](#), available on the [Current DDRS Policies](#) page at [in.gov/fssa/ddrs](http://in.gov/fssa/ddrs).

## ***Information Sharing***

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

## ***Selecting or Changing Providers***

When selecting a Case Management provider, the individual (or the individual's legal representative, when indicated) must participate in the following:

- Choosing a CMCO (provider agency) from a pick list of DDRS-approved and IHCP-enrolled CMCOs
  - For newly approved applicants preparing to enter into waiver services, the Case Management list is generated by the BDDS.
  - For individuals already active on the waiver, the Case Management pick list may be generated by the BDDS or by the current provider of Case Management services.
- Interviewing and choosing a Case Manager.
- Completing the service-planning process.

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

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

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

See the [Helpful Hints for Participants and Guardians Selecting Waiver Providers](#) section.

## ***Participating in Risk Plan Development and Implementation***

The individual (or the individual's legal representative, when indicated) must participate in the following:

- Development of risk plans for the individual, per current BDDS and BQIS procedures
- Implementation of risk plans developed for the individual, in lieu of documented risk negotiation with the individual's IST and a signed risk nonagreement document

## ***Allowing Representatives of the State into the Individual's Home***

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

## ***Consequences for Nonparticipation***

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

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

## ***Helpful Hints for Participants and Guardians Selecting Waiver Providers***

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

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

## **General Topics to Discuss with Service Providers**

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

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

- How would the provider ensure the implementation of the PC/ISP?
- What connections has the provider established in the community? How would the provider assist in building a support system in the community?

## Questions to Ask Prospective Service Providers

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

- What is the provider's mission? (Does it match the intent you are seeking?)
- Is the provider certified, accredited, or licensed? What are the standards of service?
- What kind of safety measures does the provider have in place to protect the participant and assure effective treatment?
- How does the provider assure compliance with the person's rights? Did you (and family members and advocates) receive copies of your rights as a consumer of services, as well as have these rights explained?
- Is the provider interested in what you and your family member want or are hopeful about?
- Is the provider connected to other programs that you may need, such as day support, local school and education services, or work programs? How is the provider connected? Ask for specific contacts.
- If you are to live in a home shared with other people, can families drop in whenever they wish?
- How are birthdays, vacations, and special events handled?
- How would family money issues be handled? What is the policy on personal and client finances?
- How would minor illnesses and injuries be handled? What about *major* illnesses and injuries?
- What information is routinely reported to families?
- Can you get a copy of the provider's complaint policies and procedures? Is there someone else whom family members can talk to if there is a disagreement?
- How are behavior problems handled? Are staff allowed to contact a behavioral support provider? How are new staff trained on the behavior support plan? Are they trained before working with waiver participants? What is the relationship between residential provider and behavioral provider?
- How is medication handled? What happens if medication is refused?
- What is the smoking policy?
- How are planning meetings scheduled and conducted, and who attends? Can a family member call a meeting? How does the provider assure that what is agreed on in the meeting is actually provided?
- Who would be the provider's contact person, how will that contact occur, and how often? Is someone available 24 hours a day in case of emergencies?
- How many people with disabilities have the agency terminated or discontinued from services? Why? What happened to them?
- Has the agency received any abuse or neglect allegations? Who made these allegations? What were the outcomes? What is the process for addressing allegations of abuse or neglect?
- What challenges does the provider think the waiver participant will create for him or her?
- As a provider of waiver services, what are the provider's strengths and weaknesses?
- What is the process for hiring staff? Are background checks conducted and training given? Who provides services to the waiver participant while a new staff person is hired and trained?

- How is direct staff supervised? What training does the staff receive? What is the average experience or education of staff?
- How is staffing covered if someone on regular staff is ill? What happens if staff does not show up for the scheduled time? How often does that happen?
- What is the staff turnover rate? How are the staffs' needs for respite handled?
- What kind of support does staff have? Who can staff call if a problem develops?

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

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

- How do the staff and housemates interact? Do they seem to respect and like each other?
- Does the environment look comfortable? Is there enough to do? Are there concerns about behaviors or support in the home?
- What kind of food is available and who selects it? Are choices encouraged and available? Are diets supervised?
- Do people have access to banks, shops, restaurants, and so on? How is transportation handled? Are trips to access these resources planned or do they occur as needed?
- Is there a telephone available to housemates (with privacy)? Is the telephone accessible (equipped with large buttons, volume control, other access features) if needed?
- Does each person have his or her own bedroom? Is each person allowed to individually decorate the bedroom?
- Do housemates seem to get along well? What happens when they don't?
- Are there restrictions on personal belongings? What are the procedures for lost personal items? Are personal items labeled? Are lost items replaced?
- Are pets allowed? What are the rules regarding pets?
- How much time is spent in active learning (neighborhood, home, or community) and leisure activities? Is there a good balance with unstructured time?
- Is there evidence that personal hygiene and good grooming (hair, teeth, nails, and so on) are encouraged?
- How are personal need items, clothing, and so on, paid for?
- Does each person have privacy when he or she wants to be alone or with a special friend?
- Does each person have the opportunity to belong to a church, club, community group, and so on?
- Do staff knock on doors and wait for a response before entering a private room?
- What kind of rules are there within the living situation? What are the consequences for breaking rules?
- Does each housemate have opportunities to pursue 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

---

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

### Section 2.1: Provider Application Process

Applications to provide Indiana’s Home and Community-Based Services (HCBS) waiver services through the Bureau of Developmental Disabilities Services (BDDS) may be submitted year round. Applications for becoming a Case Management Company (CMCO) provider must be requested from the Family and Social Services Administration (FSSA) Division of Disability and Rehabilitative Services (DDRS) Provider Services Department. All components of the provider application packet must be completed. When a completed application is received, the information submitted is reviewed by the FSSA DDRS Provider Services Department. Provider applicants may receive a written Request for Information if the application components are not clear or questions exist. If the provider applicant meets the requirements of *Indiana Administrative Code 460 IAC 6* and DDRS policies, the application will be moved forward as authorized to start the process of applying for enrollment with Indiana Health Coverage Programs (IHCP). Initial approval by BDDS is issued for 12 months. If the application packet is not completed in its entirety (with all documentation provided in full, labeled correctly, and in the order requested per the application instructions), or the applicant does not meet the requirements outlined for the services, the application will be denied by DDRS Provider Services.

Completed applications may be submitted to:

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

### ***Provider Application Documents***

There are two versions of provider applications. The first version is specific to Case Management providers, and the second version covers all other BDDS HCBS Waiver services. Each application version comprises the following documents (available on the [BDDS Provider Application Process](#) page at [in.gov/fssa/ddrs](http://in.gov/fssa/ddrs)):

- *Application Overview*
- *List of Services by Category*
- *Application Form and Policy and Procedure Submission Requirements*
- *County Listing*
- *Application Signature Page*
- *Provider Application Proposed Services* (for non-Case Management provider applicants only)

As part of the provider application, applicants are required to submit the following:

- Legal documentation such as:
  - Transcripts
  - Diplomas
  - Proof of training
  - Proof of licensure or certification
  - Criminal history search/background checks
  - Other documentation specified in the provider approval process
- Proof of insurance details
- General administrative requirements for providers that include but are not limited to: compliance with Medicaid and Medicaid waivers, collaboration, and quality control and quality assurance
- Financial status for providers documenting financial stability and other fiscal issues
- Professional qualifications and requirements
- Proof of accreditation or proof of application and scheduled survey for accreditation by a preapproved national accrediting organization. A provider may select from approved national accreditation organizations. The approved organizations are set forth in *Indiana Code IC 12-11-1(i)*. Specific services require accreditation as detailed in the application. Accreditation by an approved organization must be secured within 12 months of initial BDDS approval.

## Section 2.2: Provider Reapproval

The DDRS Bureau of Quality Improvement Services (BQIS) reviews the performance of Medicaid HCBS waiver service providers and makes a reapproval determination at least once every 3 years. Providers may be reapproved for terms of 6, 12, or 36 months.

The BQIS initiates the reapproval process and evaluates the following information for each provider:

- Findings from provider's prior compliance review
- Numbers of complaints BQIS has received about the provider and number of substantiated allegations
- Numbers of and types of incident reports related to abuse, neglect, exploitation, medical, and behavioral issues
- Implementation of quality assurance systems
- Staff training
- Any other information the DDRS deems necessary to assess a provider's performance
- Compliance Evaluation Review Tool (CERT)

Every new provider receives at least one provider compliance review in its initial term. The BQIS conducts this review using the CERT, which looks at:

- A provider's qualifications
- The required policies in place
- Staff records containing documentation of required general qualifications and training
- Evidence of the provider's quality assurance and quality improvement system being implemented
- Accreditation by a national accreditation organization (*Note: A provider may select from approved national accreditation organizations set forth in IC 12-11-1(i)*)

Although Case Management providers are not permitted to provide any other waiver services, residential and day program providers may choose to obtain accreditation (specific to Indiana programs) for other waiver services that they are approved to provide. However, this accreditation is not required. Some accreditation entities accredit the organization, whereas others allow providers to select the services they wish to accredit. The BQIS does not conduct compliance reviews on any accredited services. This means that if a provider chooses to accredit only some of its services, the BQIS continues to conduct provider compliance reviews on all the provider's nonaccredited services. All services are reviewed at least once every 3 years, either by the BQIS or the accreditation entity of the provider's choosing.

The process for reapproving providers is outlined in the DDRS [Policy on Provider Reapproval for Waiver Services](#). Further information about the reapproval process and related tools is available on the [DDRS BQIS](#) page at [in.gov/fssa/ddrs](http://in.gov/fssa/ddrs).

The director of the BQIS issues providers notices of 6-, 12-, or 36-month reapproval terms. This notice also specifies that the reapproval term is contingent on the provider submitting a signed Provider Agreement within 30 calendar days. The provider's reapproval term begins when the document is received by the BQIS.

If a provider fails to return a Provider Agreement within the 30 calendar days, the provider will have been deemed to have failed to meet the requirements for reapproval and will receive a letter indicating that it is under 6-month probationary approval and may be referred to the DDRS Sanctions Committee for civil sanctions or a potential moratorium on new admissions.

At the end of the 6-month probationary period, the provider must repeat the DDRS provider reapproval process and submit all the required data analysis and systems descriptions necessary to assure that the quality of services meets or exceeds the required standards.

## ***Administrative Review***

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

- States facts demonstrating that the provider is:
  - A provider to whom the action is specifically directed
  - Aggrieved or adversely affected by the action
  - Entitled to review under any law
- Is filed with the director of the DDRS within 15 calendar days after the provider receives notice of the sanctioning order. Per the *Administrative Orders and Appeals Act* (AOPA), the petition must also be filed with [AOPAAppeals@fssa.in.us](mailto:AOPAAppeals@fssa.in.us).
- Is conducted in accordance with *IC 4-21.5-3-7*.

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

## **Section 2.3: Claims and Billing**

### ***Waiver Authorization – Service Definitions and Requirements***

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

- The IHCP does not reimburse time spent by office staff billing claims.
- Providers may bill only for those services authorized on an approved Notice of Action (NOA).

- A claim may include dates of service within the same month. Claims may not be submitted with dates that span more than 1 month on the same claim.
- The units of service as billed to the IHCP must be substantiated by documentation in accordance with the appropriate *Indiana Administrative Code* (IAC) regulations and the waiver documentation standards issued by the FSSA Office of Medicaid Policy and Planning (OMPP) and the DDRS.
- Services billed to the IHCP must meet the service definitions and parameters as published in the aforementioned rules and standards.

Updated information is disseminated through IHCP [provider bulletins](#) posted on [in.gov/medicaid/providers](http://in.gov/medicaid/providers) and announcements on the [DDRS website](http://in.gov/fssa) at [in.gov/fssa](http://in.gov/fssa). Each provider is responsible for obtaining the information and implementing new or revised policies and procedures as outlined in these notices.

### ***Third-Party Liability Exempt***

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

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

### ***Electronic Visit Verification System Required for Personal Care Services***

The *21st Century Cures Act* requires Medicaid providers of personal care services to use an electronic visit verification (EVV) system to document services rendered. Use of an EVV system to document personal care services must be implemented by January 1, 2020. However, the effective date has been updated to January 1, 2021, contingent upon Indiana working cohesively with providers throughout the 2020 calendar year to implement EVV.

Affected providers may use an EVV system of their choice; however, providers are responsible for ensuring that the system selected complies with federal requirements, including documentation of the following information:

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

## **Section 2.4: Financial Oversight – Waiver Audits**

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

data, allowing them to identify providers and claims that indicate aberrant billing patterns and other risk factors.

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

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

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

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

### ***FSSA Audit Oversight***

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

### ***Medicaid Fraud Control Audit Overview***

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

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

When the MFCU identifies a provider that has violated regulations in one of these areas, the provider's case is presented to the State or federal prosecutors for appropriate action. Providers can access information about the [MFCU](http://in.gov/attorney-general) at [in.gov/attorney general](http://in.gov/attorney-general).



## Section 3: Additional Medicaid Information

---

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

### Section 3.1: Other Program Information

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

See the [Member Eligibility and Benefit Coverage](#) module at [in.gov/medicaid/providers](http://in.gov/medicaid/providers) for detailed information about member eligibility and services.

### Section 3.2: Medicaid Prior Authorization and Funding Streams

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

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

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

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

*Note: For additional information regarding PA, see the [Prior Authorization](#) page at [in.gov/medicaid/providers](http://in.gov/medicaid/providers).*





## **Section 4: Intellectual/Developmental Disabilities Services Waivers**

---

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

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

Both waivers can be found on the [BDDS](https://www.in.gov/fssa/ddrs) page at [in.gov/fssa/ddrs](https://www.in.gov/fssa/ddrs).

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

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

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

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

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

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

## Section 4.2: State Definition of Intellectual/Developmental Disability

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

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

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

## Section 4.3: Cost Neutrality

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

## Section 4.4: Coordination with Medicaid State Plan Services

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

## Section 4.5: Family Supports Waiver (FSW)

### ***Purpose***

The FSW program provides Medicaid HCBS to participants residing in a range of community settings as an alternative to care in an intermediate care facility for individuals with intellectual/developmental disabilities (known as an ICF/IID) or related conditions. The FSW serves persons with intellectual/developmental disabilities, or autism who have substantial functional limitations, as defined in *Code of Federal Regulations 42 CFR 435.1010*. Participants may choose to live in their own home, family home, or community setting appropriate to their needs. Participants develop a Person-Centered/Individualized Support Plan (PC/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 friends. The participant with the IST, selects services, identifies service providers of their choice, and develops a plan of care/cost comparison budget (POC/CCB).

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

*Note: The POC/CCB is subject to an annual waiver services cost cap of \$17,300.*

### ***Goals and Objectives***

The FSW accomplishes the following:

- Provides access to meaningful and necessary home and community-based services and supports
- Implements services and supports in a manner that respects the participant's personal beliefs and customs
- Ensures that services are cost-effective
- Facilitates the participant's involvement in the community where he or she lives and works
- Facilitates the participant's development of social relationships in his or her home and work communities
- Facilitates the participant's independent living

### ***Services Available***

The following services are available:

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

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

### ***Goals and Objectives***

The CIH Waiver accomplishes the following:

- Provides access to meaningful and necessary home and community-based services and supports
- Seeks to implement services and supports in a manner that respects the participant's personal beliefs and customs

- Ensures that services are cost-effective
- Facilitates the participant's involvement in the community where he or she lives and works
- Facilitates the participant's development of social relationships in his or her home and work communities
- Facilitates the participant's independent living

## ***Services Available***

The following services are available:

- 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
- Prevocational Services
- Psychological Therapy
- 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

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

### Section 5.1: Request for Application

An individual or his or her guardian may apply for the FSW or the CIH Waiver program through the local Division of Disability and Rehabilitative Services (DDRS) Bureau of Developmental Disabilities Services (BDDS) office. An individual or his or her guardian 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 Developmental Disability Services (State Form 55068 [8-12])*, which is available on the DDRS [Forms](#) page at [in.gov/fssa/ddrs](http://in.gov/fssa/ddrs). Other individuals or agency representatives may help the individual or guardian complete the application and forward it to the BDDS office serving the county in which the individual currently resides. The application may be submitted in person, by mail, or by fax.

Upon receiving the waiver application, the BDDS staff must contact the individual and his or her guardian, and discuss the process for determining eligibility for the waiver (documentation of an intellectual/developmental disability, Medicaid eligibility, and initial level of care [LOC]). If the applicant is not a Medicaid member, he or she is 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 CIH Waiver program are advised of those services and the availability of a funded priority slot. See [Section 5.6: Entrance into the Community Integration and Habilitation Waiver Program](#) for details.

### Section 5.2: Medicaid Eligibility

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

Applicants under the age of 18 should submit the Plan of Care/Cost Comparison Budget (POC/CCB) approval letter (see [Section 5.8: State Authorization of the Initial POC/CCB](#)) to the Family and Social Services Administration (FSSA) Division of Family Resources (DFR) when submitting an application for Medicaid benefits or when requesting a change of Medicaid Aid Category to qualify for waiver eligibility.

*Note: Medicaid eligibility is required before starting waiver services. See the [Apply for Medicaid](#) page at [in.gov/medicaid/members](http://in.gov/medicaid/members) for instructions on how to apply for Medicaid.*

### Section 5.3: Initial Level of Care Evaluation

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

- Initial LOC determinations are made by a BDDS service coordinator.
- Reevaluations are performed by the selected provider of Case Management services.

- For those applicants whose initial LOC evaluation was unfavorable, the information is submitted to the BDDS Central Office for a tertiary review. The FSSA Office of Medicaid Policy and Planning (OMPP) retains final authority for determination of eligibility.
- Only individuals (State employees) who are Qualified Intellectual Disability Professionals (QIDP), as specified by the standard in *Code of Federal Regulations 42 CFR 483.430(a)*, may perform initial LOC determinations.
- If collateral records are not available or are not valid reflections of the individual, additional assessments may be obtained from contracted psychologists, physicians, nurses, and licensed social workers. Following review of the collateral records, the LOC assessment tool applicable to individuals with intellectual/developmental disabilities and other related conditions is completed to ascertain if the individual meets ICF/IID LOC.
- The LOC assessment tool is used for:
  - Reviewing and referencing documentation related to the intellectual/developmental disabilities of the applicant or 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 in which the individual may exhibit a substantial functional limitation, including the areas of mobility, understanding and use of language, self-care, capacity for independent living, learning, self-direction, economic self-sufficiency, and the State definition of developmental disability found in *Indiana Code IC 12-7-2-61*
- The BDDS service coordinator (initial LOC) or selected provider of Case Manager (reevaluations) reviews the LOC assessment tool and collateral material applicable to individuals with intellectual/developmental disabilities and other related conditions to ascertain whether the individual meets ICF/IID LOC requirements. An applicant or participant must meet requirements for three of six substantial functional limitations and each of four basic conditions (lists follow) to meet LOC criteria.

The basic conditions are:

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

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

- Self-care
- Learning
- Self-direction
- Capacity for independent living
- Understanding and use of language
- Mobility

## Section 5.4: Waiting List for the Family Supports Waiver

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



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

For initial placement on a single, statewide Home and Community-Based Services (HCBS) waiver waiting list, the following requirements must be met:

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

## ***Waiting List Targeting for a Family Supports Waiver Slot***

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

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

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

## ***Responsibilities of Individuals on a Waiting List***

Individuals on a waiting list have the following responsibilities:

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

## **Section 5.5: Targeting Process for the Family Supports Waiver**

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

- Accept or decline the waiver slot within 30 calendar days.
- Apply for Medicaid if he or she hasn’t already done so.
- Provide or obtain confirmation of his or her diagnosis from a physician on the *Confirmation of Diagnosis (State Form 54727)*, available from the [DDRS Forms](http://in.gov/fssa/ddrs) page at in.gov/fssa/ddrs.

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

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

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

If an individual accepts the offer for an FSW slot:

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

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

Because parental income is not factored into a minor receiving waiver services, proof of an approved POC/CCB may be required before some minors can obtain Medicaid eligibility. For that reason, the BDDS service coordinator creates an initial POC/CCB, although selection of a Case 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, generating the 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 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 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 CIH Waiver program now occurs only by meeting and being approved for certain priority criteria known as reserved waiver capacity.*

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

Entrance into the HCBS CIH Waiver program requires the following:

- Individual must meet and be approved for the specific priority criteria of at least one of the following reserved waiver capacity categories:
  - Eligible individuals transitioning to the community from a nursing facility (NF), Extensive Support Needs Home (ESN), or a State-Operated Facility (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 choosing to leave an ICF/IID
  - Eligible individuals meeting one of the following emergency placement criteria:
    - Death of a primary caregiver when there is no other caregiver available
    - Caregiver over 80 years of age when there is no other caregiver available
    - Evidence of abuse or neglect in the current institutional or SGL placement
    - Extraordinary health and safety risk as reviewed and approved by the division director
- Individual, his or her legal representatives, or other persons acting on the individual's behalf must request and apply for a priority waiver slot when it appears that the individual meets the specific criteria of one or more reserved waiver capacity categories.

- It is necessary to complete an application and submit the application to the local BDDS office to apply for HCBS waiver services.
- The individual and any legal guardian are expected to participate in completing the following:
  - Application
  - Collateral information, including the following:
    - LOC assessment tool
    - Supporting documents:
      - Diagnostic evaluations
      - Functional evaluations
      - Psychological reports
      - Individualized Education Programs from schools
      - School records
      - Physician’s diagnosis and remarks
      - Existing evaluation done by Supplemental Security Income or vocational rehabilitation
      - IQ testing done at any time
    - Medicaid application for individuals over 18 years of age
    - Supplemental Security Income application, if applicable
- LOC must be assessed for all individuals.
- An individual must meet the following:
  - The State definition of a developmental disability in *IC 12-7-2-61(a)*
  - ICF/IID LOC with substantial functional limitations, as defined in *42 CFR 435.1010*
    - Additionally, if an individual meets the LOC criteria listed in [Section 5.3: Initial Level of Care Evaluation](#), and a funded priority slot is available in the reserved waiver capacity category met by the individual, the BDDS office first determines whether other potential placement options have been exhausted before offering the slot to the individual.
    - Individuals are responsible for maintaining current collateral and contact information with their local BDDS office.

### ***Application for a CIH Waiver Priority Slot***

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

### ***Responsibilities of Individuals Applying for a CIH Waiver Priority Slot***

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

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

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

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

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

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

The individual or guardian has 60 calendar days letter from the BDDS offering a CIH Waiver priority slot to apply for and obtain Medicaid when the individual does not yet have Medicaid coverage.

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

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

After all assessments have been made, the BDDS gives applicants younger than the age of 18 and their legal guardians a pick list of Case Management providers that are approved by the DDRS and enrolled through the IHCP to provide service in the applicant's county of residency. Due to the disregard of parental income for minors receiving waiver services, proof of a POC/CCB may be required before some minors can obtain Medicaid eligibility. In those situations, the BDDS creates the POC/CCB, enabling the minor to obtain Medicaid. Otherwise, selection of a Case Management provider 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 Management provider submits a POC/CCB for waiver service.

After the BDDS provides the Case Management provider information, the individual or guardian has:

- Five calendar days to interview and choose a Case Management provider
- 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 has 3 calendar days to review and sign service-planning documents.

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

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

## Section 5.7: Initial Plan of Care/Cost Comparison Budget Development

The State monitors and recently enhanced its Person-Centered Planning (PCP) process to ensure compliance with *CMS 2249-F* and *CMS 2296-F*. The new Person-Centered/Individualized Support Plan (PC/ISP) approach enhances the way in which supports and services are explained to individuals and families so that their needs, aspirations and opportunities for the achievement of self-determination, interdependence, productivity, integration and inclusion in all facets of community life can be identified and explored. Additionally, the PC/ISP drives the development of the Plan of Care/Cost Comparison Budget (POC/CCB). The PC/ISP is the new plan that identifies the array of services and supports, paid and unpaid from all sources that will be utilized to implement desired outcomes and ensure the participant's health and welfare while the CCB identifies those supports and services which are funded by the waiver. The participant, Case Manager, and others of the participant's choosing form the Individual Support Team (IST). The participant has the right and power to command and direct the entire PC/ISP process with focus on his or her preferences, aspirations, and needs. The process empowers participants to create life plans and direct the planning and allocation of resources to meet his or her self-directed life goals. The CCB is developed by the participant-chosen Case Manager a minimum of 6 weeks prior to the initial start date of services and then 6 weeks prior to the end date of each annual service plan. The CCB is routinely developed to cover a time frame of 12 consecutive months.

Although the FSW is already capped at \$17,300 annually, budgeted amounts for POC/CCBs developed under the CIH Waiver use the objective-based allocation process described in [Section 6: Objective-Based Allocation](#).

- Coordination of waiver services and other services is completed by the Case Manager. Within 30 days of implementation of the plan, the Case Manager is responsible for ensuring that all identified services and supports have been implemented as identified in the PC/ISP 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. The IST is advised of any concerns or needs for updates that may require scheduling of additional team meetings by the Case Manager.
- Most waiver service providers are required to submit a quarterly report summarizing the level of support provided to the participant, based on the identified supports and services in the PC/ISP and the POC/CCB. As part of the 90-day review process, the Case Manager reviews these reports for consistency with the PC/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 POC/CCB electronically to the State's waiver specialist, who reviews the POC/CCB and confirms that the individual is a current Medicaid member in one of the following categories:

- Aged (MA A)
- Blind (MA B)
- Low-income families (MA GF)
- Disabled (MA D)
- Disabled worker (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 to 5 – *Sec 1902(a)(10)(A)(i)(VI)* (MA Z)
- Children age 1 through 18 – *Sec 1902(a)(10)(A)(i)(VII)* (MA 9, MA 2)
- Transitional medical assistance – *Sec 1925 of the Act* (MA F)

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

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

The waiver specialist also confirms the following:

- The individual has a current ICF/IID LOC approval.
- The individual has been targeted for an available waiver slot.
- The individual’s identified needs are addressed with a plan to assure his or her health, safety, and welfare.
- The individual or guardian has signed, indicating acceptance of the POC/CCB, that he or she has been offered choice of DDRS-approved waiver service providers and 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 signed Notice of Action (NOA) (*HCBS Form 5*) are electronically transmitted to the Case Manager, BDDS (for initial POC/CCBs only), and service providers. Within 3 calendar days of receiving the initial POC/CCB approval letter and NOA, the Case Manager must provide copies of the approval letter, signed NOA, and addendum (containing information from the POC/CCB) to the individual or guardian. The individual’s chosen waiver service providers are required to register so that they receive the NOA and the addendums electronically.

## ***The Notice of Action (NOA)***

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

- If the waiver specialist approves the POC/CCB pending Medicaid eligibility or change of aid category (for minors only), disenrollment of a child from Hoosier Healthwise, facility discharge, or other reasons, the pending approval letter is to be transmitted to the Case Manager, the BDDS, and the service providers. The Case Manager must notify the individual or guardian within 3 calendar days of receipt of the pending approval and provide a copy of the initial approval letter naming the pending conditions. No NOA is generated until all pending issues are resolved and a final approval letter is released.
- If the waiver specialist denies the initial POC/CCB, a denial letter must be transmitted to the Case Manager, the BDDS (for initial and annual POC/CCBs only), and service providers. Within 3 calendar days of receipt of the denial, the Case Manager must provide a copy of the NOA (*HCBS*

*Form 5*), the appeal rights as an HCBS waiver services recipient, and an explanation of the decision to deny to the individual or guardian. The Case Manager discusses other service options with the individual and guardian, unless the individual or guardian files an appeal.

*Note: After waiver services begin, waiver participants are sometimes referred to as “beneficiaries” or “members” for Medicaid purposes.*

## Section 5.9: Initial Service Plan Implementation

An individual cannot begin waiver services under the FSW program or the CIH Waiver program before the approval of the initial POC/CCB by the State’s waiver specialist. The initial POC/CCB represents the service plan identified for the individual resulting from the PC/ISP development process. If the waiver specialist issues an initial approval letter pending certain conditions being met, those conditions must be resolved before the start of the individual’s waiver services. For applicants under the age of 18, if the individual’s Medicaid eligibility is approved pending waiver approval, the Case Manager notifies the local DFR caseworker when the waiver has been approved. The DFR caseworker and waiver Case Manager coordinate the Medicaid eligibility date and waiver start date. If Medicaid eligibility depends on eligibility for the waiver, the Medicaid start date is usually the first day of the month following approval of the POC/CCB.

If an individual is in a Hoosier Healthwise, Hoosier Care Connect, or Medicaid managed care program, the Case Manager must contact the local DFR caseworker to coordinate the managed care program stop date and waiver services start date. Individuals receiving the IHCP hospice benefit do not have to disenroll from the hospice benefit to receive waiver services that are not related to the terminal condition and are not duplicative of hospice care. If applicable, the Case Manager and managed care benefit advocate must inform the individual and individual’s parent or guardian of his or her options to ensure 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 3 calendar days after the individual begins waiver services, the Case Manager must complete the *Confirmation of Waiver Start* form in the INsite database and electronically transmit it to the State through the DDRS INsite database.

For all waiver starts, when the Case Manager completes the *Confirmation of Waiver Start* form in the INsite database and electronically transmits it to the DDRS database, the FSSA is also electronically notified to enter the individual’s waiver start information in the Core Medicaid Management Information System (CoreMMIS) database.

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

**Within 3 calendar days of receiving the initial POC/CCB approval letter and signed NOA (*HCBS Form 5*), the Case Manager must provide copies of the approval letter, signed NOA, and addendum (containing information from the POC/CCB) to the individual or guardian.** The individual’s chosen waiver service providers are required to register so they receive the NOA form and the Addendums electronically.

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



## Section 6: Objective-Based Allocation

---

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

### Section 6.1: OBA Development

In 2007, the DDRS and an external group of stakeholders consisting of advocates, providers, and industry professionals began the research and development of an 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 (Algo). As is further explained in *the following section*, the OBA is determined by combining the overall Algo (determined by the Inventory for Client and Agency Planning [ICAP] and the ICAP addendum), age, employment, and living arrangement.

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

### Section 6.2: ICAP Assessment and Algo Level Development

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

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

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

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

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

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

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

## Section 6.3: Algo Level Descriptors

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

Table 1 – Algo Level Descriptors

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

## Section 6.4: Translating Algo Level into a Budget Allocation

Based on the Algo, age, and living arrangement, overall/total budget allocations have been established by taking a predetermined baseline from that Algo level group to calculate a dollar amount for each of three categories of funds (Other/Residential Habilitation and Support [RHS]\*, Behavioral Support Services [BMAN], and day services [DAYS]). Funding is no longer dedicated to the particular buckets/categories from which the total allocation is established. Participants are now able to utilize their total allocation with greater flexibility to support their community integration needs identified through the person-centered planning process.

After the ICAP and ICAP addendum assessments (described in [Section 6.2: ICAP Assessment and Algo Level Development](#)) are completed and the information is received by the State, participants in the CIH Waiver program and their support teams are required to review the information and ensure that it accurately reflects them. Upon completion of their review, 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 Algo level. The supporting documentation is reviewed, as are the person-centered/individualized support plans, behavior-support plans, risk plans, and any other collateral documentation needed to analyze the individual's Algo level.

*\*Note: RHS funding amounts come from the budget category referred to as "Other," because that category must also cover all other (non-BMAN and non-DAYS) services, such as Environmental Modifications, Vehicle Modifications, Specialized Medical Equipment and Supplies, Personal Emergency Response Systems, Family and Caregiver Training, Electronic Monitoring, and so on, when and if these other services are selected by the individual and his or her support team. While the total allocation is still established by using the three categories, these funds are no longer dedicated within specific categories.*

Table 2 shows an example of a budget allocation for individuals 19–24 not attending school and individuals over the age of 25, using the service hours defined in 460 IAC 13-5-2 and the rates that were in effect as of January 2014. The example below indicates the allocation amounts, but the combination of an individual's living arrangement and Algo level determines which budget amount (Total Allocation) he or she may use when selecting the services required to meet his or her needs.

Table 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**
<b>Living with Family Example</b>							
<b>BMAN Component</b>	\$0	\$0	\$2,620.80	\$5,241.60	\$7,862.40	\$10,483.20	\$10,483.20
<b>DAYS Component</b>	\$10,500.00	\$10,500.00	\$10,500.00	\$10,500.00	\$10,500.00	\$18,000.00	\$18,000.00
<b>Other/ RHS Services</b>	\$1,730.10	\$17,301.00	\$25,951.50	\$43,252.50	\$50,870.05	\$58,137.20	\$58,137.20
<b>Total Allocation</b>	\$12,230.10	\$27,801.00	\$39,072.30	\$58,994.10	\$69,232.45	\$86,620.40	\$86,620.40
<b>Living Alone or Not Sharing RHS Staff with Others Example</b>							
<b>BMAN Component</b>	\$0	\$0	\$2,620.80	\$5,241.60	\$7,862.40	\$10,483.20	\$10,483.20
<b>DAYS Component</b>	\$10,500.00	\$10,500.00	\$10,500.00	\$10,500.00	\$10,500.00	\$18,000.00	\$18,000.00
<b>Other/ RHS Services</b>	\$1,730.10	\$22,491.30	\$39,792.30	\$56,683.77	\$73,398.22	\$79,938.65	\$79,938.65
<b>Total Allocation</b>	\$12,230.10	\$32,991.30	\$52,913.10	\$72,425.37	\$91,760.62	\$108,421.85	\$108,421.85
<b>Living with One Other or Sharing RHS Staff with One Other Example</b>							
<b>BMAN Component</b>	\$0	\$0	\$2,620.80	\$5,241.60	\$7,862.40	\$10,483.20	\$10,483.20
<b>DAYS Component</b>	\$10,500.00	\$10,500.00	\$10,500.00	\$10,500.00	\$10,500.00	\$18,000.00	\$18,000.00
<b>Other/ RHS Services</b>	\$1,730.10	\$22,491.30	\$38,515.90	\$56,683.77	\$79,938.65	\$87,205.80	\$87,205.80
<b>Total Allocation</b>	\$12,230.10	\$32,991.30	\$51,636.70	\$72,425.37	\$98,301.05	\$115,689.00	\$115,689.00
<b>Living with Two Others or Sharing RHS Staff with Two Others Example</b>							
<b>BMAN Component</b>	\$0	\$0	\$2,620.80	\$5,241.60	\$7,862.40	\$10,483.20	\$10,483.20
<b>DAYS Component</b>	\$10,500.00	\$10,500.00	\$10,500.00	\$10,500.00	\$10,500.00	\$18,000.00	\$18,000.00
<b>Other/ RHS Services</b>	\$1,730.10	\$22,491.30	\$39,792.30	\$56,683.77	\$73,398.22	\$79,938.65	\$79,938.65
<b>Total Allocation</b>	\$12,230.10	\$32,991.30	\$52,913.10	\$72,425.37	\$91,760.62	\$108,421.85	\$108,421.85

Living Arrangement	Overall Algo 0	Overall Algo 1	Overall Algo 2	Overall Algo 3	Overall Algo 4	Overall Algo 5	Overall Algo 6**
<b>Living with Three or More Others or Sharing RHS Staff with Three or More Others Example</b>							
<b>BMAN Component</b>	\$0	\$0	\$2,620.80	\$5,241.60	\$7,862.40	\$10,483.20	\$10,483.20
<b>DAYS Component</b>	\$10,500.00	\$10,500.00	\$10,500.00	\$10,500.00	\$10,500.00	\$18,000.00	\$18,000.00
<b>Other/RHS Services</b>	\$1,730.10	\$20,761.20	\$37,197.15	\$53,050.20	\$68,311.21	\$72,671.50	\$72,671.50
<b>Total Allocation</b>	\$12,230.10	\$31,261.20	\$50,317.95	\$68,791.80	\$86,673.61	\$101,154.70	\$101,154.70
<b>Structured Family Caregiving (SFC) Example</b>							
<b>BMAN Component</b>	\$0	\$0	\$2,620.80	\$5,241.60	\$7,862.40	\$10,483.20	\$10,483.20
<b>DAYS Component</b>	\$10,500.00	\$10,500.00	\$10,500.00	\$10,500.00	\$10,500.00	\$10,500.00	\$10,500.00
<b>Other/SFC Services</b>	\$18,932.55	\$18,932.55	\$27,619.55	\$37,547.55	\$37,547.55	\$37,547.55	\$37,547.55
<b>Total Allocation</b>	\$29,432.55	\$29,432.55	\$40,740.35	\$53,289.15	\$55,909.95	\$58,530.75	\$58,530.75

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

### **\*\*Algo 6**

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

## **Section 6.5: Budget Review Questionnaire and Budget Modification Request**

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

### **The BRQ**

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

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

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

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

- The IST identifies that the individual's needs are not being met through shared staffing.
  - An explanation of why it is not feasible for the individual to share staffing or live with housemates
- The individual completes his or her education.
  - A copy of certificate of completion or other documentation from school noting the final date for attendance
- The IST believes the Algo level is incorrect.
  - The IST's review of the ICAP assessment with detailed notes on areas needing reviewed
  - The medical and behavioral documentation needed to update the addendum
- Health or medical condition prevents the individual from attending day programs.
  - Documentation from a medical professional outlining why the condition negates a day program, the duration of the condition, and risk factors to consider
- The IST believes that the Wellness Coordination Health score is inaccurate and needs to be reviewed.
  - Documentation from a medical professional outlining the change in condition or diagnosis, with an anticipated duration of the condition, risk factors to consider, and any other special considerations
- An individual's behavioral conditions change.
  - A copy of the behavioral support plan
  - Monthly documentation supporting the change in condition(s)
  - Incident reports
- The IST believes the ICAP assessment has significant errors.
  - The IST's review of the ICAP assessment with detailed notes on areas needing reviewed
  - The medical and behavior documentation needed to update the addendum
- The IST believes the ICAP addenda (behavioral and health factors) are incorrect.
  - Documentation from a medical professional outlining the change in condition or diagnosis, with an anticipated duration of the condition, risk factors to consider, and any other special considerations

- A copy of the behavioral support plan
- Monthly documentation supporting the change in condition(s)
- Incident reports

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

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

## ***The BMR***

The BMR allows participants on the CIH Waiver to obtain additional funds for a short-term when the individual experiences an unanticipated event that requires a higher budget to meet 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 should complete the BMR and attach all required documentation in the BDDS case management system. If approved, the increased budget shall not exceed 180 days.

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

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

1. An event or status lasting longer than 14 consecutive days is eligible for BMR review by the PAR Unit.
2. The provider notifies the individual's Case Manager of the identified status change within 7 days of identification of a 14-consecutive-day event or status, resulting in a potential need for budget modification.
3. The Case Manager coordinates and documents with the individual's IST of the proposed modification within 14 days of receipt of the notice from the identifying provider.
4. The Case Manager collects and submits BMR information and request within 10 days of the meeting with the individual's team via the format and required documentation noted in the current BDDS data entry system.
5. The individual's BDDS district office must provide an initial response to the team's BMR request within 7 days of receipt.
6. The BDDS central office must provide an initial response within 7 days of the district office's approval of the request.

Unanticipated events defined in the Budget Modification Request policy include:

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

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

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

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

- For BMRs resulting from a loss of a housemate, the IST should provide documentation that includes the following:
  - A schedule identifying when each service is being used, including non-RHS services activities
  - A plan with strategies that the IST will use to find a new housemate
- The documentation must demonstrate the alternative support options the IST considered before making the submission. The following is a nonexhaustive list of potential alternative support options:
  - Shared staffing with housemates
  - Electronic monitoring services
  - Medicaid prior authorization (PA) services
  - Family and community supports

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

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

The BDDS responds to new BMRs within 7 business days of submission. Final decisions on BMRs are not made until Case Managers respond to all inquiries from the BDDS.



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

For further guidance, see the following BDDS policies and procedures found on the [Current DDRS Policies](#) page at [in.gov/fssa/ddrs](http://in.gov/fssa/ddrs):

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

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

## Section 6.6: Implementation of Objective-Based Allocations

The Case Manager for each individual participating in the CIH Waiver program receives the new OBA 3 months before the participant's annual renewal date. The Case Manager must review the OBA with the participant and his or her 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 BRQ (see [Section 6.5: Budget Review Questionnaire and Budget Modification Request](#)).

*Note: The OBA is not used with the FSW.*

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

Applicable only to participants in the CIH Waiver program, an IST may request a PAR through the Case Manager via a BRQ. The BRQ states the reason for allocation review. The full list of acceptable reasons for allocation review is found in [Section 6.5: Budget Review Questionnaire and Budget Modification Request](#), and examples include:

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

The BRQ is submitted by the Case Manager to the BDDS. The BRQ, supporting documentation and information are reviewed by the PAR Unit within the DDRS. The PAR Unit determines whether an individual's Algo score is supported based on the provided information. The BDDS reviews the BRQ within 7 business days of submission.

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

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

The PAR Unit will notify the waiver Case Manager of any changes in the Algo or allocation. If a change in the Algo score is appropriate, an Update CCB must be submitted at the correct allocation level so that an NOA with appeal rights may be generated by the BDDS and distributed to the participant through the waiver Case Manager.

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

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

The appeal process is located on the back pages of the NOA and is described in the following sections.

*Note: Participant appeal rights and process are included in this section for provider reference.*

## ***Your Appeal Right as an Applicant for HCBS Benefits***

If you question the indicated decision, discuss it with your Case Manager.

## ***Your Right to Appeal and Have a Fair Hearing***

The NOA 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 in the following section, *How to Request an Appeal*. If you appeal and 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***

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

- Thirty-three calendar days following the effective date of the action being appealed; or
- Thirty-three calendar days from the date of the notice of agency action, whichever is later

To file an appeal, sign, date, and return the Hearings & Appeals portion of the NOA via mail or fax:

**MS04  
Indiana Family and Social Services Administration  
Office of Hearings and Appeals  
402 West Washington Street, Room W363  
Indianapolis, IN 46204  
Fax: (317) 232-4412**

If you are unable to sign, date, and return this form to the preceding address or fax number, you may have someone assist you in requesting the appeal.

## ***After Your Request Is Submitted***

After you submit your appeal:

- You will be notified in writing by the FSSA's Office of Hearings and Appeals, the date, time, and location for the hearing. Before or at the hearing, you have the right to examine the entire contents of your case record maintained by the Case Manager.
- You may represent yourself at the hearing or you may authorize another person, such as an attorney, relative, or other spokesperson, to represent you. At the hearing, you 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.

*Note: On receiving an official Notice of Action (NOA), the budget is locked by the PAR Unit. Please carefully read the NOA's Part 2 – "Your 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 required to repay assistance paid in your behalf during the appeal process.*



# Section 7: Monitoring and Continuation of Waiver Services

---

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

## Section 7.1: Level of Care Reevaluation

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

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

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

## Section 7.2: Medicaid Eligibility Redetermination

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

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

As ongoing Medicaid eligibility is required for participation in the FSW and CIH waiver programs, HCBS providers must ensure the participants served obtain/maintain Medicaid eligibility.

## Section 7.3: Annual Plan of Care/Cost Comparison Budget Development

All individuals and participants (also known as members) receiving waiver services must have a new Plan of Care/Cost Comparison Budget (POC/CCB) approved at least annually. The new Person-Centered/Individualized Support Plan (PC/ISP) planning approach enhances the way in which supports and services are explained to individuals and families, so that their needs, aspirations and opportunities to achieve self-determination, interdependence, productivity, integration and inclusion in all facets of community life, can be identified and explored.

Additionally, the PC/ISP drives the development of the POC/CCB. The PC/ISP is the new plan that identifies the array of services and supports, paid and unpaid from all sources that will be utilized to implement desired outcomes and ensure the participant's health and welfare while the POC/CCB identifies those supports and services which are funded by the waiver. The participant, Case Manager, and others of the participant's choosing form the Individual Support Team (IST). The participant has the right and power to command and direct the entire PC/ISP process, with focus on his or her preferences, aspirations, and

needs. The process empowers participants to create life plans and allows the participant to direct the planning and allocation of resources to meet his or her self-directed life goals. The annual POC/CCB is developed by the participant-chosen Case Manager a minimum of 6 weeks prior to the end date of each annual service plan. The POC/CCB is routinely developed to cover 12 consecutive months. The following apply to this process:

- Although the FSW is already capped at \$17,300 annually, budgeted amounts for POC/CCBs developed under the CIH Waiver use the objective-based allocation process described in [Section 6: Objective-Based Allocation](#).
- Coordination of waiver services and other services is completed by the Case Manager. Within 30 days of implementation of the plan, the Case Manager is responsible for ensuring that all identified services and supports have been implemented as identified in the PC/ISP 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. The IST is advised of any concerns or needs for updates that may require scheduling of additional team meetings by the Case Manager.
- Most waiver service providers are required to submit a quarterly report summarizing the level of support provided to the participant based on the identified supports and services in the PC/ISP and the POC/CCB. As part of the 90-day review process, the Case Manager reviews these reports for consistency with the PC/ISP and POC/CCB, and works with providers as needed to address findings from this review.
- If an annual POC/CCB is not submitted or cannot be approved in a timely manner, the most recently approved POC/CCB is automatically converted to a new annual POC/CCB. The total cost and amount of services on the “auto-converted” or “default” POC/CCB is determined by the cost of services and supports appearing on the most recently approved but expiring POC/CCB. The auto-converted or default POC/CCB ensures that there is no loss of services for the member. The Case Manager is subsequently contacted and required to complete the annual person-centered planning process to update the PC/ISP and POC/CCB as needed.
- Risks are assessed during the PC/ISP process 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 PC/ISP and POC/CCB.

- The 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 Updates and Revisions

The PC/ISP and POC/CCB are reviewed a minimum of every 90 calendar days by the Case Manager and updated a minimum of every 365 calendar days with involvement of the IST. The participant can request a change to the POC/CCB at any point, whether a new service provider or a change in the type or amount of service. If a change to the PC/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 POC/CCB electronically to the State's waiver specialist, who will review the POC/CCB and confirm the following:

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

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

- If the waiver specialist denies the POC/CCB, a denial letter must be transmitted to the Case Manager and service providers. Within 3 calendar days of receipt of the denial, the Case Manager must provide a copy of a Notice of Action (NOA) (*HCBS Form 5*), the appeal rights as an HCBS waiver services recipient, and an explanation of the decision to deny to the individual or guardian.
- If the waiver specialist approves the POC/CCB, an approval letter and signed NOA are transmitted to the Case Manager, BDDS (for initial and annual CCBs only), and service providers. The Case Manager notifies the individual or guardian within 3 calendar days of receipt of the approval and provides a copy of the approval letter, signed NOA, and addendum (containing information from the POC/CCB).

## Section 7.6: Service Plan Implementation and Monitoring

Case Managers are responsible for the implementation and monitoring of the service plan (inclusive of the PC/ISP, CCB, and often, other nonfunded services) and the participant's 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 or as frequently as needed to support the participant. The Case Manager reviews current concerns, progress, and implementation of the POC in addition to any risk assessment(s) incorporated in the PC/ISP to ensure the participant's needs are being met. Meetings may occur in the home of the participant or another location convenient to the participant. For

participants living in a home owned or controlled by the waiver provider, there must be at least one unannounced visit in the home each year. IST meetings are now required at least semiannually, or when requested by the individual, family, BDDS or other team members. However, face-to-face contact and team meeting requirements for individuals with high risk or health needs remain at least every 90 days or more often as determined by the IST.

- A 90-Day Checklist/Monitoring Checklist is used by the Case Manager and IST to systematically review the status of the CCB, the PC/ISP, any behavioral support program, the participant's choice and rights, medical needs, medications, including psychotropic medications (if applicable), seizure management (if applicable), nutritional/dining needs, incident review, staffing issues, fiscal issues, risk plans, and any other issues that may be identified in regard to the satisfaction and health and welfare of the 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 providers of services through home and community visits or by phone to coordinate care, monitor progress, and address any immediate needs. During each of these contacts, the Case Manager assesses the service plan implementation and monitors the participant's needs.
- The monitoring and follow-up methods 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 telephone contacts. The Case Manager asks:
  - Are the services being rendered in accordance with the POC?
  - 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?
  - Does the participant have access to nonwaiver services identified in the POC, including access to health services?
- At all times, full, immediate and unrestricted access to the individual data is available to the State, including the DDRS Case Management Liaison position as well as other members of the DDRS executive management team and the FSSA Office of Medicaid Policy and Planning (OMPP).

## ***Service Problems***

Problems regarding services provided to 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/Monitoring Checklist, obtaining agreement of the IST for any needed updates.
- Case Managers investigate the quality of participant services and indicate whether there are any problems related to participant services not being in place. This information is recorded on the 90-Day Checklist/Monitoring Checklist. For each identified problem, the Case Manager identifies the time frame and person responsible for corrective action, communicates this information to the IST, and monitors to ensure that corrective action takes place by the designated deadline.



- Case Manager supervisors, directors, or other identified executive management staff within each Case Management provider agency monitor each problem quarterly via a report from the State's case management system to ensure that Case Managers are following up on and closing out any pending corrective actions for identified problems.
- At least every 90 calendar days, in conjunction with the 90 Day Checklist/Monitoring Checklist, Case Managers update the participant's PC/ISP progress notes to indicate whether all providers and other team members are current and accurate in their implementation of plan activities on behalf of the 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 meets one of the following:

- Voluntarily withdrawals
- Chooses institutional placement/enters a 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 LOC criteria
- Is no longer eligible for Medicaid services
- No longer requires home and community-based services
- Is no longer intellectually or developmentally disabled

Other examples of circumstances appropriate for interruption/termination may include a participant being:

- Arrested
- In jail
- Awaiting trial, or
- 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 autogenerates the NOA. For all other reasons, the termination DEW is reviewed by a waiver specialist who determines the appropriate next action.

Within 3 calendar days of a processed termination, the Case Manager must provide the individual or guardian with a copy of the NOA, the *Appeal Rights as an HCBS Waiver Services Recipient* instructions, and an explanation of the termination. As appropriate, other service options are to be discussed with the individual and guardian.

## Section 7.8: Waiver Slot Retention after Termination and 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 the waiver 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:
  - CIH Waiver: October 1 through September 30
  - 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 LOC approval date and the POC/CCB if the individual’s condition has not significantly changed, and the POC/CCB continues to meet his or her needs. The following must occur:
  - The Case Manager must certify that the individual continues to meet LOC criteria
  - The Case Manager must complete a “Re-Start” DEW in the INsite database and submit it electronically into the DDRS case management database. The information will be reviewed by a waiver specialist and automatically transmitted to the OMPP to enter into the *CoreMMIS* database.
- If an individual who has been terminated from the waiver program longer than 30 calendar days, wishes to return to the program, and is otherwise eligible, the following must occur:
  - The Case Manager is responsible for reevaluating the LOC and developing the POC/CCB following the same processes described in [Section 7.1: Level of Care Reevaluation](#) and the [Section 5.7: Initial Plan of Care/Cost Comparison Budget Development](#), minus the need for a new confirmation of diagnosis form. The Case Manager is to indicate a “Re-Entry” CCB when electronically submitting the CCB to the State waiver specialist via the DDRS case management database.
  - When the individual “re-enters” waiver services, the Case Manager must enter a *Confirmation of Waiver Start* form in the INsite database and electronically transmit it to the DDRS case management database. The information will be automatically transmitted to the OMPP to enter in the *CoreMMIS* database.
  - When the *Confirmation of Waiver Start* form is received electronically by the DDRS, it is reviewed. After the form is received, reviewed, and accepted, an NOA form will be automatically transmitted to the Case Manager and all the individual’s waiver service providers.
  - Within 3 calendar days of receiving the Re-Entry POC/CCB approval letter, the Case Manager must provide copies of the approval letter, signed NOA, and addendum (containing information from the POC/CCB) to the individual or guardian.
- When an individual “reenters” waiver services:
  - If within 30 calendar days of terminating waiver services, the annual LOC and the POC/CCB dates remain the same dates as they were prior to the termination of waiver services.
  - If more than 30 calendar days since terminating waiver services, the new LOC and the POC/CCB dates are used for determining when future annual LOC determinations and the POC/CCBs are due.

If an individual 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, and Relatives Providing Waiver Services

Parents, stepparents, 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 participants. Per *Section 4442.3.B.1* of the *State Medicaid Manual*, the Version 3.5 Instructions, Technical Guide and Review Criteria and *42 CFR 440.167*, all of which are published by the Centers for Medicare & Medicaid Services (CMS), this prohibition is based on the presumption that legally responsible individuals may not be paid for supports that they are ordinarily obligated to provide.

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

\*\*For all purposes pertaining to waiver-funded programs operated by the DDRS, “related/relative” implies any of the following natural, adoptive and/or step relationships, whether by blood or by marriage, inclusive of half and/or in-law status:

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

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

- The relative must be at least 18 years of age.
- The relative is employed by or a contractor of an agency that is approved by the DDRS to provide care under the waiver.
- The relative meets the appropriate provider standards (per *Indiana Administrative Code 460 IAC 6*) for the services being provided.
- The decision for the relative to provide services to a waiver participant is part of the PC/ISP planning process, which indicates that the relative\*\* (defined previously) is the best choice of persons to provide services from the DDRS-approved provider agency, and this decision is recorded and explained in the PC/ISP.
- There is detailed justification as to why the relative is providing service.
- The decision for a relative to provide services is evaluated periodically (for example, at least annually) to determine whether it continues to be in the best interest of the waiver participant.
- Payment is made only to the DDRS-approved Medicaid enrolled waiver provider agency in return for specific services rendered.

- The services must be rendered one-on-one with the participant or in shared settings with group sizes allowable per specified waiver service definitions and documented as acceptable by all relevant ISTs.
- Authorization for shared or group services must be documented in the approved NOA for each group participant. With the exception of groups of waiver participants as noted previously, the relative\*\* (defined above) may not be responsible for others (including their other children or family members) nor engaged in other activities while providing services.

*Note: Regarding Participant Assistance and Care (PAC) under the FSW and Residential Habilitation and Support (RHS) under the CIH Waiver, the weekly total of reimbursable waiver funded services furnished to a waiver participant by any combination of relatives\*\* and/or legal guardians may not exceed 40 hours per week.*

## Section 8: Appeal Process

---

This section presents information about the appeal process and all that is involved, from beginning to end of the process.

### 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 (ALJ) 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, 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.
- Notice of Action (NOA) (*HCBS Form 5*) is used to notify each Medicaid Home and Community-Based Services (HCBS) waiver applicant or participant of any action that affects the applicant, participant, or prospective participant, including:
  - Choice of HCBS as an alternative to institutional care
  - Medicaid benefits related to HCBS waivers, including determinations regarding level of care (LOC)
  - 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). "*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 associated with the right to appeal. "*How to Request an Appeal*" provides instructions regarding the procedures that are necessary in the appeal process, including the right of the appellant to authorize representation by an attorney, relative, or other spokesperson on behalf of the appellant.
- The Case Manager advises HCBS waiver participants of the right to appeal and request a fair hearing. 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.
- When the Case Manager generates the Plan of Care/Cost Comparison Budget (POC/CCB) and the POC/CCB is authorized by the BDDS, an NOA is generated and sent to the HCBS waiver participant. The NOA specifies any adverse determination (when the participant 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 into the Community Integration and Habilitation (CIH) Waiver or the Family Support Waiver (FSW) 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 (OBA) amount.
- Upon 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 and the address for submission of the appeal. The Case Manager can also provide an

opportunity to discuss the issue being appealed. However, due to conflict-free Case Management requirements, the Case Manager may not file an appeal or appear at an appeal hearing on behalf of a member unless the Case Manager is the Medicaid authorized representative noted on the member's record with the Division of Family Resources, as doing so could result in a conflict of interest.

- The request for an appeal and a fair hearing should be recorded in a case note by the Case Manager, as well as recorded at the FSSA Hearing and Appeals office.

## Section 8.2: Group Appeals

The following pertain to group appeals:

- The FSSA Office of General Counsel (OGC) 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, 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 ALJ may limit the discussion in a group hearing to the sole issue under appeal. When an appellant's request for a hearing adds issues to the (sole) issue serving as the basis for the group hearing, the appeal is handled as an individual hearing. An appellant scheduled for a group hearing may choose to withdraw and be granted an individual hearing, even if the 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:

- 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 the FSSA within 33 calendar days of the NOA.
- 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) LOC: The applicant, participant, or his or her legal guardian/authorized representative has the right to appeal LOC within 15 calendar days of the decision. The decision letter contains the appeal rights of the applicant/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 OGC 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 telephone
  - For DD and/or waiver eligibility-related issues, is conducted by telephone
- 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 so that it reaches the appellant at least 10 calendar days before the hearing.

*Note: Please contact the ALJ from OGC 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 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 OGC’s 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 the following:

- 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: Contact the Office of Hearings and Appeals for all questions or issues related to scheduling a hearing; contact the OGC 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, DDRS Central Office, or BDDS Waiver Unit) should review the proposed action to determine whether the proposed action is appropriate.

Upon request, the designated State staff 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 Case Manager 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 or she is to be assisted by the BDDS service coordinator and/or the Case Manager or the DDRS Central Office in promptly notifying the Office of Hearings and Appeals or OGC ALJ in writing of the decision. No pressure is to be exerted on the appellant to withdraw the appeal. The withdrawal must be acknowledged in writing and it is only with the receipt of a signed voluntary withdrawal statement from the appellant that the appeal is to be dismissed.
- 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 service coordinator, Case Manager, DDRS Central Office, or BDDS Waiver Unit regarding issues relating to the FSW or the CIH Waiver. An ALJ, who is an employee of the FSSA, Office of Hearings and Appeals, or OGC 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, DDRS Central Office, or BDDS Waiver Unit) will attend the hearing and present evidence supporting the action under appeal.



## Section 8.9: Preparation for Hearing by Appellant

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

- Have an informal meeting to discuss the issue being appealed with the BDDS District representative, 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 BDDS District representative, BDDS Waiver Unit representative, or the DDRS Central Office representative at the hearing, noting that the State's appeal-related evidence is sent by the State to the appellant free of charge prior to the hearing.
- The appeal notice informs the appellant of his or her right to 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 his or her 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 ALJ and for the State.*

*For budget-related appeals, the appellant submits his or her exhibits to the BDDS Appeal Coordinator, who will distribute the copies to the ALJ. The appellant should submit exhibits to:*

**MS18  
BDDS Appeal Coordinator  
402 W. Washington St., 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 his or her exhibits to:*

**MS27  
Office of General Counsel  
402 W. Washington St., 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 having the most direct contact with the action being proposed or taken. In the absence of the person with the most knowledge of the hearing situation, a person familiar with the action and the case record should substitute.

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

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

*State's Exhibit A, page 3 of 3*

- Make one copy of labeled exhibits for the ALJ and one copy for the appellant (unless already given to the appellant). A duplicate copy of the notice sent to the appellant advising of the proposed action should be included as part of the documentation.
- Prepare a written outline that can be used as a tool in presenting the testimony at the hearing. Bear in mind when preparing the outline that the ALJ knows nothing about the situation. The outline should focus on all the following:
  - 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
  - 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 ALJ conducts the hearing. The appellant and the appropriate State representative have the opportunity to:

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

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

*Note: See [Section 8.9: Preparation for Hearing by Appellant](#) and [Section 8.10: Preparation for Hearing by the BDDS Service Coordinator or District Representative, BDDS Waiver Unit, or the DDRS Central Office](#) of this module. The State shall ensure that the appellant receives the State's exhibits and the appellant shall ensure that the State receives any exhibits submitted by the appellant prior to the day of the hearing.*

## Section 8.12: Continuance of Hearing

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

## Section 8.13: The Hearing Record

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

## Section 8.14: The Fair Hearing Decision

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

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

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

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

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

## Section 8.16: Agency Review

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

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

## **Section 8.17: Judicial Review**

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

## **Section 8.18: Lawsuit**

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

# ***Section 9: Bureau of Quality Improvement Services***

---

## **Section 9.1: Overview**

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

## **Section 9.2: Provider Compliance Reviews**

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

- The Compliance Evaluation and Review Tool (CERT) is designed to capture provider compliance with IAC 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).
  - The provider has evidence of implementing quality assurance and quality improvement systems.
- 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 3 years.
- Provider compliance reviews are conducted onsite. Following the review, providers receive a report of findings and a request to develop a corrective action plan. The BQIS will validate that the corrective action plan is being implemented.
- Copies of the CERT Tool and findings template are available on the [DDRS BOIS](#) web page under the *Compliance Evaluation and Review Tool* section.
- All residential habilitation and day program providers (according to Indiana code) and all Case Management providers (according to the Community Integration and Habilitation [CIH] Waiver and Family Supports Waiver [FSW]) must be accredited by one 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 National Committee for Quality Assurance or its successor
  - The ISO-9001 human services quality assurance (QA) system
  - The Council on Accreditation or its successor
  - An independent national accreditation organization approved by the secretary

- Residential and day program providers may choose to obtain accreditation (specific to Indiana programs) for other waiver services that they are approved to provide; however, this is not required.
- Some accreditation entities accredit the organization, whereas others allow providers to select the services they wish to accredit. The BQIS will not conduct compliance reviews on any accredited services. This means if a provider chooses to accredit only some of its services, the 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 3 years, by the BQIS or the accreditation entity of the provider's choosing.

## Section 9.3: Incident Reports

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

- Alleged, suspected, or actual abuse, neglect, or exploitation of an individual
  - This event includes physical, sexual, emotional/verbal, and domestic abuse. An incident in this category must also be reported to Adult Protective Services (APS) or Child Protection Services (CPS), as applicable. The provider will suspend staff involved in an incident from duty, pending investigation by the provider.
- Peer-to-peer aggression that results in significant injury
- Death of an individual
  - A death shall also be reported to APS or CPS, as applicable. If death is a result of alleged criminal activity, the death must be reported to law enforcement.
- Structural or environmental issues with a service delivery site that compromise the health and safety of an individual; fire that jeopardizes or compromises the health or welfare of an individual
- Elopement of an individual that results in evasion of required supervision as described in the Person-Centered/Individualized Support Plan (PC/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 an incorrect dosage, missed medication, wrong route, and failure to give medication at the appropriate time
  - Medication error that jeopardizes an individual’s health and welfare and requires medical attention
- Use of any aversive technique, including but not limited to:
  - Seclusion
  - Painful or noxious stimuli
  - Denial of a health-related necessity
  - Other aversive technique identified by the DDRS policy
- Use of any PRN (as needed/when necessary) medication related to an individual’s behavior.
- Use of any physical or mechanical restraint, regardless of whether it was planned, was approved by a Human Rights Committee (HRC), or there was informed consent.

View the full [Policy on Incident Reporting and Management](#) at [in.gov/fssa](http://in.gov/fssa). Additional information about incident reporting is available on the BQIS [Incident Reporting](#) page at [in.gov/fssa/ddrs](http://in.gov/fssa/ddrs).

## Section 9.4: Complaints

Any individual, guardian, family member, service provider, or community member has the right to file a complaint on the behalf of an individual receiving Supporting Living Services:

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

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

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

Currently, complaints can be filed via email at [BQIS.Help@fssa.in.gov](mailto:BQIS.Help@fssa.in.gov) or through the BQIS toll-free telephone number at 1-866-296-8322.

## Section 9.5: Mortality Reviews

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

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

See the [Policy on Mortality Review](#) at [in.gov/fssa](http://in.gov/fssa) for further information regarding mortality reviews and the MRC.

## Section 9.6: National Core Indicator (NCI) Project

The DDRS participates in the National Core Indicator (NCI) Project. This national research project, administered through the Human Services Research Institute and the National Association of 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 BQIS Quality Vendor conducts these interviews across the State with individuals selected based on representative random samples from each DDRS waiver. Participation in this project allows the DDRS to make comparisons with other states providing waiver services across the country.

## Section 9.7: Case Record Reviews

The BQIS is responsible for conducting case record reviews (CRRs) on files for individuals who receive HCBS waiver services to ascertain Case Manager compliance with 460 IAC 7 and the FSW and CIH Waiver. Case record reviews include:

- Review of the PC/ISP
- Risk assessment (embedded in PC/ISP)
- Identified risk plans
- Annual choice of waiver services
- Nonwaiver services or choice to not receive ICF/IID Medicaid services (BDDS Signature Page/Freedom of Choice Section)
- Signed pick lists for each service
- An updated PC/ISP when an individual's conditions or circumstances changed

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

## Section 9.8: Data Driven Reviews

Data Driven Review (DDR) is a quality improvement initiative conducted by the BQIS. The DDR is centered on identifying statewide weaknesses in the provision of services within the Home and Community-Based Services (HCBS) waiver system. These challenges have been identified through State-level review of quarterly data, which may include incident reports (IRs), complaint findings, and/or other data that points to a concerning trend. After the issues are identified, providers that appear (based on the data) to be experiencing difficulty in the identified area are offered technical assistance through the DDR process. Each provider is assigned a DDR team member to support them for the purpose of assisting the provider in reviewing data, completing a root cause analysis, and developing a comprehensive quality improvement plan correlating to one or more of the root causes identified.

## Section 9.9: 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 email, in hard copy format, or by referral.
- Types of complaints received include complaints initiated by families and/or participants involving rights or issues of participant choice, and complaints requiring coordination between legal services, administrating agency services, and provider services.
- The ombudsman is expected to initiate contact with the complainant as soon as possible after the complaint is received. However, precise timelines for the final resolution of each complaint are not established. Although it is expected that the ombudsman will diligently and persistently pursue the

resolution of each complaint determined to require investigation, it is recognized that circumstances surrounding each investigation vary.

- Time frames for complaint resolution vary in accordance with the required research, in the collection of evidence, and in the numbers and availability of persons who must be contacted, interviewed, or brought together to resolve the complaint. Although the statewide waiver ombudsman is considered “independent” by statute, the DDRS Director is responsible for oversight of the ombudsman.
- With the consent of the waiver 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 ensures that the identity of the participant will not be disclosed without either the participant’s written consent or a court order.
- At the conclusion of an investigation of a complaint, the ombudsman reports the ombudsman’s findings to the complainant. If the ombudsman does not investigate a complaint, the ombudsman notifies the complainant of the decision not to investigate and the reasons for the decision.
- The statewide waiver ombudsman prepares a report at least annually (or upon request), describing the operations of the program. A copy of the report is provided to the governor, the legislative council, and the director of the DDRS. Trends are identified so that recommendations for needed changes in the service delivery system can be implemented.
- The administrative agency is required to maintain a statewide toll-free telephone line continuously open to receive complaints regarding waiver 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 prerequisite or a substitute for a Medicaid Fair Hearing when the problem falls under the scope of the Medicaid Fair Hearing process.
- A person who does any of the following commits a Class B misdemeanor:
  - Intentionally prevents the work of the ombudsman
  - Knowingly offers compensation to the ombudsman in an effort to affect the outcome of an investigation or a potential investigation
  - Knowingly or intentionally retaliates against a participant, a client, an employee, or another person who files a complaint or provides information to the ombudsman

# Section 10: Service Definitions and Requirements

## Section 10.1: Service Definition Overview

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

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

By March 17, 2022, all services will be compliant with the HCBS Final Rule settings requirements as outlined in [Indiana's Statewide Transition Plan](#) at [in.gov/fssa/ddrs](http://in.gov/fssa/ddrs).

*Note: Indiana Health Coverage Programs (IHCP) members can incur a transfer of property penalty while receiving services, including from nursing facilities, other medical institutions where members receive equivalent nursing facility services, HCBS, and the following waiver programs:*

- *Aged and Disabled (A&D)*
- *Community Integration and Habilitation (CIH)*
- *Family Supports Waiver (FSW)*
- *Traumatic Brain Injury (TBI)*

*Claims submitted for these services during a member's transfer of property penalty period will be denied.*

*The transfer of property penalty is a period during which a member who is transferring assets will be ineligible for Medicaid services, as required by federal guidelines.*

*Providers can determine whether a member is in the transfer of property penalty period using either the IHCP Provider Healthcare Portal (Portal) or electronic data interchange (EDI). For more information, refer to IHCP Banner Page [BR201931](#).*

## Section 10.2: Medicaid Waiver Services, Codes, and Rates

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

Table 3 – Medicaid Waiver Services, Codes, and Rates for FSW and CIH Waivers, Effective August 1, 2018

Waiver		INsite Code	Service Description	HCPCS Code	Modifiers				Rate	Unit/Size	Unit/\$ Limit
FSW	CIH				1	2	3	4			
■	■	ADS1	Adult Day Services, Level 1	S5101	U7	U5	U1		\$23.05	0.50/Day	2 Units/Day
■	■	ADS2	Adult Day Services, Level 2	S5101	U7	U5	U2		\$30.24	0.50/Day	2 Units/Day
■	■	ADS3	Adult Day Services, Level 3	S5101	U7	U5	U3		\$36.00	0.50/Day	2 Units/Day
■	■	AS14	Adult Day Services, ¼ Hour, Level 1	S5100	U7	U5	U1		\$1.45	0.25/Hour	12 Units/Day
■	■	AS24	Adult Day Services, ¼ Hour, Level 2	S5100	U7	U5	U2		\$1.89	0.25/Hour	12 Units/Day
■	■	AS34	Adult Day Services, ¼ Hour, Level 3	S5100	U7	U5	U3		\$2.25	0.25/Hour	12 Units/Day
■	■	BMGO	Behavior Management, Basic	H0004	U7	U5	U2		\$18.20	0.25/Hour	
■	■	BG10	Behavior Management, Level 1	H0004	U7	U5	U1		\$18.20	0.25/Hour	
■	■	CMGT	Case Management	T2022	U7	U5			\$131.25	1/Month	1 Unit/Month
	■	TRCM	Transitional Case Management Activities	T2038	U7	U5	UA		\$131.25	1/Month for up to 6 months based on successful transition to Waiver Services	1 Unit per month for up to 6 Units/Successful Transition
■	■	AISP	Case Management – Annual PC/ISP Work	T2024	U7	U5			\$150.00	1/Year based on completion of PC/ISP	1 Unit/Year
■	■	CHIO	Community Habilitation, Individual	T2020	U7	U5			\$24.85	1/Hour	
■	■	CHG2	Community Habilitation, Group (2:1)	T2020	U7	U5	U2		\$8.90	1/Hour	
■	■	CHG3	Community Habilitation, Group (3:1)	T2020	U7	U5	U3		\$8.90	1/Hour	
■	■	CHG4	Community Habilitation, Group (4:1)	T2020	U7	U5	U4		\$8.90	1/Hour	
■	■	CHG6	Community Habilitation, Group (6:1)	T2020	U7	U5	U6		\$4.96	1/Hour	
■	■	CHG8	Community Habilitation, Group (8:1)	T2020	U7	U5	U8		\$4.96	1/Hour	
■	■	CHGB	Community Habilitation, Group (10:1)	T2020	U7	U5	UB		\$4.96	1/Hour	
	■	CT	Community Transition	T2038	U7	U5			Individual	1/Unit	\$1,000 Lifetime
	■	EM1	Electronic Monitoring, 1 Participant	A9279	U7	U5	UA		\$13.62	1/Hour	
	■	EM2	Electronic Monitoring, 2 Participants	A9279	U7	U5	U2		\$6.81	1/Hour	
	■	EM3	Electronic Monitoring, 3 Participants	A9279	U7	U5	U3		\$4.54	1/Hour	
	■	EM4	Electronic Monitoring, 4 Participants	A9279	U7	U5	U4		\$3.41	1/Hour	

Waiver		INsite Code	Service Description	HCPCS Code	Modifiers				Rate	Unit/Size	Unit/\$ Limit
FSW	CIH				1	2	3	4			
	■	EMOI	Environmental Modification, Install	S5165	U7	U5	NU		Individual	1/Unit	\$15,000 Lifetime
	■	EMOM	Environmental Modification, Maintain	S5165	U7	U5	U8		Individual	1/Unit	\$500/Year
	■	INSP	Equipment – Assess/Inspect/Train	T1028	U7	U5			\$17.99	0.25/Hour	
■	■	EXTS	Extended Services	T2025	U7	U5	UA		\$36.96	1/Hour	
■	■	FBS	Facility Based Support	T1020	U7	U5	UA		\$1.94	1/Hour	
■	■	FHIO	Facility Habilitation, Individual	T2020	U7	U5	UA		\$24.85	1/Hour	
■	■	FHG2	Facility Habilitation, Group (2:1)	T2020	U7	U5	UA	U2	\$8.90	1/Hour	
■	■	FHG4	Facility Habilitation, Group (4:1)	T2020	U7	U5	UA	U4	\$8.90	1/Hour	
■	■	FHG6	Facility Habilitation, Group (6:1)	T2020	U7	U5	UA	U6	\$4.96	1/Hour	
■	■	FHG8	Facility Habilitation, Group (8:1)	T2020	U7	U5	UA	U8	\$4.96	1/Hour	
■	■	FHGB	Facility Habilitation, Group (10:1)	T2020	U7	U5	UA	UB	\$4.96	1/Hour	
■	■	FHGC	Facility Habilitation, Group (12:1)	T2020	U7	U5	UA	UC	\$3.15	1/Hour	
■	■	FHGD	Facility Habilitation, Group (14:1)	T2020	U7	U5	UA	UD	\$3.15	1/Hour	
■	■	FHG9	Facility Habilitation, Group (16:1)	T2020	U7	U5	UA	U9	\$3.15	1/Hour	
■	■	FCAR	Family & Caregiver Training, Family	S5111	U7	U5			Individual	1/Unit	\$2,000/Year
■	■	FCNF	Family & Caregiver Training, Non-Family	S5116	U7	U5			Individual	1/Unit	\$2,000/Year
■	■	IBI1	Intensive Behavioral Intervention, Level 1	H2020	U7	U5	U1		\$104.60	1/Hour	
■	■	IBI2	Intensive Behavioral Intervention, Level 2	H2020	U7	U5	U2		\$25.00	1/Hour	
■	■	MUTH	Music Therapy	H2032	U7	U5	U1		\$10.78	0.25/Hour	
■	■	OCTH	Occupational Therapy	G0152	U7	U5	UA		\$17.99	0.25/Hour	
■		PAC	Participant Assistance and Care	T2033	U7	U5			\$24.40	1/Hour	
■	■	PRSI	Personal Response System, Install	S5160	U7	U5			\$52.07	1/Unit	2 Units/CCB
■	■	PRSM	Personal Response System, Maintain	S5161	U7	U5			\$52.07	1/Unit	1 Unit/Month
■	■	PHTH	Physical Therapy	G0151	U7	U5	UA		\$18.12	0.25/Hour	
■	■	PV02	Prevocational (2:1)	T2015	U7	U5	U2		\$8.90	1/Hour	
■	■	PV04	Prevocational (4:1)	T2015	U7	U5	U4		\$8.90	1/Hour	
■	■	PV06	Prevocational (6:1)	T2015	U7	U5	U6		\$4.96	1/Hour	
■	■	PV08	Prevocational (8:1)	T2015	U7	U5	UA		\$4.96	1/Hour	
■	■	PV10	Prevocational (10:1)	T2015	U7	U5	UB		\$4.96	1/Hour	
■	■	PV12	Prevocational (12:1)	T2015	U7	U5	UC		\$3.15	1/Hour	
■	■	PV14	Prevocational (14:1)	T2015	U7	U5	UD		\$3.15	1/Hour	
■	■	PV16	Prevocational (16:1)	T2015	U7	U5	U9		\$3.15	1/Hour	
■	■	PSTF	Psychological Therapy, Family	90846	U7	U5			\$17.27	0.25/Hour	
■	■	PSTG	Psychological Therapy, Group	90853	U7	U5			\$4.81	0.25/Hour	
■	■	PSTI	Psychological Therapy, Individual	H0004	U7	U5	U3		\$15.45	0.25/Hour	
■	■	RETH	Recreational Therapy	H2032	U7	U5	U2		\$10.78	0.25/Hour	

Waiver		INsite Code	Service Description	HCPCS Code	Modifiers				Rate	Unit/Size	Unit/\$ Limit
FSW	CIH				1	2	3	4			
	■	R&F	Rent & Food for Unrelated Live-In Caregiver	T2025	U7	U5			\$545.00	1/Month	
	■	RH10	Residential Habilitation Services, Level 1 (35 or Less Hrs/Week)	T2016	U7	U5	UA		\$26.15	1/Hour	
	■	RH20	Residential Habilitation Services, Level 2 (Over 35 Hrs/Week)	T2016	U7	U5			\$21.97	1/Hour	
	■	RD1	RHS Daily Level 1 (2-Person Setting, Algo Level 3)	T2016	U7	U5	UN	UA	\$171.33	1/Day	1 Unit/Day
	■	RD2	RHS Daily Level 2 (2-Person Setting, Algo Level 4)	T2016	U7	U5	UN	UB	\$241.63	1/Day	1 Unit/Day
	■	RD3	RHS Daily Level 3 (2-Person Setting, Algo Level 5)	T2016	U7	U5	UN	UC	\$263.59	1/Day	1 Unit/Day
	■	RD4	RHS Daily Level 4 (3-Person Setting, Algo Level 3)	T2016	U7	U5	UP	UA	\$171.33	1/Day	1 Unit/Day
	■	RD5	RHS Daily Level 5 (3-Person Setting, Algo Level 4)	T2016	U7	U5	UP	UB	\$221.85	1/Day	1 Unit/Day
	■	RD6	RHS Daily Level 6 (3-Person Setting, Algo Level 5)	T2016	U7	U5	UP	UC	\$241.63	1/Day	1 Unit/Day
	■	RD7	RHS Daily Level 7 (4-Person Setting, Algo Level 3)	T2016	U7	U5	UQ	UA	\$160.35	1/Day	1 Unit/Day
	■	RD8	RHS Daily Level 8 (4-Person Setting, Algo Level 4)	T2016	U7	U5	UQ	UB	\$206.47	1/Day	1 Unit/Day
	■	RD9	RHS Daily Level 9 (4-Person Setting, Algo Level 5)	T2016	U7	U5	UQ	UC	\$219.66	1/Day	1 Unit/Day
■	■	RNUR	Respite Nursing Care, RN	T1005	U7	U5	TD		\$7.79	0.25/Hour	
■	■	RNUR	Respite Nursing Care, LPN	T1005	U7	U5	TE		\$5.91	0.25/Hour	
■	■	RSPO	Respite Care Services	S5151	U7	U5			\$26.15	1/Hour	
	■	ATCH	Specialized Medical Equip/Supply, Install	T2029	U7	U5	NU		Individual	1/Unit	
■		ATCH	Specialized Medical Equip/Supply, Install	T2029	U7	U5	NU		Individual	1/Unit	\$7,500 Lifetime
■	■	ATCM	Specialized Medical Equip/Supply, Maintain	T2029	U7	U5	U8		Individual	1/Unit	\$500/Year
■	■	SPTH	Speech/Language Therapy	92507	U7	U5	UA		\$18.12	0.25/Hour	
	■	AF01	Structured Family Caregiving, Level 1	T2033	U7	U5	U1		\$51.87	1/Day	1 Unit/Day
	■	AF02	Structured Family Caregiving, Level 2	T2033	U7	U5	U2		\$75.67	1/Day	1 Unit/Day
	■	AF03	Structured Family Caregiving, Level 3	T2033	U7	U5	U3		\$102.87	1/Day	1 Unit/Day
■		TRNO	Transportation	T2002	U7	U5			\$5.25	1/Trip	2 Trips/Day
	■	TRNO	Transportation, Level 1	T2002	U7	U5			\$5.25	1/Trip	2 Trips/Day, \$2,625/Year
	■	TRN2	Transportation, Level 2	T2002	U7	U5	U2		\$21.00	1/Trip	2 Trips/Day, \$5,250/Year
	■	TRN3	Transportation, Level 3	T2002	U7	U5	U3		\$42.00	1/Trip	2 Trips/Day, \$7,875/Year

Waiver		INsite Code	Service Description	HCPCS Code	Modifiers				Rate	Unit/Size	Unit/\$ Limit
FSW	CIH				1	2	3	4			
	■	VMOD	Vehicle Modification, Install	T2039	U7	U5			Individual	1/Unit	\$15,000 Lifetime
■		VMOD	Vehicle Modification, Install	T2039	U7	U5			Individual	1/Unit	\$7,500 Lifetime
■	■	VMOM	Vehicle Modification, Maintain	T2039	U7	U5	U8		Individual	1/Unit	\$500/Year
	■	WEL1	Wellness Coordination Tier 1	T2022	U7	U5	U1		\$52.77	1/Month	1 Unit/Month
	■	WEL2	Wellness Coordination Tier 2	T2022	U7	U5	U2		\$111.96	1/Month	1 Unit/Month
	■	WEL3	Wellness Coordination Tier 3	T2022	U7	U5	U3		\$223.92	1/Month	1 Unit/Month
■	■	WPA	Workplace Assistance	T1020	U7	U5			\$27.69	1/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, nonresidential 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 ADS on a planned basis. A maximum of 12 hours per day shall be allowable.

A half-day unit is defined as one unit of 3 hours to a maximum of 5 hours per day. Two units is more than 5 hours to a maximum of 8 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 3 hours or more than 8 hours of ADS have been provided on the same day. A maximum of 16 quarter-hour units per day are allowed.

#### **Additional Information**

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

### *Reimbursable Activities*

ADS may be used in conjunction with Transportation services.

- Basic ADS (Level 1) includes:
  - Monitoring and/or supervision of all activities of daily living (ADLs), defined as dressing, bathing, grooming, eating, walking, and toileting with hands-on assistance provided as needed
  - Comprehensive, therapeutic activities
  - Health assessment and intermittent monitoring of health status
  - Monitoring medication or medication administration
  - Appropriate structure and supervision for those with mild cognitive impairment
  - Minimum staff ratio: One staff for each eight individuals

- Enhanced ADS (Level 2) includes the Level 1 service requirements and the following additional services:
  - Hands-on assistance with two or more ADLs or hands-on assistance with bathing or other personal care
  - Health assessment with regular monitoring or intervention with health status
  - Dispensing or supervising the dispensing of medication 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 ADS (Level 3) includes the Level 1 and Level 2 service requirements and the following additional services:
  - Hands-on assistance or supervision with all ADLs and personal care
  - One or more direct health interventions required
  - Rehabilitation and restorative services, including physical therapy, speech therapy, and occupational therapy coordinated or available
  - Therapeutic intervention to address dynamic psychosocial needs such as depression or family issues affecting care
  - Therapeutic interventions for those with moderate to severe cognitive impairments
  - Minimum staff ratio: One staff for each four individuals

## ***Service Standards***

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

## ***Documentation Standards***

The following are required documentation for ADS:

- Services outlined in the Person-Centered/Individualized Support Plan (PC/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 the document library of the State's case management system by the chosen service provider on or before the 15th day of the following month.

## ***Limitations***

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



## ***Activities Not Allowed***

Any activity that is not described under [Reimbursable Activities](#) is not included in ADS.

## ***Provider Qualifications***

ADS providers must meet the following criteria:

- Be enrolled in the Indiana Health Coverage Programs (IHCP) as an active Medicaid provider.
- Be DDRS-approved.
- Comply with *Indiana Administrative Code 460 IAC 6*, including but not limited to:
  - 460 IAC 6-10-5 Criminal Histories
  - 460 IAC 6-12 Insurance
  - 460 IAC 6-11 Financial Status of Providers
  - 460 IAC 6-5-2 Qualification for ADS
  - 460 IAC 6-14-5 Direct Care Staff Qualifications
  - 460 IAC 6-14-4 Staff Training
  - 460 IAC 6-34 Transportation Services requirements
- Comply with any applicable BDDS service standards, guidelines, policies and/or documents (see the [Current DDRS Policies](#) page at [in.gov/fssa/ddrs](http://in.gov/fssa/ddrs)).
- Obtain/maintain accreditation (specific to Indiana programs) by at least one of the following organizations:
  - The Commission on Accreditation of Rehabilitation Facilities (CARF) or its successor
  - The Council on Quality and Leadership in Supports for People with Disabilities (CQL) or its successor
  - The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or its successor
  - The National Committee for Quality Assurance or its successor
  - The ISO-9001 human services quality assurance (QA) system
  - An independent national accreditation organization approved by the secretary
  - The Council on Accreditation or its successor

## **Section 10.4: Behavioral Support Services**

### ***Service Definition***

Behavioral 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.

#### **Additional Information**

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

### ***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
- Obtaining 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 PC/ISP:

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

## ***Documentation Standards***

At minimum, documentation will include:

- Services outlined in the PC/ISP. The PC/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 PC/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 time frame identified, including a minimum time frame for review. The Plan of Care/Cost Comparison Budget (POC/CCB) identifies the name of the waiver-funded service, the name of the 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.

- The participant may be responsible for outcomes of the PC/ISP if he or she so determine.
- Documentation must include progress toward outcomes and any changes or modifications within the PC/ISP.
- Documentation in compliance with *460 IAC 6-18-4*.

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

## ***Limitations***

See [Activities Not Allowed](#).

## ***Activities Not Allowed***

The following activities are not allowed under Behavioral Support Services:

- 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
  - In this situation, billing for Level 2 services only is allowed.
- Simultaneous receipt of facility-based support services or other Medicaid-billable services and Intensive Behavioral Supports

## ***Provider Qualifications***

Providers must meet the following criteria:

- Be enrolled in the IHCP as an active Medicaid provider.
- Be DDRS-approved.
- Comply with *460 IAC 6*, including but not limited to:
  - *460 IAC 6-10-5* Criminal Histories
  - *460 IAC 6-12* Insurance
  - *460 IAC 6-11* Provider Financial Status
  - *460 IAC 6-5-4* Behavioral Support Services Provider qualifications
  - *460 IAC 6-18* Behavior Support Services Standards
- Comply with any applicable BDDS service standards, guidelines, policies and/or documents, including this module and the DDRS BDDS policies.

## Section 10.5: Community-Based Habilitation – Group

### ***Service Definition***

Community-Based Habilitation – Group services are services provided outside 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 nonresidential, integrated settings that are primarily in the community where services are not rendered within the same buildings with nonintegrated (segregated) participants.

#### **Additional Information**

- Community-Based Habilitation – Group services are available under the FSW and the CIH Waiver.

### ***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 PC/ISP. Services must address needs identified in the person-centered planning process and be outlined in the PC/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
- IHCP Member ID (also known as 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, a description 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 [Indiana Code IC 26-2-8].*)

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

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

### ***For Group Services***

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

### ***Limitations***

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 – 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

## ***Provider Qualifications***

Providers must meet the following criteria:

- Be enrolled in the IHCP as an active Medicaid provider.
- Be DDRS-approved.
- Comply with 460 IAC 6, including but not limited to:
  - 460 IAC 6-10-5 Criminal Histories
  - 460 IAC 6-12 Insurance
  - 460 IAC 6-11 Financial Status of Providers
  - 460 IAC 6-14-5 Direct Care Staff Qualifications
  - 460 IAC 6-14-4 Staff Training
  - 460 IAC 6-5-14 Health Care Coordination Services provider qualifications
  - 460 IAC 6-34 Transportation Services requirements
- Comply with any applicable BDDS service standards, guidelines, policies and/or documents, including this module and the DDRS BDDS policies.
- Obtain/maintain accreditation (specific to Indiana programs) by at least one of the following organizations:
  - The CARF or its successor
  - The CQL or its successor
  - The JCAHO or its successor
  - The National Committee for Quality Assurance or its successor
  - The ISO-9001 human services QA system
  - An independent national accreditation organization approved by the secretary
  - The Council on Accreditation or its successor

## **Section 10.6: Community-Based Habilitation – Individual**

### ***Service Definition***

Community-Based Habilitation – Individual services are services provided outside 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 nonresidential, integrated settings that are primarily out in the community where services are not rendered within the same buildings alongside other nonintegrated participants.*

#### **Additional Information**

- Activities must have a habilitation component.
- Community-Based Habilitation – Individual services are available under the FSW and CIH Waiver.

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

## ***Documentation Standards***

Community-Based Habilitation – Individual documentation must include services outlined in the PC/ISP:

- Need for service continuation and justification of goals is to be evaluated annually and reflected in the PC/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
  - IHCP Member ID (also known as 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 documentation 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 the document library of the State's case management system by the chosen service provider on or before the 15th day of the following month.

## ***Limitations***

The 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.

## ***Activities Not Allowed***

The following activities are not allowed under Community-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.
- Services rendered in a facility.

## ***Provider Qualifications***

Providers must meet the following criteria:

- Be enrolled in the IHCP as an active Medicaid provider.
- Be DDRS-approved.
- Comply with *460 IAC 6*, including but not limited to:
  - *460 IAC 6-10-5* Criminal Histories
  - *460 IAC 6-12* Insurance
  - *460 IAC 6-11* Financial Status of Providers
  - *460 IAC 6-14-5* Direct Care Staff Qualifications
  - *460 IAC 6-14-4* Staff Training
  - *460 IAC 6-5-14* Health Care Coordination Services provider qualifications
  - *460 IAC 6-34* Transportation Services requirements
- Comply with any applicable BDDS service standards, guidelines, policies and/or documents, including this module and the DDRS BDDS policies.
- Obtain/maintain accreditation (specific to Indiana programs) by at least one of the following organizations:
  - The CARF or its successor
  - The CQL or its successor
  - The JCAHO or its successor
  - The National Committee for Quality Assurance or its successor



- The ISO-9001 human services QA system
- An independent national accreditation organization approved by the secretary
- The Council on Accreditation or its successor

## Section 10.7: Community Transition

### ***Service Definition***

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

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

Items purchased through Community Transition services are the property of the individual receiving the service, and the individual should take the property with him or her in the event of a move to another residence, even if the residence from which 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 service is included in the CCB.

### ***Service Standards***

Community Transition services must be reflected in the PC/ISP. Services must address needs identified in the person-centered planning process and be outlined in the PC/ISP.

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

### ***Documentation Standards***

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

## ***Limitations***

Community Transition services are limited to one-time setup expenses, up to \$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

## ***Provider Qualifications***

Providers must meet the following criteria:

- Be enrolled in the IHCP as an active Medicaid provider.
- Be DDRS-approved.
- Comply with 460 IAC 6, including but not limited to:
  - 460 IAC 6-10-5 Criminal Histories
  - 460 IAC 6-12 Insurance
  - 460 IAC 6-11 Financial Status of Providers
  - 460 IAC 6-5-34 Community Transition Staff Qualifications
  - 460 IAC 6-14-4 Staff Training
- Comply with any applicable BDDS service standards, guidelines, policies and/or documents, including this module and the DDRS BDDS policies.

## **Section 10.8: Electronic Monitoring**

### ***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 offsite 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.

#### **Additional Information**

- Available only under the CIH Waiver. Electronic Monitoring is not available under the FSW

## ***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 onsite staffing.
- Use of the system may be restricted to certain hours through the PC/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 BDDS service coordinator will review the use of the system at 7 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 Office of Medicaid Policy and Planning (OMPP).
- Retention of written documentation is required for 7 years
- Retention of video/audio records, including computer vision, audio, and sensor information, shall be retained for 7 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 PC/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 BDDS office, the guardian (if applicable), and in the home file.
- Withdrawing consent: If the participant desires to withdraw consent, he or she would notify the Case Manager. As informed consent is a prerequisite for utilization of Electronic Monitoring services, a meeting of the IST would be needed to discuss available options for an alternate living arrangement. If video monitoring is being used under this service, participants' service plans should reflect how they want to inform visitors of the use of electronic monitoring in the setting.
- 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 PC/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 PC/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, FSSA, the DDRS, the BDDS, the BQIS, the 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 onsite staff.
  - The system would be left operating until the onsite staff arrives.
  - The electronic caregiver would turn off the system at that site after it has been relieved by an onsite 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 onsite support at the participant's residential living site, when necessary.

## ***Float Staff***

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 the individual participant's need.
- The service must be provided by one float staff for onsite 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 PC/ISP:

- To be reimbursed, the provider must prepare and be able to produce the following:
  - Status as a 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 PC/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 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 PC/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 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 RHS. 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 BDDS and BQIS procedures.
- At least every 90 calendar days, the appropriateness of continued use of the monitoring system must be reviewed; the results of these reviews must be documented in the DDRS Case Management system and/or the PC/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 the document library of the State’s case management system by the chosen service provider on or before the 15th day of the following month.

### ***Limitations and Reimbursement Parameters***

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 (see Table 4). 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

<b>Tier</b>	<b>Number of Participants</b>	<b>Reimbursement</b>
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 CIH Waiver 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 used concurrently with Structured Family Caregiving (SFC) services in the SFC home
- Electronic monitoring systems intended to monitor direct care staff
- Electronic monitoring systems in intermediate care facilities for individuals with intellectual disabilities (ICFs/IID) licensed under *IC 16-28* and *410 IAC 16.2*
- Electronic monitoring systems used in place of in-home staff to monitor minors (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

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. 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.

## ***Provider Qualifications***

Providers must meet the following criteria:

- Be enrolled in the IHCP as an active Medicaid provider.
- Be DDRS-approved.
- Comply with 460 IAC 6, including but not limited to:
  - 460 IAC 6-10-5 Criminal Histories
  - 460 IAC 6-12 Insurance
  - 460 IAC 6-11 Financial Status of Providers
  - 460 IAC 6-5-30(b)
  - 460 IAC 6-34 Transportation Services requirements
  - 460 IAC 6-14-5 Direct Care Staff Qualifications
  - 460 IAC 6-14-4 Staff Training
- Comply with any applicable BDDS service standards, guidelines, policies and/or documents, including this module and the DDRS BDDS policies.

## **Section 10.9: Environmental Modifications**

### ***Service Definition***

Environmental Modifications are those physical adaptations to the home, required by the individual's 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 DDRS waiver specialist must approve all environmental modifications prior to service being rendered.

#### **Additional Information**

- Environmental Modifications are available only under the CIH Waiver, and not under the FSW.
- Photographs of the proposed areas to be modified must be provided.
- The Environmental Modification policy appears in [Section 11: RFA Policies](#) and [Section 11.1: Environmental Modification Policy](#).

## ***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 PC/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 (PA) denial from Medicaid, if applicable
- Receipts for purchases
- Identified need in PC/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:

- 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
- 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

## ***Provider Qualifications***

Providers must meet the following criteria:

- Be enrolled in the IHCP as an active Medicaid provider.
- Be DDRS-approved.
- Comply with 460 IAC 6, including but not limited to:
  - 460 IAC 6-10-5 Criminal Histories
  - 460 IAC 6-12 Insurance
  - 460 IAC 6-11 Financial Status of Providers
  - 460 IAC 6-5-11 Environmental Modification Qualifications
- Comply with any applicable BDDS service standards, guidelines, policies and/or documents, including this module and the DDRS BDDS policies.

Where licensure is required, providers rendering waiver funded services must obtain/maintain Indiana-specific licensure.

## Section 10.10: Facility-Based Habilitation – Group

### ***Service Definition***

Facility-Based Habilitation – Group 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 nonresidential, nonintegrated settings that take place within the same buildings for the duration of the service rather than being out in the community.

#### **Additional Information**

- Activities must have a habilitation component and be available under the FSW and the CIH Waiver.

### ***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:

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

### ***Documentation Standards***

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

- Services outlined in the PC/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
  - IHCP Member ID (also known as 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, 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 documentation 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 the document library of the State's case management system by the chosen service provider on or before the 15th day of the following month.

### ***For Group Services***

Upon request, the provider must be able to verify 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 are limitations on group sizes (participants:staff) for a Facility-Based Habilitation – Group:

- 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

### ***Provider Qualifications***

Providers must meet the following criteria:

- Be enrolled in the IHCP as an active Medicaid provider.
- Be DDRS-approved.
- Comply with 460 IAC 6, including but not limited to:
  - 460 IAC 6-10-5 Criminal Histories
  - 460 IAC 6-12 Insurance
  - 460 IAC 6-11 Financial Status of Providers
  - 460 IAC 6-14-5 Direct Care Staff Qualifications
  - 460 IAC 6-14-4 Staff Training
  - 460 IAC 6-5-14 Health Care Coordination Services provider qualifications
  - 460 IAC 6-34 Transportation Services requirements
- Comply with any applicable BDDS service standards, guidelines, policies and/or documents, including this module and the DDRS BDDS policies.
- Obtain/maintain accreditation (specific to Indiana programs) by at least one of the following organizations:
  - The CARF or its successor
  - The CQL or its successor
  - The JCAHO or its successor
  - The National Committee for Quality Assurance or its successor
  - The ISO-9001 human services QA system
  - The Council on Accreditation or its successor
  - An independent national accreditation organization approved by the secretary

## **Section 10.11: Facility-Based Habilitation – Individual**

### ***Service Definition***

Facility-Based Habilitation – Individual services are provided outside 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 nonresidential, nonintegrated settings that take place within the same buildings for the duration of the service rather than being out in the community.

#### **Additional Information**

- Activities must have a habilitation component.
- Facility-Based Habilitation – Individual services are available under the FSW and the CIH Waiver.

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

## ***Documentation Standards***

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

- Services outlined in the PC/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
  - IHCP Member ID (also known as 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, 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 documentation 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 the document library of the State's case management system by the chosen service provider on or before the 15th day of the following month.

## ***Limitations***

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

- 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

## ***Provider Qualifications***

Providers must meet the following criteria:

- Be enrolled in the IHCP as an active Medicaid provider.
- Be DDRS-approved.
- Comply with *460 IAC 6*, including but not limited to:
  - *460 IAC 6-10-5* Criminal Histories
  - *460 IAC 6-12* Insurance
  - *460 IAC 6-11* Financial Status of Providers
  - *460 IAC 6-14-5* Direct Care Staff Qualifications
  - *460 IAC 6-14-4* Staff Training
  - *460 IAC 6-5-14* Health Care Coordination Services provider qualifications
  - *460 IAC 6-34* Transportation Services requirements
- Comply with any applicable BDDS service standards, guidelines, policies and/or documents, including this module and the DDRS BDDS policies.
- Obtain/maintain accreditation (specific to Indiana programs) by at least one of the following organizations:
  - The CARF or its successor
  - The CQL or its successor
  - The JCAHO or its successor

- The National Committee for Quality Assurance or its successor
- The ISO-9001 human services QA system
- The Council on Accreditation or its successor
- An independent national accreditation organization approved by the secretary

## Section 10.12: Facility-Based Support

### ***Service Definition***

Facility-Based Support services are facility-based group programs designed to meet the needs of participants with impairments through individual plans of care. 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 nonresidential, nonintegrated settings that take place within the same buildings for the duration of the service rather than being out in the community.

#### **Additional Information**

- Facility-Based Support services are available under the FSW and the CIH Waiver.

### ***Reimbursable Activities***

Reimbursable activities include the following:

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

### ***Service Standards***

The following service standards apply to Facility-Based Support:

- Facility-Based Support services must be reflected in the PC/ISP.
- Facility-Based Support services must follow a written plan of care addressing specific needs as identified in the PC/ISP.

### ***Documentation Standards***

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

- Services outlined in the PC/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
  - IHCP Member ID (also known as 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, 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 documentation 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 the document library of the State's case management system by the chosen service provider on or before the 15th day of the following month.

### ***For Group Services***

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

### ***Limitations***

The following are limitations on Facility-Based Support:

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

### ***Activities Not Allowed***

The following activities are not allowed under Facility-Based Support:

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



## ***Provider Qualifications***

Providers must meet the following criteria:

- Be enrolled in the IHCP as an active Medicaid provider.
- Be DDRS-approved.
- Comply with 460 IAC 6, including but not limited to:
  - 460 IAC 6-10-5 Criminal Histories
  - 460 IAC 6-12 Insurance
  - 460 IAC 6-11 Financial Status of Providers
  - 460 IAC 6-14-5 Direct Care Staff Qualifications
  - 460 IAC 6-14-4 Staff Training
  - 460 IAC 6-5-14 Health Care Coordination Services Provider Qualifications
  - 460 IAC 6-34 Transportation Services requirements
- Comply with any applicable BDDS service standards, guidelines, policies and/or documents, including this module and the DDRS BDDS policies.

## **Section 10.13: Family and Caregiver Training**

### ***Service Definition***

Family and Caregiver Training services provide training and education to:

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

#### **Additional Information**

- Family and Caregiver Training cannot be used to provide behavioral programs or supports or other direct services covered under other available Medicaid State Plan or waiver services.
- Family and Caregiver Training services are available under the FSW and the CIH Waiver.

### ***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:

- Family and Caregiver Training services must be included in the PC/ISP.
- The PC/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 PC/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 the document library of the State's case management system by the chosen service provider on or before the 15th day of the following month.

## ***Limitations***

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

## ***Activities Not Allowed***

The following activities are not allowed under Family and Caregiver Training:

- 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

## ***Provider Qualifications***

Providers must meet the following criteria:

- Be enrolled in the IHCP as an active Medicaid provider.
- Be DDRS-approved.
- Comply with *460 IAC 6*, including but not limited to:
  - *460 IAC 6-10-5* Criminal Histories
  - *460 IAC 6-12* Insurance
  - *460 IAC 6-11* Provider Financial Status
  - *460 IAC 6-23-1* Family and Caregiver Training Qualifications
  - *460 IAC 6-14-4* Staff Training

- Comply with any applicable BDDS service standards, guidelines, policies and/or documents, including this module and the DDRS BDDS policies.

## Section 10.14: 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)

#### **Additional Information**

- IBI services are available under the FSW and the CIH Waiver.

### ***Reimbursable Activities***

Reimbursable activities include the following:

- Preparation of an IBI support plan in accordance with the DDRS [Behavioral Support Plan Policy \(2011\)](#)
- 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 to change other behaviors that depend on them.
- Errorless teaching or other prompting procedures that have been found to support successful intervention. These procedures focus on the prevention of errors or incorrect responses while also monitoring when to fade the prompts to allow the learner to demonstrate ongoing and successful completion of the desired activity.
- Additional methods that occur and are empirically based.
- Specific and ongoing objective measurement of progress, with success closely monitored via detailed data collection.

## ***Service Standards***

The following service standards apply to Intensive Behavioral Intervention:

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

## ***Documentation Standards***

Documentation standards for Intensive Behavioral Intervention services include the following:

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

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

## ***Limitations***

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

See [Activities Not Allowed](#).

## ***Activities Not Allowed***

The following activities are not allowed under Intensive Behavioral Intervention:

- Aversive techniques as referenced within *460 IAC 6*
- Interventions that may reinforce negative behavior, such as Gentle Teaching
- Group activities
- Services furnished to a minor by parent(s), stepparent(s), or legal guardian
- Services furnished to 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

## ***Provider Qualifications***

Providers must meet the following criteria:

- Be enrolled in the IHCP as an active Medicaid provider.
- Be DDRS-approved.
- Comply with 460 IAC 6, including but not limited to:
  - 460 IAC 6-10-5-Criminal Histories
  - 460 IAC 6-12 Insurance
  - 460 IAC 6-11 Provider Financial Status
  - 460 IAC 6-14-5 Direct Care Staff qualifications
  - 460 IAC 6-14-4 Staff Training
- Comply with any applicable BDDS service standards, guidelines, policies and/or documents, including this module and the DDRS BDDS policies.
- Where licensure/certification is required, providers rendering waiver funded services must obtain/maintain Indiana-specific licensure/certification:
  - For IBI Director: Psychologist licensed under *IC 25-33*, or psychiatrist licensed under *IC 25-22.5*
  - For IBI Case Supervisor: IBI Case Supervisor must be Board Certified Behavior Analyst (BCBA)- or Board Certified Assistant Behavior Analyst (BCaBA)-certified

## **Section 10.15: Music Therapy**

### ***Service Definition***

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

#### **Additional Information**

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

### ***Reimbursable Activities***

Reimbursable activities include the following:

- Therapy to improve:
  - Self-image and body awareness
  - Fine and gross motor skills
  - Auditory perception
- Therapy to increase:
  - Communication skills
  - Ability to use energy purposefully
  - Interaction with peers and others

- Attending behavior
- Independence and self-direction
- Therapy to 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 Music Therapy
- Group services in group sizes no greater than four participants to one music therapist (unit rate divided by number of participants)

## ***Service Standards***

The following service standards apply to Music Therapy:

- Music Therapy services should be reflected in the PC/ISP of the individual.
- Services must address needs identified in the person-centered planning process and be outlined in the PC/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 PC/ISP
- Appropriate credentials for service provider
- Attendance record and therapist logs and/or chart detailing services provided, dates, and times
- Documentation in compliance with 460 IAC 6 Supported Living Services and Supports requirements

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

## ***Limitations***

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:

- 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 (Specialized equipment needed for the provision of Music Therapy services should be purchased under the Specialized Medical Equipment and Supplies service; see [Section 11.2: Specialized Medical Equipment and Supplies.](#))
- Activities delivered in a nursing facility
- Group sizes greater than four participants to one music therapist or group sizes exceeding the maximum allowable group size determined by the IST for each group participant

## ***Provider Qualifications***

Providers must meet the following criteria:

- Be enrolled in the IHCP as an active Medicaid provider.
- Be DDRS-approved.
- Comply with 460 IAC 6, including but not limited to:
  - 460 IAC 6-10-5 Criminal Histories
  - 460 IAC 6-12 Insurance
  - 460 IAC 6-11 Provider Financial Status
  - 460 IAC 6-5-15 Music Therapy Provider Qualifications
- Comply with any applicable BDDS service standards, guidelines, policies and/or documents, including this module and the DDRS BDDS policies.
- Where licensure/certification is required, providers rendering waiver funded services must obtain/maintain Indiana-specific licensure/certification.
- Be a music therapist certified by a certification board for music therapists that is accredited by a national commission for certifying agencies.

## **Section 10.16: Occupational Therapy**

### ***Service Definition***

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

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

### ***Reimbursable Activities***

Reimbursable activities include the following:

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

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

## ***Documentation Standards***

Documentation standards for Occupational Therapy services include the following:

- Documentation by appropriate assessment by a qualified therapist
- Services provided under both the Medicaid State Plan and the waiver must be outlined in the PC/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 the document library of the State's case management system by the chosen service provider on or before the 15th day of the following month.

## ***Limitations***

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

One hour of billed therapy service must include a minimum of 45 minutes of direct 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:

- 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 PA denial is required before reimbursement is available through the Medicaid waiver for this service)

## ***Provider Qualifications***

Providers must meet the following criteria:

- Be enrolled in the IHCP as an active Medicaid provider.
- Be DDRS-approved.

- Comply with 460 IAC 6, including but not limited to:
  - 460 IAC 6-10-5 Criminal Histories
  - 460 IAC 6-12 Insurance
  - 460 IAC 6-11 Provider Financial Status
  - 460 IAC 6-5-17 Occupational Therapy provider qualifications
- Comply with any applicable BDDS service standards, guidelines, policies and/or documents, including this module and the DDRS BDDS policies.
- Where licensure/certification is required, providers rendering waiver funded services must obtain/maintain Indiana-specific licensure/certification.
- For licensed occupational therapist, meet requirements set forth in IC 25-23.5.

*Note: See [Section 10.30: Participant Assistance and Care](#) for information on Participant Assistance and Care (PAC) services.*

## Section 10.17: Personal Emergency Response System

### ***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 telephone 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 PERS must be included in the PC/ISP.

### ***Documentation Standards***

Documentation standards for a PERS include the following:

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

### ***Limitations***

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

## ***Activities Not Allowed***

If the individual requires constant supervision to maintain health and safety, PERS supports are not allowed or reimbursed.

## ***Provider Qualifications***

Providers must meet the following criteria:

- Be enrolled in the IHCP as an active Medicaid provider.
- Be DDRS-approved.
- Comply with 460 IAC 6, including but not limited to:
  - 460 IAC 6-10-5 Criminal Histories
  - 460 IAC 6-12 Insurance
  - 460 IAC 6-11 Financial Status of Provider
  - 460 IAC 6-5-18 Personal Emergency Response System Qualifications
- Comply with any applicable BDDS service standards, guidelines, policies and/or documents, including this module and the DDRS BDDS policies.

## **Section 10.18: Physical Therapy**

### ***Service Definition***

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

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

#### **Additional Information**

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

### ***Reimbursable Activities***

Reimbursable activities include the following:

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

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

## ***Documentation Standards***

Physical Therapy services documentation must include the following:

- Documentation by appropriate assessment
- Services provided under both the Medicaid State Plan and the waiver must be outlined in the PC/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 PC/ISP

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

## ***Limitations***

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

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:

- 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 PA denial is required before reimbursement is available through the waiver for this service)

## ***Provider Qualifications***

Providers must meet the following criteria:

- Be enrolled in the IHCP as an active Medicaid provider.
- Be DDRS-approved.

- Comply with 460 IAC 6, including but not limited to:
  - 460 IAC 6-10-5 Criminal Histories
  - 460 IAC 6-12 Insurance
  - 460 IAC 6-11 Provider Financial Status
  - 460 IAC 6-5-19 Physical Therapy Qualifications
- Comply with any applicable BDDS service standards, guidelines, policies and/or documents, including this module and the DDRS BDDS policies.
- Where licensure/certification is required, providers rendering waiver funded services must obtain/maintain Indiana-specific licensure/certification.
- Physical therapists rendering waiver funded services must obtain/maintain Indiana licensure criteria of IC 25-27-1.

## Section 10.19: Prevocational Services

### ***Service Definition***

Prevocational Services 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.

#### **Additional Information**

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

### ***Reimbursable Activities***

Reimbursable activities under Prevocational Services include the following:

- Monitoring, training, education, demonstration, or support provided to assist with the acquisition and retention of skills in the following areas:
  - Paid and unpaid training compensated at less than 50% of the federal minimum wage
  - Generalized and transferrable employment skills acquisition
- These activities may be provided using offsite enclave or mobile community work crew models.

### ***Service Standards***

The following service standards apply to Prevocational Services:

- Prevocational Services must be reflected in the PC/ISP.

- All Prevocational Services will be reflected in the participant's plan of care as directed to habilitative rather than explicit employment objectives.
- The participant is not expected to be able to join the general workforce or participate in sheltered employment within 1 year.

## **Documentation Standards**

Prevocational Services documentation must include the following:

- Services outlined in the PC/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
  - IHCP Member ID (also known as 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, 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 documentation 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 the document library of the State's case management system by the chosen service provider on or before the 15th day of the following month.

## **For Group Services**

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

## **Limitations**

The following are limitations on group sizes (participants:staff) for Prevocational Services:

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

Monitoring of Prevocational Services occurs on a quarterly basis. The objectives of monitoring include assessment of the participant's progress toward achieving the outcomes identified on the participant's PC/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.

### ***Activities Not Allowed***

The following activities are not allowed under Prevocational Services:

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

### ***Provider Qualifications***

Providers must meet the following criteria:

- Be enrolled in the IHCP as an active Medicaid provider.
- Be DDRS-approved.
- Comply with *460 IAC 6*, including but not limited to:
  - *460 IAC 6-10-5-Criminal Histories*
  - *460 IAC 6-12 Insurance*
  - *460 IAC 6-11 Provider Financial Status*
  - *460 IAC 6-14-5 Direct Care Staff qualifications*
  - *460 IAC 6-5-20 Prevocational Services provider qualifications*
  - *460 IAC 6-14-4 Staff Training*
- Comply with any applicable BDDS service standards, guidelines, policies and/or documents, including this module and the DDRS BDDS policies.
- Obtain/maintain accreditation (specific to Indiana programs) by at least one of the following organizations:
  - The CARF or its successor
  - The CQL or its successor
  - The JCAHO or its successor
  - The National Committee for Quality Assurance or its successor
  - The ISO-9001 human services QA system
  - The Council on Accreditation or its successor
  - An independent national accreditation organization approved by the secretary

## Section 10.20: Psychological Therapy

### ***Service Definition***

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

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

#### **Additional Information**

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

### ***Reimbursable Activities***

Reimbursable activities under Psychological Therapy include the following:

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

### ***Service Standards***

The following service standards apply to Psychological Therapy:

- Therapy services should be reflected in the PC/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 PC/ISP.
- Services must complement other services the individual receives and enhance increasing independence for the individual.



## ***Documentation Standards***

Psychological Therapy services documentation must include the following:

- Documentation by appropriate assessment
- Services provided under both the Medicaid State Plan and the waiver must be outlined in the PC/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 PC/ISP

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

## ***Limitations***

If individuals under age 21 choose to receive psychological therapy, they should access psychological therapy services through EPSDT.

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:

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

## ***Provider Qualifications***

Providers must meet the following criteria:

- Be enrolled in the IHCP as an active Medicaid provider.
- Be DDRS-approved.
- Comply with *460 IAC 6*, including but not limited to:
  - *460 IAC 6-10-5* Criminal Histories
  - *460 IAC 6-12* Insurance
  - *460 IAC 6-11* Provider Financial Status
  - *460 IAC 6-5-21* (Psychological) Therapy Provider qualifications
- Comply with any applicable BDDS service standards, guidelines, policies and/or documents, including this module and the DDRS BDDS policies.

- Where licensure/certification is required, providers rendering waiver funded services must obtain/maintain Indiana-specific licensure/certification:
  - For a clinical social worker, meet requirements set forth in *IC 25-23.6*
  - For a licensed psychologist, meet requirements set forth in *IC 25-33-1-5.1*
  - For a marriage/family therapist, meet requirements set forth in *IC 25-23.6*
  - For a mental health counselor, meet requirements set forth in *IC 25-23.6*

## Section 10.21: Recreational Therapy

### ***Service Definition***

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

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

Services provided under the waiver cannot be used as a substitute for services that are provided under the Medicaid State Plan.

#### **Additional Information**

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

### ***Reimbursable Activities***

Reimbursable activities under Recreational Therapy services include the following:

- Organizing and directing adapted sports, dramatics, arts and crafts, social activities, and other recreation services designed to restore, remediate, or rehabilitate
- Planning, reporting, and write-up when in association with the actual one-on-one direct care/therapy service delivery with the waiver 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:

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

## ***Documentation Standards***

Recreational Therapy services documentation must include the following:

- Documentation by appropriate assessment
- Services provided under both the Medicaid State Plan and the waiver must be outlined in PC/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 PC/ISP

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

## ***Limitations***

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:

- 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

## ***Provider Qualifications***

Providers must meet the following criteria:

- Be enrolled in the IHCP as an active Medicaid provider.
- Be DDRS-approved.
- Comply with *460 IAC 6*, including but not limited to:
  - *460 IAC 6-10-5* Criminal Histories
  - *460 IAC 6-12* Insurance
  - *460 IAC 6-11* Provider Financial Status
  - *460 IAC 6-5-22* Recreational Therapy provider qualifications
- Comply with any applicable BDDS service standards, guidelines, policies and/or documents, including this module and the DDRS BDDS policies.

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

### ***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.

#### **Additional Information**

- Paid caregivers are not eligible for the Rent and Food for Unrelated Live-in Caregiver service.
- Rent and Food for Unrelated Live-in Caregiver services are available only under the CIH Waiver, and not under the FSW.

### ***Reimbursable Activities***

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

- The 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 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:

- Rent and Food for an Unrelated Live-in Caregiver should be reflected in the PC/ISP.
- Services must address needs identified in the person-centered planning process and be outlined in the PC/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 the following:

- Identified in the PC/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 the document library of the State's case management system by the chosen service provider on or before the 15th day of the following month.

## ***Limitations***

See [Activities Not Allowed](#).

## ***Activities Not Allowed***

The following situations are not allowed under Rent and Food for Unrelated Live-in Caregiver:

- 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

## ***Provider Qualifications***

Providers must meet the following criteria:

- Be enrolled in the IHCP as an active Medicaid provider.
- Be DDRS-approved.
- Comply with *460 IAC 6*, including but not limited to:
  - *460 IAC 6-5-24* Qualifications for RHS
  - *460 IAC 6-14-5* Direct Care Staff Qualifications
  - *460 IAC 6-14-4* Staff Training
- Comply with any applicable BDDS service standards, guidelines, policies and/or documents, including this module and the DDRS BDDS policies.

# **Section 10.23: Residential Habilitation and Support (Hourly)**

## ***Service Definition***

Residential Habilitation and Support (RHS) 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.

The service is billable as either of the following:

- RH1O – For Level 1 with 35 hours or less per week of RHS
- RH2O – For Level 2 with greater than 35 hours per week of RHS

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

**Additional Information**

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

## ***Reimbursable Activities***

RHS includes the following reimbursable activities:

- Direct supervision, monitoring, and training to implement the PC/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 PC/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.*

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.

## ***Service Standards***

The following service standards apply to Residential Habilitation and Support – Hourly:

- Services must address needs identified in the person-centered planning process and be outlined in the PC/ISP.
- RHS-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 the following:

- Services must be outlined in the PC/ISP.
- Data record of staff-to-participant service must document the complete date and time entry (including a.m. or p.m.). All staff members who provide uninterrupted, continuous service in direct supervision or care of the 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 healthcare professional, Case Manager, or BDDS staff member that involved the participant are also to be documented.
- Quarterly reporting summaries are required.
- Documentation must be in compliance with *460 IAC 6*.

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

## **Limitations**

The following are limitations on 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 the following *Activities Not Allowed* section for the definition of relative.)
- 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 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.

## **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) services 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)

## ***Provider Qualifications***

Providers must meet the following criteria:

- Be enrolled in the IHCP as an active Medicaid provider.
- Be DDRS-approved.
- Comply with *460 IAC 6*, including but not limited to:
  - *460 IAC 6-5-24* Qualifications for RHS
  - *460 IAC 6-10-5* Criminal Histories
  - *460 IAC 6-12* Insurance
  - *460 IAC 6-11* Financial Status of Providers
  - *460 IAC 6-5-14* Health Care Coordination Qualifications
  - *460 IAC 6-14-5* Direct Care Staff Qualifications
  - *460 IAC 6-14-4* Staff Training
  - *460 IAC 6-34* Transportation Services requirements
- Comply with any applicable BDDS service standards, guidelines, policies and/or documents, including this module and the DDRS BDDS policies.
- Per *House Enrolled Act 1360* (P.L.154-2012), *IC 12-11-1.1-1* is amended to state:
  - Beginning July 1, 2012, the bureau shall ensure that an entity approved to provide Residential Habilitation and Support services under HCBS waivers is accredited by an approved national accrediting body. However, if an entity is accredited to provide HCBS under a subdivision other than Residential Habilitation and Support services, the bureau may extend the time that the entity has to comply with this subdivision until the earlier of the following:
    - The completion of the entity's next scheduled accreditation survey (specific to Indiana programs)
    - July 1, 2015
- In accordance with the above citation from *IC 12-11-1.1-1*, RHS providers must be accredited (specific to Indiana programs) by at least one of the following organizations:
  - The CARF or its successor
  - The CQL or its successor
  - The JCAHO or its successor



- The National Committee for Quality Assurance or its successor
- The ISO-9001 human services QA system
- The Council on Accreditation or its successor
- An independent national accreditation organization approved by the secretary

## Section 10.24: Respite Care

### ***Service Definition***

Respite Care services means services provided to participants unable to care for themselves that are furnished on a short-term basis in order to provide temporary relief to those unpaid persons normally providing care. Respite Care can be provided in the participant's home or place of residence, in the respite caregiver's home, in a camp setting, in a DDRS-approved day habilitation facility, or in a non-private residential setting (such as a respite home).

#### **Additional Information**

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

### ***Reimbursable Activities***

Reimbursable activities under Respite Care include the following:

- Assistance with toileting and feeding
- Assistance with daily living skills, including assistance with accessing the community and community activities
- Assistance with grooming and personal hygiene
- Meal preparation, serving, and cleanup
- Administration of medications
- Supervision
- Individual services
- Group services (unit rate divided by number of participants served)

### ***Service Standards***

The following service standards apply to Respite Care:

- Respite Care must be reflected in the PC/ISP.
- Respite Nursing Care (Registered Nurse [RN]) or Respite Nursing Care (Licensed Practical Nurse [LPN]) services may be delivered only when skilled care is required and documented in the PC/ISP.

## ***Documentation Standards***

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

- Participant name
- IHCP Member ID (also known as RID) of the participant
- 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 the document library of the State's case management system by the chosen service provider on or before the 15th day of the following month.

## ***For Group Services***

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

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

## ***Activities Not Allowed***

The following activities are not allowed under Respite Care:

- Reimbursement for room and board
- Services provided to 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
- Care or supervision from the provider for other family members (such as siblings of the participant) while Respite Care is being provided/billed for the waiver participants
- Respite Care used as day/child care
- Respite Care 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 to provide service to a participant while the participant is attending school

- Respite Care to replace skilled nursing services that should be provided under the Medicaid State Plan
- Respite Care that duplicates 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

### ***Provider Qualifications***

Providers must meet the following criteria:

- Be enrolled in the IHCP as an active Medicaid provider.
- Be DDRS-approved.
- Comply with 460 IAC 6, including but not limited to:
  - 460 IAC 6-10-5 Criminal Histories
  - 460 IAC 6-12 Insurance
  - 460 IAC 6-11 Financial Status of Providers
  - 460 IAC 6-5-26 Respite Care Qualifications
  - 460 IAC 6-5-14 Health Care Coordination Qualifications
  - 460 IAC 6-14-5 Direct Care Staff Qualifications
  - 460 IAC 6-14-4 Staff Training
- Comply with any applicable BDDS service standards, guidelines, policies and/or documents, including this module and the DDRS BDDS policies.
- Where licensure/certification is required, providers rendering waiver funded services must obtain/maintain Indiana-specific licensure/certification
  - For LPNs and RNs, meet requirements set forth in IC 25-23
  - For home health agencies, meet requirements set forth in IC 16-27-1 for Home Health Agency, IC 25-23-1 for RN and LPN; IC 16-27-1.5 for Home Health Aide, Registered

## **Section 10.25: Specialized Medical Equipment and Supplies**

### ***Service Definition***

Specialized Medical Equipment and Supplies 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.

BDDS must approve all specialized medical equipment and supplies prior to the service being rendered.

#### **Additional Information**

- Specialized Medical Equipment and Supplies services are available under the FSW and the CIH Waiver.

## ***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
- Nondurable 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:

- Equipment and supplies must be of direct medical or remedial benefit to the individual.
- All items shall meet applicable standards of manufacture, design, and installation.
- Any individual item costing more than \$500 requires an evaluation by a qualified professional such as a physician, nurse, occupational therapist, physical therapist, speech and language therapist, or rehabilitation engineer.
- Annual maintenance service is available and is limited to \$500 per year. If the need for maintenance exceeds \$500, the Case Manager will work with other available funding streams and community agencies to fulfill the need.

## ***Documentation Standards***

Specialized Medical Equipment and Supplies services documentation must include the following:

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

## ***Limitations***

The following are limitations on 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:

- 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) form
- Equipment and services that are not reflected in the PC/ISP
- Equipment and services that do not address needs identified in the person-centered planning process

## ***Provider Qualifications***

Providers must meet the following criteria:

- Be enrolled in the IHCP as an active Medicaid provider.
- Be DDRS-approved.
- Comply with 460 IAC 6, including but not limited to:
  - 460 IAC 6-10-5 Criminal Histories
  - 460 IAC 6-12 Insurance
  - 460 IAC 6-11 Provider Financial Status
  - 460 IAC 6-5-27 Specialized Medical Equipment and Supplies Provider Qualifications
- Where licensure/certification is required, providers rendering waiver funded services must obtain/maintain Indiana-specific licensure/certification:
  - For licensed/certified occupational therapist, meet requirements set forth in IC 25-23.5
  - For licensed physical therapist, meet requirements set forth in IC 25-27-1
  - For DDRS-approved medical supply companies, pharmacies, electronics/computer companies, vehicle modification providers, and electronics vendors, meet requirement set forth in IC 25-26-13-18
  - For speech/language therapist, meet requirements set forth in IC 25-35.6
  - For home health agencies, meet requirements set forth in IC 16-27-1

## Section 10.26: Speech/Language Therapy

### ***Service Definition***

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

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

#### **Additional Information**

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

### ***Reimbursable Activities***

Reimbursable activities under Speech/Language Therapy services include the following:

- Screening
- Assessment
- Direct therapeutic intervention and treatment for speech and hearing disabilities such as delayed speech, stuttering, spastic speech, aphasic disorders, injuries, lip reading or signing, or the use of hearing aids
- Evaluation and training services to improve the ability to use verbal or nonverbal communication
- Language stimulation and correction of defects in voice, articulation, rate, and rhythm
- Design, fabrication, training, and assistance with adaptive aids and devices
- Consultation demonstration of techniques with other service providers and family members
- Planning, reporting, and write-up when in association with the actual one-on-one direct care/therapy service delivery with the waiver participant

### ***Service Standards***

The following service standards apply to Speech/Language Therapy:

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

### ***Documentation Standards***

Speech/Language Therapy services documentation must include the following:

- Documentation of an appropriate assessment

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

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

## ***Limitations***

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

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

## ***Activities Not Allowed***

The following activities are not allowed under Speech/Language Therapy:

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

## ***Provider Qualifications***

Providers must meet the following criteria:

- Be enrolled in the IHCP as an active Medicaid provider.
- Be DDRS-approved.
- Comply with *460 IAC 6*, including but not limited to:
  - *460 IAC 6-10-5* Criminal Histories
  - *460 IAC 6-12* Insurance
  - *460 IAC 6-11* Provider Financial Status
  - *460 IAC 6-5-28* Speech/Language Therapy Qualifications
- Comply with any applicable BDDS service standards, guidelines, policies and/or documents, including this module and the DDRS BDDS policies.
- Where licensure/certification is required, providers rendering waiver funded services must obtain/maintain Indiana-specific licensure/certification
  - For speech/language therapist, meet requirements set forth in *IC 25-35.6*
  - For home health agencies, meet requirements set forth in *IC 16-27-1*

Note: See [Section 10.31: Structured Family Caregiving](#) of this module for information on Structured Family Caregiving.

## Section 10.27A: Transportation (as Specified in the FSW)

### ***Service Definition***

Transportation services (as specified in the FSW) enable waiver participants to gain access to any nonmedical 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 PC/ISP and POC/CCB.

#### **Additional Information**

- Transportation services are available under FSW.
- There is no prohibition against using Transportation services to get to or from a place of employment providing this is reflected in the PC/ISP.
- Transportation may be used to reach any nonmedical destination or activity outlined within the PC/ISP.

### ***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 nonmedical community service, resource or place of employment as specified on the PC/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 *Code of Federal Regulations 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 PC/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

Documentation for Transportation services (as specified in the FSW) must include the following:

- Service notes
  - A service note can include multiple discrete services as long as discrete services are clearly identified.

*Note: A service note entry for this service can be part of a comprehensive daily note with other services recorded, as long it is clearly separated from other services in the note.*

- A service note must include the following:
  - Individual/waiver participant name
  - IHCP Member ID (also known as RID) of the participant
  - Date of service
  - Provider rendering service
  - Pick-up point and destination
- If contract transportation is used, contractor must provide log and invoice support that includes dates of transportation provided.
- If bus passes or alternative methods of transportation are used, invoices and attendance logs must support calendar days for which round trips are billed to the waiver.

## Limitations

Transportation services (as specified in the FSW) may not be used to meet medical transportation needs already available under the Indiana Medicaid State Plan.

## Provider Qualifications

Providers must meet the following criteria:

- Be enrolled in the IHCP as an active Medicaid provider.
- Be DDRS-approved.
- Comply with 460 IAC 6, including but not limited to:
  - 460 IAC 6-10-5 Criminal Histories
  - 460 IAC 6-12 Insurance
  - 460 IAC 6-11 Provider Financial Status
  - 460 IAC 6-5-30(b)
  - 460 IAC 6-34 Transportation Services requirements
  - 460 IAC 6-14-5 Direct Care Staff qualifications
  - 460 IAC 6-14-4 Staff Training
- Comply with any applicable BDDS service standards, guidelines, policies and/or documents, including this module and the DDRS BDDS policies.

## Section 10.27B: Transportation (as Specified in the CIH Waiver)

### ***Service Definition***

Transportation services (as specified in the CIH Waiver) enable waiver participants to gain access to any nonmedical 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 PC/ISP and POC/CCB.

**Specific to the CIH Waiver only:** Depending on the needs of the participant, there are three levels of transportation. The level of transportation service needed must be documented in the PC/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).

#### **Additional Information**

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

### ***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 nonmedical community service or resource or place of employment as specified on the PC/ISP and provided by an approved provider of Residential Habilitation and Support (a service available only under the CIH Waiver), Community-Based Habilitation, Facility-Based Habilitation, Adult Day Services, or Transportation services.
- Bus passes or alternate methods of transportation may be used for Level 1 or Level 2. Bus passes may be purchased on a monthly basis or on a per-ride basis, whichever is most cost-effective in meeting the participant's transportation needs as outlined in the PC/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 PC/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***

Documentation for transportation services (as specified in the CIH Waiver) must include the following:

- Service notes
  - A service note can include multiple discrete services as long as discrete services are clearly identified.

*Note: A service note entry for this service can be part of a comprehensive daily note with other services recorded, as long as it is clearly separated from other services in the note.*

- A service note must include the following:
  - Individual/waiver participant name
  - IHCP Member ID (also known as RID) of the participant
  - Date of service
  - Provider rendering service
  - Pick-up point and destination
- If contract transportation is used, contractor must provide log and invoice support that includes dates of transportation provided.
- If bus passes or alternative methods of transportation are used, invoices and attendance logs must support days for which round trips are billed to the waiver.

## ***Limitations***

Annual limits have been added to this nonmedical waiver Transportation service, the costs of which are paid for outside of and in addition to the participants' annual allocation amount that is determined by their Algo level. Note that no participant is excluded from participating in nonmedical waiver Transportation services. The annual limits for each level of nonmedical waiver Transportation are:

- \$2,625 for Level 1 Transportation
- \$5,250 for Level 2 Transportation
- \$7,875 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.

## ***Provider Qualifications***

Providers must meet the following criteria:

- Be enrolled in the IHCP as an active Medicaid provider.
- Be DDRS-approved.
- Comply with 460 IAC 6, including but not limited to:
  - 460 IAC 6-10-5 Criminal Histories
  - 460 IAC 6-12 Insurance
  - 460 IAC 6-11 Provider Financial Status
  - 460 IAC 6-5-30(b)
  - 460 IAC 6-34 Transportation Services requirements
  - 460 IAC 6-14-5 Direct Care Staff qualifications
  - 460 IAC 6-14-4 Staff Training
- Comply with any applicable BDDS service standards, guidelines, policies and/or manuals, including this module and the DDRS BDDS policies.

## **Section 10.28: Workplace Assistance**

### ***Service Definition***

Workplace Assistance services provide a range of personal care services and/or supports during paid competitive community employment hours and in a competitive community employment setting to enable waiver 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.

#### **Additional Information**

- Workplace Assistance services are available under the FSW and the CIH Waiver.
- May have been used in conjunction with SEFA services until June 30, 2015, and may be used in conjunction with Extended Services from July 1, 2015, forward.
- May be used with each hour the participant is engaged in paid competitive community employment, including employment hours overlapping with Extended Services.

## ***Reimbursable Activities***

Reimbursable activities under Workplace Assistance include the following:

- Direct 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 Supported Employment Follow-Along (SEFA) (until June 30, 2015)/Extended Services (from July 1, 2015 forward)
- May be used with each hour the participant is engaged in paid competitive community employment

## ***Service Standards***

The following service standards apply to Workplace Assistance:

- Workplace Assistance services must be reflected in the PC/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 the following:

- Services must be outlined in the PC/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
  - IHCP Member ID (also known as 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, 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 documentation 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 the document library of the State's case management system by the chosen service provider on or before the 15th day of the following month.

## ***Limitations***

The following are limitations on Workplace Assistance services:

- Allowed Ratio – Individual, one client to one staff.
- Reimbursement for Workplace Assistance services is available only during the 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, 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 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)

## ***Provider Qualifications***

Providers must meet the following criteria:

- Be enrolled in the IHCP as an active Medicaid provider
- Be DDRS-approved
- Comply with 460 IAC 6, including but not limited to:
  - 460 IAC 6-10-5 Criminal Histories

- 460 IAC 6-12 Insurance
- 460 IAC 6-11 Financial Status of Providers
- 460 IAC 6-14-5 Direct Care Staff Qualifications
- 460 IAC 6-14-4 Staff Training
- 460 IAC 6-34 Transportation Services requirements
- Comply with any applicable BDDS service standards, guidelines, policies and/or documents, including this module and the DDRS BDDS policies.

## Section 10.29: Case Management

### ***Service Definition***

Case Management services are 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, emotional/spiritual and other services, regardless of the funding source, paid or unpaid, for the services to which access is gained. Case Management services must be reflected in the PC/ISP and must address needs identified using Essential Lifestyle Planning, Personal Futures Planning, MAPS, PATH, LifeCourse Tools or an equivalent person-centered planning tool.

Case Management services include:

- Annual Planning and Assessment – Annual activities that support the individual in establishing an annual PC/ISP, developing a budget in support of their PC/ISP, and in establishing their eligibility for waiver services
- Ongoing Case Management Support – Services that monitor implementation of the participant’s PC/ISP and provide for regular review and modification with the individual and the Individual Support Team

#### **Additional Information**

- Case Management services are required under both the FSW and the CIH Waiver.

### ***Reimbursable Activities***

Reimbursable activities under Case Management services include the following:

- Annual Planning and Assessment:
  - Based on the principles of person-centered thinking and supported by information provided by the participant, as well as formal and informal assessments completed by providers, health professionals, and other individuals supporting the individual
  - Annual Planning and Assessment includes:
    - Annual development and update of the PC/ISP using Essential Lifestyle Planning, Personal Futures Planning, MAPS, PATH, LifeCourse Tools, or an equivalent person-centered planning tool
    - Ensuring the participant directs their annual PC/ISP meeting to the maximum extent possible, and is enabled to make informed choices and decisions
    - Assessing, identifying and addressing risks as part of the annual PC/ISP development
    - Developing an annual POC/CCB that is consistent with the participant’s PC/ISP and using the State-approved process
    - Completing and processing the annual level of care (LOC) determination

- Annual Planning and Assessment is reimbursed based on a milestone for the following completed on an annual basis:
  - LOC assessment
  - PC/ISP
  - POC/CCB
- Annual Planning and Assessment is limited to one unit per calendar year unless otherwise approved by the DDRS.
- Ongoing Case Management Support:
  - Based on the principles of person-centered thinking
  - Driven by the PC/ISP and primarily focused on ensuring that the PC/ISP is being implemented consistently with the participant's needs and preferences
  - The focus on person-centeredness is accomplished by:
    - Regularly reviewing and updating the PC/ISP using the person-centered planning process, documenting progress toward outcomes and any changes or modifications within the PC/ISP
    - Convening team meetings at least semiannually and as needed or determined by the individual/guardian or other team members to review progress toward outcomes identified within the PC/ISP and any other issues needing consideration in relation to the participant
    - Assessing, identifying and addressing risks when there is a change in the participant's status or new, relevant information is obtained about the participant
    - Conducting face-to-face contacts with the individual (and family members, as appropriate) at least once every 90 days and as needed to monitor implementation of the PC/ISP, to obtain feedback from the participant, to ensure the participant's health and welfare and to address any reported problems or concerns
      - At least one visit each year should be held in the home of the waiver participant.
      - For individuals residing in provider owned, controlled, or operated (POCO) settings (as defined by the Centers for Medicare & Medicaid Services [CMS] and DDRS), Case Managers must ensure at least one visit each year is unannounced.
    - Updating POC/CCB and timely submission of budget requests consistent with the participant's PC/ISP and using the State-approved process
    - 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 PC/ISP
    - Monitoring participants' health and welfare
    - Monitoring participants' satisfaction and service outcomes
    - 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 oversight and monitoring by the Case Management agency
    - Completing case notes and necessary PC/ISP revisions documenting each encounter with or on behalf of the participant within 7 calendar days of the event or activity
    - Completing and processing the Monitoring Checklist
    - Disseminating information including all Notices of Action and forms to the participant and the IST
    - Maintaining files in accordance with State standards
- Case Management services may be available during the last 180 consecutive days of a Medicaid eligible individual's institutional stay to allow case management activities to be performed specifically related to transitioning the individual from an institutional setting which include the following: nursing facility, extensive special needs group home, state psychiatric facility, intermediate care facility for individuals with intellectual disabilities (ICF/IID) to DDRS HCBS services. The individual must be approved for Medicaid waiver services and fully transitioned into a



DDRS HCBS waiver setting for case management to be billed. If the individual dies during the transition process, billing can still be an option.

- The need for the transitional service should be clearly outlined and documented in the PC/ISP.
- Ongoing Case Management Support is reimbursed on a monthly rate.
- At least one monthly case note documenting an encounter with or on behalf of the individual must be recorded to support billing for On-Going Case Management Support.

## ***Activities Not Allowed***

The Case Management entity (provider agency) may not own or operate another waiver service agency, nor may the Case Management entity (provider agency) be an approved provider of any other waiver service or otherwise have a financial investment in 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 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:

- Perform the activities listed in the [Reimbursable Activities](#) section.
- Case Managers must understand, maintain, and assert that the Medicaid program functions as the payer of last resort. The role of the Case Manager includes care planning, service monitoring, working to cultivate and strengthen informal and natural supports for each 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 BDDS-approved training entity or person; observed a facilitation; and participated in a person-centered planning meeting prior to leading an IST.
- At minimum, the Case Management 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' 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 PA of the monthly Case Management service unit will be sent from the administrative agency (DDRS) to the contractor of the Medicaid Management Information System (MMIS). Therefore, it is *recommended* that transitions from one Case Management 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 7 calendar days of an activity or event.

## ***Provider Qualifications***

Case Management service agencies/companies must meet the following criteria:

- Be enrolled in the IHCP as an active Medicaid provider.
- Be DDRS-approved.
- Comply with 460 IAC 6, including but not limited to:
  - 460 IAC 6-10-5 Criminal Histories
  - 460 IAC 6-11 Financial Status of Providers
  - 460 IAC 6-12 Insurance
  - 460 IAC 6-19 Case Management
- Comply with any applicable BDDS service standards, guidelines, policies and/or documents, including this module and the DDRS BDDS policies.
- Obtain/maintain accreditation (specific to Indiana programs) by at least one of the following organizations:
  - The CARF or its successor
  - The CQL or its successor
  - The JCAHO or its successor
  - The National Committee for Quality Assurance or its successor
  - The ISO-9001 human services QA system
  - The Council on Accreditation or its successor
  - An independent national accreditation organization approved by the secretary
- Carry professional liability insurance on all Case Managers hired by the agency.
- Employ or contract with at least one registered nurse who obtains/maintains valid Indiana licensure.
- Retain at least two full-time certified Case Managers within the organizational structure to submit an application and receive approval as a DDRS-approved provider of Case Management services.
- Require initially and annually, that each Case Manager employed by the DDRS-approved Case Management agency obtain certification/proof of competency demonstrated through successful

completion of the BDDS-approved Case Management training curriculum, attaining a test score no lower than 80%.

- Ensure, ongoing, that criminal background checks are conducted for every employee/partner hired or associated with the approved Case Management provider agency.
- Retain at least one full-time compliance officer to actively monitor all areas of compliance.
- Be approved by the DDRS and in ongoing compliance with any applicable BDDS service standards, guidelines, policies and/or documents, including minimum qualifications of Case Managers. Case Management minimum qualifications state that all Case Managers providing services must comply with one or more of the following qualifications:
  - Hold a bachelor’s degree in one of the following specialties from an accredited college or university:
    - Social work
    - Psychology
    - Sociology
    - Counseling
    - Gerontology
    - Nursing
    - Special education
    - Rehabilitation
    - Or related degree if approved by the DDRS or OMPP representative
  - Be a registered nurse with one year experience in human services.
  - Hold a bachelor’s degree in any field with a minimum of 1 year full-time, direct experience working with persons with intellectual/developmental disabilities.
  - Hold a master’s degree in a related field may substitute for required experience.
- The Case Manager must meet the requirements for a qualified intellectual disability professional in *42 CFR 483.430(a)*.
- Provide and maintain a 24/7 emergency response system that does not rely upon the area 911 system and provides assistance to all waiver participants. The 24/7 line staff must assist participants or their families with addressing immediate needs and contact the participant’s Case Manager to ensure arrangements are made to address the immediate situation and to prevent reoccurrences of the situation.
- Maintain sufficient technological capability to submit required data electronically in a format and through mechanisms specified by the State.
- Electronically enter all case information at the frequency specified by the State.
- Ensure each Case Manager is properly equipped to conduct onsite processing and person-centered planning.
- Ensure each Case Manager is properly equipped to conduct two-way mobile communications and is accessible as needed to the participants he or she serves (has a cell phone, smart phone, or other similar equipment).
- Maintain a sufficient number (no fewer than two) of qualified Case Managers in the approved service area.
- Ensure that Case Managers are trained in the person-centered planning process.
- Ensure that Case Managers meet with their participants on a regular basis to develop and support the execution of individualized service plans.
- Have a mechanism for monitoring the quality of services delivered by Case Managers and reporting on and addressing any quality issues that are discovered.

- All DDRS-approved Case Management agencies specifically agree to comply with the provisions of the *Americans with Disabilities Act of 1990* (42 U.S.C. 12101 et seq. and 47 U.S.C. 225).
- Have the capability to effectively and efficiently communicate with each participant by whatever means is preferred by the participant, including accommodating participants with Limited English Proficiency (LEP).
- Case Managers shall have the ability to identify or assess potential cultural barriers that may exist for participants in accessing services and supports and work to ensure participants' culture and value are respected and included in the person-centered planning process.
- Application for a survey through the accrediting entity for a new service must be submitted within 1 year of receiving approval.
- The agency must submit to the BDDS proof of application for an accreditation survey (specific to Indiana programs), and a copy of the letter from the accrediting entity indicating accreditation for a one to 3-year period.
- Comply with Indiana's conflict-free Case Management policy, which 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.
  - Authorized to make financial or health-related decisions on behalf of the participant.

## Section 10.30: Participant Assistance and Care

### ***Service Definition***

Participant Assistance and Care services are provided to allow participants (individuals) with intellectual/developmental disabilities to remain and live successfully in their own homes, function and participate in their communities, and avoid institutionalization. PAC services support and enable the 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.

**Additional Information**

- Participants will use any appropriate services available under the Indiana Medicaid State Plan.
- Utilization of PAC services does not prohibit the use of any other service available under the FSW that is outlined on the PC/ISP.
- PAC services are available only under the FSW. PAC is not available under the CIH Waiver.

**Reimbursable Activities**

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

- Activities may include any task or tasks of direct benefit to the 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 to claim reimbursement)

**Service Standards**

The following service standards apply to Participant Assistance and Care:

- PAC services must follow a written POC addressing the specific needs determined by the participant's assessment and identified in the PC/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 paid staff members as well as the date and start/stop time of each waiver-funded shift
- Documentation in compliance with *460 IAC 6*

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

## ***Limitations***

The following are limitations on Participant Assistance and Care services:

- Parent(s), stepparent(s) and legal guardians may not be paid to provide care to minor children while other relatives (defined in this section) 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 (defined in this section) 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 (defined in previous section) 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 (defined in previous section) 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

### ***Provider Qualifications***

Providers must meet the following criteria:

- Be enrolled in the IHCP as an active Medicaid provider.
- Be DDRS-approved.
- Comply with 460 IAC 6, including but not limited to:
  - 460 IAC 6-10-5 Criminal Histories
  - 460 IAC 6-11 Financial Status
  - 460 IAC 6-12 Insurance
  - 460 IAC 6-14-4 Staff Training
  - 460 IAC 6-14-5 Direct Care Staff Qualifications
- Have training in completion of task list
- Comply with any applicable BDDS service standards, guidelines, policies and/or documents, including this module and the DDRS BDDS policies.

## **Section 10.31: Structured Family Caregiving**

### ***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 nonfamily 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 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.

#### **Additional Information**

- SFC services are available only under the CIH Waiver. SFC is not available under the FSW.

### ***Service Levels and Rates***

There are three service levels of SFC, each with a unique rate. 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 PC/ISP

## ***Service Standards***

The following service standards apply to SFC:

- SFC services must be reflected in the PC/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 PC/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 SFC support services.
  - Maintain financial and service records to document services provided to the individual.
  - Establish a criteria for the acceptance of the family caregiver or foster parent, screen potential family caregivers/foster parents for qualities of stability, maturity, and experiences so as to ensure the safety and well-being of the individual, and obtain a criminal background and reference check.
  - Coordinate/provide adequate initial training and ongoing training, consultation, and supervision to the family caregiver/foster parent.
  - Provide for the safety and well-being of the 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 the family caregiver/foster parent.



## ***Documentation Standards***

SFC services documentation must include:

- Written policies and procedures, including for screening and accepting family caregivers/foster parents
- Maintaining financial and service records to document services provided to the participant
- Documenting 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 the document library of the State's case management system by the chosen service provider on or before the 15th day of the following month.

## ***Documentation by Families***

Under SFC services, families must provide the following documentation:

- One dated entry per day detailing an issue concerning the participant
- The entry should detail any outcome-oriented activities, tying those into measurable progress toward the participant's outcome (as identified in the PC/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***

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 Support (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.

## ***Provider Qualifications***

Providers must meet the following criteria:

- Be enrolled in the IHCP as an active Medicaid provider.
- Be DDRS-approved.
- Comply with 460 IAC 6, including but not limited to:
  - 460 IAC 6-10-5 Criminal Histories
  - 460 IAC 6-12 Insurance
  - 460 IAC 6-11 Provider Financial Status
  - 460 IAC 6-5-3 Adult Foster Care qualifications
  - 460 IAC 6-14-5 Direct Care Staff qualifications
  - 460 IAC 6-14-4 Staff Training
- Comply with any applicable BDDS service standards, guidelines, policies and/or documents, including this module and the DDRS BDDS policies.
- Where licensure is required, providers rendering waiver funded services must obtain/maintain Indiana-specific licensure.

## **Section 10.32: Wellness Coordination**

### ***Service Definition***

Wellness Coordination services means the development, maintenance, and routine monitoring of the waiver participant's Wellness Coordination Plan and the medical services required to manage his or her health care needs. A Comprehensive Medical Risk Plan may substitute for the Wellness Coordination Plan or individual risk plans.

Wellness Coordination services extend beyond those services provided through routine doctor/healthcare visits required under the Medicaid State Plan and are specifically designed for participants requiring the assistance of an RN or LPN to properly coordinate their medical needs. The following levels of support have these requirements:

- Tier I: Healthcare needs require a face-to-face visit once a month with an RN or LPN and consultations/reviews based on the individual's current healthcare needs.
- Tier II: Healthcare needs require a face-to-face visit twice a month with an RN or LPN and consultations/reviews based on the individual's current healthcare needs.
- Tier III: Healthcare needs require a face-to-face visit once a week with an RN or LPN and consultations/reviews based on the individual's current healthcare needs.

### ***Conditions and Requirements***

Necessity for Wellness Coordination services will typically be reserved for 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 PC/ISP.
- The member has a wellness coordination plan.

## ***Reimbursable Activities***

Coordination of Wellness Services by the Wellness Coordinator, who must be an RN or LPN, must include, but is not limited to the following:

- Completion of risk assessment information gathered by the IST and documented by the Case Manager in the PC/ISP
- Development, oversight, and maintenance of a Wellness Coordination Plan, while noting that a Comprehensive Medical Risk Plan may substitute for the Wellness Coordination Plan or individual risk plans
- Development, oversight, and maintenance of the Medical Risk Plan, which includes:
  - Determination of the appropriate mode of training to be used for the direct support professional to ensure implementation of risk plans, noting that training may be by staff trained by the RN or LPN with the exception of nursing delegated tasks or other items the nurse feels that only a licensed nurse should train
  - Ensuring the completion of training of direct support professionals to ensure implementation of risk plans
  - Consultation with the individual's healthcare providers
  - Face-to-face consultations with the individual as described in the support plan based on tier level
  - Consultation with the individual's support team
  - Active involvement at annual team meetings (and any additional team meetings if an individual is having a medical concern or a health and safety issue that the IST needs to address), reporting on the Wellness Coordination Plan as it relates to the individual's full array of services as listed in the PC/ISP

## ***Limitations***

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 is not available under the following circumstances:

- The individual does not require Wellness Coordination services.
- Services are furnished to a minor by a parent(s), stepparent(s), or legal guardian.
- Services are furnished to a participant by the participant's spouse.

## **Documentation Standards**

Wellness Coordination services documentation standards are as follows:

- Wellness Coordination services must be documented in agency files:
  - Weekly consultations/reviews
  - Face-to-face visits with the individual
  - Other activities, as appropriate
- Services must address needs identified in the person centered planning process and be outlined in the PC/ISP.
- The provider of Wellness Coordination will provide a written report to pertinent parties at least quarterly. (“Pertinent parties” include the individual, guardian, BDDS service coordinator, and waiver Case Manager.)
- As applicable, monthly/quarterly reports must be uploaded to the document library of the State’s case management system by the chosen service provider on or before the 15th day of the following month.
- Within the Wellness Coordination Plan, the provider must document what level of consultation/visits has been deemed necessary or appropriate for the individual.

## **Provider Qualifications**

Providers must meet the following criteria:

- Be enrolled in the IHCP as an active Medicaid provider.
- Be DDRS-approved.
- Comply with *460 IAC 6*, including but not limited to:
  - *460 IAC 6-10-5* Criminal Histories
  - *460 IAC 6-12* Insurance
  - *460 IAC 6-11* Financial Status of Providers
  - *460 IAC 6-14-5* Direct Care Staff Qualifications
  - *460 IAC 6-14-4* Staff Training
  - *460 IAC 6-5-14* Health Care Coordination Services\*\* provider qualifications

\*\*Wellness Coordination is referred to as Health Care Coordination within *460 IAC 6*
- Comply with any applicable BDDS service standards, guidelines, policies and/or documents, including this module and the DDRS BDDS policies.
- Where licensure/certification is required, providers rendering waiver funded services must obtain/maintain Indiana-specific licensure/certification:
  - For an RN, meet requirements set forth in *IC 25-23-1*
  - For an LPN, meet requirements set forth in *IC 25-23-1* and working under the supervision of an RN

## Section 10.33: Extended Services

### ***Service Definition***

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

The initial job placement, training, 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 (see the [Provider Qualifications](#) section).

Ongoing employment support services are identified in the participants' PC/ISP 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.

#### **Additional Information**

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

### ***Reimbursable Activities***

Reimbursable activities include the following:

- Ensuring that natural supports at the worksite are secured through interaction with supervisors and staff (A tangible outcome of this activity would be a decrease in the number of hours of Extended Services an individual accessed over time.)
- Training for the 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
- Travel by the provider to the worksite as part of the delivery of this service

Individual (one-on-one) services can be billed in 15 minute increments. For Extended Services provided in a group setting, reimbursement equals the unit rate divided by the number of individuals served.

With the exception of 1:1 on-the-job coaching, support, and observation, the potential exists for all components of the Extended Services service definition to be applicable to either 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.

### ***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 individual's PC/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 PC/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
- IHCP Member ID (also known as RID) 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 documentation may reside in multiple locations but must be clearly and easily linked to the individual or the standard will not be met.

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

## ***Limitations***

Group services may only be rendered at the discretion of the IST and in group sizes no greater than four individuals to one staff. In addition, the provider must be able to provide appropriate documentation, as outlined under [Documentation Standards](#) for Extended Services, demonstrating that the ratio for each claimed time frame of services did not exceed the maximum allowable ratio determined by the IST for each group 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 PC/ISP
- Payment for supervisory activities rendered as a normal part of the business setting
- Services provided to a minor by a parent(s), step-parent(s), or legal guardian, or spouse
- Waiver funding for the provision of vocational services delivered in facility-based or sheltered work settings, where individuals are supervised for the primary purpose of producing goods or performing services
- Provision of transportation
- Group supports delivered to individuals who are using different support options (For example, one individual in the group is using Extended Services and another individual in the same group setting is using Facility-Based Habilitation.)

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

## **Provider Qualifications**

Providers must meet the following criteria:

- Be enrolled in the IHCP as an active Medicaid provider.
- Be DDRS-approved.
- Comply with 460 IAC 6, including but not limited to:
  - 460 IAC 6-10-5 Criminal Histories
  - 460 IAC 6-12 Insurance
  - 460 IAC 6-11 Financial Status of Providers
  - 460 IAC 6-14-5 Direct Care Staff Qualifications
  - 460 IAC 6-14-4 Staff Training
- Comply with any applicable BDDS service standards, guidelines, policies and/or documents, including this module and the DDRS BDDS policies.
- Obtain/maintain accreditation (specific to Indiana programs) by at least one of the following organizations:
  - The CARF or its successor
  - The CQL or its successor
  - The JCAHO or its successor
  - The National Committee for Quality Assurance or its successor
  - The ISO-9001 human services QA system
  - The Council on Accreditation or its successor
  - An independent national accreditation organization approved by the secretary
- To be eligible to perform this service, meet the standards as a Community Rehabilitation Provider as outlined in IC 12-12-1-4.1.

## **Section 10.34: Residential Habilitation and Support – Daily (RHS Daily)**

### ***Service Definition – Available Only on CIH Waiver***

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 the following criteria are eligible for and may choose to use RHS Daily services:

- Individuals who have an Algo score of 3, 4, or 5 on their Objective Based Allocation (OBA)
- Individuals who are living with housemates and are using a shared staffing model
- Individuals who are living outside their family home

## Algo Level Descriptors

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 (ICAP) was selected to be the primary tool for individual assessment.

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

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

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

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

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

See [Section 6: Objective-Based Allocation](#) of this module for further details.

**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 nonpaid (natural support) supports versus paid staff.

- Working with the participant to meet the goals they have set for themselves on their PC/ISP
- Training the participant to enhance their homemaking skills, meal preparation, household chores, money management, shopping, communication skills, social skills, and positive behavior
- Provision of transportation to fully participate in social and recreational activities in the community (such as transportation to church, the park, the library, the YMCA, and classes)
- Provision of transportation to community employment and/or volunteer activities
- Coordination and facilitation of medical and wellness services to meet the healthcare and wellness needs, including physician consults, medications, implementation of risk plans, dining plans and wellness plans; maintenance of each participant's health record
- Electronic Monitoring only when billed as a component of RHS Daily (this service may not be billed concurrently with RHS Daily)

## ***Service Standards***

The following service standards apply to RHS Daily:

- Services must address needs identified in the person centered planning process and be outlined in the PC/ISP.
- RHS Daily should complement but not duplicate habilitation services provided in other settings.
- The individual must be present and receive RHS Daily services for at least a portion of any day the provider bills as a day of RHS Daily service.

## ***Documentation Standards***

A minimum of one daily note for each day the individual is present and receiving RHS Daily services, with appropriate elements, documenting one or more distinct actions or behaviors as outlined in the [Reimbursable Activities](#) section, per individual served is required to support the billing of RHS Daily Services. The RHS Daily Service provider must be able to demonstrate through relevant time keeping records or other similar documentation which staff members were working during the RHS Daily Service provided upon audit, or upon request by the State or its contracted agents.

RHS Daily documentation standards are as follows:

- Documentation of services rendered as outlined in the PC/ISP
- 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 healthcare professional, Case Manager, or BDDS staff member
- Documentation in compliance with *460 IAC 6*
- Quarterly summaries as specified by BDDS and monthly, quarterly, and/or annual outcome data as specified by BDDS

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

## Limitations

Reimbursable waiver funded 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 the [Activities Not Allowed](#) section for definition of relative.)

Additionally, the following limitations apply:

- 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 in the Electronic Monitoring [Service Standards](#) section.
- 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 nonbillable 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 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) (defined in this section) 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)

## ***Provider Qualifications***

Providers must meet the following criteria:

- Be enrolled in the IHCP as an active Medicaid provider.
- Be DDRS-approved.
- Comply with 460 IAC 6, including but not limited to:
  - 460 IAC 6-5-24 Qualifications for RHS
  - 460 IAC 6-10-5 Criminal Histories
  - 460 IAC 6-12 Insurance
  - 460 IAC 6-11 Financial Status of Providers
  - 460 IAC 6-14-5 Direct Care Staff Qualifications
  - 460 IAC 6-14-4 Staff Training
  - 460 IAC 6-5-14 Health Care Coordination Services provider qualifications, and
  - 460 IAC 6-34 Transportation Requirements
- Comply with any applicable BDDS service standards, guidelines, policies and/or documents, including this module and the DDRS BDDS policies.

Per House Enrolled Act 1360 (P.L.154-2012), *IC 12-11-1.1-1* is amended to state:

- Beginning July 1, 2012, the bureau shall ensure that an entity approved to provide Residential Habilitation and Support services under HCBS waivers is accredited by an approved national accrediting body. However, if an entity is accredited to provide HCBS under a subdivision other than Residential Habilitation and Support services, the bureau may extend the time that the entity has to comply with this subdivision until the earlier of the following:
  - The completion of the entity's next scheduled accreditation survey
  - July 1, 2015
- In accordance with the above citation from *IC 12-11-1.1-1*, RHS providers must obtain/maintain accreditation (specific to Indiana programs) by at least one of the following organizations:
  - The CARF or its successor
  - The CQL or its successor
  - The JCAHO or its successor
  - The National Committee for Quality Assurance or its successor
  - The ISO-9001 human services QA system
  - The Council on Accreditation or its successor
  - An independent national accreditation organization approved by the secretary



## Section 11: RFA Policies

---

The following policies address use of the required *Request for Approval to Authorize Services* (RFA) form for authorization of the Environmental Modification, Specialized Medical Equipment and Supplies, and Vehicle Modification services.

### Section 11.1: Environmental Modification Policy

#### Waiver Policy Notification

Authority: *Code of Federal Regulations 42 CFR 441.302*

Policy Topic: Environmental Modification Policy Clarification

Impacts the following Home and Community-Based Services (HCBS) waivers:

- Aged and Disabled (A&D) Waiver – Division of Aging
- Traumatic Brain Injury (TBI) Waiver – Division of Aging
- Community Integration and Habilitation (CIH) Waiver – Division of Disability and Rehabilitative Services (DDRS)

*Note: Not a covered service for the Family Supports Waiver (FSW) – DDRS.*

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 (for example, Specialized Medical Equipment and Supplies). In addition to the \$15,000 lifetime cap, \$500 is allowable annually for the repair, replacement, or an adjustment to an existing environmental modification that was funded by a 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 the *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 home modification bids must be obtained for all modifications over \$1,000.
- If three bids cannot be obtained, it must be documented to show what efforts were made to secure the three bids and explain why fewer than three bids were obtained (including provider name, dates of contact, response received).
- For modifications under \$1,000, one bid is required and pricing must be consistent with the fair market price for such modification(s).
- Bids must be itemized to include information shown in the example in Table 5.

Table 5 – Bid Itemization Example

Scope of work labor	Material	Related
Ramp 15" long	\$\$	\$\$
Widen front door to 36"	\$\$	\$\$
Widen bathroom door to 36"	\$\$	\$\$
Install ADA toilet	\$\$	\$\$
Building permits (specify)	\$\$	\$\$
<b>Total Cost:</b>	\$\$\$\$	\$\$\$\$

- Requests for modifications at two or more locations may only be approved at the discretion of the State division director or State agency designee.
- Requests for modifications may be denied if the State division director or State agency designee determines the documentation does not support residential stability and/or the service requested.



## ***Service Standards***

- Environmental Modification must be of direct medical or remedial benefit to the individual.
- To ensure that environmental modifications meet the needs of the individual and abide by established federal, state, local, and Family and Social Services Administration (FSSA) standards, as well as ADA requirements. When applicable, approved environmental modifications will include:
  - Assessment of the individual’s specific needs, conducted by an approved, qualified individual who is independent of the entity providing the environmental modifications
  - Independent inspections during, as well as at the completion of, the modification process, prior to authorization for reimbursement
- Modifications must meet applicable standards of manufacture, design, and installation.
- Modifications must be compliant with applicable building codes.

## ***Documentation Standards***

- The identified direct benefit or need must be documented within the following:
  - POC/CCB
  - Physician prescription and/or clinical evaluation as deemed appropriate
  - Person-Centered/Individual Support Plan (PC/ISP) if under the Community Integration and Habilitation (CIH) 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
  - Land survey if required when exterior modification(s) approach property line
  - Signed and approved RFA
  - Signed and approved POC/CCB
  - Receipts for all incurred expenses by service provider related to the modification
  - Anything needed to be in compliance with FSSA and Division-specific guidelines and/or policies

## ***Reimbursement***

Reimbursement is available for modifications that satisfy each of the following:

- Service and documentation standards outlined within this policy
- Allowable under current Medicaid waiver guidelines
- Not available under the *Rehabilitation Act of 1973*, as amended
- Included in the individual’s approved POC/CCB
- Authorized on the RFA and linked to the POC/CCB
- Included on a State-approved and signed Notice of Action (NOA)

- Completed by an approved Medicaid waiver service provider (who is approved to perform this service)
- Completed in accordance with the applicable building permits

### ***Modifications/Items – Covered***

Justification and documentation is required to demonstrate that the modification is necessary to meet the individual's identified needs:

- Adaptive door openers and locks – Limited to one per individual primary residence for an individual living alone or who is alone without a caregiver for substantial periods of time but has a need to open, close or lock the doors and cannot do so without special adaptation.
- Bathroom modification – Limited to one existing bathroom per individual primary residence when no other accessible bathroom is available. The bathroom modification may include:
  - Removal of existing bathtub, toilet and/or sink
  - Installation of roll in shower, grab bars, ADA toilet and wall mounted sink
  - Installation of replacement flooring, if necessary due to bath modification
- Environmental control units – Adaptive switches and buttons to operate medical equipment, communication devices, heat and air conditioning, and lights for an individual living alone or who is alone without a caregiver for a substantial portion of the day.
- Environmental safety devices limited to:
  - Door alarms
  - Anti-scald devices
  - Hand-held shower head
  - Grab bars for the bathroom
- Fence – Limited to 200 linear feet (individual must have a documented history of elopement).
- Ramp – Limited to one per individual primary residence, and only when no other accessible ramp exists:
  - In accordance with the ADA or ADAAG, unless this is not in the best interest of the client
  - Portable – Considered for rental property only
  - Permanent
  - Vertical lift – May be considered in lieu of a ramp if there is photographic and written documentation that shows it is not possible for a ramp to be used
- Stair lift – If required for access to areas of the home necessary to meet the direct medical or remedial benefit of the individual per POC/CCB (and PC/ISP under CIH Waiver).
- Single-room air conditioners/single- room air purifiers – If required for access to areas of the home necessary to meet the direct medical or remedial benefit of the individual per POC/CCB (and PC/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 plexiglass or other shatterproof material when there is a documented medical/behavioral reason(s).
- Upon the completion of the modification, painting, wall coverings, doors, trim, flooring, and so forth will be matched (to the degree possible) to the previous color/style/design.
- Maintenance – Limited to \$500 annually for the repair and service of environmental modifications that have been provided through a HCBS waiver:
  - Requests for service must detail parts cost and labor cost.
  - If the need for maintenance exceeds \$500, the Case Manager will work with other available funding streams and community agencies to fulfill the need. If service costs exceed the annual limit, those parts and labor costs funded through the waiver must be itemized clearly to differentiate the waiver service provision from those parts and labor funded through a nonwaiver funding source.
- Items requested which are not listed above, must be reviewed and decision rendered by the State division director or State agency designee.

### ***Modifications/Items – Noncovered***

Examples/descriptions of modifications/items not covered include, but are not limited to the following, 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 (for example, sinks, commodes, tub, wall, window and door coverings, and so forth) which replace existing standard (non-ADA or ADAAG) home fixtures
  - Roof repair
  - Structural repair
  - Garage doors
  - Elevators
  - Ceiling track lift systems
  - Driveways, decks, patios, sidewalks, household furnishings
  - Replacement of carpeting and other floor coverings
  - Storage (for example, cabinets, shelving, closets), sheds
  - Swimming pools, spas, or hot tubs
  - Video monitoring system
  - Adaptive switches or buttons to control devices intended for entertainment, employment, or education
  - Home security systems
- Modifications that create living space or facilities where they did not previously exist (for example, installation of a bathroom in a garage/basement, and so forth)
- Modifications that duplicate existing accessibility (for example, second accessible bathroom, a second means of egress from home, and so forth)

- Modifications that will add square footage to the home
- Completion of, or modifications to, new construction or significant remodeling/reconstruction unless there is documented evidence of a significant change in the individual's medical or remedial needs that now require the requested modification
- Individuals living in foster homes, group homes, assisted living facilities, or homes for special services (any licensed residential facility) (*Note: The responsibility for environmental modifications rests with the facility owner or operator.*)
- Individuals living in a provider owned residence (*Note: The responsibility for environmental modifications rests with the facility owner or operator.*)

### ***Decision-Making Authority***

Each division, with approval from the FSSA Office of the Secretary, shall identify designees to render decisions based on the articles in this policy. The designees are responsible for preparing and presenting testimony for all fair hearings – see [Section 8: Appeal Process](#). The Case Management entity, working as an agent of the State, shall not attend fair hearings in opposition of the State, unless requested by the individual when there is no other advocate to represent the individual at the hearing. If the Case Manager does attend the hearing, working as an agent of the State, he or 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, explaining his or her role at the hearing.

Each division shall implement a quality assurance plan. In the event of inappropriate authorizations being granted, any or all of the following actions may be required:

- A corrective action plan
- Reimbursement to Medicaid
- Loss of decision-making authority

## **Section 11.2: Specialized Medical Equipment and Supplies**

### **Waiver Policy Notification**

Authority: *42 CFR 441.302*

Policy Topic: Specialized Medical Equipment and Supplies Policy Clarification

Impacts the following HCBS waivers:

- Aged and Disabled (A&D) Waiver – Division of Aging
- Traumatic Brain Injury (TBI) Waiver – Division of Aging
- Community Integration and Habilitation (CIH) Waiver – 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 POC/CCB, which are necessary to assure the health, welfare, and safety of the individual, which enable the individual to function with greater independence in the home, and without which the individual would require institutionalization.

Under the FSW, a lifetime cap of \$7,500 is available for Specialized Medical Equipment and Supplies.

## **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 for the desired equipment or supplies through Indiana Medicaid State Plan, which may require prior authorization (PA):
  - There should be no duplication of services between HCBS waiver and Medicaid State Plan.
  - The refusal of a Medicaid vendor to accept the Medicaid reimbursement through the Medicaid State Plan is not a justification for waiver purchase.
  - Preference for a specific brand name is not a medically necessary justification for waiver purchase. Medicaid State Plan often covers like equipment but may not cover the specific brand requested. When this occurs, the individual is limited to the Medicaid State Plan covered service/brand.
  - Reimbursement is limited to the Medicaid State Plan fee schedule, if the requested item is covered under Medicaid State Plan.
  - See *Indiana Administrative Code 405 IAC 5-19* for additional information regarding Medicaid State Plan coverage. All requests for items to be purchased through a Medicaid waiver must be accompanied by documentation of Medicaid State Plan PA request and decision, if the requested item is covered under the State Plan.
- Specialized Medical Equipment and Supplies shall be authorized only when it is determined to be medically necessary and shall have direct medical or remedial benefit for the waiver individual. This determination includes the following considerations:
  - The request is the most cost effective or conservative means to meet the individual's specific needs.
  - The request is individualized, specific, and consistent with, but not in excess of, the individual's needs.
  - Three bids must be obtained for items over \$1,000.
  - If three bids cannot be obtained, it must be documented to show what efforts were made to secure the three bids and explain why fewer than three bids were obtained (including provider name, dates of contact, response received).
  - For requested items under \$1,000, one bid is required and pricing must be consistent with the fair market price.
  - Bids must be itemized to include a picture of the product and detailed product information, including make/model number of the item as shown in the example in Table 6.

Table 6 – Bid Itemization Example

Scope	Make/Model Number	Material
Adapted plates/bowls		\$\$
Interpreter service		\$\$
Wheelchair		\$\$
Portable generator		\$\$
<b>Total Cost:</b>		\$\$

- Requests will be denied if the State division director or State agency designee determines the documentation does not support the service requested.

### ***Service Standards***

- Specialized medical equipment and supplies must be of direct medical or remedial benefit to the individual.
- All items shall meet applicable standards of manufacture, design and service specifications.
- Under the FSW and CIH Waiver, requests for items over \$500 require that the individual first be evaluated by a qualified professional such as a physician, nurse, occupational therapist, physical therapist, speech and language therapist or rehabilitation engineer as required per the approved waiver.

### ***Documentation Standards***

Documentation standards include the following:

- The identified direct benefit or need must be documented within all the following:
  - POC/CCB
  - Physician prescription and/or clinical evaluation as deemed appropriate
  - PC/ISP under the FSW and CIH Waiver
- Medicaid State Plan prior authorization request and the decision rendered, if applicable
- Signed and approved *Request for Approval to Authorize Services* (RFA)
- Signed and approved POC/CCB
- Provider of services must maintain receipts for all incurred expenses related to this service
- Must be in compliance with FSSA and Division-specific guidelines and/or policies

### ***Reimbursement***

Reimbursement is available for Specialized Medical Equipment and Supplies that satisfy each of the following:

- Service and documentation standards outlined within this policy
- Allowable under current Medicaid waiver guidelines
- Not available under the *Rehabilitation Act of 1973*, as amended
- Included in the individual's approved POC/CCB
- Authorized on the RFA and linked to the POC/CCB

- Included on a State-approved and signed NOA
- Completed by an approved Medicaid waiver service provider (that is approved to perform this service)

### ***Items – Covered***

Justification and documentation is required to demonstrate that the request is necessary to meet the individual's identified needs.

- Communication Devices – Computer adaptations for keyboard, picture boards, and so forth.
- RFA must be accompanied by documentation of Medicaid State Plan PA request and decision rendered under Medicaid State Plan.
- Generators (portable) – When either ventilator, daily use of oxygen via a concentrator, continuous infusion of nutrition (tube feeding), or medication through an electric pump are medical requirements of the individual. The generator is limited to the kilo-wattage necessary to provide power to the essential life-sustaining equipment, and is limited to one generator per individual per 10-year period.
- Interpreter service – Provided in circumstances where the interpreter assists the individual in communication during specified scheduled meetings for service planning (for example, waiver case conferences, team meetings) and is not available to facilitate communication for other service provision.
- Self-help devices – Including over the bed tables, reachers, adaptive plates, bowls, cups, drinking glasses and eating utensils that are prescribed by a physical therapist or occupational therapist.
- Strollers – When needed because individual's primary mobility device does not fit into the individual's vehicle/mode of transportation, or when the individual does not require the full time use of a mobility device, but a stroller is needed to meet the mobility needs of the individual outside of the home setting. 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 nonwaiver 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 – Noncovered***

The following items and equipment are not covered:

- Hospital beds, air fluidized suspension mattresses/beds
- Therapy mats
- Parallel bars
- Scale
- Activity streamers
- Paraffin machines or baths
- Therapy balls
- Books, games, toys
- Electronics – such as CD players, radios, cassette players, tape recorders, televisions, VCRs and DVDs, cameras or film, videotapes, and other similar items
- Computers and software
- Adaptive switches and buttons
- Exercise equipment such as treadmills or exercise bikes
- Furniture
- Appliances – such as refrigerator, stove, hot water heater
- Indoor and outdoor play equipment such as swing sets, swings, slides, bicycles adaptive tricycles, trampolines, play houses, merry-go-rounds
- Swimming pools, spas, hot tubs, portable whirlpool pumps
- Tempur-Pedic mattresses, positioning devices, pillows
- Bathtub lifts
- Motorized scooters
- Barrier creams, lotions, personal cleaning cloths
- Totally enclosed cribs and barred enclosures used for restraint purposes
- Medication dispensers
- Any equipment or items that can be authorized through Medicaid State Plan
- Any equipment or items purchased or obtained by the individual, his or her family members, or other nonwaiver providers



*Note: In rare circumstances, a new or unanticipated item may be presented for consideration as a covered item under this service. Prior to submission of an RFA for this item, a written proposal justifying the need for this item must be sent to the FSSA OMPP for submission to the FSSA Policy Governance Board for consideration and determination of appropriateness as a covered item. The written proposal should be directed to:*

**Director of Agency Coordination and Integration**  
Office of Medicaid Policy and Planning  
402 W. Washington St., Room W374  
Indianapolis, IN 46204-2739

*These requests should be extremely rare and should not include items on the noncovered list, which have been previously vetted at the State, and determined to be noncovered items.*

### ***Decision-Making Authority***

- Each division, with approval from the FSSA Office of the Secretary, shall identify a designee(s) to render decisions based upon the articles within this policy.
- The designee(s) is responsible for preparing and presenting testimony for all Fair Hearings.
- The Case Management entity, working as an agent of the State, shall not attend Fair Hearings in opposition of the State, unless requested by the individual when there is no other advocate to represent the individual at the Hearing. If the Case Manager does attend the Hearing; working as an agent of the State, 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 or 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 HCBS waivers:

- Aged and Disabled (A&D) Waiver – Division of Aging
- Traumatic Brain Injury (TBI) Waiver – Division of Aging
- Community Integration and Habilitation (CIH) Waiver – 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 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 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 A&D, CIH, and TBI waivers. Under the FSW, a lifetime cap of \$7,500 is available for Specialized Medical Equipment and Supplies, 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 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 an 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 10 years old and has less than 100,000 miles on the odometer.
    - If the vehicle is more than 5 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 modification bids must be obtained for all modifications over \$1,000.

- If three bids cannot be obtained, it must be documented to show what efforts were made to secure the three bids and explain why fewer than three bids were obtained (for example, provider name, dates of contact, response received).
- For modifications under \$1,000, one bid is required and pricing must be consistent with the fair market price for such modification (s).
- All bids must be itemized to include the items as shown in the example in Table 7.

Table 7 – Bid Itemization Example

Make: _____ Model: _____ Mileage: _____ Year: _____		
Scope of work	Materials Cost	Related Labor
Lift	\$\$	\$\$
Tie down	\$\$	\$\$
<b>Total Cost:</b>	\$\$\$\$	

- 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 CIH Waiver, requests for items over \$500 require that the individual first be evaluated by a qualified professional such as a physician, nurse, occupational therapist, physical therapist, speech and language therapist, or rehabilitation engineer as required per the approved waiver.

### ***Documentation Standards***

- The identified direct benefit or need must be documented within all the following:
  - POC/CCB
  - Physician prescription and/or clinical evaluation as deemed appropriate
  - Person-Centered/Individual Support Plan (PC/ISP) if under the FSW and CIH Waiver
- Documentation/explanation of service within the *Request for Approval to Authorize Services* (RFA) must include:
  - Ownership of vehicle to be modified or vehicle owner’s relationship to the individual and the following information:
    - Make, model, mileage, and year of vehicle to be modified
    - Signed and approved RFA
    - Signed and approved POC/CCB
    - Receipts for all incurred expenses related to the modification
    - Any documentation needed to be in compliance with FSSA and Division-specific guidelines and/or policies

## ***Reimbursement***

Reimbursement is available for modifications that satisfy each of the following:

- Service and documentation standards outlined within this policy
- Allowable under current Medicaid waiver guideline
- Not available under the *Rehabilitation Act of 1973*, as amended
- Included in the individual's approved POC/CCB
- Authorized on the RFA and linked to the POC/CCB
- Included on a State-approved and signed NOA
- Completed by an approved Medicaid waiver service provider (that is approved to perform this service)

## ***Modifications/Items – Covered***

Justification and documentation is required to demonstrate that the modification is necessary to meet the individual's identified need(s) for the following:

- Wheelchair lifts
- Wheelchair tie-downs (if not included with lift)
- Wheelchair/scooter hoist
- Wheelchair/scooter carrier for roof or back of vehicle
- Raised roof and raised door openings
- 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 nonwaiver funding source.

Items requested that are not listed above must be reviewed and decision rendered by the State division director or State agency designee.

## ***Modifications/Items – Noncovered***

Examples/descriptions of modifications/items not covered include, but are not limited to, the following:

- 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
- Driver's 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 FSSA Office of the Secretary, shall identify a designee(s) to render decisions based upon the articles within this policy.
- The designee(s) is responsible for preparing and presenting testimony for all fair hearings – see [Section 8: Appeal Process](#).
- The Case Management entity, working as an agent of the State, shall not attend Fair Hearings in opposition of the State, 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 or 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