INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Division of Disability, Aging and Rehabilitative Services

Home- and Community-Based Services Waivers

Note: For updates to the information in this module, see the following Indiana Health Coverage Programs (IHCP) bulletins, accessible from the IHCP Bulletins webpage at in.gov/medicaid/providers:

- *BT2026155 – IHCP updates billing requirements for specific waiver services and specific vision services*
- *BT2026154 – IHCP announces BDS waiver case management service level agreement changes*
- *BT202687 – IHCP announces document delivery requirements for Medicaid HCBS waiver providers*
- *BT202623 – FSSA announces an update on the Medicaid HCBS FS and CIH waiver capacity*
- *BT202614 – CMS approves waiver amendment for Medicaid HCBS H&W and TBI waivers*
- *BT202613 – CMS approves waiver amendment for Medicaid HCBS CIH waiver*
- *BT202612 – CMS approves waiver amendment for Medicaid HCBS Family Supports waiver*
- *BT202609 – OMPP further clarifies TB test requirements for direct care HCBS, adding SFC to example list*
- *BT202606 – BDS establishes transition process from Supervised Group Living settings to CIH Waiver*
- *BT202603 – FSSA implements extraordinary care allowance for Attendant Care and Participant Assistance and Care*
- *BT202602 – FSSA provides information about Short-Term Budget Requests for the CIH Medicaid waiver*
- *BT2025190 – IHCP revises previously announced changes to HCBS assisted living billing policy*
- *BT2025173 – IHCP updates the billing policy for HCBS assisted living providers*
- *BT2025169 – IHCP and DDARS announce changes to waiver services, effective Jan. 1, 2026*
- *BT2025168 – Behavioral Support Services has new documentation requirements beginning Dec. 31*

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Section 1: Roles and Responsibilities

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

Section 1.1: Centers for Medicare & Medicaid Services

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

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

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

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

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

Section 1.2: FSSA Division of Disability, Aging and Rehabilitative Services

As a division of the Indiana Family and Social Services Administration (FSSA), the DDARS 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 Disabilities Services (BDS) is under the DDARS.

For more information, see the DDARS website at in.gov/fssa/ddars.

Section 1.3: Bureau of Disabilities Services

Within the DDARS, the BDS administers individualized, integrated community-based services for individuals with disabilities and their families, including four 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) or to a nursing facility (NF). The HCBS waiver programs provide services to individuals in a range of community settings, as an alternative to care in an ICF/IID or NF.

The HCBS waivers administered by the BDS, and corresponding LOC requirements, are as follows:

- **Community Integration and Habilitation (CIH) Waiver** – Requires an **ICF/IID** LOC determination
- **Family Supports (FS) Waiver** – Requires an **ICF/IID** LOC determination
- **Health and Wellness (H&W) Waiver** – Requires an **NF** LOC determination
- **Traumatic Brain Injury (TBI) Waiver** – Requires either an **ICF/IID** LOC *or* **an NF** LOC determination

> *Note: The FS and CIH waivers are governed by Indiana Administrative Code (IAC) 460 IAC 6, whereas the H&W and TBI waivers are governed by 455 IAC 2. Due to differences in the applicable administrative code requirements, minor differences exist between the two sets of waiver programs. Guidance unique to the H&W and TBI waiver programs is found in Section 11.*

The BDS has statutory authority over the state's home and community-based services for individuals of all ages with intellectual/developmental disabilities, and for individuals age 59 and under with physical disabilities. The BDS 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.

To ensure provision of services and supports statewide, the BDS has established eight BDS districts with nine offices serving specific regions in Indiana. The BDS service coordinators determine initial eligibility for intellectual/developmental disability services, including services that require an ICF/IID LOC determination. BDS service coordinators also determine a new "initial" ICF/IID LOC for individuals who have been terminated from the HCBS waiver program, but desire to return to waiver services within the same waiver year. (For information about obtaining an NF LOC determination, see *Section 11.1: Eligibility for H&W and TBI Waiver Services*.)

The BDS is also responsible for certifying providers to deliver FS and CIH waiver services, as described in *Section 2.1: Provider Application Process for FS and CIH Waivers*.

Additional information about the BDS is available on the *BDS* webpage at in.gov/fssa/ddars.

BDS Quality Assurance Services

Previously, the responsibility of the quality assurance belonged to the Bureau of Quality Improvement Services (BQIS), which has been integrated into BDS. The BDS is now responsible for developing and implementing quality improvement and quality assurance systems to assure the health and welfare of individuals receiving Medicaid HCBS waiver services, including the CIH, FS, H&W and TBI waivers. The oversight activities include the following:

- Developing policy
- Conducting case record reviews
- Investigating complaints

- Reviewing mortality
- Managing the state's automated system for reporting incidents of abuse, neglect and exploitation
- Assuring compliance with Indiana waiver regulations
- Researching best practices
- Conducting quality on-site provider reviews

Additional information about the BDS quality assurance services is available on the *BDS Quality Assurance* webpage at in.gov/fssa/ddars.

BDS Documentation Requests

Each individual's BDS documentation is housed within the state's case management system/document library and is the property of the state of Indiana. This information may not be shared with external entities without proper written consent, except as authorized by state and federal regulations. All entities that receive requests for an individual's BDS records must submit requests directly to the BDSdocumentationrequests@fssa.in.gov email inbox.

For information specific FS and CIH waiver case management organizations, see the *Documentation Request Guidance for Selected Contracting Case Management Organizations* section.

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

Section 1.4: FSSA Office of Medicaid Policy and Planning

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

The OMPP is also responsible for certifying providers to deliver services under the H&W and TBI waivers, as described in *Section 11.2: H&W and TBI Waiver Provider Certification, Enrollment and Responsibilities*.

Additional information about the OMPP is available on the Office of Medicaid Policy & Planning website at in.gov/fssa/ompp.

Section 1.5: 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 for programs including:

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

To receive CIH, FS, H&W or TBI waiver coverage, the individual must be determined eligible for and enrolled in Traditional Medicaid (fee-for-service full Medicaid coverage). For Medicaid eligibility requirements, see the *Eligibility Guide* webpage at in.gov/medicaid/members. Information about Traditional Medicaid, as well as the other healthcare programs offered through the IHCP – including the Healthy Indiana Plan (HIP), Hoosier Care Connect, Hoosier Healthwise, Indiana PathWays for Aging (PathWays) – is available from the *IHCP Programs and Services* webpage at in.gov/medicaid/providers. For more detailed information, see the *Member Eligibility and Benefit Coverage* provider reference.

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

Section 1.6: Waiver Service Providers

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 approval from the DDARS (for FS and CIH waiver providers) or OMPP (for H&W and TBI waiver providers), the provider must then enroll as a Medicaid provider with the Indiana Health Coverage Programs (IHCP), to qualify for reimbursement of services provided to HCBS waiver participants. Detailed instructions for these processes, as well as related waiver provider requirements and responsibilities, appear in *Section 2: Provider Information*.

Waiver providers must understand the service definitions and parameters for each service authorized on a participant's service authorization. All waiver providers are subject to audit and potential recoupment if the services provided are not in agreement with the services authorized as indicated on the approved service authorization. If the needs of a member change, the provider must contact the case manager to discuss revising the service plan.

Providers of the H&W and TBI waivers are required to furnish at least 30 calendar days' written notice before terminating waiver services to a member. Providers of the FS and CIH waivers are required to furnish at least 60 calendar days' written notice before terminating waiver services to a member. This notice must be made to the member, legal representative (if applicable), member's case manager and the DDARS BDS.

Selected Contracting Case Management Organizations (For FS and CIH Waivers)

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

- Implementing the recently enhanced person-centered planning process
- Helping the individual identify members of the Individualized Support Team (IST)
- Developing and submitting to the state the service plan known as the plan of care/service plan
- Developing a person-centered individualized support plan (PCISP)

Case management providers often refer to themselves as *case management organizations*, using the acronym CMOs. Specific responsibilities of the case management provider, including monitoring activities, are described in *Section 9.6: Case Management for FS and CIH Waivers*.

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

> *Note: Section 11.5: Care Coordination for H&W and TBI Waivers outlines care coordination requirements for individuals served by the H&W or TBI waiver programs.*

Documentation Request Guidance for Selected Contracting Case Management Organizations

With the exception of BDS records, case managers are specifically required to disseminate information, such as PCISPs and Notices of Action, to individuals (or the parents of minor children or legal representatives, as applicable), as outlined in *Section 9.6: Case Management for FS and CIH Waivers*. BDS records may not be shared by case managers.

If selected contracting case management organizations or their case managers receive requests from external entities for BDS records, the requesting entity should be referred to the FSSA BDS Documentation Requests email inbox at BDSdocumentationrequests@fssa.in.gov.

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

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

- ***Subpoenas*** – If the case management organization receives a subpoena, the case manager shall:
  - Review the BDS Portal to ensure all profile information, including legal status, is correct and up to date.
  - Submit the original request for documentation, including the subpoena, to FSSA BDS Documentation Requests at BDSdocumentationrequests@fssa.in.gov.

Section 1.7: Office of Administrative Law Proceedings

Replacing the former FSSA Office of Hearings and Appeals (OHA), the Office of Administrative Law Proceedings (OALP) receives and processes appeals from people receiving services within FSSA programs (including Medicaid HCBS Waiver programs) and many other programs. Administrative hearings are held throughout the state of Indiana, usually at county DFR locations, at which time all parties have the opportunity to present their cases to an administrative law judge (ALJ) in OALP. The ALJs are no longer employees of the FSSA. See *Section 7: Appeal Process* for additional information about the hearing and appeal process.

Interested parties may also review the new OALP website at in.gov/oalp. The new physical location of the OALP is:

Office of Administrative Law Proceedings
100 N. Senate Avenue, Suite N802
Indianapolis, IN 46204
Phone: 317-234-6689

Section 1.8: Participating Individuals and Guardians

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

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

For additional information, see *Individual and guardian responsibilities*, available on the *Current BDS Policies* webpage at in.gov/fssa/ddars.

Information Sharing

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

Selecting or Changing Waiver Providers

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

- Choosing a CMO/care management agency from a provider choice list of DDARS-approved and IHCP-enrolled provider organizations/agencies
  - For newly approved applicants preparing to enter into FS or CIH waiver services, the case management list is generated by the BDS; for the TBI or H&W waivers, the care management list is generated by the Area Agency on Aging (AAA).
  - For individuals already active on the waiver, the case/care management choice list may be generated by the BDS or by the current provider of case/care 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 BDS to secure replacement of any other type of provider within one of the following time frames:

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

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

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

Participating in Risk Plan Development and Implementation

The individual (or the individual's legal representative, when indicated) and the individual's IST must work together to identify risks for the individual. This includes recognizing that adverse consequences may occur resulting from an individual participating in, or not participating in, any given situation or activity. Dignity of risk is having the right to choose and either succeed or fail.

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

The following guidelines should be followed by the individual's legal representative and IST:

- Development of risk plans for individuals will follow current BDS procedures and be clearly reflected in the PCISP
- Potential risks should be identified by category, including:
  - Health
  - Personal Safety
  - Behavior
- After risks are categorized, the IST can further identify:
  - Nature of the risk
  - Likelihood of occurrence

  - Severity of consequences from the risk
  - If a risk mitigation plan is warranted
- Key points include:
  - One plan for each identified risk should be developed
  - The IST should determine who will write the plan
  - All providers must implement the plan
  - If a team member disagrees with the components of the plan, it should be discussed with the entire IST
- Implementation of the risk mitigation plan requires:
  - All support staff must be trained on the plan
  - Adjustment to the plan is made as needed
  - At least annually, the team will discuss the continued need for the plan
- The goal is not to remove all risks that may exist in everyday life but to support the individual in navigating risks to reduce the negative outcomes and potential likelihood of the risk.

Risk assessment and planning tools and additional guidance are available on the *BDS Quality Assurance* webpage at in.gov/fssa/ddars and includes the following:

- Person-centered risk management webinar recording (6/30/2021)
- Person-centered risk management PowerPoint (6/30/2021)
- Risk assessment and planning FAQ
- Risk issues identification tool (Word document) – Teams may use this tool to identify and plan to mitigate risks for an individual. The tool can be edited to suit the individual's circumstances.
- Risk issues identification tool example – A completed example of how a team may use the tool to identify and plan to mitigate risks for an individual.
- Risk matrix – A tool for teams to assess potential risks for an individual.

Allowing State Representatives Into the Individual's Home

The individual (or the individual's legal representative, when indicated) must allow representatives from the BDS, BDS Quality Assurance designees, the selected CMO or care management agency, and any DDARS-contracted vendor into the individual's home for visits scheduled at least 72 hours prior to the visit. Additionally, HCBS waiver case managers are required to complete unannounced visits with HCBS waiver participants, and participants and/or their legal representatives are expected to allow and participate in these visits as a condition of participation in the HCBS waiver program.

Consequences for Nonparticipation

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

Should a termination occur, the individual (or the individual's legal representative, when indicated) has a right to appeal the state's decision. See *Section 7: Appeal Process* for further information regarding appeals.

Helpful Hints for Individuals and Guardians Selecting Waiver Providers

HCBS 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 the individual and their family member before beginning the process. A list of certified waiver providers for each county is available through the individual's case manager. If new to waiver services, or current agency has terminated the individual's service, the individual will need to prioritize the providers and try to schedule interviews and visits within a short time frame, so the process does not become extended. Individuals who are new to the waiver program are asked to select a provider within 14 calendar days of receiving the provider choice list. Individuals who have been terminated by the current provider must select and transition to a new provider within 60 calendar days of termination.
- Individuals will be able to make an informed choice by reading information, such as the BDS Fact Sheets found on the *BDS* webpage at in.gov/fssa/ddars, or by discussing alternatives with the case manager or an advocate. Individuals may want to visit a participant who is currently receiving waiver services or meet with various service providers. Case managers can assist in setting up visits or meetings with service providers.
- Sometimes a provider can arrange for individuals to visit people who are receiving services from the provider. When visiting a house or apartment where waiver services are being provided, individuals need to remember that they 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 to ask depend on what kind of service it is and whether the individual will be served in their family home or in their own home or apartment, with or without housemates. Many of the questions are applicable to any setting, and others can be skipped or modified as needed.

General Topics to Discuss With Service Providers

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

- What areas of service are absolute requirements for the individual and their family members, such as medications being administered on time, direct supervision, sign-language training and so on?
- What makes the individual and their family members happy? What causes pain? How can the provider maximize opportunities for the former, and minimize or eliminate instances of the latter?
- What do the individual and their family members 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 the individual or their family members like? Anything else? Are these wishes or requirements?
- What are the risks for the individual or their family members? Examples include daily seizures, a lack of street-safety skills, the inability to talk or use sign language, forgetfulness, a tendency to hit others when angry, and so on. How will the provider deal with those risks?
- What is the provider's experience working with children and adults with disabilities, or adults who are elderly?
- How would the provider ensure the implementation of the PCISP?

- What connections has the provider established in the community? How would the provider assist in building a support system in the community?

Questions to Ask Prospective Service Providers

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

- What is the provider's mission? (Does it match the intent the individual is seeking?)
- Is the provider certified, accredited or licensed? What are the standards of service?
- What kind of safety measures does the provider have in place to protect the individual and assure effective treatment?
- How does the provider assure compliance with the person's rights? Did the individual (and family members and advocates) receive copies of their rights as a consumer of services, as well as have these rights explained?
- Is the provider interested in what the individual and their family member want or are hopeful about?
- Is the provider connected to other programs that the individual may need, such as day support, local school and education services, or work programs? How is the provider connected? Ask for specific contacts.
- If the individual is 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 the individual 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 behavioral support plan? Are they trained before working with waiver individuals? What is the relationship between residential provider and behavioral provider?
- How is medication handled? What happens if medication is refused?
- What is the smoking policy?
- How are planning meetings scheduled and conducted, and who attends? Can a family member call a meeting? How does the provider assure that what is agreed on in the meeting is actually provided?
- Who would be the provider's contact person, how will that contact occur, and how often? Is someone available 24 hours a day in case of emergencies?
- How many people with disabilities have the agency terminated or discontinued from services? Why? What happened to them?
- Has the agency received any abuse or neglect allegations? Who made these allegations? What were the outcomes? What is the process for addressing allegations of abuse or neglect?
- Does the provider foresee any possible challenges or risks associated with providing this service to the waiver individual?As a provider of waiver services, what are the provider's strengths and weaknesses?
- What is the process for hiring staff? Are background checks conducted and training given? Who provides services to the waiver individual while a new staff person is hired and trained?

- How is direct staff supervised? What training does the staff receive? What is the average experience or education of staff?
- How is staffing covered if someone on the regular staff is ill? What happens if the 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 contact if a problem develops?

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

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

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

This section includes information about becoming a provider of, and receiving reimbursement for, services authorized under the Home- and Community-Based Services (HCBS) waivers administered by the Indiana Family and Social Services Administration (FSSA) Division of Disability, Aging and Rehabilitative Services (DDARS).

Section 2.1: Provider Approval and Reverification Processes for FS and CIH Waivers

The DDARS Bureau of Disabilities Services (BDS) performs the initial approval, as well as subsequent reverification of credentials, for entities wishing to provide HCBS waiver services through the Family Supports (FS) or the Community Integration and Habilitation (CIH) waiver.

Provider Approval for FS and CIH Waivers

The DDARS Bureau of Disabilities Services (BDS) performs the initial approval, as well as subsequent reverification, for entities wishing to provide HCBS waiver services to individuals participating in the FS or the CIH waiver.

Applications for approval to provide FS or CIH waiver services may be submitted to the BDS year-round. Case management organization (CMO) providers must also be approved by the FSSA DDARS Provider Services Department, but case management is now provided through a selective contracting waiver approved by the Centers for Medicare & Medicaid Services (CMS) to operate concurrently with the Medicaid HCBS waivers operated by DDARS.

For the FS and CIH waiver, the first step is to submit an electronic inquiry to the BDS Provider Services email at BDSProviderServices@fssa.in.gov as outlined in the policy in the *New Provider Approval Process* document available at in.gov/fssa/ddars. New provider applicants will then receive the full New Provider Applicant instructions and application including all necessary forms, documents and other requirements.

Completed new provider applications must be submitted electronically in PDF format to BDSProviderServices@fssa.in.gov. Scanned applications are not accepted. Applications should be submitted in a single email. If additional emails are required due to file size, this must be identified in the initial email and all emails must be received on the same calendar date. All materials must be included, and the application must be complete. The BDS does not accept incomplete applications. If an incomplete application is received, it will be returned to the applicant with instructions to review the requirements and resubmit when the application is complete. An applicant submitting an incomplete application may resubmit an application one additional time during a calendar year. If a second incomplete application is received, the BDS will issue a denial, and the applicant will be unable to resubmit a BDS New Provider Application for two years from the date of the denial letter.

If the BDS determines that all initial documentation requirements are met, the application is placed in "provisional approval" status. Prior to receiving final approval from the BDS, the applicant's leadership team as documented in the application must attend the BDS Leadership Training Series – Initial Session within one year of the date of the provisional approval notice. Required attendees include:

- Chief executive office (CEO)/executive director
- Chief operating officer (COO)/chief financial officer (CFO)
- Waiver administrator
- Systems administrator

No extension of the one-year deadline is offered. The application is considered voluntarily withdrawn if the application is in provisional approval status one year after the date provisional approval status was granted. If the applicant desires further consideration, a new application must be submitted. Upon an applicant's successful completion of the BDS Leadership Training Series – Initial Session, BDS Provider Services reviews all application materials and issues a final determination. If approved, the applicant will receive all necessary materials for enrolling with the Indiana Medicaid agency. Successful enrollment must occur within 12 months of BDS approval of the application will be considered voluntarily withdrawn.

To be considered a completed application, all components of the New Provider Application must be completed as instructed. BDS reviews completed applications within 60 days of receipt. A Request for Information (RFI) may be issued to the applicant to obtain additional information or clarification regarding the application. If an RFI is issued, the applicant has 30 days from the date the RFI is issued to fully respond. Failure to respond within 30 days will result in automatic denial of the application. After an applicant receives final approval and is determined to have met the requirements of *Indiana Administrative Code 460 IAC 6* and DDARS 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 the BDS is issued for 12 months.

Applications determined to not meet the requirements of *Indiana Administrative Code 460 IAC 6*, DDARS policies and other regulatory statutes will be denied by BDS Provider Services. The applicant will not be able to resubmit a New Provider Application for a period of two years from the date of denial. This denial is considered an administrative action and may be appealed. Applications determined to contain false or misleading information or information that otherwise violates *460 IAC 6*, DDARS policies or other applicable state/federal regulatory guidelines will be denied.

Provider Reverification for FS and CIH Waivers

BDS Provider Services reviews the performance of FS and CIH waiver service providers and makes a reverification determination at least once every four years.

BDS Provider Services initiates the reverification process and evaluates the following information submitted by each provider:

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

BDS Provider Services also evaluates the provider's data from monitoring activities such as:

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

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

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

The process for reverifying CIH and FS waiver providers is outlined in the following DDARS policies:

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

Further information about the reverification process and related tools is available on the *BDS Quality Assurance* webpage at in.gov/fssa/ddars.

The BDS provider accreditation and reverification specialist issues providers notices of up to 48-month terms. This notice also specifies that the reverification term is contingent on the provider submitting a signed Provider Agreement within 30 calendar days. The provider's reverification term begins when the document is received by the BDS.

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

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

Administrative Review of DDARS Orders

To qualify for administrative review of a DDARS order*, a provider shall file a written petition for review that 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

This written petition must be filed with the director of the DDARS within 15 calendar days after the provider receives notice of the sanctioning order. Per the Administrative Orders and Appeals Act (AOPA), the petition must also be filed with the Office of Administrative Law Proceedings (OALP) at the following email or fax number:

Office of Administrative Law Proceedings
Fax: 317-232-4412
Email: fssa.appeals@oalp.in.gov

Administrative reviews are conducted in accordance with *IC 4-21.5-3-7.*

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

If a provider has complied with the renewal timelines, and if the BDS 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 BDS acts on the provider's request for renewal of approved services.

Section 2.2: Provider Certification and Renewal Processes for H&W and TBI Waivers

The FSSA Office of Medicaid Policy and Planning (OMPP) performs the initial certification, as well as subsequent recertification of credentials, for entities and individuals wishing to provide HCBS waiver services through the Health and Wellness (H&W) Waiver or the Traumatic Brain Injury (TBI) Waiver.

Provider Certification for H&W and TBI Waivers

The FSSA OMPP is responsible for certifying providers for the H&W Waiver and the TBI Waiver. Information on the application process, including additional educational tools regarding OMPP Certification, is located on the *Medicaid HCBS Certification* webpage at in.gov/fssa/ompp. Providers wishing to provide services under the H&W and/or TBI waiver must complete an application and submit required documentation via the OMPP HCBS Certification Portal.

This portal is used to certify new providers, add services for existing providers and make a change in ownership. An application for certification can be denied if the screening process determines that the provider does not meet the requirements for participation, or an application can be expired if required supporting documentation or information is missing from the submission. A letter is sent to notify applicants of this decision and advise them of the necessary actions needed for resubmission of the expired application. An application for certification will be approved by a Provider Certification team member after a determination is made that conditions of participation have been met. Upon approval, a provider will be advised of the next steps, which will include the following: enrolling with Gainwell, enrolling in MCE provider networks and completing settings rule compliance if applicable. Providers must be approved or certified through the OMPP and IHCP.

When a provider submits an HCBS application (as a brand-new enrollment, a change of ownership or add services), the application will be placed into the provider applications queue. A notification will be sent to the group email address for the Provider Certification manager to assign each application record. The provider certification manager will be responsible for assigning all applications to a provider certification specialist. Applications are to be assigned within two business days of submission".

A separate certification application is required for each service that will be provided. Providers must submit all required documentation for each service in which they wish to be certified.

> *Note: Because Indiana PathWays for Aging (PathWays) Waiver services mirror Health and Wellness (H&W) waiver services, separate certification is not required to deliver the same service under both waivers.*

If a provider has more than one service location, a separate certification application must be submitted for each location. For facility-based services (such as Adult Day Services, Adult Family Care, Assisted Living or Structured Day Program), each location where a given service is provided must be individually certified. For non-facility-based services, each location where HCBS business is conducted for a given service must be individually certified. Each individually certified service location will need to be separately enrolled in the IHCP and assigned its own unique IHCP Provider ID.

Multiple certification applications may be submitted under a single account in the OMPP HCBS Certification Portal, as long as the services and locations are all for a single provider entity.

Applications for OMPP certification will be reviewed within four business days of submission. Applicants will be notified of one of the following outcomes:

- An application for certification can be **denied** if the screening process determines that the provider does not meet the requirements for participation.
- An application can be **expired** if required supporting documentation or information is missing from the submission. A letter is sent to notify applicants of this decision and advise them of the necessary actions needed for submitting a new application.
- An application for certification will be **approved** by an OMPP Provider Certification team member after a determination is made that conditions of participation have been met. Upon OMPP approval, a provider will receive a *Waiver Service Certification Letter* advising them of the next steps, which will include the following: enrolling as a provider with the IHCP (see *Section 2.2: IHCP Enrollment as a Medicaid Waiver Provider* for instructions) and completing settings rule compliance if applicable. The application materials are sent to DDARS BDS for entry into applicable data systems. If additional information is required, the BDS will reach out to the provider to obtain supplemental information or materials required for the BDS Portal.

> *Note: Existing waiver providers can also use the OMPP HCBS Certification Portal to request certification for additional services (Add Service), add additional locations (New Application) or report a change of ownership. When a currently certified provider completes the application to add a service, they should include all their current services, as well, to ensure that all services (existing as well as newly added) are reflected within the OMPP HCBS Certification Portal. Providers that use the OMPP HCBS Certification Portal to submit changes to their certification will receive a new certification letter and will then need to update their IHCP provider enrollment profile.*

Provider Certification Renewals for H&W and TBI Waivers

All H&W and TBI waiver providers are required to renew their provider certification through the OMPP HCBS Certification Portal and undergo a compliance review every three years. Noncompliance will result in corrective action and ultimately decertification. Providers will receive notification of their renewal three months prior to their due date. Providers that have not created an account through the OMPP HCBS Certification Portal will be contacted via the email address provided to the IHCP to initiate the recertification process.

Administrative Review of OMPP Orders

To qualify for administrative review of an OMPP order*, a provider shall file a written petition for review that 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

This written petition must be filed with the director of the OMPP within 15 calendar days after the provider receives notice of the sanctioning order. Per the Administrative Orders and Appeals Act (AOPA), the petition must also be filed with the Office of Administrative Law Proceedings (OALP) at the following email or fax number:

Office of Administrative Law Proceedings
Fax: 317-232-4412
Email: fssa.appeals@oalp.in.gov

Administrative reviews are conducted in accordance with *IC 4-21.5-3-7.*

> * *"Order," as defined in IC 4-21.5-1-9, means: "an agency action of particular applicability that determines the legal rights, duties, privileges, immunities or other legal interests of one (1) or more specific persons. The term includes: (1) a license; or (2) a determination under IC 4-21.5-3-6(a)(3) or IC 4-21.5-3-6(a)(4)."*

If a provider has complied with the renewal timelines, and if the OMPP 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 OMPP acts on the provider's request for renewal of approved services.

Section 2.3: IHCP Enrollment as a Medicaid Waiver Provider

After a prospective waiver provider receives notification of approval from the BDS (for the FS or CIH waiver) or from the OMPP (for the H&W or TBI waiver), the enrollment process with the IHCP begins. **The IHCP enrollment application MUST be submitted within 90 calendar days of approval.**

The prospective provider can enroll online or by mail:

- Prospective providers may enroll online through the IHCP Provider Healthcare Portal (IHCP Portal), accessible from the homepage at in.gov/medicaid/providers. Click the **Provider Enrollment** link to begin the enrollment process.
- To enroll by mail, a prospective provider may obtain an IHCP provider enrollment packet by downloading it from the *Complete an IHCP Provider Enrollment Application* webpage at in.gov/medicaid/providers.

> *Note: Providers are strongly encouraged to use the IHCP Portal for provider enrollment applications, revalidations and profile updates whenever possible, as electronic transactions can be processed more efficiently than paper submissions. Not only is the IHCP Portal designed to reduce errors in initial submissions, but it also provides a tracking number that is helpful in tracking subsequent submissions if follow-up is needed for missing information or documents. However, providers unable to use the IHCP Portal do have the option to submit paper enrollment applications.*

For detailed enrollment instructions, see the *Provider Enrollment* provider reference module, accessible from in.gov/medicaid/providers.

IHCP Provider Classification

When applying for enrollment in the IHCP, providers must select a provider classification based on their business structure. HCBS waiver providers must be enrolled under one of the following classifications:

- Billing provider (sole practitioner)
- Group provider (must have members linked to the group)
- Rendering provider (must be linked to a group)

Rendering providers cannot bill for services; the group bills for services, identifying the rendering provider as the performer of the service. For FS or CIH waiver group enrollments, all rendering providers linked to the group as well as the group itself must be approved by the BDS. For TBI or H&W waiver group enrollments, all rendering providers linked to the group as well as the group itself must be certified by the OMPP.

When applying by mail rather than online, the provider classification determines which enrollment packet the waiver provider should complete:

- *IHCP Waiver Billing Provider Enrollment and Profile Maintenance Packet*
- *IHCP Waiver Group Provider Enrollment and Profile Maintenance Packet*
- *IHCP Waiver Rendering Provider Enrollment and Profile Maintenance Packet*

IHCP Provider Type and Specialty

Each prospective waiver provider must designate a "type" and "specialty," as well as one or more secondary specialties, during IHCP enrollment.

The IHCP provider type for HCBS waiver providers is 32 – *Waiver Provider*. The following specialties are available under this provider type:

- 350 – *PathWays/Health & Wellness Waiver*
- 356 – *Traumatic Brain Injury Waiver*
- 359 – *Community Integration and Habilitation Waiver*
- 360 – *Family Supports Waiver*
- 363 – *Money Follows the Person (MFP) [Demonstration Grant]*

The provider's secondary specialties must be the same ones it is certified for by the BDS or the OMPP. If a provider does not wish to enroll with a certified service, the provider must contact the BDS or the OMPP to have that service removed from their certification. See the *IHCP Provider Enrollment Type and Specialty Matrix* for a complete list of waiver specialties and secondary specialties.

IHCP Application Submission and Processing

The enrollment application must be signed and submitted with the requested documentation, including a current *W-9* form, electronic funds transfer (EFT) form and a copy of the BDS *New Provider Approval Letter* or the FSSA OMPP *Waiver Service Certification Letter*. An *IHCP Provider Agreement* is also included in the enrollment application. Enrollments submitted via the IHCP Portal allow electronic signatures and electronic attachments.

All paper enrollment forms and attachments must be sent to the following address, to ensure proper processing:

IHCP Provider Enrollment
PO Box 50443
Indianapolis, IN 46250-0418

Enrollment documents are logged into a document tracking system and issued an application tracking number (ATN).

The IHCP Provider Enrollment Unit has dedicated staff members assigned to coordinate and handle all HCBS waiver provider enrollments and updates. These staff members work closely with the FSSA to ensure timely and accurate maintenance of HCBS waiver provider enrollment processes.

The IHCP staff members review the IHCP provider enrollment packet to ensure completeness according to the Provider Enrollment guidelines:

- If the information is completed accurately and approved, the IHCP Provider Enrollment Unit then enters the provider's information into the IHCP *Core*MMIS. For enrollment applications submitted via the IHCP Portal, the provider's information transfers automatically into *Core*MMIS. A provider

letter is generated from the IHCP notifying the provider agency that it is now a Medicaid-enrolled HCBS waiver provider. This letter is sent to the provider detailing the assigned IHCP Provider ID and enrollment information entered into *Core*MMIS. Providers are encouraged to review this letter to ensure enrollment accuracy.

- If a provider enrollment packet needs correcting or is missing required documentation, the IHCP Provider Enrollment Unit will contact the applicant by telephone, email or mail. This contact is intended to communicate what needs to be corrected, completed and submitted before the IHCP can process the enrollment transaction. If an application is expired for missing or incomplete information, a letter will be sent indicating what needs to be corrected or attached; a copy of this letter must be included when submitting the corrected or missing information.

The provider's IHCP enrollment effective date with the IHCP will automatically match the BDS or OMPP certification date, by service, for each certified service.

Section 2.4: IHCP Waiver Provider Responsibilities

Medicaid-enrolled HCBS waiver providers are enrolled in the IHCP and have executed an *IHCP Provider Agreement* with the FSSA. This agreement states that the provider will comply, on a continuing basis, with all the federal and state statutes and regulations pertaining to the IHCP, including the waiver programs' rules and regulations. The *IHCP Provider Agreement* is included in the IHCP enrollment application; see the *IHCP Application Submission and Processing* section for submission details. By signing the agreement, the provider agrees to follow the information provided in the IHCP provider reference modules (including this module), as amended periodically, as well as all provider bulletins and notices. All amendments to the IHCP provider reference modules (including this module), and all applicable *Indiana Administrative Code* (IAC) rules and regulations are binding on publication. This provider reference module and all IHCP publications are accessible online from the *Bulletins and Reference Modules* webpage at in.gov/medicaid/providers.

The information is made available to assist all those who administer, manage and participate in the HCBS waivers. Current HCBS waiver requirements can be found in the Centers for Medicare & Medicaid Services (CMS)-approved waiver applications as well as the DDARS rules in *460 IAC 6* (for FS and CIH waivers) or *455 IAC 2* (for H&W and TBI waivers).

Office of Inspector General Exclusionary List

The U.S. Health and Human Services Office of Inspector General (HHS-OIG) excludes certain providers (both individuals and entities) from participation in Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP) and all federal healthcare programs (as defined in *Section 1128B[f]* of the *Social Security Act*). When the HHS-OIG has excluded a provider, federal healthcare programs – including Medicaid and SCHIP programs – are generally prohibited from paying for any items or services furnished, ordered or prescribed by the excluded individual or entity (see *Section 1903[i][2]* of the *Social Security Act* and *42 CFR 1001.1901[b]*). This payment ban applies to any items or services reimbursable under a Medicaid program that are furnished by an excluded individual or entity. The prohibition applies to payments for any items or services directed or prescribed by an excluded physician or other authorized person when the individual or entity furnishing the services knew or should have known of the exclusion, even when the payment itself is made to another provider, practitioner or supplier that is not excluded.

The HHS-OIG maintains the List of Excluded Individuals and Entities (LEIE), a database that provides information about parties excluded from participation in Medicare, Medicaid and all other federal healthcare programs. The LEIE database is accessible to the general public from the *Exclusions Program* webpage at oig.hhs.gov, for online searching or to be downloaded. The online searchable Exclusions Database identifies currently excluded individuals or entities by name. When a match is identified, it is possible for the searcher to verify the accuracy of the match using a Social Security number (SSN) or employer identification number (EIN). The downloadable version of the database may be compared against

an existing database maintained by a provider. However, unlike the online format, the downloadable database does not contain SSNs or EINs.

All current IHCP providers and providers applying to participate in the IHCP are required to take the actions outlined in this section to determine whether their employees and contractors are excluded individuals or entities. Providers are required to agree to comply with these obligations as a condition of enrollment:

- Screen all employees and contractors to determine whether any of them have been excluded. Providers can access the LEIE database on the HHS-OIG website at oig.hhs.gov and search by the names of any individual or entity.
- Search the HHS-OIG website monthly to capture exclusions and reinstatements that have occurred since the last search.
- Report to the state any exclusion information discovered by contacting the Provider and Member Concerns Line toll free at 800-457-4515.

Because it is prohibited by federal law, no payments can be made for any amount expended for items or services (other than an emergency item or service not provided in a hospital emergency room) by an individual or entity while being excluded from participation (unless the claim for payment meets an exception listed in *42 CFR section 1001.1901[c]*). Any such payments actually claimed for federal financial participation (FFP) constitute an overpayment and are therefore subject to recoupment. The amount of the Medicaid overpayment for such items or services is the actual amount of Medicaid dollars that were expended for those items or services. When Medicaid funds have been expended to pay an excluded individual's salary, expenses or fringe benefits, the amount of the overpayment is the amount of those expended Medicaid funds. Civil monetary penalties may be imposed against Medicaid providers and managed care entities (MCEs) that employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid recipients.

For examples of types of items or services that, when provided by excluded parties, are not reimbursable and would constitute an overpayment subject to recoupment, see the *Provider and Member Utilization Review* provider reference module at in.gov/medicaid/providers.

Background Checks

Pursuant to the signed provider agreement, and as required by *455 IAC 2* and *460 IAC 6*, a current background check must be submitted for each employee, officer or agent involved in the direct management, administration or provision of services. The background check must not show any evidence of acts, offenses or crimes affecting the applicant's character or fitness to care for waiver participants in their homes or other locations. If the background check returns with a conviction described in *460 IAC 6-10-5* (for FS or CIH waivers) or *455 IAC 2-15-2* (for H&W or TBI waivers), the individual will not be eligible for hire.

The minimum accepted background is a limited history check. A report may be requested through the Indiana State Police *Get Limited Criminal History* webpage at in.gov/isp. A report from a third party would also be accepted. A copy of the individual's driver's license must be provided with this background check. National background checks, as well as fingerprint-based background checks, are acceptable.

Additionally, for entities seeking certification for services that the IHCP has assigned to the **high-risk** enrollment category, all *owners* and *managing individuals* are required to undergo a national fingerprint-based background check. For HCBS waiver, this mandate includes entities enrolling to provide the following services:

- Attendant Care services
- Specialized Medical Equipment and Supplies

This requirement applies to all individuals who have at least 5% ownership or controlling interest in the enrolling business entity, including the board of directors if the enrolling entity is not-for-profit. Instructions for the fingerprinting registration process are available on the *Provider Enrollment Risk Levels and Screening* webpage at in.gov/medicaid/providers.

Background checks are maintained in agency files and are available upon request.

Licensed professionals are checked for findings through the Indiana Professional Licensing Agency (IPLA). Additionally, pursuant to *455 IAC 2-6-2* and *460 IAC 6-10-5*, direct care staff must also be checked against the nurse aide registry maintained by the IPLA. The provider must obtain and submit a current document from Indiana's nurse aide registry, verifying that each unlicensed employee involved in the direct provision of services has no finding entered into the registry before providing direct care to members receiving services. The FSSA OMPP or BDS verifies receipt of such documentation as part of provider certification.

Nurse aide registry documents must be maintained in agency files and made available upon request.

> *Note: Providers are not permitted to provide services under the traditional model or self-directed model prior to completion and/or review of their background check.*

TB Test Requirement for Direct Care Employees

To certify for direct care HCBS certification, providers must meet the following requirements:

- A tuberculosis (TB) test is required for all direct care employees upon hire prior to face-to-face interaction with clients. The TB test is to be stored in the employee's personnel file.
- The provider's personnel policy will include that the agency will provide yearly TB education to direct care employees.
- The provider's personnel policy will include that an employee will be required to have an updated TB test upon known TB exposure. If the TB test is positive, a negative X-ray is required.

CPR/First Aid Requirements for Direct Care Employees

The FSSA requires direct service staff to receive training in first aid and cardiopulmonary resuscitation (CPR), which includes topics such as emergency precautions and injury and medical emergencies. The FSSA also requires direct service staff to have demonstrated competency in CPR through CPR certification from an approved entity, such as the American Heart Association or the American Red Cross. The certification should be updated in accordance with these entities. To certify as a provider of direct services for the HCBS waivers, providers must meet the following requirements:

- CPR/first-aid training and certification are required for all direct service staff upon hire, prior to face-to-face interaction with clients. The CPR and first-aid certification are to be stored in the employee's personnel file.
- The provider's personnel policy will include that the agency requires updated training and certification in accordance with an approved entity.
- The provider's personnel policy will include that all direct service staff are required to have CPR certification and first-aid training current and documented in the employee's personnel file.

The FSSA expects direct service staff – direct support professionals and patient care aides – to be trained in CPR/first aid and to administer it, if needed. The IDOH does not regulate direct service staff in HCBS waivers; however, in alignment with IDOH oversight in the state licensed residential care facilities (licensed assisted living), home health agencies and personal service agencies, the FSSA expects CPR/first aid to be provided if needed.

Provider Record Updates

To ensure timely communication of all information, waiver providers must notify all appropriate FSSA divisions when their enrollment record information changes, including the BDS (for all DDARS-administered waivers), the OMPP (for H&W and TBI waivers), and the IHCP Provider Enrollment Unit. If the provider is licensed through the Indiana Department of Health (IDOH), the provider must also notify the IDOH of any changes to the provider's information, such as contacts, name, physical and mailing address or telephone number.

Provider information is stored in several FSSA systems, including the following:

- **Core Medicaid Management Information System (*Core*MMIS)** is maintained by the IHCP fiscal agent, Gainwell Technologies. The fiscal agent must have accurate information on file for all providers, including the current pay-to, mail-to, service location and provider *W-9* (home office/owner) address. It is the provider's responsibility to ensure that the information on file with the fiscal agent is correct. As described in the *Provider Enrollment* provider reference module, providers are required to submit updated information to the IHCP within 10 business days of any applicable change. Provider profile maintenance forms are available at the *Update Your Provider Profile* webpage at in.gov/medicaid/providers, or updates can be made via the IHCP Provider Healthcare Portal, accessible from the homepage of in.gov/medicaid/providers.

  Note: For waiver providers, many types of updates require BDS approval or a new Waiver Service Certification Letter. These updates must first be emailed to BDSProviderServices@fssa.in.gov (for FS and CIH waiver providers) or entered into the OMPP HCBS Certification Portal (for H&W and TBI waiver providers) before they can be submitted to the IHCP. After submission to the IHCP, the updates will be entered into CoreMMIS.

- The **BDS Portal** is the system that the DDARS uses to store member eligibility information along with the member's service plans, service authorizations, level-of-care (LOC) information and case notes entered by the case managers for individual members. The BDS Portal also has a provider database that is maintained by BDS staff and is intended to provide up-to-date information about the status of waiver providers. Provider selection profiles (choice lists) are generated from the BDS Portal; therefore, it is very important that the information listed in the BDS Portal is the most current and up-to-date information available. H&W and TBI waiver providers need to send information changes to BDS Provider Services at BDSProviderServices@fssa.in.gov.

  FS and CIH waiver providers must have a provider system administrator log in to the BDS Portal and confirm the provider profile information at a minimum of every 90 days. The provider profile information should always be updated anytime there is a change. Providers should also check their provider referrals grid in the BDS Portal and respond to referrals within 30 days. After viewing the referral, the provider can accept, reject or request additional information by selecting the record. For assistance with completing the provider attestation or provider referral, see the BDS Portal User Guide for Providers located in the Resource Section of the BDS Portal under the "User Guides" tab.

- The **OMPP HCBS Certification Portal** stores certification information for H&W and PathWays waiver providers. Provider information changes may be made directly by the provider within the OMPP HCBS Certification Portal.

Updates to the following information must be submitted within 10 calendar days of the change:

- Name changes
- Tax identification changes
  - Requires a new waiver service certification

- Additional service locations
  - Requires a new application and waiver service certification
- Changes to counties served
  - Requires a new waiver service certification
- Specialty changes (all specialties must be certified)
  - Requires a new application and waiver service certification
- Changes in ownership (CHOWs)
  - Requires a new application and waiver service certification

For updates that require a new certification from the BDS or OMPP, after certification update requirements for the provider have been met, the provider will receive a new *Waiver Service Certification Letter* detailing the approved services and instructing the provider to begin the update process with the IHCP.

Providers can then update their information with the IHCP using the IHCP Provider Healthcare Portal or by mail using the appropriate enrollment packet or profile maintenance form, available from the *Update Your Provider Profile* webpage at in.gov/medicaid/providers. The new *Waiver Service Certification Letter* must be included with the update.

Section 2.5: Billing and Reimbursement for Waiver Services

The following sections provide general information about billing and reimbursement for DDARS HCBS waiver services.

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

Verifying IHCP Member Eligibility for HCBS Waiver Services

All service providers must verify IHCP eligibility for each member on each date of service, before initiating services. Providers can verify member eligibility, and view details about the member's coverage, by using any of the following Eligibility Verification System (EVS) options:

- IHCP Provider Healthcare Portal (IHCP Portal)
- Approved vendor software for the 270/271 electronic data interchange (EDI) transactions
- Virtual assistant (GABBY) at 800-457-4584, option 2

For more information about verifying eligibility, see the *Member Eligibility and Benefit Coverage* provider reference module at in.gov/medicaid/providers.

Individuals determined eligible for the CIH, FS, H&W or TBI waiver must first be enrolled in Traditional Medicaid – a fee-for-service (FFS) program with full Indiana Medicaid State Plan benefits – before the waiver benefit plan can be assigned in *Core*MMIS.

Individuals enrolled in the Healthy Indiana Plan (HIP), Hoosier Care Connect or Hoosier Healthwise managed care program must be transitioned to FFS Traditional Medicaid to receive CIH, FS, H&W or TBI waiver services. The waiver case/case manager must contact the local FSSA Division of Family Resources (DFR) caseworker to coordinate the managed care program stop date and waiver services start date. If applicable, the case manager and managed care benefit advocate must inform the individual and

individual's parent or guardian of their options to ensure that the individual (or individual's parent or guardian) makes an informed choice.

> *Note: The fiscal agent cannot add or correct a waiver benefit plan assignment in CoreMMIS nor terminate a managed care enrollment.*

If a member does not have an active HCBS waiver benefit plan and/or is not enrolled in an appropriate IHCP Medicaid program on the date on which waiver services were provided, any claim submitted for those services may not be paid.

Waiver Liability

It is important to remember that, for a member with an HCBS waiver liability, the IHCP does not reimburse providers for HCBS waiver services until the member's waiver liability is met for the month. The eligibility verification process indicates the member's monthly obligation and the amount remaining for the month (based on paid claims). Providers may not bill the member for their liability amount until after the claim has been submitted to the IHCP and adjudicated.

Information about a member's waiver liability obligation is available from the IHCP EVS options.

Transfer of Property Penalty

IHCP members can incur a transfer-of-property penalty while receiving certain services, including institutional services from nursing facilities and other medical institutions where members receive equivalent care, as well as the HCBS waiver programs (CIH, FS, H&W, PathWays and TBI waivers).

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

Providers can determine whether a member is in the transfer-of-property penalty period using the IHCP EVS.

Electronic Visit Verification System Required for Personal Care Services

The *21st Century Cures Act* directs state Medicaid programs to require providers of personal care services and home health services to use an electronic visit verification (EVV) system to document services rendered.

For applicable services, federal law requires that providers use the EVV system to document the following information:

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

In accordance with federal requirements, the IHCP requires providers to use an EVV system to document designated personal care services, including applicable CIH, FS, H&W and TBI waiver services. For a list

of specific services (procedure code and modifier combinations) that require EVV, see *Service Codes That Require Electronic Visit Verification*, accessible from the *Code Sets* webpage at in.gov/medicaid/providers.

The IHCP is using Sandata as the state-sponsored system for implementing federal EVV requirements. In partnership with Gainwell Technologies, the Core Medicaid Management Information System (*Core*MMIS) claim-processing system has been configured to integrate with the Sandata EVV system.

Providers may choose to use an EVV system other than Sandata. However, those providers will be required to export data from their alternate system to the Sandata "Aggregator" for integration with *Core*MMIS. The Aggregator will capture EVV data from both Sandata users and from users of alternate EVV systems.

Additional information and resources on EVV, system specifications, services requiring EVV, and training are available on the *IHCP Electronic Visit Verification* webpage at in.gov/medicaid/providers.

Waiver Claim Completion and Submission

HCBS waiver services are billed as **professional** claims, using the IHCP Portal, 837P electronic transaction or *CMS-1500* paper claim form, as follows:

- The IHCP Portal is an interactive web application that allows providers to submit claims and attachments, check eligibility, and check status of claims. The IHCP Portal is fast, free and does not require special software. Providers must register on the IHCP Portal before they can use it to submit claims, verify member eligibility and maintain enrollment data. See the *Provider Healthcare Portal* provider reference module for instructions on how to register.
- Professional claims can also be submitted via the 837P electronic transaction. To use this transaction, the provider must become an IHCP trading partner. For more information, see the *Electronic Data Interchange* provider reference module at in.gov/medicaid/providers.
- Paper copies of the *CMS-1500, Version 02/12* form are available from the U.S. Government Bookstore or other online retailers. Providers wishing to bill using the paper copies, must use an original *CMS-1500* form; black-and-white copies of the form are not accepted.

Instructions for completing the claim are in the *Home- and Community-Based Services Billing Guidelines* and *Claim Submission and Processing* provider reference modules at in.gov/medicaid/providers.

> *Note: The fiscal agent and the FSSA recommend submitting claims electronically. For assistance, contact the electronic data interchange (EDI) technical assistance line at 800-457-4584 (option 3 and then option 3).*

Waiver providers are considered atypical providers and must bill using their IHCP-assigned Provider ID, even if the provider maintains a separate National Provider Identifier (NPI) for an additional enrollment type (such as a home health agency). The IHCP does not allow waiver (type 32) providers to add an NPI to their provider profile. As a result, billing with an NPI will result in claim denials for the IHCP-enrolled waiver provider.

Providers bill services based on an approved authorization for the individual member, using an appropriate procedure code and the pricing method associated with the procedure code, such as per unit, per day, or per month. Additional pricing information is available on the Professional Fee Schedule, accessible from the *IHCP Fee Schedules* webpage at in.gov/medicaid/providers. General guidelines include:

- Do not bill for services before they are provided.
- If a unit of service equals 15 minutes, a minimum of eight minutes must be provided to bill for one unit.
- Activities requiring less than eight minutes may be accrued to the end of that date of service.

- At the end of the day, partial units may be rounded up as follows: units totaling eight or more minutes may be rounded up and billed as one unit.
- Partial units totaling less than eight minutes may not be billed.
- Monthly units are billed at the end of the month.
- Daily units may be billed daily, weekly, or monthly.

Claim Tips and Reminders

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

- The IHCP does not reimburse for time spent by office staff billing claims.
- Providers may bill only for services that were authorized on an approved service authorization and delivered to the member.
- A claim may include dates of service within the same month. Claims may not be submitted with dates that span more than one month on the same claim.
- The units of service as billed to the IHCP must be substantiated by documentation in accordance with the appropriate *Indiana Administrative Code* (IAC) regulations and the waiver documentation standards issued by the FSSA OMPP and DDARS.
- Services billed to the IHCP must meet the service definitions and parameters as published in the rules and standards.

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

Claim Voids and Replacements

If a paid or denied claim must be adjusted (replaced), the initial claim is voided and a new claim takes the place of the old claim. If the claim was paid before the adjustment was made, any money paid is recouped by setting up an accounts receivable (A/R) for the amount of the recoupment, which is identified on the remittance advice (RA).

Waiver claim adjustments may be performed electronically or by mail. For instructions, see the *Claim Adjustments* provider reference module at in.gov/medicaid/providers. Adjustments requested by mail must be submitted on the *IHCP Professional, Dental, or Medicare Part B Crossover Claim Adjustment Request* form, available on the *Forms* webpage at in.gov/medicaid/providers.

Third-Party Liability

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, including modifiers for CIH, FS, H&W and TBI waiver services.

Reimbursement for FS and CIH Waiver Services During Hospitalization

In accordance with the recent amendment to *Section 1902(h)* of the *Social Security Act (42 USC 1396a[h])*, states' Medicaid programs are permitted to provide Home- and Community-Based Services (HCBS) to individuals in acute care hospitals.

The BDS has developed the following guidance for the delivery of HCBS in acute care hospitals. This guidance is applicable only for individuals receiving FS or CIH waiver services who are seeking or

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

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

- The waiver service is accurately documented in the person-centered individualized support plan (PCISP).
- The waiver service provided meets the needs of the individual that are not met through the provision of hospital services.
- The waiver service is being provided to ensure a smooth transition between the acute care setting and home- and community-based setting and to preserve the individual's functional abilities.
- The waiver service cannot be duplicative of what is being provided in the acute care setting.
- For those waiver services requiring electronic visit verification (EVV), EVV must still be used.

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

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

- Which waiver services will be provided during the acute hospital stay
- Description of how the waiver services will assist in returning to the community and preserve the individual's functional abilities
- Coordination and communication activities among individualized support team members
- Anticipated length of acute hospital stay
- Anticipated frequency and duration of the waiver services

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

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

Individuals receiving services on the CIH Waiver who may need additional supports while receiving care in an acute care hospital setting may submit a Short-Term Budget Request (STBR) that documents the need for increased supports, anticipated length of temporary supports needed and availability of staff to provide the support.

All FS and CIH waiver rules and service limitations still apply (for example, 40-hour rule, incident reporting guidelines, EVV and so on).

Special Billing Instructions for Assisted Living Facilities

Assisted living facility (ALF) providers are now able to bill monthly or daily for services up to 29 days. Monthly billing can still be done even when a resident is out of the facility, as long as their time out of the facility does not exceed 30 consecutive days.

Example 1: The ALF provider normally bills monthly. During the month, the facility's resident, Mary, discharged to the hospital on Feb. 13, 2024, with plans to return to the ALF. She was at the hospital for four days and then discharged to a skilled nursing facility (SNF). Mary remained in the SNF for 14 days. While in the SNF, Mary's family decided to move her to another ALF when she discharged from the SNF. On the date of discharge from the SNF (March 2, 2024), Mary's family informed her ALF provider that she would not be returning and that they wanted her to go to a different ALF.

In this scenario, the original ALF provider would need to bill daily only for the days that Mary was in the facility. If the ALF provider had already submitted monthly billing for Mary, the provider would need to void the original claim and rebill the claim for only the dates of services (DOS) that Mary was in its facility. The new ALF provider would also need to bill the first month using the daily method.

Example 2: The ALF provider normally bills monthly. During the month, the facility's resident, Mary, discharged to the hospital on Feb. 13, 2024, with plans to return to the ALF. She was in the hospital for four days and then discharged to a SNF for seven days. She returned to the ALF on Feb. 24, 2024. The ALF can still bill the monthly rate for the entire month because Mary was not out of the ALF for 30 consecutive days. The ALF provider would need to choose a single DOS from Feb. 1, 2024, through Feb. 12, 2024, ***or*** from Feb. 24, 2024, through Feb. 29, 2024. The provider can bill for one date in the date range, for 1 unit (for example, From Date of Service [FDOS] Feb. 2, 2024 – To Date of Service [TDOS] Feb. 2, 2024), and bill for T2031 U7 with either U1, U2 or U3 modifiers and UA for one unit.

> *Note: The modifiers determine the reimbursement rate and the LOC for the member. Providers receive an authorization via email before the member is admitted to the facility (and whenever there are changes to the authorization). The authorization lists the procedure code and basic modifiers, as well as the total dollar amount that the provider may bill. The authorization does not list modifier UA for monthly billing. However, the provider **may** choose monthly billing instead of daily.*

Example 3: The ALF provider normally bills monthly. During the month, the facility's resident, Mary, discharged to the hospital on Feb. 3, 2024. Mary remained in the hospital for 10 days and then discharged to a SNF for 21 days. She returned to the ALF on March 5, 2024. In this scenario, Mary was out of the facility for more than 30 consecutive days. The ALF would need to bill daily only for the days that Mary was in the facility during February and March. If the monthly billing had already been completed for February, then the ALF would need to void the original claim and rebill for only Feb. 1, 2024, through Feb. 2, 2024. For the month of March, the provider would bill daily for the DOS March 5, 2024, through March 31, 2024.

> *Note: The authorization will **not** list the **UA** modifier. The authorization will list the daily rate as done previously. However, the maximum dollar amount will equal the monthly rate amounts for each LOC. If the ALF chooses to continue to bill for the daily rate, **29** is the maximum number of days that can be billed in any given month.*

Section 2.6: Financial Oversight – Waiver Audits

The state of Indiana employs a hybrid program integrity approach to overseeing waiver programs, incorporating oversight and coordination by the Program Integrity staff, 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 activity that includes provider self-audits, desk audits and on-site audits. Program Integrity 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 claim 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 is composed of key stakeholders that meet biweekly to review and approve audit plans and provider communications, and make policy and system recommendations to affected program areas. The Program Integrity staff 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 Program Integrity waiver specialist is a subject matter expert (SME) responsible for directly coordinating with the waiver divisions. This specialist also analyzes data to identify potential areas of risk and identify providers that appear to be outliers warranting review. The SME may also perform desk or on-site audits and be directly involved in reviewing waiver providers and programs.

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

Program Integrity 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 on the *Medicaid Fraud & Patient Abuse* webpage at in.gov/attorneygeneral.

Section 3: Disabilities Services Waivers

This section presents an overview of the Medicaid waiver program, as well as the state's definition of intellectual/developmental disability as it applies to waiver service eligibility, cost neutrality of the waivers and coordinating Home- and Community-Based Services (HCBS) waiver services with other Indiana Health Coverage Programs (IHCP) services.

This section also provides general information about the four HCBS waiver programs that the Division of Disability, Aging and Rehabilitative Services (DDARS) oversees:

- Community Integration and Habilitation (CIH) Waiver
- Family Supports (FS) Waiver
- Health and Wellness (H&W) Waiver
- Traumatic Brain Injury (TBI) Waiver

Additional information about the DDARS waivers can be found on the *BDS* webpage at in.gov/fssa/ddars.

Section 3.1: Medicaid Waiver Overview

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

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

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

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

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

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

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

Section 3.2: Cost Neutrality

Indiana must demonstrate that average per capita expenditure for individuals participating in the CIH, FS, H&W or TBI waiver program 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 3.3: Coordination With Indiana Medicaid State Plan Services and Other Funding Streams

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

1. Private insurance, Medicare, Department of Education/school funding
2. Indiana Medicaid State Plan services, including Early and Periodic Screening, Diagnostic and Treatment (EPSDT) 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.

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

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)

Section 3.4: 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 at least one of the following:
  - Intellectual/developmental disability, cerebral palsy, epilepsy or autism
  - 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 DDARS. See *Section 4.3: Initial Level of Care Evaluation for FS and CIH Waivers* for details.

> *Note: For LOC information related to the H&W and TBI waivers, see the Level of Care (LOC) Requirements section in Section 11.*

Section 3.5: Community Integration and Habilitation Waiver

Purpose

The CIH Waiver program provides Medicaid HCBS to individuals residing in a range of community settings as an alternative to care in an intermediate care facility for individuals with intellectual/developmental disabilities or related conditions (known as 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 DDARS to meet priority criteria of one or more federally approved *reserved waiver capacity* categories, a funded slot is available, and the DDARS determines that other placement options are neither appropriate nor available.

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

Goals and Objectives

The CIH Waiver accomplishes the following:

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

Services Available Under the CIH Waiver

The following services are available through the CIH Waiver (for service definitions, see *Section 9: Service Definitions and Requirements for FS and CIH Waivers*):

- Adult Day Services
- Behavioral Support Services
- Career Exploration and Planning
- Case Management (the only mandatory service)
- Community Transition
- Day Habilitation
- Extended Services
- Facility-Based Support
- Family and Caregiver Training
- Home Modification Assessment
- Home Modifications
- Intensive Behavioral Intervention
- Music Therapy
- Occupational Therapy
- Personal Emergency Response System
- Physical Therapy
- Prevocational Services
- Psychological Therapy
- Recreational Therapy
- Remote Supports
- Rent and Food for Unrelated Live-in Caregiver
- Residential Habilitation and Support – Hourly (RHS Hourly)
- Residential Habilitation and Support – Daily (RHS Daily)
- Respite

Library Reference Number: PRPR10014
Published: Sept. 24, 2026
Policies and procedures as of Aug. 1, 2025
Version: 12.2

- Specialized Medical Equipment and Supplies
- Speech/Language Therapy
- Structured Family Caregiving
- Transportation
- Vehicle Modifications
- Wellness Coordination
- Workplace Assistance

Section 3.6: Family Supports Waiver

Purpose

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

See *Section 4.4: Waiting List for FS Waiver* and *Section 4.5: Entrance Into FS Waiver Program (for Targeted Individuals)* for information about entrance to the FS Waiver.

> *Note: The POC/service plan is subject to an annual waiver services cost cap of $26,482.*

Goals and Objectives

The FS Waiver accomplishes the following:

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

Services Available Under the FS Waiver

The following services are available through the FS Waiver (for service definitions, see *Section 9: Service Definitions and Requirements for FS and CIH Waivers*):

- Adult Day Services
- Behavioral Support Services
- Career Exploration and Planning
- Case Management (the only mandatory service)
- Day Habilitation
- Extended Services
- Facility-Based Support
- Family and Caregiver Training
- Home Modification Assessment
- Home Modifications
- Intensive Behavioral Intervention
- Music Therapy
- Occupational Therapy
- Participant Assistance and Care
- Personal Emergency Response System
- Physical Therapy
- Prevocational Services
- Psychological Therapy
- Recreational Therapy
- Remote Supports
- Respite
- Specialized Medical Equipment and Supplies
- Speech/Language Therapy
- Transportation
- Vehicle Modifications
- Workplace Assistance

Section 3.7: Health and Wellness Waiver

The H&W Waiver is designed to provide an alternative to NF admission for Medicaid-eligible persons ages 59 and younger with a disability by providing supports to complement and supplement informal supports for persons who would require care in an NF if waiver services or other supports were not available. The services available through this waiver are designed to help members remain in their own homes, as well as to help individuals residing in NFs to return to community settings, such as their own homes, apartments, assisted living or adult family care.

> *Note: For information about the H&W Waiver, including eligibility requirements and available services, see Section 11: Health and Wellness (H&W) and Traumatic Brain Injury (TBI) Waivers.*

Section 3.8: Traumatic Brain Injury Waiver

The TBI Waiver's goal is to ensure that individuals with a traumatic brain injury receive appropriate services based on their needs and the needs of their families. The TBI Waiver provides home- and community-based services to individuals who, but for the provision of such services, would require institutional care.

> *Note: For information about the TBI Waiver, including eligibility requirements and available services, see Section 11: Health and Wellness (H&W) and Traumatic Brain Injury (TBI) Waivers.*

Section 3.9: Indiana Money Follows the Person

Purpose

In an effort to prioritize those individuals living in qualifying facility settings to live in the community with needed supports, the DDARS administers Indiana's Money Follows the Person (MFP) program. Indiana's MFP program provides Medicaid HCBS to individuals residing in a range of community settings as an alternative to care in an ICF/IID or nursing facility.

An applicant must be living in a qualifying Medicaid institution or facility to be eligible for Indiana's MFP program. To apply for Indiana's MFP program, the applicant must be a resident of a qualifying institution/facility for at least 60 consecutive days or more. The applicant must have needs that can be met safely through services available in the community. Also, the applicant must meet the minimum requirements for a funding source that is currently partnering with Indiana's MFP program. These funding sources currently include the following:

- Community Integration & Habilitation (CIH) Waiver
- Health and Wellness (H&W) Waiver

> *Note: The MFP program for individuals who meet the requirements for the H&W Waiver is available to those who meet the requirements for the Indiana PathWays for Aging (PathWays) Waiver. MFP services are carved out of managed care for PathWays members.*

An Indiana MFP participant completes their transition and enters the participation phase of the program on the day they are discharged from the qualifying institution/facility and begin living in the community. Participation in Indiana's MFP program lasts for 365 participation days. At the end of the 365 participation days in the MFP program, funding for the supports received by the participant will seamlessly change from MFP to the partnering funding source for which the participant is eligible and that they have chosen. See the *Money Follows the Person* webpage at in.gov/fssa/ddars/bba for more information.

Goals and Objectives

The MFP program accomplishes the following:

- Improves the delivery of home- and community-based services (HCBS)

- Enhances the ability of Medicaid programs to provide HCBS
- Increases the use of HCBS and reduces the use of institutionally based services
- Establishes and implements procedures to provide quality assurance and improves HCBS

The DDARS has also established My Friend & Peer, a 1:1 peer mentoring support specifically designed to provide friendship and natural support for individuals transitioning out of skilled nursing facility settings to increase the likelihood of their success in the community. These MFP participants are offered peer mentoring throughout their MFP 365 participation days.

Services Available

Each MFP plan has the same available services as the corresponding waiver plan. For example, only CIH waiver services are available under the CIH MFP.

Section 4: Application for and Start of FS and CIH Waiver Services

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

See *Section 11: Health and Wellness (H&W) and Traumatic Brain Injury (TBI) Waivers* for information about the H&W and TBI waiver programs.

Section 4.1: Request for Application

An individual or the individual's guardian may apply for the FS or CIH waiver program through the local Division of Disability, Aging and Rehabilitative Services (DDARS) Bureau of Disabilities Services (BDS) office. An individual or the individual's guardian has the right to apply without questions or delay.

To apply for BDS services, including the FS or CIH waiver, the individual or guardian now has two options available.

- The first option is to use the BDS Gateway, an online application available 24 hours a day, seven days a week where individuals and families seeking may submit an application for services. The BDS Gateway may be accessed at: Bdsgateway.fssa.in.gov.
- The second option is to complete, sign and date an *Application for Developmental Disability Services (State Form 55068 [8-12])*, which is available on the DDARS *Forms* webpage at in.gov/fssa/ddars. The form may be completed as a fillable PDF or handwritten. The form must be printed, signed and returned to the local BDS office via fax, mail or in-person delivery. Other individuals or agency representatives may help the individual or guardian complete the application and forward it to the BDS office serving the county in which the individual currently resides.

Upon receiving the waiver application, the BDS staff must contact the individual and the individual's guardian and discuss the process for determining eligibility for the waiver (documentation of an intellectual/developmental disability, Medicaid eligibility and initial level of care [LOC]). If the applicant is not a Medicaid member, they are referred to the local Division of Family Resources (DFR) office to apply for Medicaid.

Applicants who have requested, met and been 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 4.6: Entrance Into the CIH Waiver Program* for details.

Section 4.2: Medicaid Eligibility

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

Medicaid enrollment is required before starting Home- and Community-Based Services (HCBS) waiver services. See the *Apply for Coverage* webpage at in.gov/medicaid/members for instructions on how to apply for Medicaid.

Applicants under the age of 18 should submit the plan of care (POC)/service plan approval letter (see *Section 4.8: State Authorization of the Initial Plan of Care/Service Plan)* 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.

Section 4.3: Initial Level of Care Evaluation for FS and CIH Waivers

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

  - Understanding and use of language
  - Mobility
- After the evaluation is complete, an LOC decision letter is sent to the individual or legal guardian. Each LOC decision letter provides a Right to Appeal Notice explaining the individual's right to appeal the decision as well as how to file an appeal. For more on appeals, see *Section 7: Appeals Process* in this provider reference module.

Section 4.4: Waiting List for FS Waiver

> *Note: For information about the waiting list for the H&W Waiver, see the Section 11.1: Eligibility for H&W and TBI Waiver Services.*

The BDS 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 BDS office.

Initial Placement on a Single, Statewide Waiting List

For initial placement on a single, statewide waiting list for the FS Waiver, the following requirements must be met:

- An individual or their legal representative must complete an application and submit the application to their local BDS office to apply for HCBS waiver services.
- The individual or their legal representative is expected to participate in the completion of the following:
  - Application
  - Collateral information, including the following:
    - LOC assessment tool
    - Supporting documents:
      - Diagnostic evaluations
      - Functional evaluations
      - Psychological reports
      - Individualized Education Program from schools
      - School records
      - Physician's diagnosis and remarks
      - Existing evaluation done by Supplemental Security Income (SSI) or Vocational Rehabilitation
    - Intelligence Quotient (IQ) testing done at any time
      - Medicaid application for individuals more than 18 years of age
      - SSI application, if applicable
- LOC must be assessed for all individuals.
- An individual must meet these requirements:
  - The state definition of a developmental disability found in *IC 12-7-2-61(a)*
  - ICF/IID LOC with substantial functional limitations as defined in *42 CFR 435.1010*
- If an individual completes the application and meets the LOC criteria listed in *Section 4.3: Initial Level of Care Evaluation for FS and CIH Waivers*, they are placed on a waiting list using the individual's application date.

Responsibilities of Individuals on a Waiting List

Individuals on a waiting list have the following responsibilities:

- An individual, or an individual's legal representative, is expected to maintain current contact information with their local BDS office. This information includes any change in address or telephone number.
- If, after a reasonable number of attempts, the BDS 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.

Waiting List Targeting for a Family Supports Waiver Slot

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

- Individuals are targeted for an FS 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 FS Waiver 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.*

Section 4.5: Entrance Into FS Waiver Program (for Targeted Individuals)

When a slot becomes available under the FS Waiver, an individual on the single statewide waiting list for FS Waiver services will receive a letter from the BDS Central Office, asking the individual to do the following:

- Accept or decline the waiver slot within 30 calendar days.
- Apply for Medicaid if they have not already done so.
- Provide or obtain confirmation of their diagnosis from a physician on the *Confirmation of Diagnosis (State Form 54727)*, available from the DDARS *Forms* webpage at in.gov/fssa/ddars

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

Individuals may be eligible to enter into FS Waiver services by meeting one of the specific priority criteria of the following reserved waiver capacity categories:

- Individuals ages 18 through 24 who have aged out of, graduated from, or permanently separated from their school setting may be eligible to enter waiver services under the FS Waiver on that separation, if funded slots are available
- Eligible individuals transitioning from 100% state-funded services
- Eligible individuals receiving services under the Health & Wellness (H&W) Waiver who no longer meet nursing facility level of care

- Eligible children who are either:
  - A child of an active member/veteran of the armed forces of the United States, defined in *IC-5-9-4-2*
  - A child of an active member/veteran of the National Guard

If an individual declines the offer for an FS Waiver slot, their name is removed from the single statewide waiting list for FS Waiver services.

If an individual accepts the offer for an FS Waiver slot:

- An "intake" meeting with a service coordinator from the local BDS District Office is scheduled for the BDS 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 the date of the letter.
- The individual and/or any legal guardian has 60 calendar days to apply for and obtain Medicaid if the individual does not yet have Medicaid coverage.
- If the individual already has Medicaid coverage, but the aid category to which the individual's Medicaid eligibility has been assigned is not compatible with waiver program requirements, they have 30 calendar days from the date on the contact letter from the BDS to request that the DFR process the needed change in Medicaid aid category.
- The individual or guardian must cooperate fully with requests related to the application for Medicaid eligibility and any change needed in the Medicaid aid category.

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

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

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

The timely completion of requirements for the PCISP and service plan should be done through the BDS Portal at bddsportal.fssa.in.gov:

- Initial PCISPs are due 45 calendar days following the confirmation date of the initial service plan at a minimum.
- Annual PCISPs are due on or before the start date of the plan year.
- Revisions to PCISPs are due within seven calendar days of the Individualized Support Team (IST) meeting, face-to-face visit or conversation in which the desire or need for revision is identified. Updated PCISPs are required in any of the following situations:
  - When the needs or circumstances of the individual changes
  - When services are added or removed

  - When requested by the individual and/or legal representative
  - For nonannual team meetings to record team discussion on outcomes and any related plan changes
- Annual service plans are due 45 calendar days prior to the end of the current plan year.

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

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

Section 4.6: Entrance Into the CIH Waiver Program

Entrance into the HCBS CIH Waiver program requires the following:

- Individuals must meet and be approved for the specific priority criteria of at least one of the following reserved waiver capacity categories:
  - Eligible individuals transitioning to the community from a nursing facility (NF), Extensive Support Needs Home (ESN) or a State Psychiatric Hospital (SPH)
  - Eligible individuals determined to no longer need/receive active treatment in Supervised Group Living (SGL)
  - Eligible individuals transitioning from 100% state-funded services
  - Eligible individuals aging out of Indiana Department of Education facility/residential placement; the Indiana Department of Child Services foster care; facility, residential or group home placement; or Indiana Medicaid Supervised Group Living
  - Eligible individuals choosing to leave an ICF/IID
  - Eligible individuals meeting one of the following emergency placement criteria:
    - Death of a primary caregiver when there is no other caregiver available
    - Caregiver over 80 years of age when there is no other caregiver available
    - Evidence of abuse or neglect in the current institutional or home placement
    - Extraordinary health and safety risk as reviewed and approved by the division director
- Individuals, their legal representatives or other persons acting on the individual's behalf must request and apply for a priority waiver slot when it appears that the individual meets the specific criteria of one or more reserved waiver capacity categories.
- It is necessary to complete an application and submit the application to the local BDS office to apply for CIH 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 4.3: Initial Level of Care Evaluation for FS and CIH Waivers*, and a funded priority slot is available in the reserved waiver capacity category met by the individual, the BDS 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 BDS 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 BDS office, including changes in address or telephone number
- If the BDS attempts to contact an individual or the individual's legal guardian or the identified secondary contact person, and is unable to make contact by mail or telephone, the individual will forfeit the current opportunity for a CIH Waiver priority slot, but may reapply at any time

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

If an individual or an individual's legal representative accepts placement through the offer of a funded CIH Waiver priority slot, an intake meeting with a service coordinator from the BDS 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 on the BDS letter offering a CIH Waiver priority slot.

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

If the individual already has Medicaid coverage, but the aid category to which the individual's Medicaid eligibility has been assigned is not compatible with waiver program requirements, they have 30 calendar days from the date on the contact letter from the BDS 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 BDS gives applicants younger than the age of 18 and their legal guardians a choice list of case management providers that are approved by the DDARS and enrolled through the IHCP to provide selected contracting Case Management services. Due to the disregard of parental income for minors receiving waiver services, proof of a POC/service plan may be required before some minors can obtain Medicaid eligibility. In those situations, the BDS creates the POC/service plan, enabling the minor to obtain Medicaid. Otherwise, selection of a DDARS-approved provider of contracted Case Management services is required before the POC/service plan can be created. For adults, generating the BDS case management organization choice list and selecting a case management organization does not occur until after all eligibility criteria are met, including establishing Medicaid eligibility in a waiver-compatible aid category. Thereafter, the applicant or guardian (if applicable) completes the service planning process and chooses service providers for any other selected services, and the case management provider submits a POC/service plan for waiver service.

The timely completion of requirements for the PCISP and service plan should be done through the BDS Portal at bddsportal.fssa.in.gov:

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

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

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

Section 4.7: Initial Plan of Care /Service Plan Development for FS and CIH Waivers

The state monitors its person-centered planning process to ensure compliance with *CMS 2249-F* and *CMS 2296-F*. The person-centered individualized support plan (PCISP) approach enhances the way in which supports and services are explained to individuals and families so that their needs, aspirations and opportunities for the achievement of self-determination, interdependence, productivity, integration and inclusion in all facets of community life can be identified and explored. Additionally, the PCISP drives the development of the POC/service plan. The PCISP is the plan that identifies the array of services and supports, paid and unpaid from all sources that will be used to implement desired outcomes and ensure the individual's health and welfare while the POC/service plan identifies those supports and services that are funded by the waiver. The individual, case manager, selected providers and other persons chosen by the individual form the IST. The individual has the right and power to command and direct the entire PCISP process with a focus on their preferences, aspirations and needs. The process empowers individuals to create life plans and direct the

planning and allocation of resources to meet their self-directed life goals. The POC/service plan is developed by the individual-chosen case manager a minimum of six weeks prior to the initial start date of services and then six weeks prior to the end date of each annual service plan. The POC/service plan is routinely developed to cover a time frame of 12 consecutive months.

While the FS Waiver is capped at $26,482 annually for each individual, budgeted amounts for POC/service plans developed under the CIH Waiver use the objective-based allocation process described in *Section 5: Objective-Based Allocation for CIH Waiver*.

Coordination of waiver services and other services is completed by the case manager. Within 30 days of implementation of the plan, the case manager is responsible for ensuring that all identified services and supports have been implemented as identified in the PCISP and the POC/service plan. The case manager is responsible for monitoring and coordinating services on an ongoing basis and is required to record a case note for each encounter with, or on behalf of, the individual. A formal 90-day review is also completed by the case manager using information received from the individual, family or guardian as applicable, and other IST members before, during and after the face-to-face visit or IST meeting. The IST is advised of any concerns or needs for updates that may require scheduling of additional team meetings by the case manager.

Most waiver service providers are required to submit a quarterly report summarizing the level of support provided to the individual, based on the identified supports and services in the PCISP and the POC/service plan. As part of the 90-day review process, the case manager reviews these reports for consistency with the PCISP and POC/service plan and works with providers as needed to address findings from this review.

Section 4.8: State Authorization of the Initial Plan of Care/Service Plan

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

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

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

- Supplemental Security Income (SSI)-eligible individuals will be automatically enrolled in the Indiana Health Coverage Programs (IHCP) and will not need to file a separate *Indiana Application for Health Coverage*. Members with SSI will be assigned to the new Modified Adjusted Gross Income (MAGI)

eligibility aid category. Individuals deemed disabled by the Social Security Administration and who are receiving SSI based on that determination will not be required to undergo a separate determination of disability from Indiana's Medical Review Team (MRT).

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

The waiver specialist also confirms the following:

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

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

If the waiver specialist approves the initial POC/service plan, the initial approval letter and signed service authorization are electronically transmitted to the case manager, BDS (for initial POC/service plans only) and service providers. Within three calendar days of receiving the initial POC/service plan approval letter and service authorization, the case manager must provide copies of the approval letter, signed service authorization and addendum (containing information from the POC/service plan) to the individual or guardian. The individual's chosen waiver service providers are required to register so that they receive the service authorization and the addendums electronically.

Service Authorization

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

- If the waiver specialist approves the POC/service plan 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 BDS and the service providers. The case manager must notify the individual or guardian within three calendar days of receipt of the pending approval and provide a copy of the initial approval letter naming the pending conditions. No service authorization is generated until all pending issues are resolved and a final approval letter is released.
- If the waiver specialist denies the initial POC/service plan, a denial letter must be transmitted to the case manager, the BDS (for initial and annual POC/service plans only) and service providers. Within three calendar days of receipt of the denial, the case manager must provide a copy of the service authorization, the appeal rights as an HCBS waiver services recipient and an explanation of the decision to deny to the individual or guardian. The case manager discusses other service options with the individual and guardian, unless the individual or guardian files an appeal.

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

Section 4.9: Initial Service Plan Implementation for FS and CIH Waivers

An individual cannot begin waiver services under the FS or CIH waiver program before the approval of the initial POC/service plan by the state's waiver specialist. The initial POC/service plan represents the service

plan identified for the individual resulting from the PCISP development process. If the waiver specialist issues an initial approval letter pending certain conditions being met, those conditions must be resolved before the start of the individual's waiver services. For applicants under the age of 18, if the individual's Medicaid eligibility is approved pending waiver approval, the case manager notifies the local DFR caseworker when the waiver has been approved. The DFR caseworker and waiver case manager coordinate the Medicaid eligibility date and waiver start date. If Medicaid eligibility depends on eligibility for the waiver, the Medicaid start date is usually the first day of the month following approval of the POC/service plan.

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

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

Following discharge from the facility and within three calendar days after the individual begins waiver services, the case manager must complete the *Confirmation of Waiver Start* form in the INsite database and electronically transmit it to the state through the DDARS 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 DDARS database, the FSSA is also electronically notified to enter the individual's waiver start information in the Core Medicaid Management Information System (*Core*MMIS) database.

When the *Confirmation of Waiver Start* form is received electronically by the DDARS, 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/service plan is from the effective date of the confirmation form through the end date of the initial POC/service plan that was previously approved by the waiver specialist.

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

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

Section 5: Objective-Based Allocation for CIH Waiver

This section presents the objective-based allocation (OBA) methodology that the Family and Social Services Administration (FSSA) Division of Disability, Aging and Rehabilitative Services (DDARS) 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 5.1: OBA Development for CIH Waiver

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

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

> *Note: The OBA methodology is **not** used with the already capped Family Supports (FS), Traumatic Brain Injury (TBI) or Health and Wellness (H&W) waiver.*

Section 5.2: ICAP Assessment and Algo Level Development for CIH Waiver

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 behavioral and health factors, determines an individual's level of functioning on behavioral 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 5.5: Long-Term Budget Request and Short-Term Budget Request for CIH Waiver* addresses potential adjustments to the allocation amount.

Section 5.3: Algo Level Descriptors for CIH Waiver

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

Table 1 – Algo Level Descriptors

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

Section 5.4: Translating Algo Level Into a Budget Allocation for CIH Waiver

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

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

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

After the ICAP and ICAP addendum assessments (described in *Section 5.2: ICAP Assessment and Algo Level Development for CIH Waiver*) are completed and the information is received by the state. Individuals in the CIH Waiver program and their support teams are required to review the information and ensure that it accurately reflects them. Upon completion of their review, individuals and their support teams are notified of their OBA through their case managers.

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

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

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

Table 2 – Algo to Budget – Example

Annual OBA for Adults Ages 25 and Older (Using Rates Effective October 2017 – EXAMPLE ONLY) and for Young Adults Ages 19-24 **not** Attending School

Living With Family Example

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

Living Alone Example

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

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

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

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

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

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

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

Structured Family Caregiving Example

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

*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.*

Section 5.5: Long-Term Budget Request and Short-Term Budget Request for CIH Waiver

This section describes the Long-Term Budget Request (LTBR) and the Short-Term Budget Request (STBR).

Long-Term Budget Request (LTBR)

Previously known as the Budget Review Questionnaire, or BRQ, and applicable only to the CIH Waiver program, a Long-Term Budget Request (LTBR) is a set of qualifying questions, responses and supporting documentation used to determine why a budget review is necessary. The LTBR and responses are submitted by the individual's case manager based on information provided by the IST.

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

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

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

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

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

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

- The IST believes that the Wellness Coordination Health score is inaccurate and needs to be reviewed.
  - Documentation from a medical professional outlining the change in condition or diagnosis, with an anticipated duration of the condition, risk factors to consider and any other special considerations
- An individual's behavioral conditions change.
  - A copy of the behavioral support plan (BSP)
  - Monthly documentation supporting the change in conditions
  - 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 BSP
    - Monthly documentation supporting the change in conditions
    - Incident reports

When requested, the LTBR and supporting documentation and information are reviewed by the waiver specialist with the BDS. The waiver specialist may request additional information from the case manager to support the LTBR 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 waiver specialist, the request to modify the individual's budget may be denied. However, when all needed supporting documentation is provided, the waiver specialist 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 waiver specialist will notify the waiver case manager of any changes in the Algo or allocation. An individual who is dissatisfied with the waiver specialist's determination may appeal the service authorization within 33 days of the date of the notice. During an appeal, the BDS maintains the budget from the last agreed-upon budget allocation. An individual or the individual's legal representative may appeal the Algo if they feel the Algo level is inaccurate. Refer to *Section 7: Appeal Process* in this provider reference module for additional information on appeals.

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

Short-Term Budget Request (STBR)

Previously known as the Budget Modification Request, or BMR, the Short-Term Budget Request (STBR) allows individuals on the CIH Waiver to obtain additional funds for a short-term when the individual experiences an unanticipated event that requires a higher budget to meet their needs.

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

STBRs must be filed within 45 calendar days of the event or status change. A residential provider may submit an STBR; however, the HCBS waiver case manager must review and submit it to the BDS.

The following timeline for filing an STBR appears in the Short-Term Budget Request Timeline policy. Although providers, individuals and support teams do not have to follow this exact timeline, the process must be completed within 45 calendar days of the qualifying event:

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

Unanticipated events defined in the STBR policy include:

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

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

- For STBRs 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 STBR

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

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

The residential provider or waiver case manager may submit an additional STBR 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 STBRs are submitted by case managers. The notification is sent to the service authorization 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 STBR is intended to cover, and the associated PCISP.

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

The individual or legal guardian has the right to appeal any waiver-related decision of the state within 33 calendar days of the service authorization. A service authorization is issued with the release of each state decision pertaining to a PCISP. Each service authorization contains the individual's appeal rights, as well as instructions for filing an appeal. Refer to *Section 7: Appeal Process* in this provider reference module for additional information on appeals.

For further guidance, see the following BDS policies and procedures found on the *Current BDS Policies* webpage at in.gov/fssa/ddars:

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

> *Note: The LTBR and STBR processes are not used with the already capped Family Supports (FS), Traumatic Brain Injury (TBI) or Health and Wellness (H&W) waiver.*

Section 5.6: Implementation of Objective-Based Allocations for CIH Waiver

The case manager for each individual participating in the CIH Waiver program receives the new OBA three months before the individual's annual renewal date. The case manager must review the OBA with the individual and the individual's IST prior to the development of a new annual service plan. If there has been a significant change in the life of the individual, with agreement of the IST, the case manager is responsible for requesting a LTBR (see *Section 5.5: Long-Term Budget Request and Short-Term Budget Request for CIH Waiver*).

> *Note: The OBA is not used with the already capped Family Supports (FS), Traumatic Brain Injury (TBI) or Health and Wellness (H&W) waiver.*

Section 5.7: Personal Allocation Review (PAR) and Appeal Process for CIH Waiver

Applicable only to individuals in the CIH Waiver program, an IST may request a personal allocation review (PAR) through the case manager via an LTBR. The LTBR states the reason for allocation review. The full list of acceptable reasons for allocation review is found in *Section 5.5: Long-Term Budget Request and Short-Term Budget Request for CIH Waiver*, 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 LTBR is submitted by the case manager to the BDS. The LTBR, supporting documentation and information are reviewed by the waiver specialist with the BDS. The waiver specialist determines whether an individual's Algo score is supported based on the provided information. The BDS reviews the LTBR within seven business days of submission.

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

If the documentation provided with the LTBR is complete, the waiver specialist 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 waiver specialist will notify the waiver case manager of any changes in the Algo or allocation. If a change in the Algo score is appropriate, an updated PCISP must be submitted at the correct allocation level so that a service authorization with appeal rights may be generated by the BDS and distributed to the individual through the waiver case manager. If the individual questions the indicated decision, the individual may discuss it with the case manager.

An individual who is dissatisfied with the waiver specialist's determination may appeal the service authorization within 33 days of the date of the notice. During the appeal, the BDS shall maintain the budget from the last agreed-upon budget allocation.

> *Note: The LTBR and STBR processes are not used with the already capped Family Supports (FS), Traumatic Brain Injury (TBI) or Health and Wellness (H&W) waiver.*

The appeal process is located on the back pages of the service authorization and is also described in *Section 7: Appeals Process*.

Section 6: Monitoring and Continuation of FS and CIH Waiver Services

This section describes the different processes that occur to monitor and continue Family Supports (FS) and Community Integration and Habilitation (CIH) waiver services.

See *Section 11: Health and Wellness (H&W) and Traumatic Brain Injury (TBI) Waivers* for information about the H&W and TBI waiver programs.

Section 6.1: Level of Care Reevaluation for FS and CIH Waivers

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

FS and CIH waiver program individuals must be reevaluated each year to meet the LOC for intermediate care facilities for individuals with intellectual disabilities (ICF/IID).

Only individuals who are qualified intellectual disability professionals (QIDPs) as specified by the federal standard within *Code of Federal Regulations 42 CFR 483.430(a)*, may perform LOC determinations.

Section 6.2: Medicaid Eligibility Redetermination

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

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

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

Section 6.3: Annual Person-Centered Individualized Support Plan Development

All individuals (also known as participants) receiving FS and CIH waiver services must have a new person-centered individualized support plan (PCISP)/service authorization approved at least annually. The new PCISP planning approach enhances the way in which supports and services are explained to participants 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.

The PCISP is the new plan that identifies the array of services and supports, paid and unpaid from all sources that will be used to implement desired outcomes and ensure the individual's health and welfare while the PCISP/service authorization identifies those supports and services which are funded by the waiver. The participant, case manager and others of the participant's choosing from the Individualized Support Team (IST). The participant has the right and power to command and direct the entire PCISP process, with a focus on their preferences, aspirations and needs. The process empowers participants to create life plans and allows the individual to direct the planning and allocation of resources to meet their self-directed life goals. The annual PCISP is developed by the participant working with their case manager a minimum of six weeks prior to the end date of each annual service plan. The PCISP is routinely developed to cover 12 consecutive months. The following apply to this process:

- Although the FS Waiver is already capped at $26,482 annually, budgeted amounts for PCISPs developed under the CIH Waiver use the objective-based allocation process described in *Section 5: Objective-Based Allocation for CIH Waiver*.
- Coordination of waiver services and other services is completed by the case manager. Within 30 days of implementation of the plan, the case manager is responsible for ensuring that all identified services and supports have been implemented as identified in the PCISP. 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 individual based on the identified supports and services in the PCISP/service authorization. As part of the 90-day review process, the case manager reviews these reports for consistency with the PCISP and POC/service plan and works with providers as needed to address findings from this review.
- If an annual PCISP/service authorization is not submitted or cannot be approved in a timely manner, the most recently approved PCISP/service authorization is automatically converted to a new annual PCISP/service authorization. The total cost and amount of services on the "auto converted" or "default" PCISP/service authorization is determined by the cost of services and supports appearing on the most recently approved but expiring PCISP/service authorization. The auto-converted or default PCISP/service authorization ensures that there is no loss of services for the participant. The case manager is subsequently contacted and required to complete the annual person-centered planning process to update the PCISP and service authorization as needed.
- Risks are assessed during the PCISP process to help identify risks related to health*, behavior, safety and support needs for waiver participants.

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

See Section 11 for requirements specific to the H&W and TBI Waivers.

- The PCISP/service authorization 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 PCISP/service authorization.

Section 6.4: PCISP/Service Authorization Updates and Revisions

For the FS and CIH waivers, the PCISP and service authorization are reviewed a minimum of every 90 calendar days by the case manager and updated a minimum of every 365 calendar days with involvement of the IST. The individual can request a change to the PCISP/service authorization at any point, whether a new service provider or a change in the type or amount of service. If a change to the PCISP and/or the service authorization is determined necessary during that time, the individual and/or family or legal representative and IST will meet to discuss the change. The actual updating of the PCISP/service authorization is completed by the case manager based on the individual and the IST discussion and determination.

Section 6.5: State Authorization of Service Authorization

For the FS and CIH waivers, the case manager will transmit the service authorization electronically to the state's waiver specialist, who will review the service authorization 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 the identified needs of the individual and the services to be provided.
- Signatures indicate that the individual and/or guardian accepts the service authorization; 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 service authorization:

- If the waiver specialist denies the service authorization, a denial letter must be transmitted to the case manager and service providers. Within three calendar days of receipt of the denial, the case manager must provide a copy of a service authorization, 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 service authorization, an approval letter and signed service authorization are transmitted to the case manager, BDS (for initial and annual service authorizations only) and service providers. The case manager notifies the individual or guardian within three calendar days of receipt of the approval and provides a copy of the approval letter, signed service authorization and addendum (containing information from the PCISP/service authorization).

Section 6.6: Service Plan Implementation and Monitoring

For the FS and CIH waivers, case managers are responsible for the implementation and monitoring of the service plan (inclusive of the PCISP, service authorization and, often, other nonfunded services) and the individual's health and welfare.

- A minimum of one face-to-face contact between the case manager and the individual is required at least every 90 calendar days or as frequently as needed to support the individual. The case manager reviews current concerns, progress and implementation of the PCISP in addition to any risk assessments incorporated in the PCISP to ensure the individual's needs are being met. Meetings may occur in the home of the individual or another location convenient to the individual. For individuals living in a home owned or controlled by the waiver provider, there must be at least one unannounced visit in the home each year. IST meetings are now required at least semiannually, or when requested by the individual, family, BDS or other team members. However, face-to-face contact and team meeting requirements for individuals with high risk or health needs remain at least every 90 days or more often as determined by the IST.
- A monitoring checklist is used by the case manager and IST to systematically review the status of the PCISP/service authorization, any behavioral support program, the individual's choice and rights, medical needs, medications (including psychotropic medications if applicable), seizure management (if applicable), nutritional/dining needs, incident review, staffing issues, fiscal issues, risk plans and any other issues that may be identified in regard to the satisfaction and health and welfare of the individual. The checklist is also used to verify that emergency contact information is in place in the home, including the telephone numbers for Adult Protective Services or Child Protective Services and the BDS Quality Assurance Services. Case managers educate the individual by offering examples of when the emergency contact numbers should be called.
- The case manager is required to enter a case note for each encounter (at least one per month) with the individual indicating the progress and implementation of the service plan. The case manager also maintains regular contact with the individual, family/guardian and the providers of services through home and community visits or by phone to coordinate care, monitor progress and address any immediate needs. During each of these contacts, the case manager assesses the service plan implementation and monitors the individual's needs.
- The monitoring and follow-up methods used by the case manager include conversations with the individual, the parent/guardian and providers to monitor the frequency and effectiveness of the services through team meetings and regular face-to-face and telephone contacts. The case manager asks:
  - Are the services being rendered in accordance with the PCISP/service authorization?
  - Are the service needs of the individual being met?
  - Do individuals exercise freedom of choice of providers?
  - What is the effectiveness of the crisis and backup plans?
  - Is the individual's health and welfare being ensured?
  - Does the individual have access to nonwaiver services identified in the PCISP, including access to health services?
- At all times, full, immediate and unrestricted access to the individual data is available to the state, including the DDARS case management liaison position as well as other members of the DDARS executive management team and the FSSA Office of Medicaid Policy and Planning (OMPP).

Service Problems

For the FS and CIH waivers, problems regarding services provided to individuals are targeted for follow-up and remediation by the case management provider in the following manner:

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

Section 6.7: Interruption/Termination of Waiver Services

For the FS and CIH waivers, an individual's waiver services will be terminated when the individual:

- Voluntarily withdraws
- Chooses to be placed in an institution or is otherwise placed in an institution
- Is convicted, sentenced and incarcerated for more than 30 days
- Remains in a Medicaid-funded long-term care facility for more than 30 days
- Dies
- Needs services so substantial that the total cost of Medicaid services for the individual would jeopardize the waiver program's cost-effectiveness
- No longer meets ICF/IID LOC criteria
- Is no longer eligible for Medicaid services
- No longer requires home- and community-based services
- Is no longer intellectually or developmentally disabled

Examples of circumstances appropriate for interruption of waiver services may include when the individual:

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

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

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 service authorization.

Within three calendar days of a processed termination, the case manager must provide the individual or guardian with a copy of the service authorization, the *Your Appeal Right as an Applicant for HCBS Benefits* instructions and an explanation of the termination. As appropriate, other service options are to be discussed with the individual and guardian.

Section 6.8: Waiver Slot Retention After Termination and Reentry

For the FS and CIH waivers, the following situations related to waiver slot retention after termination are contingent upon review and approval by the state:

- Upon review and approval of the state, if an individual who has been terminated from the waiver wishes to return to the program, they may do so within the same waiver year of their termination, if otherwise eligible. The individual shall return to the waiver without going on a waiting list.
  - "Within the same waiver year" means from July 16 through July 15 of the following year for both the FS and CIH waivers
- 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 PCISP/service authorization if the individual's condition has not significantly changed, and the PCISP/service authorization continues to meet their needs. The following must occur:
  - The case manager must certify that the individual continues to meet LOC criteria.
  - The case manager must complete a "Re-Start" DEW in the INsite database and submit it electronically into the DDARS case management database. The information will be reviewed by a waiver specialist and automatically transmitted to the OMPP to enter into the Core Medicaid Management Information System (*Core*MMIS) database.
- If an individual who has been terminated from the waiver program longer than 30 calendar days, wishes to return to the program, and is otherwise eligible, the following must occur:
  - The BDS service coordinator determines a new "initial" LOC for the individual
  - The case manager is responsible for developing the PCISP/service authorization following the same processes described in *Section 4.7: Initial Plan of Care/Service Plan Development for FS and CIH Waivers* minus the need for a new confirmation of diagnosis form. The case manager is to indicate a "Re-Entry" service authorization when electronically submitting the service authorization to the state waiver specialist via the DDARS 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 DDARS case management database. The information will be automatically transmitted to the OMPP to enter in the *Core*MMIS database.
  - When the *Confirmation of Waiver Start* form is received electronically by the DDARS, it is reviewed. After the form is received, reviewed and accepted, a service authorization will be automatically transmitted to the case manager and all the individual's waiver service providers.
  - Within three calendar days of receiving the Re-Entry service authorization, the case manager must provide copies of the approval letter, signed service authorization and addendum (containing information from the PCISP/service authorization) 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 PCISP/service authorization 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 PCISP/service authorization dates are used for determining when future annual LOC determinations and the PCISP/service authorizations are due.

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

Section 6.9: Parents, Guardians and Relatives Providing FS and CIH Waiver Services

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

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

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

Definition of a Relative

For all purposes pertaining to waiver-funded programs operated by the DDARS, "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)

Criteria for a Relative To Be a Provider

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 DDARS to provide care under the waiver.
- The relative meets the appropriate provider standards (per *Indiana Administrative Code 460 IAC 6*) for the services being provided.
- The decision for the relative to provide services to a waiver individual is part of the PCISP planning process, which indicates that the relative (defined previously) is the best choice of persons to provide services from the DDARS-approved provider agency, and this decision is recorded and explained in the PCISP.
- There is detailed justification as to why the relative is providing service.
- The decision for a relative to provide services is evaluated periodically (for example, at least annually) to determine whether it continues to be in the best interest of the waiver individual.
- Payment is made only to the DDARS-approved Medicaid enrolled waiver provider agency in return for specific services rendered.
- The services must be rendered one-on-one with the individual or in shared settings with group sizes allowable per specified waiver service definitions and documented as acceptable by all relevant ISTs.
- Authorization for shared or group services must be documented in the approved service authorization for each group individual. With the exception of groups of waiver individuals as noted previously, the relative (defined above) may not be responsible for others (including their other children or family members) nor engaged in other activities while providing services.

Note: Regarding Participant Assistance and Care (PAC) under the FS Waiver and Residential Habilitation and Support (RHS) under the CIH Waiver, reimbursable waiver funded residential habilitation services furnished to an adult waiver individual by a paid relative and/or legal guardian may not exceed a total of 40 hours a week per paid relative and/or legal guardian caregiver.

This section presents information about the appeal process as it pertains to Medicaid Home- and Community-Based Services (HCBS) waiver applicants, participants and providers.

Note that changes were implemented within the appeal process, moving administrative law judge (ALJ) offices from the Family and Social Services Administration (FSSA) to a new Office of Administrative Law Proceedings (OALP). The ALJs are no longer employees of the FSSA. Appeals are now submitted and processed as outlined in Sections 7.1 through 7.18 in this section. Interested parties may review the OALP website at in.gov/oalp. The physical location of the OALP is:

Office of Administrative Law Proceedings
100 N. Senate Avenue, Suite N802
Indianapolis, IN 46204

Phone: 317-234-6689

Section 7.1: Appeal Request

An appeal is a request for a hearing before an ALJ with the OALP. The purpose of an appeal is to determine whether a decision made by a service coordinator, waiver specialist, the Division of Disability, Aging and Rehabilitative Services (DDARS) Central Office, or other entities affecting the waiver applicant, waiver participant or provider was correct. An appeal request must be made in writing and forwarded to the hearing authority.

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

The request for an appeal and a fair hearing should be recorded in a case note by the case manager, as well as recorded at the OALP.

Appeal rights are contained in, and communicated with, decisions that impact HCBS waiver participation, including but not limited to the following:

- Eligibility/level-of-care (LOC) determinations
- Service authorizations generated for the initial approval/denial of a service plan or updates to a service plan
- Changes in allocation or objective-based allocation (OBA)

Eligibility/Level-of Care Decisions

The *LOC Decision Letter* contains a *Right to Appeal Notice* instructing the individual how to file an appeal, if desired.

When a request for entrance into an HCBS waiver program is denied, the denial letter advises the applicant of their right to file an appeal with the OALP.

Service Authorizations

Service authorizations are used to notify each Medicaid HCBS waiver participant or prospective participant of any action that affects their HCBS services, including:

- Choice of HCBS as an alternative to institutional care
- Authorized services and service providers
- HCBS waiver service actions, including reduction, termination or denial of a service

Service authorizations generated for the initial approval/denial of a service plan, updates to service plan, changes in allocation or objective-based allocation (OBA), eligibility/LOC changes, and/or other decisions impacting waiver participation, contain appeal rights.

> *Note: Data Entry Worksheets (DEWs) related to the interruption, termination or withdrawal from HCBS waiver services may be appealed. Waivers may not be interrupted or terminated due to individual/family/guardian non-responsiveness without prior approval from BDS. However, for waiver terminations due to institutionalization or death, the termination DEW entered by the case manager and accepted by the state autogenerates the service authorization.*

The case manager provides each participant and eligible prospective participant (as well as the individual's guardian or advocate, as appropriate) with a copy of the service authorization.

The service authorization specifies any adverse determination (when the individual is denied the services or the providers of their choice, or when actions are taken to deny, suspend, reduce or terminate services). The service authorization informs the individual (and the individual's guardian or advocate, as appropriate) of their right to appeal the determination and request a fair hearing, and also advises the individual that services will be continued if they file the appeal in a timely manner. **Appeals must be received by the FSSA within 33 calendar days of the decision date noted on the service authorization.**

An explanation regarding an appellant's appeal rights and the opportunity for a fair hearing can be found on the back of the service authorization:

- *"Your Right to Appeal and Have a Fair Hearing"* advises the appellant (the petitioner) – who may be an applicant, waiver participant, prospective waiver participant or provider, – of their right to appeal and the timeliness requirements associated with the right to appeal.
- *"How to Request an Appeal"* provides instructions regarding the procedures that are necessary in the appeal process, including the right of the appellant to authorize representation by an attorney, relative or other spokesperson on behalf of the appellant.

Allocations

Individuals participating in the CIH Waiver have the right to appeal the assessment used to determine the OBA amount. Individuals of the CIH Waiver have the right to appeal decisions of the waiver specialist, including decisions related to the Long-Term Budget Request (LTBR) and the Short-Term Budget Request (STBR) described in *Section 5.5: Long-Term Budget Request and Short-Term Budget Request for CIH Waiver* and *Section 5.7: Personal Allocation Review (PAR) and the Appeal Process*.

> *Note: The FS Waiver has a capped allocation that is not subject to appeal.*

Section 7.2: Group Appeals

The OALP may respond to a series of requests for hearings by providing *group hearings*, on similar questions or changes in federal or state law or regulation. Similarly, a group of individuals that wishes to appeal some aspect of policy may request to be heard as a group. If there is disagreement as to whether the issue is one of federal or state law, regulation, or the facts of an appellant's personal situation, OALP makes the decision as to whether the appeal may be included in a group hearing.

The ALJ may limit the discussion in a group hearing to the sole issue under appeal. When an appellant's request for a hearing adds issues to the (sole) issue serving as the basis for the group hearing, the appeal is handled as an individual hearing. An appellant scheduled for a group hearing may choose to withdraw and be granted an individual hearing, even if the matter under appeal is limited to the sole issue involved in the group hearing.

Policies governing the conduct of individual hearings are pertinent to group hearings. Each appellant (or authorized representative) is given full opportunity to present the case (or have an authorized representative present the case).

Section 7.3: Time Limits for Requesting Appeals

The following are time limits for requesting appeals:

- **Service authorization:** The applicant for HCBS waiver supports, waiver individual or their legal guardian/authorized representative has the right to appeal any waiver-related decision of the state. A service authorization is issued with the release of each state decision pertaining to a service authorization. Each service authorization contains the appeal rights of the applicant/individual, as well as instructions for filing an appeal. The appeal must be received by the OALP within 33 calendar days of the service authorization.
- **Objective-based allocation:** The individual, or their legal guardian/authorized representative, has the right to appeal the OBA within 30 calendar days of the service authorization. Each service authorization contains the appeal rights of the individual, as well as instructions for filing an appeal.
- **Developmentally Disabled (DD) eligibility:** The applicant, individual or their legal guardian/ authorized representative has the right to appeal DD eligibility within 15 calendar days of the decision. The decision letter will contain the appeal rights of the applicant/individual, as well as instructions for filing an appeal. Per *Indiana Code IC 12-11-1.1-1*, an individual must be found to have a developmental disability to qualify for BDS services.
- **Level of Care determination:** The applicant, individual or their legal guardian/authorized representative has the right to appeal LOC within 15 calendar days of the decision. The decision letter contains the appeal rights of the applicant/individual, as well as instructions for filing an appeal. Per *Code of Federal Regulations 42 CFR §441.301(b)(6)*, to qualify for HCBS waiver services under the FS or CIH waivers administered by the DDARS, an individual must be found to require the same state-defined level of care specified for admission/entrance to an intermediate care facility for individuals with intellectual disabilities (ICF/IID). To qualify for H&W waiver, the individual must be found to require the same state-defined LOC specified for admission to a nursing facility (NF). To qualify for TBI waiver, the individual must be found to require either ICF/IID or NF LOC.
- **Reserved Waiver Capacity (priority criteria):** The applicant, individual or their legal guardian/authorized representative has the right to appeal a denial for entrance to the waiver via priority criteria within 18 calendar days of the decision. The decision letter will contain the appeal rights of the applicant/individual, as well as instructions for filing an appeal.

Section 7.4: Notice of Scheduled Hearing

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

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

The Notice of Scheduled Hearing contains the following:

- Includes a statement of the date, time, place and nature of the hearing. In most cases, both budget-related and eligibility/LOC related hearings are conducted telephonically unless otherwise directed by the ALJ.
- Advises the appellant of the name, address and telephone number of the person to notify in the event it is not possible for them to attend.
- Specifies that the hearing request may be dismissed if the appellant fails to appear for the hearing without good cause.
- Specifies that the appellant may request a continuance of the hearing if good cause is shown
  - Request for a continuance must be submitted in writing.
- Includes the appellant's rights, information and procedures to provide the appellant or authorized representative with an understanding of the hearing process.
- Explains that the appellant may examine the case record prior to the hearing.

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

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

Section 7.5: Request for Continuance

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

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

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

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

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

Section 7.6: Review of Action

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

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

Section 7.7: 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 BDS service coordinator, DDARS Central Office, the appellant or another designee realizes that the proposed action or action taken is incorrect, adjusting action may be taken. The appeal process continues unless/until the appellant formally withdraws in writing.
- If the appellant wishes to withdraw the appeal, they are to be assisted by the BDS service coordinator and/or the case manager or the DDARS Central Office in promptly notifying the OALP ALJ in writing of the decision. No pressure is to be exerted on the appellant to withdraw the appeal. The withdrawal must be acknowledged in writing and it is only with the receipt of a signed voluntary withdrawal statement from the appellant that the appeal is to be dismissed by the ALJ.
- An appeal may be dismissed when the appellant (or authorized representative), without good cause, does not appear at a scheduled hearing. Both parties will be notified of the appeal being dismissed by the OALP.

Section 7.8: Fair Hearing

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

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

Section 7.9: Preparation for Hearing by Appellant

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

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

The appeal notice informs the appellant of their right to be represented by legal counsel at the appeal hearing.

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

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

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

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

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

Office of Administrative Law Proceedings
100 N. Senate Avenue, Suite N802
Indianapolis, IN 46204

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

Section 7.10: Preparation for Hearing by BDS Service Coordinator or District Representative, BDS Waiver Unit, DDARS Central Office, or Other State Designee

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

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

  Staff should be prepared to answer questions related to the case proposed by both the ALJ and the appellant.
- Include the labeled exhibits at the appropriate point in the presentation outline.

Section 7.11: Conduct of 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 BDS service coordinator or other District representative, the DDARS Central Office, or the BDS waiver unit at the hearing.

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

> *Note: See Section 7.9: Preparation for Hearing by Appellant and Section 7.10: Preparation for Hearing by BDS Service Coordinator or District Representative, BDS Waiver Unit, DDARS Central Office, or Other State Designee. The state shall ensure that the appellant receives the state's exhibits and the appellant shall ensure that the state receives any exhibits submitted by the appellant prior to the day of the hearing. As directed in the hearing notice and in most cases, exhibits should be submitted at least 10 calendar days prior to the scheduled hearing.*

Section 7.12: 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 7.13: 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 7.14: 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 the law. The decision is to be explained to the appellant upon request.

Section 7.15: Actions of Administrative Law Judge's Decision

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

Section 7.16: Agency Review

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

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

Section 7.17: 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 7.18: Lawsuit

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

Section 8: BDS Quality Assurance for HCBS Waiver Program Services

Section 8.1: Overview

Within the Family and Social Services Administration (FSSA) Division of Disability, Aging and Rehabilitative Services (DDARS), the BDS Quality Assurance Services team and authorized vendors are 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 BDS 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 BDS Quality Assurance Services can be found on the *BDS Quality Assurance* webpage at in.gov/fssa/ddars.

For quality assurance information specific to the Traumatic Brain Injury (TBI) Waiver and the Health and Wellness (H&W) Waiver, see *Section 11.3: Quality Assurance/Quality Improvement*.

Section 8.2: Incident Reports

The BDS and its authorized vendors are responsible for managing the DDARS 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), accessible from the *BDS Incident Reporting* webpage. Reportable incidents are defined as any event or occurrence characterized by risk or uncertainty resulting in or having the potential to result in significant harm or injury to an individual or death of an individual. According to Indiana Administrative Code (IAC) and the DDARS policy, the following types of events are reportable:

- Alleged, suspected or actual abuse, neglect or exploitation of an individual
  - This event includes physical, sexual, emotional/verbal and domestic abuse. An incident in this category must also be reported to Adult Protective Services (APS) or Child Protection Services (CPS), as applicable. The provider will suspend staff involved in an incident from duty, pending investigation by the provider.
- Peer-to-peer aggression that results in significant injury
- Death of an individual
  - A death shall also be reported to APS or CPS, as applicable. If death is a result of alleged criminal activity, the death must be reported to law enforcement.
- Structural or environmental issues with a service delivery site that compromise the health and safety of an individual; fire that jeopardizes or compromises the health or welfare of an individual
- Elopement of an individual that results in evasion of required supervision as described in the PCISP, as necessary for the individual's health and welfare
- Missing person when an individual wanders away and no one knows where they are
- Alleged, suspected or actual criminal activity by a staff member, employee, agent of a provider or an individual receiving services
- An emergency intervention for an individual resulting from a physical symptom, a medical or psychiatric condition, or any other event
- Injury to an individual when the origin or cause of the injury is unknown, and the injury requires medical evaluation or treatment

- A significant injury to an individual, including but not limited to:
  - A fracture
  - A burn greater than first degree
  - Choking that requires intervention
  - Bruises or contusions larger than three inches or lacerations requiring more than basic first aid
  - Any puncture wound penetrating the skin
  - Any pica ingestion requiring more than first aid
- A fall resulting in injury, regardless of severity of the injury
- A medication error, except for refusal to take medications, including the following:
  - Medication given that was not prescribed or ordered for the individual, or wrong medication
  - Failure to administer medication as prescribed, including an incorrect dosage, missed medication, wrong route, and failure to give medication at the appropriate time
  - Medication error that jeopardizes an individual's health and welfare and requires medical attention
- Use of any aversive technique, including but not limited to:
  - Seclusion
  - Painful or noxious stimuli
  - Denial of a health-related necessity
  - Other aversive technique identified by the DDARS 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/ddars. Additional information about incident reporting is available on the *BDS Incident Reporting* at in.gov/fssa/ddars.

Section 8.3: Complaints

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

- The BDS quality vendor is responsible for operating the BDS Complaint System for individuals receiving HCBS waiver services administered by the DDARS.
- 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 DDARS 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 BDS 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 BDS again to file a complaint. When requested, complainants can choose to be anonymous.
- The BDS quality vendor reviews and categorizes all initial complaints as *urgent or critical* and assigns a complaint investigator to investigate the case within specified time parameters. Certain

circumstances may require the BDS to contact APS, DCS, local law enforcement and/or the provider to take immediate measures to ensure the individual's health and welfare.

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

Currently, complaints can be filed using the online complaint form or through the BDS toll-free telephone number at 800-545-7763.

Section 8.4: Mortality Reviews

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

- The BDS quality vendor is responsible for conducting the mortality review process, which begins when the BDS 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 BDS Quality Assurance director or other BDS staff that has a concern.
- The MRC is facilitated by the BDS quality vendor. Committee members include representatives from APS, the Indiana Department of Health (IDOH), Indiana Disability Rights, the Office of Medicaid Policy and Planning (OMPP), the statewide waiver ombudsman, BDS field service staff and community advocates.
- Based on their discussion, the MRC makes recommendations for systemic improvements, such as developing new DDARS policy, revising policy, training, or the development and sharing of critical service area fact sheets and posting to the *BDS Quality Assurance* webpage. The MRC also makes provider-specific recommendations that are included in the closure letter from the MRC.
- The MRTT and/or the MRC can refer a case to BDS for a mortality investigation to review key areas of a provider's system that appear to have not been in place or to have been ineffective at the time of an individual's death. Providers may be required to develop CAPs to address identified issues and to prevent other individuals from experiencing negative outcomes.
- See the *Policy on Mortality Review* at in.gov/fssa for further information regarding mortality reviews and the MRC.

Section 8.5: National Core Indicator (NCI) Project

The DDARS participates in the National Core Indicator (NCI) Project for individuals served by the Family Supports (FS) and Community Integration and Habilitation (CIH) waivers and will continue gathering data for the Traumatic Brain Injury (TBI) and Health and Wellness (H&W) waivers through the NCI survey process previously established by the Bureau of Better Aging (BBA) with an NCI-AD survey contractor. This national research project, administered through the Human Services Research Institute and the National Association of State Developmental Disabilities Directors (NASDDDS), was developed to obtain a standardized set of consumer outcome measures for community-base

d services. NCI Project information is designed to be captured through face-to-face consumer satisfaction interviews. The BDS quality vendor or the NCI-AD survey contractor conducts these interviews across the state with individuals selected based on representative random samples from each DDARS waiver. Participation in this project allows the DDARS to make comparisons with other states providing waiver services across the country.

Section 8.6: Case Record Reviews

From October 2014 through September 2022 for the FS and CIH waivers, the BDS Quality Assurance services and authorized vendors were 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 FS and CIH waivers. Based on the requirement that the service plan is centered around the individual's needs and preferences using person-centered services that support them and their families in living their defined best life, case record reviews included:

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

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

Section 8.7: Quality On-Site Provider Review for FS and CIH Waivers

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

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

What is the Quality On-Site Provider Review?
The Bureau of Disabilities Services is using the Quality On-Site Provider Review to ensure the quality of the Home- and Community-Based Services (HCBS) waiver services individuals receive. These person-centered services should empower the individual to live, love, learn, work, play and pursue their dreams.

What is the Quality On-Site Provider Tool?
The tool is organized around the Charting the LifeCourse domains and includes indicators that will support BDS in determining if individual outcomes are being achieved as well as provider compliance with the HCBS Settings Rule. The Quality On-Site Provider Review has two sets of indicators. One set is used to assess a provider's systems to support people to have their best life. The second set of indicators is used in conversations with individuals supported by the provider. Each indicator is given a rating: disagree, met, strongly agree, not observed.

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

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

What if I have questions about the Quality On-Site Provider Review?
Contact BDS:

BDS.Help@fssa.in.gov
800-545-7763

Section 8.8: Statewide Waiver Ombudsman

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

- Complaints may be submitted to the statewide waiver ombudsman by phone, at the toll-free telephone number 800-622-4484 (option 2) or via email, as follows:
  - BDSWaiver.Ombudsman@fssa.in.gov – For waiver participants with an intellectual/developmental disability
  - LongTermCareOmbudsman@ombudsman.in.gov – For waiver participants who meet the nursing facility level of care (NF LOC)
- Types of complaints received include complaints initiated by families and/or individuals involving rights or issues of individual choice, and complaints requiring coordination between legal services, administrating agency services and provider services.
- The ombudsman is expected to initiate contact with the complainant as soon as possible after the complaint is received. However, precise timelines for the final resolution of each complaint are not established. Although it is expected that the ombudsman will diligently and persistently pursue the resolution of each complaint determined to require investigation, it is recognized that circumstances surrounding each investigation vary.
- Time frames for complaint resolution vary in accordance with the required research, in the collection of evidence, and in the numbers and availability of persons who must be contacted, interviewed or brought together to resolve the complaint. Although the statewide waiver

ombudsman is considered "independent" by statute, the DDARS director is responsible for oversight of the ombudsman.

- With the consent of the waiver individual, the ombudsman must be provided access to the individual records, including records held by the entity providing services to the individual. When it has been determined the individual is not capable of giving consent, the statewide waiver ombudsman must be provided access to the name, address and telephone number of the individual's legal representative.
- A provider of waiver services or any employee of a provider of waiver services is immune from civil or criminal liability and from actions taken under a professional disciplinary procedure for the release or disclosure of records to the statewide waiver ombudsman.
- A state or local government agency or entity that has records relevant to a complaint or an investigation conducted by the ombudsman must also provide the ombudsman with access to the records. The statewide waiver ombudsman coordinates their activities among the programs that provide legal services for individuals who are elderly and/or who have a physical or intellectual/developmental disability, the administrative agency, providers of waiver services and providers of other necessary or appropriate services. The ombudsman ensures that the identity of the individual will not be disclosed without either the individual's written consent or a court order.
- At the conclusion of an investigation of a complaint, the ombudsman reports the ombudsman's findings to the complainant. If the ombudsman does not investigate a complaint, the ombudsman notifies the complainant of the decision not to investigate and the reasons for the decision.
- The statewide waiver ombudsman prepares a report at least annually (or upon request), describing the operations of the program. A copy of the report is provided to the governor, the legislative council and the director of the DDARS. Trends are identified so that recommendations for needed changes in the service delivery system can be implemented.
- The administrative agency is required to maintain a statewide toll-free telephone line continuously open to receive complaints regarding waiver individuals with intellectual/developmental disabilities. All complaints received from the toll-free line must be forwarded to the statewide waiver ombudsman, who will advise the individual that the complaint process is not a prerequisite or a substitute for a Medicaid fair hearing when the problem falls under the scope of the Medicaid fair hearing process.
- A person who does any of the following commits a Class B misdemeanor:
  - Intentionally prevents the work of the ombudsman
  - Knowingly offers compensation to the ombudsman in an effort to affect the outcome of an investigation or a potential investigation
  - Knowingly or intentionally retaliates against an individual, a client, an employee or another person who files a complaint or provides information to the ombudsman

Section 9: Service Definitions and Requirements for FS and CIH Waivers

The Division of Disability, Aging and Rehabilitative Services (DDARS) within the Indiana Family and Social Services Administration (FSSA) administers the Family Supports (FS) and Community Integration and Habilitation (CIH) waivers, as well as the Health and Wellness (H&W) and Traumatic Brain Injury (TBI) waivers.

> *Note: For information specific to the H&W and TBI Waiver services, see Section 11: Health and Wellness (H&W) and Traumatic Brain Injury (TBI) Waivers.*

Section 9.1: Service Definition Overview

This section defines the services currently approved for the Home- and Community-Based Services (HCBS) of the FS and CIH waiver programs administered by the Division of Disability, Aging and Rehabilitative Services (DDARS). 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

Section 9.2: FS and CIH Waiver Services, Codes and Rates

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

> *Note: For procedure codes, modifiers and rates related to the H&W and TBI waivers, see Section 11.6: H&W and TBI Waiver Services, Codes and Rates.*

Table 3 – Medicaid Waiver Services, Codes and Rates for FS and CIH Waivers

INsite Code	Service Description	HCPCS Code	Modifiers	FS Rate	CIH Rate	Unit/ Size	Unit/$ Limit
ADS1	Adult Day Services, Level 1	S5101	U7 U5 U1	$37.18	$37.18	0.50/Day	2 Units/Day
ADS2	Adult Day Services, Level 2	S5101	U7 U5 U2	$43.75	$43.75	0.50/Day	2 Units/Day
ADS3	Adult Day Services, Level 3	S5101	U7 U5 U3	$54.74	$54.74	0.50/Day	2 Units/Day
AS14	Adult Day Services, 1/4 Hour, Level 1	S5100	U7 U5 U1	$2.93	$2.93	0.25/Hour	16 Units/Day
AS24	Adult Day Services, 1/4 Hour, Level 2	S5100	U7 U5 U2	$3.30	$3.30	0.25/Hour	16 Units/Day
AS34	Adult Day Services, 1/4 Hour, Level 3	S5100	U7 U5 U3	$4.20	$4.20	0.25/Hour	16 Units/Day
BMGO	Behavior Management, Basic	H0004	U7 U5 U2	$18.56	$18.56	0.25/Hour	N/A
BG1O	Behavior Management, Level 1	H0004	U7 U5 U1	$18.56	$18.56	0.25/Hour	N/A
CEP	Career Exploration and Planning – Individual	97537	U7 U5	$37.06	$37.06	1/Hour	Shall not exceed 20 hours/month for six months in any 12-month period
CEPG	Career Exploration and Planning – Group	97537	U7 U5 U2	$13.65	$13.65	1/Hour	Shall not exceed 20 hours/month for six months in any 12-month period.
CMGT	Case Management	T2022	U7 U5	$189.56	$189.56	1/Month	1 Unit/Month
TRCM	Case Management – Transitional Case Management	T2038	U7 U5 UA	N/A	$180.55	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
CT	Community Transition	T2038	U7 U5	N/A	Individual	1/Unit	$2,500 Lifetime
DHI	Day Habilitation, Individual	T2020	U7 U5 UF	$36.88	$36.88	1/Hour	N/A
DHGS	Day Habilitation, Group-Small (2:1 to 4:1)	T2020	U7 U5 U2 UF	$13.28	$13.28	1/Hour	N/A
DHGM	Day Habilitation, Group-Medium (5:1 to 10:1)	T2020	U7 U5 UA UF	$6.54	$6.54	1/Hour	N/A
DHGL	Day Habilitation, Group-Large (11:1 to 16:1)	T2020	U7 U5 UB UF	$4.20	$4.20	1/Hour	N/A
DHI	Day Habilitation, Individual	T2020	U7 U5 UG	$36.88	$36.88	1/Hour	N/A
DHGS	Day Habilitation, Small Group (2:1, 3:1, and 4:1)	T2020	U7 U5 U2 UG	$13.28	$13.28	1/Hour	N/A

INsite Code	Service Description	HCPCS Code	Modifiers	FS Rate	CIH Rate	Unit/ Size	Unit/$ Limit
DHGM	Day Habilitation, Medium Group (5:1 to 10:1)	T2020	U7 U5 UA UG	$6.54	$6.54	1/Hour	N/A
DHGL	Day Habilitation, Large Group (11:1 to 16:1)	T2020	U7 U5 UB UG	$4.20	$4.20	1/Hour	N/A
EXTS	Extended Services	T2025	U7 U5 UA	$52.85	$52.85	1/Hour	N/A
FBS	Facility-Based Support	T1020	U7 U5 UA	$2.51	$2.51	1/Hour	N/A
FCAR	Family & Caregiver Training, Family	S5111	U7 U5	Individual	Individual	1/Unit	$5,000/Year
FCNF	Family & Caregiver Training, Non-Family	S5116	U7 U5	Individual	Individual	1/Unit	$5,000/Year
HMA1/ HMA2	Home Modification Assessment	T1028	U7 U5	$628.00	$628.00	Per Project (Spec/ Exam)	Spec: $409.46 Exam: $218.54
EMOI	Home Modification, Install	S5165	U7 U5 NU	Individual	Individual	1/Unit	$20,000 Lifetime
EMOM	Home Modification, Maintain	S5165	U7 U5 U8	Individual	Individual	1/Unit	$1,000/Year
IBI1	Intensive Behavioral Intervention, Level 1	H2020	U7 U5 U1	$104.60	$104.60	1/Hour	N/A
IBI2	Intensive Behavioral Intervention, Level 2	H2020	U7 U5 U2	$39.53	$39.53	1/Hour	N/A
MUTH	Music Therapy	H2032	U7 U5 U1	$16.81	$16.81	0.25/Hour	N/A
OCTH	Occupational Therapy	G0152	U7 U5 UA	$17.99	$17.99	0.25/Hour	N/A
PAC	Participant Assistance and Care	T2033	U7 U5	$34.39	N/A	1/Hour	N/A
PRSI	Personal Emergency Response System, Install	S5160	U7 U5	$54.41	$54.41	1/Unit	1 Unit/POC/ service plan
PRSM	Personal Response System, Maintain	S5161	U7 U5	$54.41	$54.41	1/Unit	1 Unit/Month
PHTH	Physical Therapy	G0151	U7 U5 UA	$18.12	$18.12	0.25/Hour	N/A
PV02, PV04	Prevocational, Facility-Based (2:1), (4:1)	T2015	U7 U5 U1 UF	$10.81	$10.81	1/Hour	N/A
PV06, PV08, PV10	Prevocational, Facility-Based (6:1), (8:1), (10:1)	T2015	U7 U5 U3 UF	$5.66	$5.66	1/Hour	N/A
PV12, PV14, PV16	Prevocational, Facility-Based (12:1), (14:1), (16:1)	T2015	U7 U5 U8 UF	$3.73	$3.73	1/Hour	N/A
PV02, PV04	Prevocational, Community-Based (2:1), (4:1)	T2015	U7 U5 U2 UG	$10.81	$10.81	1/Hour	N/A
PV06, PV08, PV10	Prevocational, Community-Based (6:1), (8:1), (10:1)	T2015	U7 U5 U4 UG	$5.66	$5.66	1/Hour	N/A
PV12, PV14, PV16	Prevocational, Community-Based (12:1), (14:1), (16:1)	T2015	U7 U5 U9 UG	$3.73	$3.73	1/Hour	N/A

INsite Code	Service Description	HCPCS Code	Modifiers	FS Rate	CIH Rate	Unit/ Size	Unit/$ Limit
PSTF	Psychological Therapy, Family	90846	U7 U5	$17.27	$17.27	0.25/Hour	N/A
PSTG	Psychological Therapy, Group	90853	U7 U5	$4.81	$4.81	0.25/Hour	N/A
PSTI	Psychological Therapy, Individual	H0004	U7 U5 U3	$15.45	$15.45	0.25/Hour	N/A
RETH	Recreational Therapy	H2032	U7 U5 U2	$16.81	$16.81	0.25/Hour	N/A
RSE	Remote Supports, Equipment/Install	A9279	U7 U5 NU	Individual	N/A	1/Unit	$500/year
RS1	Remote Supports, 1 Individual	A9279	U7 U5 UA	$24.26	$24.26	1/Hour	N/A
RS2	Remote Supports, 2 Individuals	A9279	U7 U5 U2	$12.13	$12.13	1/Hour	N/A
RS3	Remote Supports, 3 Individuals	A9279	U7 U5 U3	$8.09	$8.09	1/Hour	N/A
RS4	Remote Supports, 4 Individuals	A9279	U7 U5 U4	$6.06	$6.06	1/Hour	N/A
R&F	Rent & Food for Unrelated Live-In Caregiver	T2025	U7 U5	N/A	$545.00	1/Month	N/A
RH1O	Residential Habilitation and Support (RHS) – Hourly, Level 1 (35 or Less Hours/Week)	T2016	U7 U5 UA	N/A	$35.02	1/Hour	N/A
RH2O	RHS Hourly, Level 2 (Over 35 Hours/Week)	T2016	U7 U5	N/A	$30.36	1/Hour	N/A
RD1	RHS Daily, Level 1 (2-Person Setting, Algo Level 3)	T2016	U7 U5 UN UA	N/A	$237.77	1/Day	1 Unit/Day
RD2	RHS Daily, Level 2 (2-Person Setting, Algo Level 4)	T2016	U7 U5 UN UB	N/A	$331.74	1/Day	1 Unit/Day
RD3	RHS Daily, Level 3 (2-Person Setting, Algo Level 5)	T2016	U7 U5 UN UC	N/A	$357.86	1/Day	1 Unit/Day
RD4	RHS Daily, Level 4 (3-Person Setting, Algo Level 3)	T2016	U7 U5 UP UA	N/A	$233.90	1/Day	1 Unit/Day
RD5	RHS Daily, Level 5 (3-Person Setting, Algo Level 4)	T2016	U7 U5 UP UB	N/A	$303.31	1/Day	1 Unit/Day
RD6	RHS Daily, Level 6 (3-Person Setting, Algo Level 5)	T2016	U7 U5 UP UC	N/A	$332.84	1/Day	1 Unit/Day
RD7	RHS Daily, Level 7 (4-Person Setting, Algo Level 3)	T2016	U7 U5 UQ UA	N/A	$220.86	1/Day	1 Unit/Day
RD8	RHS Daily, Level 8 (4-Person Setting, Algo Level 4)	T2016	U7 U5 UQ UB	N/A	$280.27	1/Day	1 Unit/Day

INsite Code	Service Description	HCPCS Code	Modifiers	FS Rate	CIH Rate	Unit/ Size	Unit/$ Limit
RD9	RHS Daily, Level 9 (4-Person Setting, Algo Level 5)	T2016	U7 U5 UQ UC	N/A	$298.60	1/Day	1 Unit/Day
RNUR	Respite Nursing Care, RN	T1005	U7 U5 TD	$17.10	$17.10	0.25/Hour	N/A
RNUR	Respite Nursing Care, LPN	T1005	U7 U5 TE	$13.69	$13.69	0.25/Hour	N/A
RSPO	Respite Care Services	S5151	U7 U5	$43.38	$43.38	1/Hour	N/A
ATCH	Specialized Medical Equip/Supply, Install	T2029	U7 U5 NU	Individual	Individual	1/Unit	$15,000 Lifetime
ATCM	Specialized Medical Equip/Supply, Maintain	T2029	U7 U5 U8	Individual	Individual	1/Unit	$1,000/Year
INSP	Equipment – Assess/Inspect/Train	T1028	U7 U5	$18.53	$18.53	0.25/Hour	N/A
SPTH	Speech/Language Therapy	92507	U7 U5 UA	$18.12	$18.12	0.25/Hour	N/A
AF01	Structured Family Caregiving, Level 1	T2033	U7 U5 U1	N/A	$77.54	1/Day	1 Unit/Day
AF02	Structured Family Caregiving, Level 2	T2033	U7 U5 U2	N/A	$99.71	1/Day	1 Unit/Day
AF03	Structured Family Caregiving, Level 3	T2033	U7 U5 U3	N/A	$133.44	1/Day	1 Unit/Day
TRNO	Transportation, Level 1	T2002	U7 U5	$15.05	$15.05	1/Trip	2 Trips/Day, $7,530/Year
TRN2	Transportation, Level 2	T2002	U7 U5 U2	$26.52	$26.52	1/Trip	2 Trips/Day, $8,255/Year
TRN3	Transportation, Level 3	T2002	U7 U5 U3	$47.88	$47.88	1/Trip	2 Trips/Day, $8,980/Year
VMOD	Vehicle Modification, Install	T2039	U7 U5	Individual	Individual	1/Unit	$15,000 for one vehicle every 10 years
VMOM	Vehicle Modification, Maintain	T2039	U7 U5 U8	Individual	Individual	1/Unit	$1,000/Year
WEL1	Wellness Coordination Tier 1	T2022	U7 U5 U1	N/A	$118.66	1/Month	1 Unit/Month
WEL2	Wellness Coordination Tier 2	T2022	U7 U5 U2	N/A	$163.02	1/Month	1 Unit/Month
WEL3	Wellness Coordination Tier 3	T2022	U7 U5 U3	N/A	$251.74	1/Month	1 Unit/Month
WPA	Workplace Assistance	T1020	U7 U5	$38.36	$38.36	1/Hour	N/A

Section 9.3: Adult Day Services for FS and CIH Waivers

The following subsections provide information and requirements for Adult Day Services for the FS and CIH waivers.

> *Note: For information about Adult Day Services available under the H&W Waiver and TBI Waiver, see Section 11.7: Adult Day Services for H&W and TBI Waivers.*

Service Definition

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

However, each meal must meet one-third of the daily Recommended Dietary Allowance. These services must be provided in a noninstitutional, community-based setting in one of three available levels of service: basic, enhanced or intensive.

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

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

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

Reimbursable Activities

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

- Basic Adult Day Services (Level 1) include:
  - Person-centered monitoring and/or support for all activities of daily living (ADLs) defined as dressing, bathing, grooming, eating, walking and toileting with hands-on assistance provided as needed
  - Comprehensive, therapeutic activities
  - Health assessment and intermittent monitoring of health status
  - Monitoring medication or medication administration
  - Appropriate structure and support for those with mild cognitive impairment
  - Minimum staff ratio: One staff for each eight individuals
- Enhanced Adult Day Services (Level 2) include the Level 1 service requirements and the following additional services:
  - Hands-on assistance with two or more ADLs or hands-on assistance with bathing or other personal care
  - Health assessment with regular monitoring or intervention with health status
  - Dispensing or supervising the dispensing of medication
  - Psychological needs assessed and addressed, including counseling as needed for individuals and caregivers
  - Therapeutic structure, support and intervention for those with mild to moderate cognitive impairments
  - Minimum staff ratio: One staff for each six individuals
- Intensive Adult Day Services (Level 3) include 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/language therapy and occupational therapy coordinated or available
- Therapeutic intervention to address dynamic psychosocial needs such as depression or family issues affecting care
- Therapeutic interventions for those with moderate to severe cognitive impairments
- Minimum staff ratio: One staff for each four individuals

Service Standards

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

Documentation Standards

The following are required documentation for Adult Day Services:

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

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

Limitations

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

Activities Not Allowed

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

This service will not be reimbursed when provided by the parent of a minor child participant or the spouse of a participant (also known as legally responsible individuals or LRIs).

Provider Qualifications

Adult Day Services providers must meet the following criteria:

- Be enrolled as an active Medicaid provider
- Be FSSA-approved
- Comply with *Indiana Administrative Code 460 IAC 6*, including but not limited to:
  - *460 IAC 6-10-5* Documentation of Criminal Histories
  - *460 IAC 6-12-1* and *460 IAC 6-12-2* Insurance
  - *460 IAC 6-11-1* to *460 IAC 6-11-3* Financial Status of Providers

- *460 IAC 6-5-2* Adult Day Services Provider Qualifications
- *460 IAC 6-14-5* Requirements for Direct Care Staff
- *460 IAC 6-14-4* Training
- *460 IAC 6-34-1* through *460 IAC 34-3* Transportation Services

- Comply with any applicable Bureau of Disabilities Services (BDS) service standards, guidelines, policies and/or manuals, including FSSA DDARS policies, written agreements and this provider reference module, accessible from the *IHCP Bulletins and Reference Modules* webpage at in.gov/medicaid/providers
- Obtain/maintain accreditation (specific to Indiana programs) by at least one of the following organizations:
  - The Commission on Accreditation of Rehabilitation Facilities (CARF) or its successor
  - The Council on Quality and Leadership in Supports for People with Disabilities (CQL) or its successor
  - The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or its successor
  - The National Committee for Quality Assurance or its successor
  - The ISO-9001 human services quality assurance (QA) system
  - An independent national accreditation organization approved by the secretary
  - The Council on Accreditation or its successor

Section 9.4: Behavioral Support Services for FS and CIH Waivers

The following subsections provide information and requirements for Behavioral Support Services for the FS and CIH Waivers.

> *Note: For information related to the similarly named but unique service, Behavior Management/Behavior Program and Counseling, available only under the TBI Waiver, see Section 11.11: Behavior Management/Behavior Program and Counseling for TBI Waiver.*

Service Definition

Behavioral supports are an array of services designed to support individuals who are experiencing or are likely to experience challenges accessing and actively participating in the community as a result of behavioral, social or emotional challenges.

Behavioral Support Services are intended to empower individuals and families (by leveraging their strengths and unique abilities) to achieve self-determination, interdependence, productivity, integration and inclusion in all facets of community life, across all environments, across the lifespan. Behavioral supports should be individually designed to offer choice while creating social opportunities to generate integration, collaboration and inclusion in the community.

Behavioral Support Services encourage individuals to live their best life while exploring their community with social experiences that may include work and employment opportunities. Behavioral Support Services emphasize learning hands-on in the community and providing opportunities for individuals to gain experience in community-based settings. Behavioral Support Services may offer improved training and expectations around competitive integrated employment designed for positive outcomes that will promote healthy and fulfilling everyday life.

Reimbursable Activities

Reimbursable activities of Behavioral Support Services include:

- Completing the functional behavioral assessment:
  - This includes observation, environmental assessment, record reviews, interviews, data collection, complete psychosocial and biomedical history to identify targeted behaviors, the function of those behaviors, and to hypothesize the underlying need for new learning.
  - Based on the principles of person-centered thinking and positive behavioral support, the assessment process should inform the recommendations for development of the behavioral support plan (BSP).
- Developing a comprehensive BSP and subsequent revisions:
  - This includes devising proactive and reactive strategies designed to support the individual.
  - Any restrictive techniques employed as part of the BSP must be approved by a human rights committee (HRC), be time-limited and regularly reviewed for elimination or reduction of the restrictive techniques to ensure appropriate reduction in these interventions over time.
  - Either a Level 1 or Level 2 clinician can develop the BSP, but any BSPs developed by a Level 2 clinician (behavior consultant) must be submitted for review and written approval by a Level 1 clinician (licensed psychologist) prior to implementation for the development to be a reimbursable activity. All other reimbursable activities can be performed by either a Level 1 or Level 2 clinician.
- Obtaining consensus of the Individualized Support Team (IST) that the BSP is feasible for implementation and uses the least restrictive methods possible
- Supporting the individual in learning new, positive behaviors as outlined in the BSP
  - This may include coping strategies, improving interpersonal relationships or other positive strategies to reduce targeted behaviors and increase quality of life.
- Training staff, family members, housemates or other IST members on the implementation of the BSP
- Consulting with team members to achieve the outcomes of assessment and behavioral support planning
- Concurrent service delivery of Behavioral Support Services with other approved Medicaid services under the following conditions:
  - The service being provided concurrently with Behavioral Support Services is not similar in nature, does not have a similar purpose, and does not promote similar outcomes to Behavioral Support Services.
  - The need for the concurrent service is clearly documented in the BSP, and outlines the individualized assessed need, and how the Behavioral Support Services will support or contribute to the specified need.

Service Standards

Behavioral Support Services must be reflected in the PCISP:

- Services must address needs identified in the person-centered planning process and be outlined in the PCISP.
- The behavior supports specialist will observe the individual in their own milieu and develop a specific plan to address identified issues.
- The behavior supports specialist must ensure that Residential Habilitation and Support (RHS) direct service staff are aware of and are active individuals in the development and implementation of the

BSP. The BSP will meet the requirements stated in the DDARS *Behavioral Support Plan Policy (2011)* at in.gov/fssa/ddars.

- 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, BDS service coordinator, waiver case manager, all service providers and other involved entities.

The PCISP must identify the Behavioral Support Services needed by the individual to pursue their desired outcomes as identified during the person-centered planning process. The need for service continuation is to be evaluated annually by the Individualized Support Team (IST) and reflected in the PCISP. Each outcome within the PCISP has at least one associated proposed strategy/action step designed to address potential barriers or maintenance needs in relation to the desired outcomes and the support and services needed to facilitate the outcomes.

The proposed strategy/action step also identifies all paid and unpaid responsible parties and includes the names of each responsible party including the provider, the service and the staffing positions within the agency that are responsible for the strategy/action step. The individual may be the responsible party for a strategy/action step initiative if they so determine. In addition, each proposed strategy/activity has a specific time frame identified, including a minimum time frame for review. The service authorization identifies the name of the waiver-funded service, the name of the individual-chosen provider of that service, the cost of the service per unit, the number of units of service, and the start and end dates for each waiver service identified on the service authorization.

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

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

Documentation Standards

Documentation shall include:

- Services outlined in the PCISP
- A functional behavior assessment
- A BSP, which must be attached to the PCISP
- The service authorization identifies the name of the waiver-funded service, the name of the individual-chosen provider of that service, the cost of the service per unit, the number of units of service, and the start and end dates for each waiver service identified on the service authorization
- Documentation must include progress toward outcomes and any changes or modifications within the PCISP
- Documentation in compliance with *460 IAC 6-18-4*

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

- Name of individual served

- IHCP Member ID of the individual
- Name of provider
- Date of service, including the year
- Time frame of service (include a.m. or p.m.)
- Duration of service
- Summary of the specific, person-centered behavioral support activities conducted
- Summary of the behavior support progress made toward outcomes
- Signature of the person providing the Behavioral Support Services
  - Electronic signatures are permissible when in compliance with the *Uniform Electronic Transactions Act [IC 26-2-8]*.

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

The quarterly report shall contain the following elements:

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

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

Limitations

See *Activities Not Allowed*.

Activities Not Allowed

The following activities are not allowed under Behavioral Support Services:

- Restrictive techniques – any techniques not approved by the IST and the human rights committee

- Therapy services provided to the individual within the educational/school setting or as a component of the individual's school day
- Services provided to a minor by parents, stepparents or legal guardian
- Services provided to an individual by the individual's spouse
- In the event that a Level 1 clinician performs Level 2 clinician activities, billing for Level 1 services
- In this situation, billing for Level 2 services only is allowed
- Simultaneous receipt of Facility-Based Support services or other Medicaid-billable services and intensive behavioral supports
- Service provided by the parent of a minor child participant or the spouse of a participant (also known as LRIs)

Provider Qualifications

Behavioral Support Services providers must meet the following criteria:

- Be enrolled as an active Medicaid provider
- Be FSSA-approved
- Comply with *Indiana Administrative Code 460 IAC 6*, including but not limited to:
  - *460 IAC 6-10-5* Documentation of Criminal Histories
  - *460 IAC 6-12-1* and *460 IAC 6-12-2* Insurance
  - *460 IAC 6-11-1* to *460 IAC 6-11-3* Financial Status of Providers
  - *460 IAC 6-5-4* Behavioral Support Services Provider Qualifications
  - *460 IAC 6-18-1* to *460 IAC 6-18-7* Behavioral Support Services
- Comply with any applicable BDS service standards, guidelines, policies and/or manuals, including FSSA DDARS policies and this provider reference module, accessible from the *IHCP Bulletins and Reference Modules* webpage at in.gov/medicaid/providers

Section 9.5: Career Exploration and Planning for FS and CIH Waivers

The following subsections provide information and requirements for Career Exploration and Planning services for the FS and CIH waivers.

Service Definition

Career Exploration and Planning is a targeted service designed to help an individual make an informed choice about whether they wish to:

- Pursue competitive integrated employment (CIE) including self-employment.
- Obtain information to dissuade myths around or hesitation about CIE.
- Identify the career path they would like to pursue either independently or with available supports.

This service is ideal for individuals newly transitioning from school-based services who are unsure as to their path toward CIE and may be used to gather information in preparation for a referral to Indiana Vocational Rehabilitation (VR), American Jobs Center or other employment supports. This service may be used for individuals who are employed to explore advancement opportunities in their chosen career or to explore other CIE career objectives which are more consistent with their skills and interests.

Reimbursable Activities

Activities to identify an individual's specific interests and aptitudes for CIE, including experience and skills transferable to CIE.

Exploration of CIE opportunities in the local area that are specifically related to the individual's identified interests, experiences and/or skills. This can include:

- Business tours
- Informational interviews
- Job shadows
- Work experiences
- Setup, preparation and debriefing for each exploration opportunity
- Introductory education on available employment supports, work incentives, Supported Employment services, and benefits of working in competitive integrated employment settings

Service Standards

Service may be provided on an individual basis or in groups dependent on participant choice. When group services are offered, the group shall not exceed four persons and must be based on shared CIE interests of the group members. Services must be provided in community settings.

Documentation Standards

Development of documentation around individual's interests and aptitudes, stated career objectives, and development of a strengths-based career profile for use and guidance when seeking individual employment support. This profile must include the individual's determined career path and outcome documented in the PCISP. Career profiles may also be used to develop an individual's resume and inform outreach to local employers. When applicable, career profiles should include:

- Dreams, goals and interests
- Talents, skills and knowledge
- Learning styles
- Positive personality traits and values
- Workplace and environmental preferences
- Dislikes and situations/careers to avoid
- Previous work experiences
- Support system and community resources
- Specific challenges and possible solutions (including benefits considerations and accommodation needs)
- Career opportunities (including preferred career paths and potential contributions to community employers)

Limitations

Career Exploration and Planning is intended to be a time-limited service along the continuum of employment supports. Career Exploration and Planning shall not exceed 20 hours a month for six months in any12-month period.

Activities Not Allowed

Services that are available under *Section 110* of the *Rehabilitation Act of 1973* or *Section 602(16) and (17)* of *Individual with Disabilities Education Act* (IDEA). Documentation must be maintained verifying that the service is not otherwise available or funded under the *Rehabilitation Act of 1973*, as amended, or the IDEA.

Provider Qualifications

Providers of Career Exploration and Planning must meet the following criteria:

- Be enrolled as an active Medicaid provider
- Be FSSA-approved
- Comply with *Indiana Administrative Code 460 IAC 6*, including but not limited to:
  - *460 IAC 6-10-5* Documentation of Criminal Histories
  - *460 IAC 6-12-1* and *460 IAC 6-12-2* Insurance
  - *460 IAC 6-11-1* to *460 IAC 6-11-3* Financial Status of Providers
  - *460 IAC 6-5-27* Specialized Medical Equipment and Supplies Supports Provider Qualifications
- Comply with any applicable BDS service standards, guidelines, policies and/or manuals, including FSSA DDARS policies and this provider reference module, accessible from the *IHCP Bulletins and Reference Modules* webpage at in.gov/medicaid/providers
- Obtain/maintain accreditation (specific to Indiana programs) by at least one of the following organizations:
  - The Commission on Accreditation of Rehabilitation Facilities (CARF), or its successor
  - The Council on Quality and Leadership In Supports for People with Disabilities, or its successor
  - The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or its successor
  - The National Committee for Quality Assurance, or its successor
  - The ISO-9001 human services quality assurance (QA) system
  - An independent national accreditation organization approved by the FSSA Secretary

Section 9.6: Case Management for FS and CIH Waivers

The following subsections provide information and requirements for Case Management services for the FS and CIH waivers.

> *Note: For information on the similarly named but unique Care Management service available under the H&W and TBI Waivers, see Section 11.12: Care Management for H&W and TBI Waivers.*

Service Definition

Case Management provides an array of services that assist individuals in gaining access to needed waiver and other Indiana Medicaid State Plan services, as well as medical, social, educational and other services, regardless of the funding source for the services or community supports to which access is gained. Case

managers advocate alongside the individual to ensure their access and opportunities for participation in all paid and unpaid services, programs and settings which allow for building social capital, skill development and personal fulfillment.

Case Management services include annual planning and assessment and ongoing case management support.

Additional Information:

- Case Management services are mandatory for all waiver individuals under the FS and CIH waivers.
- Case Management services are provided only by the DDARS-approved case management organizations/entities awarded contracts through the selected contracting process of the §1915(b)(4) waiver, which operates concurrently with the §1915(c) waivers.

Reimbursable Activities

Reimbursable activities under Case Management services include the following:

- Annual planning and assessment – initial and annual activities outlined by BDS that support the individual in:
  - Establishing a person-centered, strengths-based PCISP that supports the individual's vision of a good life through offering opportunities for integrated supports. The individual must be present and supported to facilitate development of the plan to the greatest extent possible
  - Developing an annual budget in support of the PCISP
  - Determining continued eligibility for services
- Ongoing Case Management services are based on the principles of person-centered thinking and driven by the PCISP. Person-centered practices include:
  - Convening IST meetings at least semiannually:
    - IST meetings may be held in a manner desired by the individual and guardian, if applicable.
    - Individual and guardian, if applicable, must be present for all IST meetings.
  - Conducting face-to-face contacts with the individual and guardian, if applicable, for the purpose of relationship building and knowledge of individual at least once semiannually and as needed:
    - At least one visit each year must be held in the home of the waiver individual.
    - For individuals residing in provider owned and/or controlled settings (as defined by the CMS and DDARS), case managers must make one annual unannounced visit to the individual's home.
    - Face-to-face visits must be intentional interactions and may not be held as drop-in visits at a day program.
    - IST meetings and face-to-face contacts are both required in a manner that ensures interaction at least every 90 days.
  - Regularly reviewing and updating the PCISP including when:
    - The needs or circumstances of the individual have changed.
    - Services are added or changed.
    - The individual and guardian make a request, if applicable.
    - For nonannual team meetings, a request is made to record team discussions on outcomes and any related plan changes.
  - Identifying, assessing and addressing risks initially and as needed
  - Updating service plans and timely submission of budget requests consistent with the individual's PCISP
  - Monitoring service delivery and utilization to ensure that services are being delivered in accordance with the PCISP

- Monitoring individuals' health and safety
- Assessing individuals' satisfaction and service outcomes and sharing the results with BDS at least annually
- Completing and processing the Monitoring Checklist within the BDS established timeline
- Completing, submitting and following up on incident reports as established by the BDS
- Completing case notes and necessary PCISP revisions documenting each encounter with or on behalf of the individual within seven calendar days at a minimum
  - Case managers must have at least one documented meaningful encounter monthly to support billing.
- Disseminating information including the PCISP, all Notices of Action and forms to the individual, guardian (if applicable) and the IST
- Maintaining files in accordance with state standards
- In the absence of a residential provider, conducting mortality reviews in accordance with *460 IAC 6* and BDS policy and guidance

For the **CIH Waiver only**:

- Case Management services may be available during the last 180 consecutive days of a Medicaid-eligible individual's institutional stay in a nursing facility, comprehensive rehabilitative management needs facility, state psychiatric facility or ICF/IID, to allow Case Management activities to be performed specifically related to transitioning the individual from an institutional setting to DDARS HCBS waiver services.
  - The individual must be approved for Medicaid waiver services at the time the transitional case management services are provided, and the services cannot be billed to the IHCP until after the individual has fully transitioned into a DDARS HCBS waiver setting. If the individual dies during the transition process, billing can still be an option.
  - The need for transitional service should be clearly documented in the PCISP.
  - Case Management services may be available in adherence to specific Money Follow the Person (MFP)-related activities or requirements for individuals transitioning to the community from an institutional setting.

Note: The need for the transitional case management service should be clearly documented in the PCISP.

Activities Not Allowed

- The case management entity may not own or operate another waiver service agency, nor may the case management entity be an approved provider of any other waiver service or otherwise have a financial investment in any other waiver service.
- The case management entity may not subcontract with another agency or case manager for the provision of direct Case Management services.
- Case managers may not be contractors of the case management entity.
- Caseload average in excess of 45 across the case management entity's active, full-time case managers who carry caseloads.
- The case management entity may not bill in a month for solely non-case management related activities or tasks such as mailing greeting cards or holiday text messages, for example reimbursement is not available through Case Management services for the following activities or any other activities that do not fall under the previously listed definition:
  - Services delivered to persons who do not meet eligibility requirements established by DDARS BDS

- Counseling services related to legal issues. Such issues shall be directed to the Indiana Disability Rights, the designated Protection and Advocacy agency under the *Developmental Disabilities Act* and *Bill of Rights Act, P.L. 100-146*)
- Case Management conducted by a person related through blood or marriage to any degree to the waiver individual

Service Standards

The following service standards apply to Case Management by any organization/entity selected as a contractor of Case Management services:

- Perform the activities listed in the *Reimbursable Activities* section.
- Case managers must understand, maintain and assert that the Medicaid program functions as the payer of last resort. The role of the case manager includes care planning, service monitoring, working to cultivate and strengthen informal and natural supports for each individual, and identifying resources and negotiating the best solutions to meet identified needs. Toward these ends, case managers are required to:
  - Demonstrate a willingness and commitment to explore, pursue, access and maximize the full array of non-waiver-funded services, supports, resources and unique opportunities available within the individual's local community, thereby enabling the Medicaid program to complement other programs or resources.
  - Be a trained facilitator who has completed a training provided by a BDS-approved training entity or person; observed a facilitation; and participated in a person-centered planning meeting prior to leading an IST.
- At minimum, the case management entity must provide a 60-day notice to the individual (and to their legal guardian, if applicable) prior to the termination of Case Management services.
- Upon request of the individual and/or their legal guardian, if applicable, the individual's most recently selected case management entity must provide a provider choice list of alternate DDARS-approved contractors of Case Management services and assist the individual in selecting a new provider of Case Management.

Noting the individuals' right to select and transition to a new provider of Case Management services at any time, only one selected contractor of Case Management services may bill for the authorized monthly unit of Case Management services during any given month. With the state's approval of the individual's service authorization, a single PA of the monthly Case Management service unit will be sent from the administrative agency (DDARS) to the contractor of the Medicaid Management Information System (MMIS). Therefore, it is *recommended* that transitions from one case management entity/organization to another occur on the first day of the month. When transitions occur on other days of the month, the two providers of Case Management services must determine which contracting provider entity will bill and whether one entity owes the other a portion of the monthly fee. Providers will handle any such transactions and/or arrangements amongst themselves, with both (or all involved) contracting provider entities being held responsible for documenting these transactions regarding future financial audits.

Documentation Standards

Case managers must perform and document one meaningful activity with or on behalf of the waiver individual each calendar month in case notes to support billing. The case note must include applicable information that informs the reader:

- Who the contact or activity was with
- What was the purpose of the contact or activity
- What was discussed and what decisions were reached

- What next steps will be taken
- Where or how the activity occurred
- What was the date of the contact or activity

Examples:

1. Case Manager Smith contacted Sam and his mother Judy to schedule the annual planning meeting due in September. An agenda for the meeting was discussed as well as who Sam and his mother would like to be invited to the meeting. Sam is enjoying camping with his family and would like to have the meeting in his backyard so he can show his team his new tent. The meeting will be held on September 20 at Sam's house. The case manager will share the time and location with the team and ask them to bring their own lawn chairs. Mom will contact Sam's aunt, as he would like her to be at his team meeting.
2. Case Manager Smith called Mary to schedule a face-to-face meeting but there was no answer. As the case noted, the case manager has tried to reach Mary for a couple of months, but Mary has not returned the calls, texts or emails sent. An unannounced visit was attempted on July 5, 2024, but no one was home. Case Manager Smith will contact Supervisor Jones to see if a certified letter should be sent or BDS contacted for assistance in connecting with Mary.

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

Provider Qualifications

Selected contracting organizations/entities must meet the following criteria to provide Case Management services:

- Be enrolled as an active Medicaid provider
- Be FSSA-approved
- Be eligible to provide Case Management services in every Indiana county
- Comply with *Indiana Administrative Code*, *460 IAC 6*, including but not limited to:
  - *460 IAC 6-10-5* Documentation of Criminal Histories
  - *460 IAC 6-12-1* and *460 IAC 6-12-2* Insurance
  - *460 IAC 6-11-1* to *460 IAC 6-11-3* Financial Status of Providers
  - *460 IAC 6-19-1* through *460 IAC 6-19-9* Case Management
  - *460 IAC 6-5-5* Case Management Services Provider Qualifications
- Obtain/maintain accreditation (specific to Indiana programs) by at least one of the following organizations:
  - The Commission on Accreditation of Rehabilitation Facilities (CARF), or its successor
  - The Council on Quality and Leadership In Supports for People with Disabilities, or its successor
  - The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or its successor
  - The National Committee for Quality Assurance, or its successor
  - The ISO-9001 human services quality assurance (QA) system
  - An independent national accreditation organization approved by the FSSA Secretary
- Develop and enforce a code of ethics aligned with *460 IAC 6-14-7* and BDS policy, practices and guidance.
- Maintain enough case managers to provide statewide* coverage while maintaining an average caseload size of no more than 45 cases across full-time case managers who actively provide Case Management services to Individuals receiving waiver services. A full-time case manager is defined

as a case manager with a caseload of at least 21 cases. The state will monitor adherence to this caseload limit on a quarterly basis.

> ** Note: Five of the six awarded selected contracting case management organizations (CMO) were already operating statewide at the time of the state's request for services. The one remaining CMO was given a six-month window as of the Oct.1, 2021, award announcement to become statewide for the concurrent operation of the* ***§1915(c) and §1915(b)(4) waivers.***

- Ensure ongoing criminal background checks are conducted for every employee hired or associated with the approved case management entity as stated Indiana Administrative Code, Indiana Code and BDS policy.

Compliance

- Retain at least one full-time employee to actively monitor and ensure all areas of compliance and quality.
  - Persons in this role may not carry a case load of more than 10 cases.
  - Persons in this role may not do quality and compliance reviews on their own caseload.
  - Persons in this role will monitor and identify any violation of rules, regulations or established requirements that are discovered and report them to the BDS through the incident reporting system as outlined in Indiana Administrative Code, Indiana Code and BDS policy.
- Have a mechanism for monitoring the quality of services delivered by case managers that aligns with BDS practices; and addressing any quality issues that are discovered and reporting them to BDS.
- All DDARS-approved case management organizations/agencies specifically agree to comply with the provisions of the *Americans with Disabilities Act of 1990* (*U.S. Code 42 USC 12101* et seq. and *47 USC 225*).
- Case management entities must:
  - Ensure compliance with any applicable FSSA BDS service standards, guidelines, policies and/or manuals, including policies, written agreements and this provider reference module, accessible from the *IHCP Bulletins and Reference Modules* webpage at in.gov/medicaid/providers
  - Ensure case managers meet with waiver individuals on a regular basis or as requested by the individual to develop, update and support the execution of person-centered individualized support
  - Require initially and annually, that each case manager employed by the DDARS-approved case management organization/agency obtain proof of competency demonstrated through successful completion of the DDARS BDS case management training curriculum and certification exam
  - Ensure case managers complete and demonstrate competency of the BDS required training
  - Ensure case managers complete the required hours of BDS approved, case management entity provided, training
  - Ensure that case managers are trained in the person-centered planning process aligned with BDS mission, vision and values, including participation in any BDS person-centered trainings
  - Ensure case managers shall have the ability to employ whatever tools necessary to effectively and efficiently communicate with each individual by whatever means is preferred by the individual
  - Ensure case managers meet with one or more of the following qualification standards:
    - Hold a bachelor's degree in one of the following specialties from an accredited college or university:
      - Social work, psychology, sociology, counseling, gerontology, nursing, special education, rehabilitation or related degree if approved by the FSSA DDARS or Office of Medicaid Policy and Planning (OMPP)

- Be a registered nurse with one-year experience in human services.
- Hold a bachelor's degree in any field with a minimum of one year full-time, direct experience working with persons with intellectual/developmental disabilities.
- Holding a master's degree in a related field may substitute for required experience.

- The case manager must meet the requirements for a qualified intellectual disability professional in *42 CFR 483.430(a)*.
- Technology case management entities must:
  - Provide and maintain a 24/7 emergency response system that does not rely upon the area 911 system and provides assistance to all waiver individuals. The 24 hours a day, seven days a week line staff must assist individuals or their families with addressing immediate needs and contact the individual's case manager to ensure arrangements are made to address the immediate situation and to prevent reoccurrences of the situation.
  - Maintain sufficient technological capability to submit required data electronically in a format and through mechanisms specified by the state.
  - Ensure each case manager is properly equipped with a cell phone, smart phone or similar device that allows the case manager to be accessible as needed to the individuals they serve.

Conflict-Free Case Management

- Indiana maintains a conflict-free case management policy. This covers conflict of interest in terms of provision of services as well as in relationship to the individual being served.
- Conflict-free means:
  - Case management organizations/agencies may not be an approved provider of any other waiver service.
  - The owners of one case management organization/agency may not own multiple case management organizations/agencies.
  - The owners of one case management organization/agency may not be a stakeholder of any other waiver service agency.
  - There may be no financial relationship between the referring case management organization/agency, its staff and the provider of other waiver services.
  - Case managers may not be financially influenced in the course of their service delivery.
- In addition, case managers must not be:
  - Related by blood or marriage to the waiver participant
  - Related by blood or marriage to any paid caregiver of the waiver participant
  - Financially responsible for the waiver participant
  - Authorized to make financial or health-related decisions on behalf of the waiver participant

Note: Case Management services are mandatory for all waiver participants.

Section 9.7: Community Transition for CIH Waiver

The following subsections provide information and requirements for Community Transition services for the CIH Waiver.

Note:	*Community Transition services are **not** available under the FS Waiver.* *For information about Community Transition services available under the H&W and TBI Waivers, see Section 11.14: Community Transition for H&W and TBI Waivers.*

Service Definition

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

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

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

Reimbursable Activities

Reimbursable activities include the following:

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

When the individual is receiving residential habilitation and support, Structured Family Caregiving services or Day Habilitation services under the CIH Waiver, the Community Transition service is included in the service authorization.

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

Service Standards

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

Services must address needs identified in the PCISP and the service authorization.

Documentation Standards

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

Limitations

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

Activities Not Allowed

The following activities are not allowed under Community Transition services:

- Apartment or housing rental expenses
- Food
- Appliances
- Diversional or recreational items such as hobby supplies
- Television
- Cable TV access
- VCRs or DVD players
- Streaming services such as Netflix, Hulu and so on
- Service provided by the parent of a minor child participant or the spouse of a participant (also known as LRIs)

Provider Qualifications

Community Transition providers must meet the following criteria:

- Be enrolled as an active Medicaid provider
- Be FSSA-approved
- Comply with *Indiana Administrative Code*, *460 IAC 6*, including but not limited to:
  - *460 IAC 6-10-5* Documentation of Criminal Histories
  - *460 IAC 6-12-1* and *460 IAC 6-12-2* Insurance
  - *460 IAC 6-11-1* to *460 IAC 6-11-3* Financial Status of Providers
  - *460 IAC 6-5-34* Community Transition Supports Provider Qualifications
  - *460 IAC 6-14-4* Staff Training and *460 IAC 6-14-4* Training
- Comply with any applicable BDS service standards, guidelines, policies and/or manuals, including FSSA DDARS policies and this provider reference module, accessible from the *IHCP Bulletins and Reference Modules* webpage at in.gov/medicaid/providers

Section 9.8: Day Habilitation for FS and CIH Waivers

The following subsections provide information and requirements for Day Habilitation services for the FS and CIH waivers.

Service Definition

Day Habilitation services are specified in the PCISP and support learning and assistance in the areas of: self-care, sensory/motor development, socialization, daily living skills, communication, community living and social skills. Day Habilitation activities are intended to build relationships and natural supports.

Services are provided in a variety of settings in the community or in a facility owned or operated by an FSSA-approved provider. Settings are nonresidential and separate from an individual's private residence or other residential living arrangements.

Reimbursable Activities

Reimbursable activities include the following:

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

Service Standards

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

The PCISP must outline the Day Habilitation services needed by the individual to pursue their desired outcomes as identified during the person-centered planning process. The need for service continuation is to be evaluated annually by the Individualized Support Team (IST) and reflected in the PCISP. As with any outcome within the PCISP, the Day Habilitation service has at least one associated proposed strategy/ activity step designed to address potential barriers or maintenance needs in relation to the desired outcomes and the support and services needed to facilitate the outcomes. The proposed strategy/action steps also identify all paid and unpaid responsible parties and includes the names of each responsible party including the provider, the service and the staffing positions within the agency that are responsible for the strategy/activity. The individual may be the responsible party for a strategy/action steps initiative if they so determine. In addition, each proposed strategy/action step has a specific time frame identified, including a minimum time frame for review. The service authorization identifies the name of the waiver-funded service, the name of the individual-chosen provider of that service, the cost of the service per unit, the number of units of service, and the start and end dates for each waiver service identified on the service authorization.

An allowable relative of the individual may be a direct support professional of Day Habilitation services. The relative must be employed by a BDS approved waiver provider. The decision that a relative is the most appropriate option to provide supports must be part of the person-centered planning process and documented in the PCISP. When the direct support professional is a relative, an annual review by the IST is required to determine whether the individual's relative should continue to be the direct support professional of Day Habilitation services.

Services may be provided in a group setting. The decision that services should be provided in a group setting must be included as a part of the person-centered planning process and documented in the PCISP. The PCISP must also reflect the ratio appropriate for the individual during service delivery. Upon request, the provider must be able to verify in a concise format the ratio for each individual during the claimed time frame of service.

Documentation Standards

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

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

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

The quarterly report shall contain the following elements:

- Name of individual served
- IHCP Member ID of the individual
- Name of provider
- Date range of services
- Service rendered primary type of service: Community or Facility
- Notation of the ratio for service delivery
- Percent of time in community
- Percent of time in a facility
- Brief summary of progress toward PCISP outcomes
- Challenges hindering progress toward PCISP outcomes, if applicable
- A positive event that occurred during the quarter that contributed to the individual's good life

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

For Group Services

Further guidance related to day habilitation, including group services, is posted on the *Current BDS Policies* webpage at in.gov/fssa/ddars and at the direct link for *Day Habilitation: Service Definition and Standards*.

Limitations

The following are limitations on group sizes:

- 1:1 Individual
- 2:1 to 4:1 Small Group
- 5:1 to 10:1 Medium Group
- 11:1 to 16:1 Large Group (applies only to a facility setting)

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

Activities Not Allowed

The following activities are not allowed under Day Habilitation:

- Services that are available under the *Rehabilitation Act of 1973* or *PL 94-142*
- Skills training for any activity that is not identified as directly related to an individual's habilitation outcome
- Activities that do not foster the acquisition and retention of skills
- Activities that duplicate or replace supports provided through Residential Habilitation and Support (RHS) services.
- Services furnished to a minor by parents, stepparents or legal guardian
- Services furnished to an individual by the individual's spouse

Provider Qualifications

Providers of Day Habilitation must meet the following criteria:

- Be enrolled as an active Medicaid provider
- Be FSSA-approved
- Comply with *Indiana Administrative Code*, *460 IAC 6*, including but not limited to:
  - *460 IAC 6-10-5* Documentation of Criminal Histories
  - *460 IAC 6-12-1* and *460 IAC 6-12-2* Insurance
  - *460 IAC 6-11-1* to *460 IAC 6-11-3* Financial Status of Providers
  - *460 IAC 6-14-5* Requirements for Direct Care Staff
  - *460 IAC 6-14-4* Staff Training and *460 IAC 6-14-4* Training

- *460 IAC 6-5-14* Health Care Coordination Services Provider Qualifications
- *460 IAC 6-5-30* Transportation Services Provider Qualifications

- Comply with any applicable BDS service standards, guidelines, policies and/or manuals, including FSSA DDARS policies and this provider reference module, accessible from the *IHCP Bulletins and Reference Modules* webpage at in.gov/medicaid/providers
- Obtain/maintain accreditation (specific to Indiana programs) by at least one of the following organizations:
  - The Commission on Accreditation of Rehabilitation Facilities (CARF), or its successor
  - The Council on Quality and Leadership In Supports for People with Disabilities, or its successor
  - The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or its successor
  - The National Committee for Quality Assurance, or its successor
  - The ISO-9001 human services quality assurance (QA) system
  - An independent national accreditation organization approved by the FSSA Secretary

Section 9.9: Extended Services for FS and CIH Waivers

The following subsections provide information and requirements for Extended Services for the FS and CIH waivers.

Service Definition

- Extended Services are ongoing employment support services that enable an individual to maintain integrated competitive employment in a community setting. Individuals must be employed in a community-based, competitive job that pays at or above minimum wage to access this service.
- The initial job placement, training and stabilization may be provided through Indiana Vocational Rehabilitation (VR). 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 VR services, the individual is still eligible to receive Extended Services, as long as the individual meets the qualifications (see the *Provider Qualifications* section).
- Ongoing employment support services are identified in the individuals' PCISP and must be related to the individuals' limitations in functional areas (for example, self-care, understanding and use of language, learning, mobility, self-direction, capacity for independent living, economic self-sufficiency), as necessary to maintain employment.

In the file of each individual receiving this service, documentation is maintained showing that the service is not available under a program funded under Section 110 of the *Rehabilitation Act of 1973* or the *IDEA (20 USC 1401 et seq.*). Federal financial participation is not claimed for incentive payments, subsidies or unrelated vocational training expenses such as the following:

- Incentive payments made to an employer to encourage or subsidize the employer's participation in Supported Employment; or
- Payments that are passed through to users of Supported Employment services.

Additional Information

- Individuals may also use 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 buildings alongside other nonintegrated individuals.
- Competitive integrated employment is defined as full or part-time work at minimum wage or higher, with wages and benefits similar to those without disabilities performing the same work, and fully integrated with coworkers without disabilities.
- Individuals may be self-employed, working from their own homes, and still receive Extended Services when the work is competitive and could also be performed in an integrated environment by and among persons without intellectual/developmental disabilities.

Reimbursable Activities

Reimbursable activities include the following:

- Ensuring that natural supports at the worksite are secured through interaction with supervisors and staff (A tangible outcome of this activity would be a decrease in the number of hours of Extended Services an individual accessed over time.)
- Training for the individual and/or the individual's employer, supervisor or coworkers, to increase the individual's inclusion at the worksite
- Regular observation or support of the individual to reinforce and stabilize the job placement
- Job-specific or job-related safety training
- Job-specific or job-related self-advocacy skills training
- Reinforcement of work-related personal care and social skills
- Training on use of public transportation and/or acquisition of appropriate transportation
- Facilitating, but not funding, driver's education training
- Coaching and training on job-related tasks, such as computer skills or other job-specific tasks
- Travel by the provider to the worksite as part of the delivery of this service

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

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

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

Service Standards

Extended Services are provided in integrated community settings where persons without disabilities are also employed. Reimbursement will only be made for the employment support services required by the individual receiving services as a result of their disability.

Extended Services do not include sheltered work or other similar types of vocational services furnished in specialized facilities or volunteer endeavors.

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

Documentation Standards

Individual informed choices and goals related to employment and the justification/need for Extended Services must be outlined in the PCISP.

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

- Name of individual served
- IHCP Member ID of the individual
- Name of provider
- Identified employment need
- Service rendered
- Expected outcome
- Date of service, including the year
- Time frame of service (include a.m. or p.m.)
- Notation of the primary location of service delivery
- A summary of services rendered to include the specific reimbursable activities that were performed and the outcomes realized from those activities
- A description of any issue or circumstance concerning the individual including, but not limited to, significant medical or behavioral incidents or any other situation that may be uncommon for the individual
- Signature that includes at least the last name and first initial of the staff person making the entry
  - Electronic signatures are permissible when in compliance with the *Uniform Electronic Transactions Act [IC 26-2-8]*.

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

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

Limitations

Group services may only be rendered at the discretion of the IST and in group sizes no greater than four individuals to one staff. In addition, the provider must be able to provide appropriate documentation, as outlined under *Documentation Standards* for Extended Services, demonstrating that the ratio for each claimed time frame of services did not exceed the maximum allowable ratio determined by the IST for each group individual, and provide documentation identifying other group individuals, by using the individuals' *Health Insurance Portability and Accountability Act* (HIPAA) naming convention.

Activities Not Allowed

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

- Any non-community-based setting where the majority (51% or more) of the individuals have an intellectual or developmental disability
- Sheltered work observation or participation
- Volunteer endeavors
- Any service that is otherwise available under the *Rehabilitation Act of 1973* or *Public Law 94-142*
- Public relations
- Incentive payments made to an employer to subsidize the employer's participation in Extended Services
- Payment for vocational training that is not directly related to the individual's Extended Service needs outlined in the PCISP
- Extended Services do not include payment for supervisory activities rendered as a normal part of the business setting.
- Extended Services provided to a minor by a parent, stepparent, legal guardian or spouse
- The provision of transportation to an individual is not a reimbursable activity within Extended Services.
- Waiver funding for the provision of vocational services delivered in facility-based or sheltered work settings, where individuals are supervised for the primary purpose of producing goods or performing services
- Group supports delivered to individuals who are using different support options (For example, one individual in the group is using Extended Services and another individual in the same group setting is using Day Habilitation.)

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

Provider Qualifications

Extended Services providers must meet the following criteria:

- Be enrolled as an active Medicaid provider
- Be FSSA-approved
- Comply with *Indiana Administrative Code 460 IAC 6*, including but not limited to:
  - *460 IAC 6-12-1* and *460 IAC 6-12-2* Insurance

  - *460 IAC 6-10-5* Documentation of Criminal Histories
  - *460 IAC 6-11-1* to *460 IAC 6-11-3* Financial Status of Providers
  - *460 IAC 6-14-5* Requirements for Direct Care Staff
  - *460 IAC 6-14-4* Staff Training and *460 IAC 6-14-4* Training
- Comply with any applicable BDS service standards, guidelines, policies and/or manuals, including FSSA DDARS policies and this provider reference module, accessible from the *IHCP Bulletins and Reference Modules* webpage at in.gov/medicaid/providers
- Obtain/maintain Indiana accreditation by at least one of the following organizations:
  - The Commission on Accreditation of Rehabilitation Facilities (CARF), or its successor
  - The Council on Quality and Leadership in Supports for People with Disabilities, or its successor
  - The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or its successor
  - The National Commission on Quality Assurance, or its successor
  - An independent national accreditation organization approved by the secretary
- Meet the standards as a community rehabilitation provider as outlined in *Indiana Code 12-12-1-4.1*

Section 9.10: Facility-Based Support for FS and CIH Waivers

The following subsections provide information and requirements for Facility-Based Support services for the FS and CIH waivers.

Service Definition

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

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

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

Reimbursable Activities

Reimbursable activities include the following:

- Monitoring and/or supervision of ADLs defined as dressing, grooming, eating, walking and toileting with hands-on assistance provided as needed
- Appropriate structure, support and intervention
- Minimum staff ratio: 1 staff for each 16 individuals
- Medication administration
- Optional or non-work-related educational and life-skill opportunities (such as how to use computers/computer programs/internet, set an alarm clock, write a check, fill out a bank deposit slip, plant and care for vegetable/flower garden, and so on) may be offered and pursued

Service Standards

The following service standards apply to Facility-Based Support:

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

Documentation Standards

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

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

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

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

For Group Services

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

Limitations

The following are limitations on Facility-Based Support:

- These services must be provided in a congregate, protective setting in groups not to exceed 16:1 (individuals: staff).

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

Activities Not Allowed

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

- Any activity that is not described in reimbursable activities is not included in this service
- Services furnished to a minor by parents, stepparents or legal guardian
- Services furnished to an individual by the individual's spouse
- Prevocational Services
- Service provided by the parent of a minor child participant or the spouse of a participant (also known as LRIs)

Provider Qualifications

Facility-Based Support providers must meet the following criteria:

- Be enrolled as an active Medicaid provider
- Be FSSA-approved
- Comply with *Indiana Administrative Code*, *460 IAC 6*, including but not limited to:
  - *460 IAC 6-10-5* Documentation of Criminal Histories
  - *460 IAC 6-12-1* and *460 IAC 6-12-2* Insurance
  - *460 IAC 6-11-1* to *460 IAC 6-11-3* Financial Status of Providers
  - *460 IAC 6-14-5* Requirements for Direct Care Staff
  - *460 IAC 6-14-4* Staff Training and *460 IAC 6-14-4* Training
  - *460 IAC 6-5-14* Health Care Coordination Services Provider Qualifications
  - *460 IAC 6-5-30* Transportation Services Provider Qualifications
- Comply with any applicable BDS service standards, guidelines, policies and/or manuals, including FSSA DDARS policies and this provider reference module, accessible from the *IHCP Bulletins and Reference Modules* webpage at in.gov/medicaid/providers

Section 9.11: Family and Caregiver Training for FS and CIH Waivers

The following subsections provide information and requirements for Family and Caregiver Training services for the FS and CIH waivers.

Service Definition

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

Additional Information:

Family and Caregiver Training services cannot be used to provide behavioral programs or supports, or other direct services covered under other available Indiana Medicaid State Plan or waiver services.

Reimbursable Activities

Reimbursable activities include the following:

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

Service Standards

The following service standards apply to Family and Caregiver Training:

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

Documentation Standards

Documentation standards for family and caregiver training services include the following:

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

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

Limitations

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

The services under Family and Caregiver Training are limited to additional services not otherwise covered under the Indiana Medicaid State Plan, including Early and Periodic Screening, Diagnosis and Treatment (EPSDT), but consistent with waiver objectives of avoiding institutionalization.

Activities Not Allowed

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

- Educational materials or training programs, workshops, and conferences that are not related to the caregiver's ability to support the individual
- Education and training provided to train providers, even when those providers will subsequently train caregivers
- Training provided to caregivers who receive training reimbursement within their Medicaid or state line item reimbursement rates
- Cost of travel, meals and overnight lodging while attending the training program, workshop or conference
- Service provided by the parent of a minor child participant or the spouse of a participant (also known as LRIs)

Provider Qualifications

Providers of Family and Caregiver Training must meet the following criteria:

- Be enrolled as an active Medicaid provider
- Be FSSA-approved
- Comply with *Indiana Administrative Code 460 IAC 6*, including but not limited to:
  - *460 IAC 6-10-5* Documentation of Criminal Histories
  - *460 IAC 6-12-1* and *460 IAC 6-12-2* Insurance
  - *460 IAC 6-11-1* to *460 IAC 6-11-3* Financial Status of Providers
  - *460 IAC 6-5-13* Family and Caregiver Training Services Provider Qualifications, and *460 IAC 6-23-1* Requirements for Provision of Services
  - *460 IAC 6-14-4* Staff Training and *460 IAC 6-14-4* Training
- Comply with any applicable BDS service standards, guidelines, policies and/or manuals, including FSSA DDARS policies and this provider reference module, accessible from the *IHCP Bulletins and Reference Modules* webpage at in.gov/medicaid/providers

Section 9.12: Home Modification Assessment for FS and CIH Waivers

The following subsections provide information and requirements for Home Modification Assessment services for the FS and CIH waivers.

> *Note: For information about Home Modification Assessment available under the H&W Waiver and TBI Waiver, see Section 11.17: Home Modification Assessment for H&W and TBI Waivers.*

Service Definition

Home modification assessment will be used to objectively determine the specifications for a home modification that is safe, appropriate and feasible to ensure accurate bids and workmanship. All participants must receive a Home Modification Assessment with a certified waiver provider selected by the

participant prior to any subsequent home modifications as well as a home modification inspection upon completion of the work.

The Home Modification Assessment will assess the home for physical adaptations to the home, which, as indicated by individual's service plan, are necessary to ensure the health, welfare and safety of the individual and enable the individual to function with greater independence in the home and without which the individual would require institutionalization.

The assessor will be responsible for writing the specifications, review of feasibility and the post-project inspection specifications to the case manager and individual for the bidding process and be paid first installment for completion of home specifications. After the project is complete, the assessor, participant and case manager will each be present on an agreed-upon date and time to inspect the work and sign off indicating the work was completed per the agreed-upon bid, and the assessor will be paid the final installment of the home modification work. In the event the participant, provider, assessor and/or the case manager become aware of discrepancies or complaints about the work being completed, the provider shall stop work immediately and contact the case manager and BDS for further instruction.

The BDS also has the ability to request additional assessment visits to help resolve a disagreement between the home modification provider and the participant. This payment is not included in the actual home modification cost category and shall not be subtracted from the participant's lifetime cap for home modifications. The case management provider entity will be responsible for maintaining related records that can be accessed by the state.

Reimbursable Activities

Reimbursable activities include the following:

- Evaluation of the current environment, including the identification of barriers, underneath the home, electrical and plumbing, which may prevent the completion of desired modifications
- Nonfeasible assessments
- Drafting of specifications
- Preparation/submission of specifications
- Examination of the modification (inspection/approve)
- Contacting county for code enforcement

Service Standards

The following service standards apply to Home Modification Assessments:

- Need for home modification must be indicated in the participant's plan of care
- Modification must address the participant's level-of-service needs.
- Proposed specifications for modification must conform to the requirements and limitations of the current approved service definition for home modification services.
- Assessment should be conducted by an approved, qualified individual who is independent of the entity providing the home modifications.
- Contact appropriate authority regarding potential code violations.

Documentation Standards

Documentation standards for Home Modification Assessments include the following:

- The need for Home Modification must be indicated in the participant's plan of care.
- Modification must address the participant's level-of-service needs.
- Any discrepancy noted by the provider, case manager and/or participant shall be detailed in the final inspection and addressed by the assessor.

Limitations

An annual cap of $628 is available for Home Modification Assessment services, unless the BDS requests an additional assessment to help mediate disagreements between the home modification provider and the participant.

Activities Not Allowed

The following activities are not allowed under Home Modification Assessment services:

- Home Modification Assessment services shall not be performed by the same provider that performs the subsequent Home Modifications.
- Home Modification Assessment services will not be reimbursed when the owner of the service organization is one of the following:
  - Parent of a minor child participant
  - Spouse of a participant
  - Attorney-in-fact (POA) of a participant
  - Health care representative (HCR) of a participant
  - Legal guardian of a participant
- This service must not be used for living arrangements that are owned or leased by providers of waiver services.
- Payment will not be made for home modifications under this service.

Provider Qualifications

Providers of Home Modification Assessment services must meet the following criteria:

- Be enrolled as an active Medicaid provider
- Be FSSA-approved
- Comply with *Indiana Administrative Code 460 IAC 6*, including but not limited to:
  - *460 IAC 6-10-5* Documentation of Criminal Histories
  - *460 IAC 6-12-1* and *460 IAC 6-12-2* Insurance
  - *460 IAC 6-11-1* to *460 IAC 6-11-3* Financial Status of Providers
  - *460 IAC 6-5-27* Specialized Medical Equipment and Supplies Supports Provider Qualifications
- Comply with any applicable BDS service standards, guidelines, policies and/or manuals, including FSSA DDARS policies and this provider reference module, accessible from the *IHCP Bulletins and Reference Modules* webpage at in.gov/medicaid/providers
- Where licensure is required, must obtain and maintain Indiana-specific licensure

- In addition to the licensure standard, either a Certified Aging-In-Place Specialist (CAPS Certification – National Association of Home Builders) or an Executive Certificate in Home Modifications (University of Southern California) is required.

Section 9.13: Home Modifications for FS and CIH Waivers

The following subsections provide information and requirements for Home Modifications services for the FS and CIH waivers.

> *Note: For information about the Home Modifications service available under the H&W and TBI Waivers, see Section 11.18: Home Modifications for H&W and TBI Waivers*

Service Definition

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

DDARS waiver services staff must approve all Home Modifications prior to service being rendered.

Additional Information:

- • The costs for Home Modifications are not included in the $26,482 cap of the FS Waiver.
- Photographs of the proposed areas to be modified must be provided.
- The Request for Approval to Authorize Services (RFA) policy for Home Modifications appears in *Section 10.1: Home Modification RFA Policy*. Policy updates are in process.

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

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

Reimbursable Activities

Reimbursable activities for Home Modifications 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

For the FS Waiver, Home Modifications are not included in the $26,482 cap.

Service Standards

The following service standards apply to Home 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.
- All participants must receive a Home Modification Assessment with a certified waiver provider selected by the participant prior to any subsequent home modifications as well as a home modification inspection upon completion of the work. Home Modifications will be used to objectively determine the specifications for a home modification that is safe, appropriate and feasible to ensure accurate bids and workmanship. (See *Section 9.12: Home Modification Assessment for FS and CIH Waivers*.)
- To ensure that home 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 home 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 Home Modifications
  - Independent inspections during the modification process and at completion of the modifications, prior to authorization for reimbursement, based on the complexities of the requested modifications
- Equipment and supplies shall be reflected in the PCISP.
- Equipment and supplies must address needs identified in the PCISP.

Documentation Standards

Documentation standards for Home Modifications include the following:

- Documentation of the identified direct medical benefit for the individual
- Documented prior authorization (PA) denial from Medicaid, if applicable
- Receipts for purchases
- Identified need in PCISP
- Signed and approved *Request for Approval to Authorize Services (RFA) (State Form 45750)*
- Documentation in compliance with *460 IAC 6,* Supported Living Services and Supports requirements

Limitations

The following limitations apply to Home Modifications:

- Reimbursement for Home Modification services has a lifetime cap of $20,000 per waiver.
- Service and repair up to $1,000 per year, outside the lifetime cap, are permitted for maintenance and repair of prior modifications that were funded by a waiver service.

- If the lifetime cap is fully used, and a need is identified, the case manager will work with other available funding streams and community agencies to fulfill the need.

Activities Not Allowed

The following activities are not allowed under Home Modifications:

- Adaptations to the home that are of general utility
- Adaptations that are not of direct medical or remedial benefit to the individual (such as carpeting, roof repair or central air conditioning)
- Adaptations that add to the total square footage of the home
- Adaptations that are not included in the PCISP
- Adaptations that have not been approved on a *Request for Approval to Authorize Services (RFA) (State Form 45750)*
- Adaptations to housing owned or leased by the providers of waiver services (*Note: Home Modifications as a service under the waiver may not be furnished to participants who receive Residential Habilitation and Support services except when such services are furnished in the participant's own home.*)
- Compensation for the costs of life-safety code modifications and other accessibility modifications made with participant waiver funds to housing owned or leased by providers of waiver services
- Service used for living arrangements that are owned or leased by providers of waiver services
- Service provided by the parent of a minor child participant or the spouse of a participant (also known as LRIs)

Provider Qualifications

Providers of Home Modifications must meet the following criteria:

- Be enrolled as an active Medicaid provider
- Be FSSA-approved
- Comply with *Indiana Administrative Code*, *460 IAC 6*, including but not limited to:
  - *460 IAC 6-10-5* Documentation of Criminal Histories
  - *460 IAC 6-12* Insurance
  - *460 IAC 6-11* Financial Status of Providers
  - *460 IAC 6-5-11* Environmental Modification Supports Provider Qualifications
- Comply with any applicable BDS service standards, guidelines, policies and/or manuals, including FSSA DDARS policies and this provider reference module, accessible from the *IHCP Bulletins and Reference Modules* webpage at in.gov/medicaid/providers
- Where licensure or certification is required, must obtain/maintain Indiana-specific licensure/certification; examples include but are not limited to:
  - Home Inspector *IC 25-20.2*
  - Plumber IC 25-28.5
  - Physical Therapist *IC 25-27-1*
  - Occupational Therapist *IC 25-23.5*
  - Speech/Language Therapist *IC 25-35.6*
  - Architect *IC 25-4-1*

Section 9.14: Intensive Behavioral Intervention for FS and CIH Waivers

The following subsections provide information and requirements for Intensive Behavioral Intervention services for the FS and CIH waivers.

Service Definition

Intensive Behavioral Intervention services focus on developing effective behavior management strategies for individuals whose challenging behavioral issues put them at risk of placement in a more restrictive residential setting. Intensive Behavioral Intervention services teach the individual, families and other caregivers how to respond to and deal with intense and challenging behaviors. These services are designed to reduce an individual's behaviors and improve independence and inclusion in the community. The need for Intensive Behavioral Intervention services is determined by a functional, behavioral needs assessment of the individual. Intensive Behavioral Intervention services are specified in the PCISP.

- Intensive Behavioral Intervention 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, Intensive Behavioral Intervention 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 Intensive Behavioral Intervention must include:
  - Measurable goals and objectives (specific targets may include appropriate social interaction, communication skills and/or language skills)
  - Heavy emphasis on skills that are prerequisites to language (attention, cooperation, imitation)

Additional Information:

If individuals under age 21 choose to use Intensive Behavioral Intervention-type services they should access equivalent service such as applied behavior analysis (ABA) under EPSDT.

Reimbursable Activities

Reimbursable activities include the following:

- Preparation of an Intensive Behavioral Intervention support plan in accordance with the DDARS *Behavioral Support Plan Policy (2011)* at in.gov/fssa/ddars
- Application of a combination of the following empirically based, multimodal and multidisciplinary comprehensive treatment approaches:
  - Intensive Teaching Trials (ITT), also called Discrete Trial Training, is a highly specific and structured teaching approach that uses empirically validated behavior change procedures. This

type of learning is instructor-driven and may use error-correction procedures or reinforcement to maintain motivation and attention to task. ITT consists of the following:
    - Antecedent: A directive or request for the individual to perform an action
    - Behavior: A response from the individual, including anything from successful performance, noncompliance, to no response
    - Consequence: A reaction from the therapist, including a range of responses from strong positive reinforcement, faint praise or a negative (not aversive) reaction
    - A pause to separate trials from each other (inter-trial interval)
  - Natural Environment Training (NET) is learner-directed training in which the learner engages in activities that are naturally motivating and reinforcing to the learner, 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 an individual with intellectual/developmental disabilities, which may include but are not limited to:
    - Precision teaching: A type of programmed instruction that focuses heavily on frequency as its main datum. It is a precise and systematic method of evaluating instructional tactics. The program emphasizes learner fluency and data analysis is regularly reviewed to determine fluency and learning.
    - Direct instruction: A general term for the explicit teaching of a skill set. The learner is usually provided with some element of frontal instruction of a concept or skill lesson, followed by specific instruction on identified skills. Learner progress is regularly assessed, and data analyzed.
    - Pivotal response training: This training identifies certain behaviors that are "pivotal" (that is, critical for learning other behaviors). The therapist focuses on these behaviors to change other behaviors that depend on them.
  - Errorless teaching or other prompting procedures that have been found to support successful intervention. These procedures focus on the prevention of errors or incorrect responses while also monitoring when to fade the prompts to allow the learner to demonstrate ongoing and successful completion of the desired activity.
  - Additional methods that occur and are empirically based.
- Specific and ongoing objective measurement of progress, with success closely monitored via detailed data collection.

Service Standards

The following service standards apply to Intensive Behavioral Intervention:

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

Documentation Standards

Documentation standards for Intensive Behavioral Intervention services include the following:

- Services outlined in the PCISP
- Documentation in compliance with *460 IAC 6*
- The Intensive Behavioral Intervention case supervisor will provide a narrative and graphical report to pertinent parties at least monthly. Pertinent parties include the individual, Intensive Behavioral Intervention director, guardian, BDS service coordinator, waiver case manager, all service providers and other entities.
- The Intensive Behavioral Intervention director will provide a narrative and graphical report to pertinent parties at least quarterly. Pertinent parties include the individual, Intensive Behavioral Intervention case supervisor, guardian, BDS 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 use Intensive Behavioral Intervention type services, they should access equivalent services, such as applied behavior analysis (ABA), under 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 parents, stepparents or legal guardian
- Services furnished to an individual by the individual's spouse

- Therapy services furnished to the individual within the educational/school setting or as a component of the individual's school day

Provider Qualifications

Intensive Behavioral Intervention providers must meet the following criteria:

- Be enrolled as an active Medicaid provider
- Be FSSA-approved
- Comply with *Indiana Administrative Code*, *460 IAC 6*, including but not limited to:
  - *460 IAC 6-10-5* Documentation of Criminal Histories
  - *460 IAC 6-12-1* and *460 IAC 6-12-2* Insurance
  - *460 IAC 6-11-1* to *460 IAC 6-11-3* Financial Status of Providers
  - *460 IAC 6-14-5* Requirements for Direct Care Staff
  - *460 IAC 6-14-4* Staff Training and *460 IAC 6-14-4* Training
- Comply with any applicable BDS service standards, guidelines, policies and/or manuals, including FSSA DDARS policies and this provider reference module, accessible from the *IHCP Bulletins and Reference Modules* webpage at in.gov/medicaid/providers
- Where licensure/certification is required, must obtain/maintain Indiana-specific licensure/certification:
  - For Intensive Behavioral Intervention director: Psychologist licensed under *IC 25-33*, or psychiatrist licensed under *IC-25-22.5*
  - For Intensive Behavioral Intervention case supervisor: Must be certified as a Board Certified Behavior Analyst (BCBA) or Board Certified Assistant Behavior Analyst (BCaBA)

Section 9.15: Music Therapy for FS and CIH Waivers

The following subsections provide information and requirements for Music Therapy services for the FS and CIH waivers.

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 the Music Therapy 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.

Reimbursable Activities

Reimbursable activities include the following:

- Therapy to improve:
  - Self-image and body awareness
  - Fine and gross motor skills
  - Auditory perception

- Therapy to increase:
  - Communication skills
  - Ability to use energy purposefully
  - Interaction with peers and others
  - Attending behavior
  - Independence and self-direction
- Therapy to prevent or reduce the likelihood of certain behaviors that interrupt or interfere with an individual's daily life
- Therapy to enhance emotional expression and adjustment
- Therapy to stimulate creativity and imagination. The music therapist may provide services directly, or may demonstrate techniques to other service personnel or family members
- Planning, reporting and write-up when in association with the actual one-on-one direct care/therapy service delivery with the waiver individual
- Individual Music Therapy
- Group services in group sizes no greater than four individuals to one music therapist (unit rate divided by number of individuals)

Service Standards

The following service standards apply to Music Therapy:

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

Documentation Standards

Documentation standards for Music Therapy services include the following:

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

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

Limitations

The services under Music Therapy are limited to additional services not otherwise covered under the Indiana Medicaid State Plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

One hour of billed therapy service must include a minimum of 45 minutes of direct individual care/therapy, with the balance of the hour spent in related-patient services. To determine if the 45/15-minute rule is met,

the BDS looks to ensure that units were billed accurately and supported with documentation and that the number of direct units billed exceeds the number of indirect units reflecting a general ratio of 75% direct units billed to 25% indirect units billed. The 75/25 ratio determination may occur through each encounter or over a period of time.

Activities Not Allowed

The following activities are not allowed under Music Therapy:

- Any services that are reimbursable through the Indiana Medicaid State Plan
- Therapy services furnished to the individual within the educational/school setting or as a component of the individual's school day
- Specialized equipment (Specialized equipment needed for the provision of music therapy services should be purchased under the Specialized Medical Equipment and Supplies service; see *Section 10.2: Specialized Medical Equipment and Supplies.*)
- Activities delivered in a nursing facility
- Group sizes greater than four individuals to one music therapist or group sizes exceeding the maximum allowable group size determined by the IST for each group individual
- Service provided by the parent of a minor child participant or the spouse of a participant (also known as LRIs)

Provider Qualifications

Music Therapy providers must meet the following criteria:

- Be enrolled as an active Medicaid provider
- Be FSSA-approved
- Comply with *Indiana Administrative Code*, *460 IAC 6*, including but not limited to:
  - *460 IAC 6-10-5* Documentation of Criminal Histories
  - *460 IAC 6-12-1* and *460 IAC 6-12-2* Insurance
  - *460 IAC 6-11-1* to *460 IAC 6-11-3* Financial Status of Providers
  - *460 IAC 6-5-15* Music Therapy Services Provider Qualifications
- Comply with any applicable BDS service standards, guidelines, policies and/or manuals, including FSSA DDARS policies and this provider reference module, accessible from the *IHCP Bulletins and Reference Modules* webpage at in.gov/medicaid/providers
- Where licensure/certification is required, must obtain/maintain Indiana-specific licensure/certification
  - Certified Music Therapist by a Certification Board for Music Therapists that is accredited by a National Commission for Certifying Agencies

Section 9.16: Occupational Therapy for FS and CIH Waivers

The following subsections provide information and requirements for Occupational Therapy services for the FS and CIH waivers.

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 Indiana Medicaid State Plan.

Reimbursable Activities

Reimbursable activities include the following:

- Evaluation and training services in the areas of gross and fine motor function, self-care, and sensory and perceptual motor function
- Screening
- Assessments
- Planning, reporting and write-up when in association with the actual one-on-one direct care/therapy service delivery with the waiver individual
- Direct therapeutic intervention
- Design, fabrication, training and assistance with adaptive aids and devices
- Consultation or demonstration of techniques with other service providers and family members
- One hour of billed therapy service must include a minimum of 45 minutes of direct patient care with the balance of the hour spent in related patient services.

Service Standards

The following service standards apply to Occupational Therapy:

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

Documentation Standards

Documentation standards for Occupational Therapy services include the following:

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

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

Limitations

If individuals under the age of 21 choose to use Occupational Therapy, they should access Occupational Therapy services through EPSDT.

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

Activities Not Allowed

The following activities are not allowed under Occupational Therapy:

- Therapy services furnished to the individual within the educational/school setting or as a component of the individual's school day
- Activities delivered in a nursing facility
- Services that are available through the Indiana Medicaid State Plan (a Medicaid State Plan PA denial is required before reimbursement is available through the Medicaid waiver for this service)
- Service provided by the parent of a minor child participant or the spouse of a participant (also known as LRIs)

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

Provider Qualifications

Occupational Therapy providers must meet the following criteria:

- Be enrolled as an active Medicaid provider
- Be FSSA-approved
- Comply with *Indiana Administrative Code*, *460 IAC 6*, including but not limited to:
  - *460 IAC 6-10-5* Documentation of Criminal Histories
  - *460 IAC 6-12-1* and *460 IAC 6-12-2* Insurance
  - *460 IAC 6-11-1* to *460 IAC 6-11-3* Financial Status of Providers
  - *460 IAC 6-5-17* Occupational Therapy Services Provider Qualifications
- Comply with any applicable BDS service standards, guidelines, policies and/or manuals, including FSSA DDARS policies and this provider reference module, accessible from the *IHCP Bulletins and Reference Modules* webpage at in.gov/medicaid/providers
- Where licensure/certification is required, must obtain/maintain Indiana-specific licensure/certification
- For licensed occupational therapist, meet requirements set forth in *IC 25-23.5*

Section 9.17: Participant Assistance and Care for FS Waiver

The following subsections provide information and requirements for Participant Assistance and Care services for the FS Waiver.

> *Note: Participant Assistance and Care is **not** available under the CIH, H&W or TBI waivers.*

Service Definition

Participant Assistance and Care services are provided to allow individuals with intellectual/developmental disabilities to remain and live successfully in their own homes, function and participate in their communities, and avoid institutionalization. Participant Assistance and Care services support and enable the individual in activities of daily living, self-care and mobility with hands-on assistance, prompting, reminders, support and monitoring needed to ensure the health and safety, of the individual.

HCBS provided during an acute care hospitalization assists the individual to maintain current levels of functioning and support, provides ongoing coordination of care, and ensures that new or additional needs are identified and addressed by the person-centered planning team as the individual prepares to return to the community.

The HCBS provided in an acute care hospital must not be duplicative of services available in the acute care hospital setting.

A relative of the individual may be a provider of Participant Assistance and Care. The decision that a relative is the best choice of persons to provide these services is a part of the person-centered planning process and is documented in the PCISP. When the provider is a relative, there is an annual review by the IST to determine whether the individual's relative should continue to be the provider of Participant Assistance and Care.

> **Additional Information:**
>
> - Individuals will use any appropriate services available under the Indiana Medicaid State Plan.
> - Utilization of Participant Assistance and Care services does not prohibit the use of any other service available under the FS Waiver that is outlined on the PCISP.

• *Reimbursable Activities*

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

- Activities may include any task or tasks of direct benefit to the individual that would generally be performed independently by persons without intellectual/developmental disabilities or by family members for or on behalf of persons with intellectual/developmental disabilities
- Examples of activities include but are not limited to the following:
  - Assistance with personal care, meals, shopping, errands, scheduling appointments, chores and leisure activities (excluding the provision of transportation)
  - Assistance with mobility – including but not limited to transfers, ambulation, use of assistive devices
  - Assistance with correspondence and bill-paying
  - Escorting the individual to community activities and appointments
  - Support and person-centered monitoring of the individual

  - Reinforcement of behavioral support
  - Adherence to risk plans
  - Reinforcement of principle of health and safety
  - Completion of task list
- Participating on the IST for the development or revision of the PCISP (staff must attend the IST meeting to claim reimbursement)
  - Participant Assistance and Care is 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 Participant Assistance and Care provider (unit rate divided by number of Participant Assistance and Care participants sharing service).

Reimbursable waiver-funded Participant Assistance and Care services furnished to a waiver participant by a paid relative and/or legal guardian may not exceed a total of 40 hours per week per paid relative and/or legal guardian caregiver. (For a list of individuals defined as relatives, see *Section 6.9: Parents, Guardians and Relatives Providing FS and CIH Waiver Services*.)

Service Standards

The following service standards apply to Participant Assistance and Care:

- Participant Assistance and Care services must follow a written PCISP/service authorization addressing the specific needs determined by the individual's assessment and identified in the PCISP
- Ability to consult with a nurse as needed (on staff or on call for the provider)
- Available individually or as a shared service:
  - Shared/group services in group sizes no greater than four individuals to one paid staff member of the Participant Assistance and Care provider (unit rate divided by number of Participant Assistance and Care individuals sharing service)

Documentation Standards

Participant Assistance and Care services documentation must include:

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

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

Limitations

The following are limitations on Participant Assistance and Care services:

- Reimbursable waiver-funded Participant Assistance and Care services furnished to a waiver individual by a paid relative and/or legal guardian may not exceed a total of 40 hours per week per paid relative and/or legal guardian. (For a list of individuals defined as relatives, see *Section 6.9: Parents, Guardians and Relatives Providing FS and CIH Waiver Services*)
- Shared/group services in group sizes no greater than four individuals to one paid staff member of the Participant Assistance and Care provider (unit rate divided by number of Participant Assistance and Care individuals sharing service)

- Regarding hospitalizations:
  - Providers may only bill for Participant Assistance and Care reimbursement during the time when an individual receiving HCBS waiver services is admitted to an acute care hospital setting for inpatient medical care or other related services for surgery, acute medical condition or injuries if all conditions specified in guidance under *Section 2.5: Billing and Reimbursement for Waiver Services* in this provider reference module are met.
  - Providers may not bill for Participant Assistance and Care reimbursement during the time when an individual is admitted for an extended stay hospitalization, or when individuals require long term care in a facility-based setting including but not limited to nursing homes, rehabilitation centers and/or treatment facilities. (As specified under guidance in *Section 2.5: Billing and Reimbursement for Waiver Services* in this provider reference module, the care and support of an individual who is admitted to a hospital or facility for long-term is a nonbillable Participant Assistance and Care activity.)

Activities Not Allowed

The following activities are not allowed under Participant Assistance and Care:

- Services provided to household members other than to the waiver individuals
- Reimbursable waiver funded services furnished to a waiver participant 18 years or over or by any relatives and/or legal guardians that exceed a total of 40 hours per week per relative
- Services furnished to a minor by the parents, stepparents or legal guardians
- Services furnished to an individual by the individual's spouse
- Tasks that are reimbursable under the Indiana Medicaid State Plan
- Services that are available under the *Rehabilitation Act of 1973* or *Section 602 (16)* and *(17)* of the *Individuals with Disabilities Education Act*
- Homeschooling, special education and related activities
- Homemaker or maid service
- Services provided as a substitute for care by a registered nurse, licensed practical nurse, licensed physician, behaviorist, licensed therapist or other health professional
- Transportation costs
- Group sizes greater than four individuals to one paid staff member from the provider of Participant Assistance and Care services, or group sizes exceeding the maximum allowable group size determined by the IST for each group individual
- Group supports delivered to individuals who are utilizing different support options
  - For example, one individual in the group is using Participant Assistance and Care and another individual in the same group setting is using Day Habilitation. This type of activity would not be allowed.

Provider Qualifications

Providers of Participant Assistance and Care services must meet the following criteria:

- Be enrolled as an active Medicaid provider
- Be FSSA-approved
- Comply with *Indiana Administrative Code*, *460 IAC 6*, including but not limited to:
  - *460 IAC 6-10-5* Documentation of Criminal Histories

- *460 IAC 6-11* Financial Status
- *460 IAC 6-12-1* and *460 IAC 6-12-2* Insurance
- *460 IAC 6-14-4* Staff Training and *460 IAC 6-14-4* Training
- *460 IAC 6-14-5* Requirements for Direct Care Staff

- Have training in completion of task list
- Comply with any applicable BDS service standards, guidelines, policies and/or manuals, including FSSA DDARS policies and this provider reference module, accessible from the *IHCP Bulletins and Reference Modules* webpage at in.gov/medicaid/providers

Section 9.18: Personal Emergency Response System for FS and CIH Waivers

The following subsections provide information and requirements for Personal Emergency Response System services for the FS and CIH waivers.

> *Note: For information on the Personal Emergency Response System service available under the H&W and TBI Waivers, see Section 11.22: Personal Emergency Response System for H&W and TBI Waivers.*

Service Definition

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

Additional Information:

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

Reimbursable Activities

Reimbursable activities for the Personal Emergency Response System include the following:

- Device installation service
- Ongoing monthly maintenance of the device

Service Standards

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

Documentation Standards

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

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

Limitations

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

Activities Not Allowed

Reimbursement is not available for the Personal Emergency Response System when the individual requires constant support to maintain health and safety.

This service will not be reimbursed when provided by the parent of a minor child participant or the spouse of a participant (also known as LRIs).

Provider Qualifications

Personal Emergency Response System providers must meet the following criteria:

- Be enrolled as an active Medicaid provider
- Be FSSA-approved
- Comply with *Indiana Administrative Code*, *460 IAC 6*, including but not limited to:
  - *460 IAC 6-10-5* Documentation of Criminal Histories
  - *460 IAC 6-12-1* and *460 IAC 6-12-2* Insurance
  - *460 IAC 6-11-1* to *460 IAC 6-11-3* Financial Status of Providers
  - *460 IAC 6-5-18* Personal Emergency Response System Supports Provider Qualifications
- Comply with any applicable BDS service standards, guidelines, policies and/or manuals, including FSSA DDARS policies and this provider reference module, accessible from the *IHCP Bulletins and Reference Modules* webpage at in.gov/medicaid/providers

Section 9.19: Physical Therapy for FS and CIH Waivers

The following subsections provide information and requirements for Physical Therapy services for the FS and CIH waivers.

Service Definition

Physical Therapy services are provided by a licensed physical therapist.

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

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

Reimbursable Activities

Reimbursable activities include the following:

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

Service Standards

The following service standards apply to Physical Therapy:

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

Documentation Standards

Physical Therapy services documentation must include the following:

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

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

Limitations

This waiver service is only provided to individuals ages 21 and over. All medically necessary Physical Therapy services for children under age 21 are covered in the Indiana Medicaid State Plan benefit pursuant to the EPSDT benefit.

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

Activities Not Allowed

The following activities are not allowed under Physical Therapy:

- Therapy services furnished to the individual within the educational/school setting or as a component of the individual's school day
- Activities delivered in a nursing facility
- Services available through the Indiana Medicaid State Plan (a Medicaid State Plan PA denial is required before reimbursement is available through the waiver for this service)
- Services provided by the parent of a minor child participant or the spouse of a participant (also known as LRIs)

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

Provider Qualifications

Physical Therapy providers must meet the following criteria:

- Be enrolled as an active Medicaid provider
- Be FSSA-approved
- Comply with *Indiana Administrative Code*, *460 IAC 6*, including but not limited to:
  - *460 IAC 6-10-5* Documentation of Criminal Histories
  - *460 IAC 6-12-1* and *460 IAC 6-12-2* Insurance
  - *460 IAC 6-11-1* to *460 IAC 6-11-3* Financial Status of Providers
  - *460 IAC 6-5-18* Physical Therapy Services Provider Qualifications
- Comply with any applicable BDS service standards, guidelines, policies and/or manuals, including FSSA DDARS policies and this provider reference module, accessible from the *IHCP Bulletins and Reference Modules* webpage at in.gov/medicaid/providers
- Where licensure/certification is required, must obtain/maintain Indiana-specific licensure/certification

Section 9.20: Prevocational Services for FS and CIH Waivers

The following subsections provide information and requirements for Prevocational Services for the FS and CIH waivers.

Service Definition

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

Activities within this service must be prevocational rather than vocational in nature. A service is determined to be prevocational when one of the following occurs:

- Services are not job-task oriented but are, instead, aimed at a generalized result.
- Services include activities that are not primarily directed at teaching specific job skills but at underlying habilitative goals
- Participants are compensated at less than 50% of the minimum wage.

The use of Prevocational Services must be documented and support the individual's stated employment outcomes in their PCISP.

Prevocational Services are intended to develop and teach general skills that lead to competitive and integrated employment including:

- Ability to communicate effectively with supervisors, coworkers and customers
- Generally accepted community workplace conduct and dress
- Ability to follow directions
- Ability to attend to tasks
- Workplace problem solving skills and strategies
- General workplace safety and mobility training

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

Prevocational Services may be delivered in a facility setting or a community setting, using an off-site enclave or mobile community work crew models. See *Table 3 – Medicaid Waiver Services, Codes and Rates for FS and CIH Waivers* for the appropriate modifiers to use when billing for services provided in each of these settings.

Facility settings are defined as nonresidential, nonintegrated settings that take place within the same building or buildings 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 or buildings alongside other nonintegrated individuals.

Reimbursable Activities

Reimbursable activities under Prevocational Services include the following:

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

Service Standards

The following service standards apply to Prevocational Services:

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

Documentation Standards

Prevocational Services documentation must include the following:

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

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

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

For Group Services

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

Limitations

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

- Small (4:1 or smaller)

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

This is a time-limited service that can be accessed by a given participant for a total of no more than 18 months throughout their time on this waiver. Exceptions to this limit will be made on a case-by-case basis by the state following the state's determination that exceeding this limit is clearly in alignment with the participant's individualized transition plan. Any provision of this service for longer than 18 months must be accompanied by a plan for transitioning, which will be revisited and updated by the individual and their IST at least every six months with progress toward transition to competitive, integrated employment or another appropriate waiver service being a necessary precursor for an extension.

Monitoring of Prevocational Services occurs on a quarterly basis. Monitoring should include the assessment of progress toward employment goals, the appropriateness of the service and input from the individualized support team lead by the individual. The objectives of monitoring include assessment of the individual's progress toward achieving the outcomes identified on the individual's PCISP related to employment and to verify the continued need for Prevocational Services. The appropriateness of Prevocational Services is determined by dividing the previous quarter's gross earnings by the hours of attendance.

If the hourly wage falls below 50% of the federal minimum wage, Prevocational Services may be continued. If the average wage exceeds 50% of the federal minimum wage, Prevocational Services should be discontinued for the next quarter and, when chosen by the individual, should be replaced with competitive integrated employment options, volunteer work experiences and/or supports that develop job specific tasks related to the individual's employment outcomes.

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) and (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 provided by the parents, stepparents, or legal guardians of a minor child participant or the spouse of a participant (also known as LRIs)

Provider Qualifications

Providers of Prevocational Services must meet the following criteria:

- Be enrolled as an active Medicaid provider
- Be FSSA-approved
- Comply with *Indiana Administrative Code*, *460 IAC 6*, including but not limited to:
  - *460 IAC 6-10-5* Documentation of Criminal Histories
  - *460 IAC 6-12-1* and *460 IAC 6-12-2* Insurance
  - *460 IAC 6-11-1* to *460 IAC 6-11-3* Financial Status of Providers
  - *460 IAC 6-5-20* Prevocational Services Provider Qualifications

- *460 IAC 6-14-5* Requirements for Direct Care Staff
- *460 IAC 6-14-4* Training

- Comply with any applicable BDS service standards, guidelines, policies and/or manuals, including FSSA DDARS policies and this provider reference module, accessible from the *IHCP Bulletins and Reference Modules* webpage at in.gov/medicaid/providers
- Obtain/maintain accreditation (specific to Indiana programs) by at least one of the following organizations:
  - The Commission on Accreditation of Rehabilitation Facilities (CARF), or its successor
  - The Council on Quality and Leadership In Supports for People with Disabilities, or its successor
  - The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or its successor
  - The National Committee for Quality Assurance, or its successor
  - The ISO-9001 human services quality assurance (QA) system
  - An independent national accreditation organization approved by the FSSA Secretary

Section 9.21: Psychological Therapy for FS and CIH Waivers

The following subsections provide information and requirements for Psychological Therapy services for the FS and CIH waivers.

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 Indiana Medicaid State Plan.

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

Reimbursable Activities

Reimbursable activities under Psychological Therapy include the following:

- Individual counseling
- Biofeedback
- Individual-centered therapy
- Cognitive behavioral therapy
- Psychiatric services
- Crisis counseling
- Family counseling
- Group counseling
- Substance abuse counseling and intervention

- Planning, reporting and write-up when in association with the actual one-on-one direct care/therapy service delivery with the waiver individual

Service Standards

The following service standards apply to Psychological Therapy:

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

Documentation Standards

Psychological Therapy services documentation must include the following:

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

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

Limitations

This waiver service is only provided to individuals ages 21 and over. All medically necessary Psychological Therapy services for children under age 21 are covered in the Indiana Medicaid State Plan benefit pursuant to the EPSDT benefit.

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

Activities Not Allowed

The following activities are not allowed under Psychological Therapy:

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

- Service provided by the parent of a minor child participant or the spouse of a participant (also known as LRIs)

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

Provider Qualifications

Psychological Therapy providers must meet the following criteria:

- Be enrolled as an active Medicaid provider
- Be FSSA-approved
- Comply with *Indiana Administrative Code*, *460 IAC 6*, including but not limited to:
  - *460 IAC 6-10-5* Documentation of Criminal Histories
  - *460 IAC 6-12-1* and *460 IAC 6-12-2* Insurance
  - *460 IAC 6-11-1* to *460 IAC 6-11-3* Financial Status of Providers
  - *460 IAC 6-5-21* Therapy Services Provider Qualifications
- Comply with any applicable BDS service standards, guidelines, policies and/or manuals, including FSSA DDARS policies and this provider reference module, accessible from the *IHCP Bulletins and Reference Modules* webpage at in.gov/medicaid/providers
- Where licensure/certification is required, 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 9.22: Recreational Therapy for FS and CIH Waivers

The following subsections provide information and requirements for Recreational Therapy services for the FS and CIH waivers.

Service Definition

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

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

Reimbursable Activities

Reimbursable activities under Recreational Therapy services include the following:

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

Service Standards

The following service standards apply to Recreational Therapy:

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

Documentation Standards

Recreational Therapy services documentation must include the following:

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

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

Limitations

Recreational Therapy service has the following limitations:

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

Activities Not Allowed

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

- Payment for the cost of the recreational activities, registrations, memberships or admission fees associated with the activities being planned, organized or directed
- Any services that are reimbursable through the Indiana Medicaid State Plan
- Therapy services furnished to the individual within the educational/school setting or as a component of the individual's school day
- Group sizes greater than four individuals to one recreational therapist or group sizes exceeding the maximum allowable group size determined by the IST for each group individual
- Group services when group settings were not determined to be appropriate by the IST for each group individual
- This service will not be reimbursed when provided by the parent of a minor child participant or the spouse of a participant (also known as LRIs)

Provider Qualifications

Recreational Therapy providers must meet the following criteria:

- Be enrolled as an active Medicaid provider
- Be FSSA-approved
- Comply with *Indiana Administrative Code*, *460 IAC 6*, including but not limited to:
  - *460 IAC 6-10-5* Documentation of Criminal Histories
  - *460 IAC 6-12-1* and Insurance *460 IAC 6-12-2*
  - *460 IAC 6-11-1* to *460 IAC 6-11-3* Financial Status of Providers
  - *460 IAC 6-5-22* Recreational Therapy Services Provider Qualifications
- Comply with any applicable BDS service standards, guidelines, policies and/or manuals, including FSSA DDARS policies and this provider reference module, accessible from the *IHCP Bulletins and Reference Modules* webpage at in.gov/medicaid/providers.

Section 9.23: Remote Supports for FS and CIH Waivers

The following subsections provide information and requirements for Remote Supports services for the FS and CIH waivers.

Service Definition

Remote Supports includes a wide range of technology-based services that allow for trained remote support professionals (RSPs) to deliver live support to an individual from a remote location in place of on-site staffing. Remote Supports are delivered by awake and alert remote support professionals whose primary duties are to provide Remote Supports from the provider's secure remote supports facility. To ensure safety and HIPAA compliance, this facility should have appropriate, stable and redundant connections. This should include, but is not limited to, backup generators, multiple internet service connections, battery backups and so on.

Remote Supports include the provision of oversight and monitoring within the residential setting of adult waiver participants and individuals 14 to 17 years of age through the use of technology, two-way

communication systems and sensors. For minors, Remote Supports are used to foster developmentally appropriate independence and not to replace typical parental supervision.

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

Remote Supports may be used with either paid or unpaid backup support as specified in the individual's service plan. Backup support is when a trained person is responsible for responding in-person/on-site in the event of an emergency or when an individual receiving Remote Supports otherwise needs assistance or the equipment used for delivery of Remote Supports stops working for any reason.

Paid backup support is provided on a paid basis by a provider of residential habilitation and support (CIH Waiver) or participant assistance and care (FS Waiver) that is both the primary point of contact for the remote supports vendor and the entity to send paid staff persons on-site when needed.

Unpaid backup support may be provided by a family member, friend or other person who the individual chooses.

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

Reimbursable Activities

Reimbursable activities include the following:

- Monitoring, oversight and support by the RSP.
- Initial and ongoing training, education and technical assistance of paid and unpaid backup support intervention to prepare for prompt engagement with the individuals and/or immediate deployment to the residential setting.
- Updates of remote support equipment and technology when the equipment and technology require regular information technology support.
- Installation of remote supports equipment and technology is allowable in residential or family home settings or unpaid back up support person location when necessary to provide Remote Supports services in place of on-site staffing.
- When all service standards are met, the service provider shall be reimbursed at the full unit rate for each hour that the Remote Supports service is rendered.

The unit rate for each hour of Remote Supports service utilization shall be divided by and among the number of waiver individuals present in the home during any portion of the hour for which reimbursement is requested.

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

Service Standards

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

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

Assessment and Informed Consent

The following are key points regarding assessment and informed consent:

- Informed consent: Informed consent by the individual using the service, their guardian and other individuals and their guardians residing in the home must be obtained and clearly state the parameters in which the Remote Supports service would be used.
- Each individual, guardian and IST must be made aware of both the benefits and risks of the operating parameters and limitations. Through an assessment by the Remote Supports provider with input from the individual and their IST the location of the devices or monitors will be determined to best meet the individual's needs.
- The PCISP will reflect the individual's control and use of the equipment. The individual must be informed by the Remote Supports provider on the operation and use of the equipment.
- Informed consent documents must be acknowledged in writing, signed and dated by the individual, guardian, case manager and provider agency representative, as appropriate. A copy of the consent shall be maintained by the local DDARS BDS office, the guardian (if applicable) and in the home file. If the individual desires to withdraw consent, they would notify the case manager. As informed consent is a prerequisite for utilization of Remote Supports services, a meeting of the IST would be needed to discuss available options for any necessary alternate supports. All residing adult and youth individuals, their guardians and their support teams impacted by the decision to withdraw consent must be immediately informed of the decision and use of remote supports in the setting must be discontinued. PCISPs should reflect how individuals want to inform visitors of the use of remote supports in the setting if video monitoring is being used under this service. Use of the system may be restricted to certain hours through the PCISPs of the individuals involved.
- Withdrawing consent: If the individual desires to withdraw consent, they would notify the case manager. As informed consent is a prerequisite for utilization of Remote Supports services, a meeting of the IST would be needed to discuss available options for any necessary alternative supports. All residing adult and youth individuals, their guardians and their support teams impacted by the decision to withdraw consent must be immediately informed of the decision and use of remote supports in the setting must be discontinued.
- Use of the system may be restricted to certain hours through the PCISPs of the individuals involved.
- PCISPs should reflect how individuals want to inform visitors of the use of remote supports in the setting if video monitoring is being used under this service.

System Design

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

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

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

Remote Support Monitoring Base Staff

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

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

Backup Support (Applicable Only to Certain Services)

The following are requirements for stand-by intervention staff/backup support used with Residential Habilitation and Support (RHS) Hourly and RHS Daily services (under the CIH Waiver) and Participant Assistance and Care (under the FS Waiver):

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

Documentation Standards

Documentation for Remote Supports must include the following:

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

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

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

Limitations and Reimbursement Parameters

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

Remote Supports provides a realistic, noninvasive way for many individuals and families to find the supports they need to build life skills and familiarity in their level of independence with a sense of security. Individuals and families who are utilizing the FS Waiver may want to try the service to see if it works for them. The first $500 of Remote Supports added to their annual service plan year will be outside of the $26,482 budget cap.

The budget will be completed for each individual based upon the total number of individuals residing within the residence. However, lower tiers may also appear on the service plans to reflect reimbursement rates for situations where one or more individual is away from the home during service utilization. Reimbursement will then be the hourly rate of $24.26 divided by and among the number of individuals who are at home during the hours of utilization (see Table 4). If only one individual from a four-individual setting is at home during service utilization, the solitary individual pays the full hourly rate of $24.26. If only two of the four individuals are home, each pays $12.13 per hour of utilization, and if three of the four are home, each pay $8.09 per hour of utilization.

Table 4 – Reimbursement Rates by Tier

Tier	Number of Individuals	Reimbursement
Tier 1	One individual in a home	$24.26
Tier 2	Two individuals in a home	$12.13
Tier 3	Three individuals in a home	$8.09
Tier 4	Four individuals in a home	$6.06

Billing clarification: When all service standards are met, the service provider shall be reimbursed at the full unit rate for each hour that the Remote Supports service is rendered. The unit rate for each hour of Remote Supports service utilization shall be divided by and among the number of waiver individuals present in the home during any portion of the hour for which reimbursement is requested.

Reimbursement for paid on-site backup responders would be billed as RHS Hourly for the CIH Waiver or as Participant Assistance and Care for the FS Waiver. Therefore, it may be necessary for the remote supports provider to contract with an RHS or Participant Assistance and Care provider.

Activities Not Allowed

The following activities are not allowed under Remote Supports:

- Remote supports used concurrently with Structured Family Caregiving services in the structured family caregiving home

> *Note: Structured Family Caregiving is available under the CIH Waiver; it is **not** available under the FS Waiver.*

- Remote supports systems intended to monitor direct care staff

- Remote Supports service in intermediate care facilities for individuals with intellectual disabilities (ICFs/IID) licensed under *IC 16-28* and *410 IAC 16.2*
- Remote supports systems used in place of in-home staff when in-person staff has been deemed necessary by IST
- Cameras in bathrooms or bedrooms
- Installation costs related to video and/or audio equipment for any purpose other than the provision of remote support services in place of on-site staffing
- Services furnished to a minor by parents, stepparents or legal guardian
- Services furnished to an individual by the individual's spouse

Remote support services may serve as a potential replacement for Participant Assistance and Care services under the FS Waiver, or as a replacement for RHS services Level 1 and Level 2.;Therefore, Remote Supports are not billable during the same time period as Participant Assistance and Care services or RHS services. Remote Supports are an allowable *component of* the RHS Daily service, but may not be billed in addition to the daily rate of the RHS Daily service.

*Note: RHS is available only under the CIH Waiver; it is **not** available under the FS Waiver.*

Provider Qualifications

Providers of Remote Supports must meet the following criteria:

- Be enrolled as an active Medicaid provider
- Be FSSA-approved
- Comply with *Indiana Administrative Code*, *460 IAC 6*, including but not limited to:
  - *460 IAC 6-10-5* Documentation of Criminal Histories
  - *460 IAC 6-12-1* and *460 IAC 6-12-2* Insurance
  - *460 IAC 6-11-1* to *460 IAC 6-11-3* Financial Status of Providers
- Comply with any applicable BDS service standards, guidelines, policies and/or manuals, including FSSA DDARS policies and this provider reference module, accessible from the *IHCP Bulletins and Reference Modules* webpage at in.gov/medicaid/providers
- Ensure that the system must be monitored by a staff person trained and oriented to the specific needs of each individual served as outlined in their PCISP
- Ensure that the paid support staff meet the qualifications for direct support professionals as set out in the DDARS BDS policy on requirements and training for direct support professional staff
- Ensure that the individual, family member, guardian, team and backup provider, if applicable, are trained on the use of remote supports equipment
- If the backup support is unpaid such as a family member, a guardian or a person the individual chooses, the need for the backup support to meet qualifications for direct support professionals would not be applicable.

Section 9.24: Rent and Food for Unrelated Live-in Caregiver for CIH Waiver

The following subsections provide information and requirements for Rent and Food for Unrelated Live-in Caregiver services for the CIH Waiver.

> *Note: Rent and Food for Unrelated Live-in Caregiver services are available only under the CIH Waiver. These services are* ***not*** *available under the FS, H&W or TBI waivers.*

Service Definition

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

> **Additional Information:**
>
> Paid caregivers are not eligible for the Rent and Food for Unrelated Live-in Caregiver service.

Reimbursable Activities

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

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

Service Standards

The following service standards apply to Rent and Food for Unrelated Live-in Caregiver:

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

Documentation Standards

Rent and Food for Unrelated Live-in Caregiver services documentation must include the following:

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

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

Limitations

See *Activities Not Allowed*.

Activities Not Allowed

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

- The individual is not permitted to live in the home of the caregiver or in a residence that is owned or leased by the provider of other services, including Medicaid waiver services.
- The live-in caregiver cannot be related by blood or marriage (to any degree) to the individual and/or has any legal responsibility to support the individual.
- The individual cannot receive live-in caregiver services and structured family caregiving services concurrently.
- This service will not be reimbursed when provided by the parent of a minor child participant or the spouse of a participant (also known as LRIs)

Provider Qualifications

Providers of the Rent and Food for Unrelated Live-in Caregiver service must meet the following criteria:

- Be enrolled as an active Medicaid provider
- Be FSSA-approved
- Comply with *Indiana Administrative Code*, *460 IAC 6*, including but not limited to:
  - *460 IAC 6-5-24* Residential Habilitation and Support Services Provider Qualifications
  - *460 IAC 6-14-5* Requirements for Direct Care Staff
  - *460 IAC 6-14-4* Training
- Comply with any applicable BDS service standards, guidelines, policies and/or manuals, including FSSA DDARS policies and this provider reference module, accessible from the *IHCP Bulletins and Reference Modules* webpage at in.gov/medicaid/providers

Section 9.25: Residential Habilitation and Support – Hourly for CIH Waiver

The following subsections provide information and requirements for Residential Habilitation and Support – Hourly (RHS Hourly) services for the CIH Waiver.

> *Note: RHS Hourly services are **not** available under the FS Waiver.*
>
> *For information related to the similarly named but unique Residential-Based Habilitation service, available only under the TBI Waiver, see Section 11.24: Residential-Based Habilitation for TBI Waiver.*

Service Definition

RHS Hourly services mean individually tailored supports that are specified in the PCISP that assist with the acquisition, retention or improvement in skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult educational supports, and social and leisure skill development that support the individual to live successfully in their own home.

HCBS provided during an acute care hospitalization assists the individual to maintain current levels of functioning and support, provides ongoing coordination of care, and provides assurance that new or additional needs are identified and addressed by the person-centered planning team as the individual prepares to return to the community.

The HCBS provided in an acute care hospital must not be duplicative of services available in the acute care hospital setting.

A relative of the individual may be a provider of RHS services. The decision that a relative is the best choice of persons to provide these services is a part of the person-centered planning process and is documented in the PCISP. When the provider is a relative, there is an annual review by the IST to determine whether the individual's relative should continue to be the provider of RHS services.

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

The service is billable as *either* of the following:

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

Algo Score/Descriptors/ICAP/OBA

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

Refer to *Table 3 – Medicaid Waiver Services, Codes and Rates for FS and CIH Waivers* for applicable billing information.

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

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

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

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

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

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

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

Reimbursable Activities

RHS includes the following reimbursable activities:

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

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

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

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

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

Service Standards

The following service standards apply to RHS Hourly:

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

Documentation Standards

RHS Hourly documentation must include the following:

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

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

Limitations

The following are limitations on RHS Hourly services:

- Reimbursable waiver funded services furnished to an adult waiver individual by a paid relative and/or legal guardian may not exceed a total of 40 hours per week per paid relative and/or legal guardian caregiver. (For a list of individuals defined as relatives, see *Section 6.9: Parents, Guardians and Relatives Providing FS and CIH Waiver Services*.
- Providers may not bill for RHS Hourly reimbursement for time when staff/paid caregiver is asleep. Only awake, engaged staff can be counted in reimbursement. (A team may decide that a staff or contractor may sleep while with an individual, but this activity is not billable.)
- Providers may only bill for RHS reimbursement during the time when an individual receiving HCBS waiver services is admitted to an acute care hospital setting for inpatient medical care or other related services for surgery, acute medical condition or injuries if all conditions specified in guidance under *Section 2.5: Billing and Reimbursement for Waiver Services* in this provider reference module are met.

- Providers may not bill for RHS reimbursement during the time when an individual is admitted for an extended stay hospitalization, or when individuals require long-term care in a facility-based setting including but not limited to nursing homes, rehabilitation centers and/or treatment facilities. (As specified under guidance in *Section 2.5: Billing and Reimbursement for Waiver Services* in this provider reference module, the care and support of an individual who is admitted to a hospital or facility for long-term is a nonbillable RHS activity.)
- RHS Level 1 and RHS Level 2 and remote support services are not billable concurrently/during the same time period.
- Intermittent use of RHS Level 1 may not exceed 35 hours of service per week.

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

Activities Not Allowed

Reimbursement is not available through RHS Hourly in the following circumstances:

- Services furnished to a minor by the parents, stepparents or legal guardian
- Services furnished to an individual by the individual's spouse
- Services to individuals in structured family caregiving services or children's foster care services
- Services that are available under the Indiana Medicaid State Plan

Provider Qualifications

Providers of RHS Hourly must meet the following criteria:

- Be enrolled as an active Medicaid provider
- Be FSSA-approved
- Comply with *460 IAC 6*, including but not limited to:
  - *460 IAC 6-5-24* Residential Habilitation and Support Services Provider Qualifications
  - *460 IAC 6-10-5* Documentation of Criminal Histories
  - *460 IAC 6-12-1* and *460 IAC 6-12-2* Insurance
  - *460 IAC 6-11-1* to *460 IAC 6-11-3* Financial Status of Providers
  - ~~4~~*60 IAC 6-5-14* Health Care Coordination Services Provider Qualifications
  - *460 IAC 6-14-4* Staff Training and *460 IAC 6-14-4* Training
  - *460 IAC 6-5-30* Transportation Services Provider Qualifications
  - *460 IAC 6-5-31* Transportation Supports Provider Qualifications
- Comply with any applicable BDS service standards, guidelines, policies and/or manuals, including FSSA DDARS policies and this provider reference module, accessible from the *IHCP Bulletins and Reference Modules* webpage at in.gov/medicaid/providers
- In accordance with *Indiana Code 12-11-1.1-1*, RHS providers must obtain/maintain accreditation (specific to Indiana programs) by at least one of the following organizations:
  - The Commission on Accreditation of Rehabilitation Facilities (CARF), or its successor

- The Council on Quality and Leadership In Supports for People with Disabilities, or its successor
- The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or its successor
- The National Committee for Quality Assurance, or its successor
- The ISO-9001 human services quality assurance (QA) system
- The Council on Accreditation, or its successor
- An independent national accreditation organization approved by the FSSA Secretary.

Section 9.26: Residential Habilitation and Support – Daily for CIH Waiver

The following subsections provide information and requirements for daily Residential Habilitation and Support – Daily (RHS Daily) services for the CIH Waiver.

> *Note: RHS Daily services **not** available under the FS Waiver.*
>
> *For information related to the similarly named but unique service Residential-Based Habilitation, available only under the TBI Waiver, see Section 11.24: Residential-Based Habilitation for TBI Waiver.*

Service Definition

RHS Daily services provide individually tailored supports that are specified in the PCISP that assist with the acquisition, retention or improvement in skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult educational supports, and social and leisure skill development that support the individual to live successfully in their own home.

The provider of the RHS services may be a relative of the individual. The decision that a relative is the best choice of persons to provide these services is a part of the person-centered planning process and is documented in the PCISP. When the provider is a relative, there is an annual review by the IST to determine whether the individual's relative should continue to be the provider of RHS services.

Individuals Eligible for RHS Daily Services

Individuals who choose RHS and meet all the following criteria are eligible for and may choose to use RHS Daily services:

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

Algo Score Descriptors

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

Refer to *Table 3 – Medicaid Waiver Services, Codes and Rates for FS and CIH Waivers* for applicable billing information.

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

The ICAP assessment determines an individual's level of functioning for broad independence and general maladaptive factors. The ICAP addendum, commonly referred to as the behavioral and health factors, determines an individual's level of functioning on behavioral 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 5: Objective-Based Allocation for CIH Waiver* in this provider reference module for further details.

Reimbursable Activities

Reimbursable activities for RHS Daily include the following:

- Assistance with acquiring, enhancing and building natural supports
  - For example, a measurable outcome would be increased hours of natural supports and a decrease in the number of hours needed for paid staff. Another measurable outcome would be the number of activities an individual participates in with nonpaid (natural support) supports versus paid staff.
- Working with the individual to meet the goals they have set for themselves on their PCISP
- Training the individual to enhance their homemaking skills, meal preparation, household chores, money management, shopping, communication skills, social skills and positive behavior
- Provision of transportation to fully participate in social and recreational activities in the community (such as transportation to church, the park, the library, the YMCA and classes)
- Provision of transportation to community employment and/or volunteer activities
- Coordination and facilitation of medical and wellness services to meet the healthcare and wellness needs, including physician consults, medications, implementation of risk plans, dining plans and wellness plans
- Maintenance of each individual's health record
- Remote Supports services when billed as a component of RHS Daily
  - Remote Supports services may not be billed concurrently with RHS Daily.
- When wellness coordination services are used in addition to RHS Daily services, the wellness coordinator is responsible for the development, oversight and maintenance of a wellness coordination plan and the health-related risk plan, noting that a comprehensive medical risk plan may substitute for the wellness coordination plan or individual risk plans.

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

Service Standards

The following service standards apply to RHS Daily:

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

Documentation Standards

A minimum of one daily note for each day the individual is present and receiving RHS Daily services, with appropriate elements, documenting one or more distinct actions or behaviors as outlined in the *Reimbursable Activities* section, per individual served is required to support the billing of RHS Daily services. The RHS Daily service provider must 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 PCISP
- Data record of service delivered documenting the complete date and time entry (including a.m. or p.m.)
  - If the person providing the service is required to be professionally licensed, the title of that individual must also be included. For example, if a nurse provides RHS Daily services, the nurse's title should be included.
- Any significant issues involving the individual requiring intervention by a healthcare professional, case manager or BDS staff member
- Documentation in compliance with *460 IAC 6*
- Quarterly summaries as specified by BDS and monthly, quarterly and/or annual outcome data as specified by BDS

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

Limitations

Reimbursable waiver funded residential habilitation services furnished to an adult waiver individual by a paid relative and/or legal guardian may not exceed a total of 40 hours a week per paid relative and/or legal guardian caregiver. (For a list of individuals defined as relatives, see *Section 6.9: Parents, Guardians and Relatives Providing FS and CIH Waiver Services*.)

The individual must be present and receive RHS Daily services for at least a portion of any day the provider bills as a day of RHS Daily service.

Additionally, the following limitations apply:

- Providers will not be reimbursed separately for Remote Supports services for individuals receiving RHS Daily services. Remote support is built into the daily rate of RHS Daily services. Providers must adhere to all Remote Supports service standards as defined within the Remote Supports service definition.
- Providers may not bill for RHS Daily reimbursement for time when staff/paid caregiver is asleep. Only awake, engaged staff can be counted in reimbursement.
- Providers may bill for RHS Daily reimbursement during times when the individual receiving the services is admitted to an acute care hospital setting for inpatient medical care or other related services for surgery, acute medical condition, or injuries **only if** all conditions specified in guidance under *Section 2.5: Billing and Reimbursement for Waiver Services* of this provider reference module are met.
- Providers may not bill for RHS Daily reimbursement during times when an individual is admitted for an extended stay hospitalization, or when individuals require long-term care in a facility-based setting including but not limited to nursing homes, rehabilitation centers and/or treatment facilities. (As specified under guidance in *Section 2.5: Billing and Reimbursement for Waiver Services* in this provider reference module, the care and support of an individual who is admitted to a hospital or facility for long-term is a nonbillable RHS activity.)

Per *IC 12-11-1.1*, supported living service arrangements providing residential services may not serve more than four unrelated individuals in anyone setting. However, a program that was in existence on Jan. 1, 2013, as a supervised group living program described within *IC 12-11-1.1* and having more than four individuals residing as part of that program, was allowed to convert to a supported living service arrangement and continue to provide services to up to the same number of individuals in the supported living setting.

Activities Not Allowed

Reimbursement is not available through RHS Daily in the following circumstances:

- Services furnished to a minor by the parents, stepparents or legal guardian
- Services furnished to an individual by the individual's spouse
- Services to individuals in structured family caregiving services
- Services that are available under the Indiana Medicaid State Plan

Provider Qualifications

RHS Daily providers must meet the following criteria:

- Be enrolled as an active Medicaid provider
- Be FSSA-approved
- Comply with *Indiana Administrative Code*, *460 IAC 6*, including but not limited to:
  - *460 IAC 6-5-24* Residential Habilitation and Support Services Provider Qualifications
  - *460 IAC 6-10-5* Documentation of Criminal Histories
  - *460 IAC 6-12-1* and *460 IAC 6-12-2* Insurance
  - *460 IAC 6-11-1* to *460 IAC 6-11-3* Financial Status of Providers
  - *460 IAC 6-5-14* Heath Care Coordination Services Provider Qualifications
  - *460 IAC 6-14-5* Requirements for Direct Care Staff

- *460 IAC 6-14-4* Training
- *460 IAC 6-34* Transportation Services Requirements

- Comply with *Indiana Administrative Code*, *460 IAC 6*, including but not limited any applicable BDS service standards, guidelines, policies and/or manuals, including FSSA DDARS policies and this provider reference module, accessible from the *IHCP Bulletins and Reference Modules* webpage at in.gov/medicaid/providers.
- In accordance with *Indiana Code 12-11-1.1-1*, RHS providers must obtain/maintain accreditation (specific to Indiana programs) by at least one of the following organizations:
  - The Commission on Accreditation of Rehabilitation Facilities (CARF), or its successor
  - The Council on Quality and Leadership In Supports for People with Disabilities, or its successor
  - The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or its successor
  - The National Committee for Quality Assurance, or its successor
  - The ISO-9001 human services quality assurance (QA) system
  - The Council on Accreditation, or its successor
  - An independent national accreditation organization approved by the FSSA Secretary

Section 9.27: Respite for FS and CIH Waivers

The following subsections provide information and requirements for Respite services for the FS and CIH waivers.

> *Note: For information on respite services available under the H&W and TBI Waivers, see Section 11.25: Respite Care Services for H&W and TBI Waivers.*

Service Definition

Respite services means services provided to individuals unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the individual. Respite can be provided in the individual's home or place of residence, in the respite caregiver's home, in a camp setting, in a DDARS-approved Day Habilitation facility or in a nonprivate residential setting (such as a respite home).

> **Additional Information:**
>
> Respite may be used intermittently to cover those hours normally covered by an unpaid caregiver.

Reimbursable Activities

Reimbursable activities under Respite include the following:

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

- Individual services
- Group services (unit rate divided by number of individuals served)

Service Standards

The following service standards apply to Respite:

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

Documentation Standards

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

- Individual name
- IHCP Member ID of the individual
- Date of service
- Provider rendering service
- Primary location of services rendered

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

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

For Group Services

On request, the provider must be able to verify, in a concise format, that the ratio for each claimed time frame of service did not exceed the maximum allowable ratio, whether or not all group individuals use 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 or items are not allowed for reimbursement under Respite:

- Reimbursement for room and board
- Services provided to an individual living in a licensed facility-based setting

- Cost of registration fees or cost of recreational activities (for example, camp)
- Service provided when Structured Family Caregiving service is being furnished to the individual
- Services provided when the individual is in children's foster care
- Other family members (such as siblings of the individual) receiving care or support from the provider while Respite is being provided/billed for the waiver individuals
- Respite used as day/child care
- Respite care provided to an individual while the individual is attending school *(Note: Respite care is not intended to be provided on a continuous, long-term basis as part of daily services that would enable the unpaid caregiver to go to work or to attend school.)*
- Respite care used to replace skilled nursing services that should be provided under the Indiana Medicaid State Plan
- Respite care duplicating any other service being provided under the individual's PCISP
- Services furnished to a minor by parents, stepparents or legal guardian
- Services furnished to an individual by the individual's spouse

Provider Qualifications

Respite providers must meet the following criteria:

- Be enrolled as an active Medicaid provider
- Be FSSA-approved
- Comply with *Indiana Administrative Code*, *460 IAC 6*, including but not limited to:
  - *460 IAC 6-10-5* Documentation of Criminal Histories
  - *460 IAC 6-12-1* and *460 IAC 6-12-2* Insurance
  - *460 IAC 6-11-1* to *460 IAC 6-11-3* Financial Status of Providers
  - *460 IAC 6-5-26* Respite Care Services Provider Qualifications
  - *460 IAC 6-5-14* Heath Care Coordination Services Provider Qualifications
  - *460 IAC 6-14-5* Requirements for Direct Care Staff
  - *460 IAC 6-14-4* Training
- Comply with any applicable BDS service standards, guidelines, policies and/or manuals, including FSSA DDARS policies and this provider reference module, accessible from the *IHCP Bulletins and Reference Modules* webpage at in.gov/medicaid/providers
- Where licensure/certification is required, 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 9.28: Specialized Medical Equipment and Supplies for FS and CIH Waivers

The following subsections provide information and requirements for Specialized Medical Equipment and Supplies services for the FS and CIH waivers.

> *Note: For information on Specialized Medical Equipment and Supplies services available under the H&W and TBI Waivers, see Section 11.26: Specialized Medical Equipment and Supplies for H&W and TBI Waivers.*

Service Definition

Specialized Medical Equipment and Supplies include:

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

DDARS waiver services staff must approve all Specialized Medical Equipment and Supplies prior to service being rendered.

> **Additional Information:**
>
> Sensory items, seizure detection devices, GPS tracking devices and other electronic devices not currently specified as items covered or reimbursable in the waiver or current Request for Approval to Authorize Services (RFA) policy may be electronically submitted for consideration under Specialized Medical Equipment and Supplies via the *Request for Approval to Authorize Services (RFA) (State Form 45750)* as outlined in *Section 10: RFA Policies*.

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 Indiana Medicaid State Plan
- Nondurable medical equipment not available under Indiana Medicaid State Plan
- Communications devices
- Interpreter services or equipment necessary to access and participate in the home and community that are not otherwise provided as a reasonable accommodation per state and federal law
  - ➢ It is the responsibility of the provider to offer interpreter services if needed by the individual. Per the *Introduction to the IHCP* provider reference module, the provider makes available free aids

and services to people with disabilities to communicate effectively with the provider, including qualified interpreters, written information in other formats and free language services to people whose primary language is not English.

Service Standards

The following service standards apply to Specialized Medical Equipment and Supplies:

- Equipment and supplies must be of direct medical or remedial benefit to the individual.
- All items shall meet applicable standards of manufacture, design and installation.
- Any individual item costing more than $500 requires an evaluation by a qualified professional such as a physician, nurse, occupational therapist, physical therapist, speech and language therapist, or rehabilitation engineer.
- Annual maintenance service is available and is limited to $1,000 per year. If the need for maintenance exceeds $1,000, the case manager will work with other available funding streams and community agencies to fulfill the need.

Documentation Standards

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

- Identified need in PCISP and the service authorization
- Identified direct medical benefit for the individual
- Documentation of the *request* for Indiana Medicaid State Plan PA
- Documentation of the *reason of denial* of Indiana Medicaid State Plan PA
- Signed and approved *Request for Approval to Authorize Services (RFA) (State Form 45750)*
- Receipts for purchases

Limitations

The following are limitations on Specialized Medical Equipment and Supplies services:

- Service and repair up to $1,000 per year are permitted for maintenance and repair of previously obtained specialized medical equipment that was funded by an HCBS waiver. If the need for maintenance exceeds $1,000, the case manager will work with other available funding streams and community agencies to fulfill the need.
- Specialized Medical Equipment and Supplies has a lifetime cap of $15,000 under the FS Waiver.
- Specialized Medical Equipment and Supplies has no lifetime cap under the CIH Waiver

The services under the FS and CIH waivers are limited to additional services not otherwise covered under the Indiana Medicaid State Plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Activities Not Allowed

The following activities are not allowed under Specialized Medical Equipment and Supplies:

- Equipment and services that are available under the Indiana Medicaid State Plan
- Equipment and services that are not of direct medical or remedial benefit to the individual

- Equipment and services that are not reflected in the PCISP
- Equipment and services that do not address needs identified in the person-centered planning process
- Equipment and services that have not been approved on a *Request for Approval to Authorize Services (RFA) (State Form 45750)*
- Service provided by the parent of a minor child participant or the spouse of a participant (also known as LRIs)

Provider Qualifications

Providers of Specialized Medical Equipment and Supplies must meet the following criteria:

- Be enrolled as an active Medicaid provider
- Be FSSA-approved
- Comply with *Indiana Administrative Code*, *460 IAC 6*, including but not limited to:
  - *460 IAC 6-10-5* Documentation of Criminal Histories
  - *460 IAC 6-12-1* and *460 IAC 6-12-2* Insurance
  - *460 IAC 6-11-1* to *460 IAC 6-11-3* Financial Status of Providers
  - *460 IAC 6-5-27* Specialized Medical Equipment and Supplies Supports Provider Qualifications
- Comply with any applicable BDS service standards, guidelines, policies and/or manuals, including FSSA DDARS policies and this provider reference module, accessible from the *IHCP Bulletins and Reference Modules* webpage at in.gov/medicaid/providers.
- Where licensure/certification is required, must obtain/maintain Indiana-specific licensure/certification; examples include but are not limited to:
  - For licensed/certified occupational therapist, meet requirements set forth in *IC 25-23.5*
  - For licensed physical therapist, meet requirements set forth in *IC 25-27-1*
  - For DDARS-approved pharmacies (as applicable), meet requirement set forth in *IC 25-26-13-18*
  - For speech/language therapist, meet requirements set forth in *IC 25-35.6*
  - For home health agencies, meet requirements set forth in *IC 16-27-1*

Section 9.29: Speech/Language Therapy for FS and CIH Waivers

The following subsections provide information and requirements for Speech/Language Therapy services for the FS and CIH waivers.

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 Indiana Medicaid State Plan.

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

Reimbursable Activities

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

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

Service Standards

The following service standards apply to Speech/Language Therapy:

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

Documentation Standards

Speech/Language Therapy services documentation must include the following:

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

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

Limitations

If individuals under age 21 choose to use Speech/Language Therapy, they should access Speech/Language Therapy services through EPSDT.

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

This waiver service is only provided to individuals ages 21 and over. All medically necessary Speech/Language Therapy services for children under age 21 are covered in the Indiana Medicaid State Plan benefit pursuant to the EPSDT benefit.

Activities Not Allowed

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

- Services available through the Indiana Medicaid State Plan (a Medicaid State Plan PA denial is required before reimbursement is available through the Medicaid waiver for this service)
- Therapy services furnished to the individual within the educational/school setting or as a component of the individual's school day
- Activities delivered in a nursing facility
- Service provided by the parent of a minor child participant or the spouse of a participant (also known as LRIs)

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

Provider Qualifications

Speech/Language Therapy providers must meet the following criteria:

- Be enrolled as an active Medicaid provider
- Be FSSA-approved
- Comply with *Indiana Administrative Code*, *460 IAC 6*, including but not limited to:
  - *460 IAC 6-10-5* Documentation of Criminal Histories
  - *460 IAC 6-12-1* and *460 IAC 6-12-2* Insurance
  - *460 IAC 6-11-1* to *460 IAC 6-11-3* Financial Status of Providers
  - *460 IAC 6-5-28* Speech-Language Therapy Services Provider Qualifications
- Comply with any applicable BDS service standards, guidelines, policies and/or manuals, including FSSA DDARS policies and this provider reference module, accessible from the *IHCP Bulletins and Reference Modules* webpage at in.gov/medicaid/providers
- Where licensure/certification is required, must obtain/maintain Indiana-specific licensure/certification
  - For speech/language therapist, meet requirements set forth in *IC 25-35.6*
  - For home health agencies, meet requirements set forth in *IC 16-27-1*

Section 9.30: Structured Family Caregiving for CIH Waiver

The following subsections provide information and requirements for Structured Family Caregiving services for the CIH Waiver.

> *Note: Structured Family Caregiving is **not** available under the FS Waiver.*
>
> *For unique information related to Structured Family Caregiving services available under the H&W and TBI Waivers, see Section 11.28: Structured Family Caregiving for H&W and TBI Waivers.*

Service Definition

Structured Family Caregiving means a living arrangement in which an individual lives in the private home of a primary caregiver who may be a nonfamily member (foster care) or a family member who is not the individual's spouse, the parent of the individual who is a minor, or the legal guardian of the minor individual. Guardians of adult individuals are allowed to provide Structured Family Caregiving with the agreement of the IST.

Necessary support services are provided by the primary caregiver (family caregiver) as part of Structured Family Caregiving. Only agencies may be Structured Family Caregiving providers, with the Structured Family Caregiving settings being approved, supervised, trained and paid by the approved agency provider. The provider agency must conduct two visits per month to the home – one by an RN or LPN and one by a Structured Family Caregiving home manager. The provider agency must keep daily notes that can be accessed by the state. Separate payment will not be made for homemaker or chore services furnished to an individual receiving Structured Family Caregiving, because these services are integral to and inherent in the provision of Structured Family Caregiving services.

Service Levels and Rates

There are three service levels of Structured Family Caregiving each with a unique rate. The Algo score assigned to the individual will determine the appropriate level of Structured Family Caregiving service and reimbursement to be used in the PCISP at the individual's next annual anniversary date.

- Level 1 – Appropriate for individuals choosing Structured Family Caregiving having an Algo score of 0 or 1
- Level 2 – Appropriate for individuals choosing Structured Family Caregiving and having an Algo score of 2
- Level 3 – Appropriate for individuals choosing Structured Family Caregiving and having an Algo score of 3, 4, 5 or 6

Reimbursable Activities

Reimbursable activities under Structured Family Caregiving services include the following:

- Personal care and services
- Homemaker or chore services
- Attendant care and companion care services
- Medication oversight
- Support by a substitute caregiver who has met all primary caregiver qualifications

- Transporting the participant when indicated in the PCISP (*Note: When provided, such transportation is incidental and not duplicative of any other Indiana Medicaid State Plan or waiver service.*)
- Other appropriate supports as described in the PCISP

Service Standards

The following service standards apply to Structured Family Caregiving:

- Structured Family Caregiving services must be reflected in the PCISP.
- Services must address the needs (for example, intellectual/developmental needs, vocational needs and so forth) identified in the person-centered planning process and must be outlined in the PCISP.
- Ten percent of the total per diem amount is intended for use by the provider for respite care as needed. It is the provider's responsibility to approve any providers of respite chosen by the family or the individual.
- The provider determines the total amount per month paid to the family caregiver.
- The agency's administrative/supervision fee comes from the remaining total amount and includes the following duties:
  - Publish written policies and procedures regarding Structured Family Caregiving support services
  - Maintain financial and service records to document services provided to the individual
  - Establish a criteria for the acceptance of the family caregiver or foster parent; screen potential family caregivers/foster parents for qualities of stability, maturity and experiences so as to ensure the safety and well-being of the individual; and obtain a criminal background and reference check
  - Coordinate/provide adequate initial training and ongoing training, consultation, and supervision to the family caregiver/foster parent
  - Provide for the safety and well-being of the individual by inspection of environment for compliance with the DDARS 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

Structured Family Caregiving services documentation must include:

- Written policies and procedures, including for screening and accepting family caregivers/foster parents
- Maintaining financial and service records to document services provided to the individual
- Documenting provision of training to family caregivers according to agency policies/procedures
- Reimbursement of family caregiver/foster parent
- One entry per individual per week

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

Documentation by Families

Under Structured Family Caregiving services, families must provide the following documentation:

- One dated entry per day detailing an issue concerning the individual
- The entry should detail any outcome-oriented activities, tying those into measurable progress toward the individual's outcome (as identified in the PCISP)
- The entry should also include any significant issues concerning the individual, including:
  - Health and safety management
  - Intellectual/developmental challenges and experiences aimed at increasing an individual's ability to live a lifestyle that is compatible with the individual's interest and abilities
  - Modification or improvement of functional skills
  - Guidance and direction for social/emotional support
  - Facilitation of both the physical and social integration of an individual into typical family routines and rhythms

Limitations

Separate payment will not be made for homemaker or chore services furnished to an individual receiving Structured Family Caregiving, because these services are integral to and inherent in the provision of Structured Family Caregiving services.

Activities Not Allowed

Structured Family Caregiving services will not be provided to household members other than to the waiver individuals. Reimbursement is not available through Structured Family Caregiving in the following circumstances:

- Services provided by a caregiver who is the spouse of the individual or the parent of the minor individual (also known as LRIs).
- The service of Residential Habilitation and Support (whether paid hourly or daily) is not available to individuals receiving Structured Family Caregiving services.
- Transportation services through the waiver may not be separately billed in conjunction with Structured Family Caregiving services.
- The limit is a maximum of four waiver individuals per Structured Family Caregiving household.
- Respite services through this waiver may not be used in conjunction with Structured Family Caregiving services.

> *Note: Attendant Care or Home and Community Assistance services will not be reimbursed if performed in the same calendar month as Structured Family Caregiving services.*

Provider Qualifications

Providers of Structured Family Caregiving must meet the following criteria:

- Be enrolled as an active Medicaid provider
- Be FSSA-approved
- Comply with *Indiana Administrative Code*, *460 IAC 6*, including but not limited to:
  - *460 IAC 6-10-5* Documentation of Criminal Histories

- *460 IAC 6-12-1* and *460 IAC 6-12-2* Insurance
- *460 IAC 6-11-1* to *460 IAC 6-11-3* Financial Status of Providers
- *460 IAC 6-5-3* Adult Foster Care Services Provider Qualifications
- *460 IAC 6-14-5* Requirements for Direct Care Staff
- *460 IAC 6-14-4* Staff Training and *460 IAC 6-14-4* Training

- Comply with any applicable BDS service standards, guidelines, policies and/or manuals, including FSSA DDARS policies and this provider reference module, accessible from the *IHCP Bulletins and Reference Modules* webpage at in.gov/medicaid/providers
- Where licensure is required, must obtain/maintain Indiana-specific licensure

Section 9.31: Transportation for FS and CIH Waivers

The following subsections provide information and requirements for Transportation services for the FS and CIH waivers.

> *Note: For information on Transportation services available under the H&W and TBI Waivers, see Section 11.30: Transportation for H&W and TBI Waivers.*

Service Definition

Transportation services are services to transfer individuals in a vehicle from the point of pick-up to a destination point. Transportation services enable individuals to access nonmedical community services, resources, destinations or places of employment, as well as maintain or improve their mobility within the community, increase independence and community participation and prevent institutionalization as specified by the PCISP.

Depending on the needs of the individual, there are three levels of transportation. The level of Transportation service needed must be documented in the PCISP.

- Level 1: Transportation in a private, commercial or public transit vehicle that is not specially equipped.
- Level 2: Transportation in a private, commercial or public transit vehicle specially designed to accommodate wheelchairs.
- Level 3: Transportation in a vehicle specially designed to accommodate an individual who for medical reasons must remain prone during transportation (such as ambulette).

Additional Information:

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

Reimbursable Activities

Reimbursable activities under Transportation services include the following:

- Two one-way trips per day to or from a nonmedical community service or resource or place of employment as specified on the PCISP and provided by an approved provider of RHS (a service currently available only under the CIH Waiver), Day Habilitation, Adult Day Services or Transportation services.

- Bus passes or alternate methods of transportation may be used for Level 1 or Level 2. Bus passes may be purchased on a monthly basis or on a per-ride basis, whichever is most cost-effective in meeting the individual's transportation needs as outlined in the PCISP.
- May be used in conjunction with other services, including Day Habilitation and Adult Day Services.
- This service will not be reimbursed when provided by the parent of a minor child participant or the spouse of a participant (also known as LRIs).

> *Note: Whenever possible, family, neighbors, friends or community agencies that can provide Transportation services without charge will be used.*

Service Standards

The following service standards apply to Transportation services:

- Transportation services are offered in addition to medical transportation required under *42 CFR 431.53* and Transportation services under the Indiana Medicaid State Plan, defined at *42 CFR 440.170(a)* (if applicable), and shall not replace them.
- Transportation services under the waiver shall be offered in accordance with the PCISP, and when unpaid transportation is not available.
- Whenever possible, family, neighbors, friends or community agencies that can provide this service without charge will be used.

Documentation Standards

Documentation for Transportation services must include the following:

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

Limitations

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

Annual limits are applied to the nonmedical waiver Transportation services.

- For the CIH Waiver, the costs of nonmedical Transportation services are paid for outside of and in addition to the individual's annual allocation amount that is determined by their Algo score.
  - The annual limits for each level of nonmedical waiver Transportation under the CIH Waiver are:
    - $7,530 for Level 1 Transportation
    - $8,255 for Level 2 Transportation
    - $8,980 for Level 3 Transportation
- For the FS Waiver, the costs of nonmedical Transportation services and are paid for within the waiver's $26,482 annual cap.
  - The annual limits for each level of nonmedical waiver Transportation under the FS Waiver are:
    - $7,530 for Level 1 Transportation
    - $8,255 for Level 2 Transportation
    - $8,980 for Level 3 Transportation

Activities Not Allowed

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

- May not be used to meet medical transportation needs already available under the Indiana Medicaid State Plan.
- May not be used in conjunction with the Structured Family Caregiving services available under the CIH Waiver.
- This service will not be reimbursed when provided by the parent of a minor child participant or the spouse of a participant (also known as LRIs).

Provider Qualifications

Transportation providers must meet the following criteria:

- Be enrolled as an active Medicaid provider
- Be FSSA-approved
- Comply with *Indiana Administrative Code*, 460 IAC 6, including but not limited to:
  - *460 IAC 6-10-5* Documentation of Criminal Histories
  - *460 IAC 6-12-1* and *460 IAC 6-12-2* Insurance
  - *460 IAC 6-11-1* to *460 IAC 6-11-3* Financial Status of Providers
  - *460 IAC 6-5-30* Transportation Services Provider Qualifications, *460 IAC 6-5-31* Transportation Supports Provider Qualifications, and *460 IAC 6-34-1* to *460 IAC 6-34-3* Transportation Services
  - *460 IAC 6-14-5* Requirements for Direct Care Staff
  - *460 IAC 6-14-4* Staff Training
- Comply with any applicable BDS service standards, guidelines, policies and/or manuals, including FSSA DDARS policies and this provider reference module, accessible from the *IHCP Bulletins and Reference Modules* webpage at in.gov/medicaid/providers

Section 9.32: Vehicle Modifications for FS and CIH Waivers

The following subsections provide information and requirements for Vehicle Modifications services for the FS and CIH waivers.

> *Note: For information specific to vehicle modifications services available under the H&W and TBI Waivers, see Section 11.31: Vehicle Modifications for H&W and TBI Waivers.*

Service Definition

Vehicle Modifications are the addition of adaptive equipment or structural changes to a motor vehicle that will provide the individual with a safe and accessible mode of transportation that increases their ability to access their home and community.

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

Reimbursable Activities

Justification and documentation is required to demonstrate that the modification is necessary to meet the individual's identified needs. The following are allowable under Vehicle Modifications:

- Wheelchair lifts
- Wheelchair tie-downs (if not included with lift)
- Wheelchair/scooter hoist
- Wheelchair/scooter carrier for roof or back of vehicle
- Raised roof and raised door openings
- Power transfer seat base
- Lowered floor and lowered door openings
- Wheelchair ramp for vehicle

Maintenance is limited to $1,000 annually for repair and service of items that have been funded through an HCBS waiver. Requests for service must differentiate between parts and labor costs. Pricing must be consistent with the fair market price for such modifications. If the need for maintenance exceeds $1,000, the case manager will work with other available funding streams and community agencies to fulfill the need. When service costs exceed the annual limit, those parts and labor costs funded through the waiver must be itemized clearly to differentiate the waiver service provision from those parts and labor provided through a nonwaiver funding source.

Items requested, which are not listed above, must be reviewed and a decision rendered by the state division director or state agency designee.

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

- Service and documentation standards outlined within DDARS policy
- Allowable under current Medicaid waiver guideline
- Not available under the *Rehabilitation Act of 1973*, as amended

- Included in the individual's approved PCISP/service authorization
- Authorized on the *Request for Approval to Authorize Services (RFA) State Form 45750)* and linked to the PCISP/service authorization
- Included on a state-approved and signed service authorization
- Completed by an approved Medicaid waiver service provider (that is approved to perform this service)

Service Standards

The vehicle to be modified must meet all the following:

- The individual or primary caregiver is the titled vehicle owner.
- The vehicle is registered and/or licensed under state law.
- The vehicle has appropriate insurance as required by state law.
- The vehicle is the individual's sole or primary means of transportation.
- The vehicle is less than 10 years old and has less than 100,000 miles on the odometer.
- The vehicle is not registered to or titled by a Family and Social Services Administration (FSSA) approved provider.
- Only one vehicle per an individual may be modified in a 10-year period.

Many automobile manufacturers offer a rebate for individuals purchasing a new vehicle requiring modifications for accessibility. To obtain the rebate the individual is required to submit to the manufacturer documented expenditures of modifications. If the rebate is available, it must be applied to the cost of the modifications.

Requests for modifications may be denied if the DDARS determines the documentation does not support the service requested.

All Vehicle Modifications must be approved prior to services being rendered.

All Vehicle Modification shall be authorized only when it is determined to be medically necessary and/or shall have direct medical or remedial benefit for the waiver individual. Requests to upgrade products or to use materials exceeding the individual's basic needs will not be approved.

This determination includes the following considerations:

- The modification is the most cost effective or conservative means to meet the individual's specific needs.
- The modification is individualized, specific and consistent with, but not in excess of, the individual's needs.
- Two modification bids must be obtained for all modifications over $1,000.
- If two bids cannot be obtained, it must be documented to show what efforts were made to secure the two bids and explain why fewer than two bids were obtained (for example, provider name, dates of contact, response received).

Documentation Standards

The PCISP must reflect the identified direct benefit or need for Vehicle Modifications determined to support the individual in accessing their community.

Documentation/explanation within the *Request for Approval to Authorize Services (RFA) (State Form 45750)* must include:

- The specific modification being requested to the vehicle, including a picture of the modification
- Two bids if the cost exceeds $1,000: The individual chooses which approved/certified providers will submit bids or estimates for this service. The provider with the lowest bid will be chosen, unless there is strong written justification detailing why a provider with a higher bid should be selected.
- Warranty information of the modification
- Copy of the vehicle registration
- Copy of the vehicle insurance

Provider standards for documentation include the following:

- Provider of services must maintain receipts for all incurred expenses related to the modification.
- All bids must be itemized.
- Must be in compliance with the FSSA and division-specific guidelines and/or policies.

Limitations

A cap of $15,000 is available for one vehicle per every 10-year period for an individual's household. In addition to the applicable cap, $1,000 will be allowable annually for repair, replacement or an adjustment to an existing modification that was funded by a Home- and Community-Based Services (HCBS) waiver.

Activities Not Allowed

The following activities are not allowed under Vehicle Modifications:

- Modifications/adaptations that have not been approved on a *Request for Approval to Authorize Services (RFA) (State Form 45750)*.
- Examples/descriptions of modifications/items not covered include but are not limited to the following:
  - Repair or replacement of modified equipment damaged or destroyed in an accident
  - Alarm systems
  - Auto loan payments
  - Insurance coverage
  - Driver's license, title registration or license plates
  - Emergency road service
  - Routine maintenance and repairs related to the vehicle itself
  - Specialized medical equipment or home modification items are not allowed.
  - Leased vehicles

Provider Qualifications

Providers of Vehicle Modifications must meet the following criteria:

- Be enrolled as an active Medicaid provider
- Be FSSA-approved
- Comply with *Indiana Administrative Code 460 IAC 6*, including but not limited to:
  - *460 IAC 6-10-5* Documentation of Criminal Histories

- *460 IAC 6-12-1* and *460 IAC 6-12-2* Insurance
- *460 IAC 6-11-1* to *460 IAC 6-11-3* Financial Status of Providers
- *460 IAC 6-5-27* Specialized Medical Equipment and Supplies Supports Provider Qualifications

- Comply with any applicable BDS service standards, guidelines, policies and/or manuals, including FSSA DDARS policies and this provider reference module, accessible from the *IHCP Bulletins and Reference Modules* webpage at in.gov/medicaid/providers
- Where licensure is required, must obtain/maintain Indiana licensure.

Section 9.33: Wellness Coordination for CIH Waiver

The following subsections provide information and requirements for Wellness Coordination services for the CIH Waiver.

*Note: Wellness Coordination services are **not** available under the FS, H&W or TBI waivers.*

Service Definition

Wellness Coordination services means the development, maintenance and routine monitoring of the individual's wellness coordination plan and the medical services required to manage their health care needs. A comprehensive medical risk plan may substitute for the wellness coordination plan or individual risk plans.

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

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

Conditions and Requirements

Necessity for Wellness Coordination services will typically be reserved for individuals assessed with health scores of 5 or higher through the state's objective-based allocation process. Individuals assessed with health scores of 0-4 would not require assistance of an RN or LPN to coordinate medical needs. As medical events occur and/or an individual's medical needs change, the IST is expected to obtain reassessment for potential revision to the health score and to ensure utilization of the appropriate tier of services.

Service Standards

Reimbursement is available for Wellness Coordination services only when the following circumstances are present:

- The individual requires assistance in coordinating medical needs beyond what can be provided through routine doctor/health care visits.
- Wellness Coordination services are specifically included in the individual's PCISP.
- The member has a Wellness Coordination plan.

Reimbursable Activities

Coordination of wellness services by the wellness coordinator, who must be an RN or LPN, must include, but is not limited to the following:

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

Limitations

This waiver service is only provided to individuals ages 21 and over. All medically necessary Wellness Coordination services for children under age 21 are covered in the Indiana Medicaid State Plan benefit pursuant to the EPSDT benefit.

Individuals assessed with health scores of 0-4 would not require assistance of an RN or LPN to coordinate medical needs.

Activities Not Allowed

Reimbursement for Wellness Coordination is not available under the following circumstances:

- The individual does not require Wellness Coordination services.
- Services are furnished to a minor by a parents, stepparents or legal guardian.
- Services are furnished to an individual by the individual's spouse.

Documentation Standards

Wellness Coordination services documentation standards are as follows:

- Wellness Coordination services must be documented in agency files:
  - Weekly consultations/reviews
  - Face-to-face visits with the individual
  - Other activities, as appropriate

- Services must address needs identified in the person-centered planning process and be outlined in the PCISP.
- The provider of wellness coordination will provide a written report to pertinent parties at least quarterly. ("Pertinent parties" include the individual, guardian, BDS 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

Wellness Coordination providers must meet the following criteria:

- Be enrolled as an active Medicaid provider
- Be FSSA-approved
- Comply with *Indiana Administrative Code*, *460 IAC 6*, including but not limited to:
  - *460 IAC 6-10-5* Documentation of Criminal Histories
  - *460 IAC 6-12-1* and *460 IAC 6-12-2* Insurance
  - *460 IAC 6-11-1* to *460 IAC 6-11-3* Financial Status of Providers
  - ~~*460 IAC 6-14-5* Requirements for Direct Care Staff~~
  - *460 IAC 6-14-4* Training
  - *460 IAC 6-5-14* Health Care Coordination Provider Qualifications

Note: Wellness Coordination is referred to as Health Care Coordination within 460 IAC 6.

- Comply with any applicable BDS service standards, guidelines, policies and/or manuals, including FSSA DDARS policies and this provider reference module, accessible from the *IHCP Bulletins and Reference Modules* webpage at in.gov/medicaid/providers
- Where licensure is required, must obtain/maintain Indiana licensure.

Section 9.34: Workplace Assistance for FS and CIH Waivers

The following subsections provide information and requirements for Workplace Assistance services for the FS and CIH waivers.

Service Definition

Workplace Assistance services provide a range of personal care services and/or supports during paid competitive community employment hours and in a competitive community employment setting to enable waiver individuals to accomplish tasks that they would normally do for themselves if they did not have a disability. Assistance may take the form of hands-on assistance (actually performing a personal care task for the individual) or prompting the individual to perform a personal care task. Workplace Assistance services may be provided on an episodic or on a continuous basis.

Workplace Assistance services are designed to ensure the health, safety and welfare of the individual, thereby assisting in the retention of paid employment for the individual who is paid at or above the federal minimum wage.

Additional Information:

- Workplace Assistance may be used in conjunction with Extended Services.
- Workplace Assistance may be used with each hour the individual is engaged in paid competitive community employment, including employment hours overlapping with Extended Services.

Reimbursable Activities

Reimbursable activities under Workplace Assistance include the following:

- Direct support, monitoring, training, education, demonstration or support to assist with personal care while on the job or at the job site (may include assistance with meals, hygiene, toileting, transferring, maintaining continence, administration of medication and so forth)
- May have been used in conjunction with Extended Services
- May be used with each hour the individual is engaged in paid competitive community employment

Service Standards

The following service standards apply to Workplace Assistance:

- Workplace Assistance services must be reflected in the PCISP.
- Workplace Assistance services should complement but not duplicate Day Habilitation services being provided in other settings.
- Workplace Assistance services may only be delivered in the employment setting.
- There is no requirement for a physician's prescription or authorization. The need for Workplace Assistance services is determined entirely by the IST.

Documentation Standards

Workplace Assistance service documentation must include the following:

- Services must be outlined in the PCISP.
- In addition to compliance with documentation requirements outlined in *460 IAC 6*, the following data elements are required for each service rendered:
  - Name of individual served
  - IHCP Member ID of the individual
  - Name of provider
  - Service rendered
  - Time frame of service (include a.m. or p.m.)
  - Date of service, including the year
  - Notation of the primary location of service delivery
  - A brief activity summary of service rendered
  - In addition to the brief activity summary of service rendered, a description by direct care staff of any issue or circumstance concerning the individual including, but not limited to, significant medical or behavioral incidents or any other situation that may be uncommon for the individual

- Signature that includes at least the last name and first initial of the direct care staff person making the entry
  - Electronic signatures are permissible when in compliance with the *Uniform Electronic Transactions Act [IC 26-2-8]*.

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

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

Limitations

The following are limitations on Workplace Assistance services:

- Allowed Ratio – Individual, one client to one staff.
- Reimbursement for Workplace Assistance services is available only during the individual's hours of paid, competitive community employment.

Activities Not Allowed

Reimbursement is not available through Workplace Assistance under the following circumstances:

- When services are furnished to a minor child by the parents, stepparents or legal guardian
- When services are furnished to an individual by that individual's spouse
- Any service that is otherwise available under the *Rehabilitation Act of 1973* or *Public Law 94-142*
- During volunteer activities
- In a facility setting
- In conjunction with sheltered employment
- During activities other than paid competitive community employment
- Workplace Assistance should complement but not duplicate services being provided under Extended Services.
- Workplace Assistance is ***not*** to be used for observation or supervision of the individual for the purpose of teaching job tasks or to ascertain the success of the job placement.
- Workplace Assistance is ***not*** to be used for off-site monitoring when the monitoring directly relates to maintaining a job.
- Workplace Assistance is ***not*** to be used for the provision of skilled job trainers who accompany the individual for short-term job skill training at the work site to help maintain employment.
- Workplace Assistance is ***not*** to be used for regular contact and/or follow-up with the employers, individuals, parents, family members, guardians, advocates or authorized representatives of the individuals, or other appropriate professional or informed advisors, to reinforce and stabilize the job placement.
- Workplace Assistance is ***not*** to be used for the facilitation of natural supports at the work site.
- Workplace Assistance is ***not*** to be used for individual program development, writing tasks analyses, monthly reviews, termination reviews or behavioral intervention programs.
- Workplace Assistance is ***not*** to be used for advocating for the individual.

- Workplace Assistance is ***not*** to be used for staff time in traveling to and from a work site.
- This service will not be reimbursed when provided by the parent of a minor child participant or the spouse of a participant (also known as LRIs).

Provider Qualifications

Workplace Assistance providers must meet the following criteria:

- Be enrolled as an active Medicaid provider
- Be FSSA-approved
- Comply with *Indiana Administrative Code*, *460 IAC 6*, including but not limited to:
  - *460 IAC 6-10-5* Documentation of Criminal Histories
  - *460 IAC 6-12-1* and *460 IAC 6-12-2* Insurance
  - *460 IAC 6-11-1* to *460 IAC 6-11-3* Financial Status of Providers
  - *460 IAC 6-14-5* Requirements for Direct Care Staff
  - *460 IAC 6-14-4* Staff Training and *460 IAC 6-14-4* Training
  - *460 IAC 6-5-30* Transportation Services Provider Qualifications
  - *460 IAC 6-5-31* Transportation Supports Provider Qualifications
- Comply with any applicable BDS service standards, guidelines, policies and/or manuals, including FSSA DDARS policies and this provider reference module, accessible from the *IHCP Bulletins and Reference Modules* webpage at in.gov/medicaid/providers

Section 10: RFA Policies for Select FS and CIH Waiver Services

The following policies address use of the *Request for Approval to Authorize Services (RFA) (State Form 45750)*, which is required for authorization of the Home Modifications, Specialized Medical Equipment and Supplies, and Vehicle Modification services under the Family Supports (FS) and Community Integration and Habilitation (CIH) waivers.

Section 10.1: Home Modification RFA Policy (for FS and CIH Waivers)

Waiver Policy Notification

Authority: *Code of Federal Regulations 42 CFR 441.302*

Policy Topic: Home Modification Policy Clarification

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

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

Effective July 16, 2020, Home Modifications are now a covered service under the FS and CIH waivers.

Effective Date: Dec. 1, 2007, and replaces all previous policies related to the authorization of Home Modifications. Policy updates are in process.

Description

Home Modifications services are minor physical adaptations to the home, as required by the individual's service authorization, which are necessary to ensure the health, welfare and safety of the individual. These modifications enable the individual to function with greater independence in the home and without which the individual would require institutionalization.

A lifetime cap of $20,000 is available for Home Modifications per waiver. The cap represents a cost for basic modification of an individual's home for accessibility and safety and accommodates the individual's needs for housing modifications. The cost of a Home Modifications service includes all materials, equipment, labor and permits to complete the project. No parts of a Home Modifications service may be billed separately as part of any other service category (for example, Specialized Medical Equipment and Supplies). In addition to the $20,000 lifetime cap, $1,000 is allowable annually for the repair, replacement, or an adjustment to an existing home modification that was funded by an HCBS waiver.

For the FS Waiver, Home Modifications services are not included in the $26,482 cap.

> *Note: As a reminder, HCBS waiver funding covers only basic modifications determined to be medically necessary for the waiver individual and is not available for items that exceed basic medical need. Requests to upgrade products or to use materials exceeding the individual's basic need will not be approved. For example, if a bathroom modification is necessary but the individual or family requests tiled flooring when basic vinyl flooring could be installed, the individual or family must decide whether to access waiver funds for completion of the basic modification or to assume financial responsibility for the entire modification inclusive of desired upgrades.*
>
> *Due to the state's responsibility to ensure each modification is the most cost effective or conservative means to meet the individual's needs for accessibility within the home, it is not acceptable to submit bids attempting to combine waiver funding for basic modifications with private funding to cover the higher costs of the desired upgrades.*

Home Ownership

Home 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 Home Modifications must be approved by the waiver program prior to services being rendered.

Home Modification requests must be provided in accordance with applicable state and/or local building codes and should be guided by the *Americans with Disability Act* (ADA) or ADA Accessibility Guidelines (ADAAG) requirements when in the best interest of the individual and the individual's specific situation.

Home 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 needs for accessibility within the home.
- The Home Modification is individualized, specific and consistent with, but not in excess of, the individual's needs.
- 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 modifications.
- Bids must be itemized to include information shown in the example in Table 5.

Table 5 – Bid Itemization Example – Home Modifications

Scope of work labor	Material	Related
Ramp 15 inches long	$$	$$
Widen front door to 36 inches	$$	$$
Widen bathroom door to 36 inches	$$	$$
Install ADA toilet	$$	$$
Building permits (specify)	$$	$$
Total Cost:	$$$$	$$$$

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

Service Standards

- Home modifications must be of direct medical or remedial benefit to the individual.
- To ensure that Home 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 Home Modifications will include:
  - Assessment of the individual's specific needs, conducted by an approved, qualified individual who is independent of the entity providing the Home 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:
  - Service authorization
  - Physician prescription and/or clinical evaluation as deemed appropriate
  - Person-centered individualized support plan (PCISP)
- Documentation/explanation of the service within the *Request for Approval to Authorize Services (RFA) (State Form 45750)* 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 modifications approach property line
  - Signed and approved RFA
  - Signed and approved service authorization

- 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 PCISP/service authorization
- Authorized on the RFA and linked to the PCISP/service authorization
- Included on a state-approved and signed service authorization
- Completed by an approved Medicaid waiver service provider (who is approved to perform this service)
- Completed in accordance with the applicable building permits

Modifications/Items – Covered

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

- Adaptive door openers and locks – Limited to one per individual primary residence for an individual living alone or who is alone without a caregiver for substantial periods of time but has a need to open, close or lock the doors and cannot do so without special adaptation.
- Bathroom modification – Limited to one existing bathroom per individual primary residence when no other accessible bathroom is available. The bathroom modification may include:
  - Removal of existing bathtub, toilet and/or sink
  - Installation of roll-in shower, grab bars, ADA toilet and wall-mounted sink
  - Installation of replacement flooring, if necessary due to bath modification
- Environmental control units – Adaptive switches and buttons to operate medical equipment, communication devices, heat and air conditioning, and lights for an individual living alone or who is alone without a caregiver for a substantial portion of the day.
- Environmental safety devices limited to:
  - Door alarms
  - Anti-scald devices
  - Hand-held shower head
  - Grab bars for the bathroom
- Fence – Limited to 200 linear feet (individual must have a documented history of elopement).
- Ramp – Limited to one per individual primary residence, and only when no other accessible ramp exists:
  - In accordance with the ADA or ADAAG, unless this is not in the best interest of the client
  - Portable – Considered for rental property only
  - Permanent
  - Vertical lift – May be considered in lieu of a ramp if there is photographic and written documentation that shows it is not possible for a ramp to be used

- Stair lift – If required for access to areas of the home necessary to meet the direct medical or remedial benefit of the individual per service authorization (and PCISP under CIH Waiver).
- Single-room air conditioners/single- room air purifiers – If required for access to areas of the home necessary to meet the direct medical or remedial benefit of the individual per service authorization (and PCISP under CIH Waiver):
  - There is a documented medical reason for the individual's need to maintain a constant external temperature. The documentation necessary for this equipment includes a prescription from the primary care physician.
  - The room air conditioner size is consistent with the room size (square feet) capacity to be cooled.
- Widen doorway – To allow safe egress:
  - Exterior – Modification limited to one per individual primary residence when no other accessible door exists.
  - Interior – Modification of bedroom, bathroom and/or kitchen door/doorway as needed to allow for access. (A pocket door may be appropriate when there is insufficient room to allow for the door swing).
- Windows – Replacement of glass with plexiglass or other shatterproof material when there is a documented medical/behavioral reasons.
- 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 home modifications that have been provided through an HCBS waiver:
  - Requests for service must detail parts cost and labor cost.
  - If the need for maintenance exceeds $500, the case manager will work with other available funding streams and community agencies to fulfill the need. If service costs exceed the annual limit, those parts and labor costs funded through the waiver must be itemized clearly to differentiate the waiver service provision from those parts and labor funded through a nonwaiver funding source.
- Items requested, which are not listed above, must be reviewed and decision rendered by the state division director or state agency designee.

Modifications/Items – Noncovered

Examples/descriptions of modifications/items not covered include, but are not limited to the following:

- Adaptations or improvements that are not of direct medical or remedial benefit to the individual
  - Central heating and air conditioning
  - Routine home maintenance
  - Installation of standard (non-ADA or ADAAG) home fixtures (for example, sinks, commodes, tub, wall, window and door coverings, and so forth) which replace existing standard (non-ADA or ADAAG) home fixtures
  - Roof repair
  - Structural repair
  - Garage doors
  - Elevators
  - Ceiling track lift systems
  - Driveways, decks, patios, sidewalks, household furnishings
  - Replacement of carpeting and other floor coverings
  - Storage (for example, cabinets, shelving, closets), sheds

  - Swimming pools, spas or hot tubs
  - Video monitoring system
  - Adaptive switches or buttons to control devices intended for entertainment, employment or education
  - Home security systems
- Modifications that create living space or facilities where they did not previously exist (for example, installation of a bathroom in a garage/basement and so forth)
- Modifications that duplicate existing accessibility (for example, second accessible bathroom, a second means of egress from home and so forth)
- Modifications that will add square footage to the home
- Completion of, or modifications to, new construction or significant remodeling/reconstruction unless there is documented evidence of a significant change in the individual's medical or remedial needs that now require the requested modification
- Adaptations that have not been approved on a *Request for Approval to Authorize Services (RFA) (State Form 45750)*
- Individuals living in foster homes, group homes, assisted living facilities or homes for special services (any licensed residential facility)

Note: The responsibility for home modifications rests with the facility owner or operator.

- Individuals living in a provider owned residence

Note: The responsibility for home 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 7: Appeal Process*. The case management entity, working as an agent of the state, shall not attend fair hearings in opposition of the state, unless requested by the individual when there is no other advocate to represent the individual at the hearing. If the case manager does attend the hearing, working as an agent of the state, they must also uphold the established federal, state, local and FSSA standards and division specific guidelines and/or policies. Additionally, the case manager must submit a letter, in writing to the administrative law judge at the fair hearing, explaining their role at the hearing.

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

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

Section 10.2: Specialized Medical Equipment and Supplies RFA Policy (for FS and CIH Waivers)

Waiver Policy Notification

Authority: *42 CFR 441.302*

Policy Topic: Specialized Medical Equipment and Supplies Policy Clarification

Impacts the following HCBS waivers:

- Community Integration and Habilitation (CIH) Waiver
- Family Supports (FS) Waiver
- Effective Date: Dec. 1, 2007, and replaces all previous policies related to the authorization of Specialized Medical Equipment and Supplies

> *Note: Sensory items, seizure detection devices, Global Positioning System (GPS) tracking devices and other electronic devices not currently specified as items covered or reimbursable in the waiver or current RFA policy may be electronically submitted for consideration under Specialized Medical Equipment and Supplies via the Request for Approval to Authorize Services (RFA) (State Form 45750) as outlined in this section.*

Description

Specialized Medical Equipment and Supplies are medically prescribed items required by the individual's PCISP and service authorization, which are necessary to assure the health, welfare and safety of the individual, which enable the individual to function with greater independence in the home, and without which the individual would require institutionalization.

Under the FS Waiver, a lifetime cap of $15,000 is available for Specialized Medical Equipment and Supplies. There is no lifetime cap for Specialized Medical Equipment and Supplies under the CIH Waiver.

Choice of Provider

The individual chooses which approved/certified providers will submit bids or estimates for this service. The provider with the lowest bid will be chosen, unless there is strong written justification from the case manager detailing why a provider with a higher bid should be selected.

Requirements

- All Specialized Medical Equipment and Supplies must be approved by the waiver program prior to the service being rendered.
- Individuals requesting authorization for this service through utilization of HCBS waivers must first exhaust eligibility for the desired equipment or supplies through Indiana Medicaid State Plan, which may require prior authorization (PA):
  - There should be no duplication of services between HCBS waiver and Indiana Medicaid State Plan.
  - The refusal of a Medicaid vendor to accept the Medicaid reimbursement through the Indiana 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. Indiana Medicaid State Plan often covers comparable equipment but may not cover the

specific brand requested. When this occurs, the individual is limited to the Indiana Medicaid State Plan covered service/brand.

- Reimbursement is limited to the Indiana Medicaid State Plan fee schedule, if the requested item is covered under the Indiana Medicaid State Plan.
- See *Indiana Administrative Code 405 IAC 5-19* for additional information regarding Indiana Medicaid State Plan coverage. All requests for items to be purchased through a Medicaid waiver must be accompanied by documentation of Indiana Medicaid State Plan PA request and decision, if the requested item is covered under the state plan.

- Specialized Medical Equipment and Supplies shall be authorized only when it is determined to be medically necessary and shall have direct medical or remedial benefit for the waiver individual. This determination includes the following considerations:
  - The request is the most cost effective or conservative means to meet the individual's specific needs.
  - The request is individualized, specific and consistent with, but not in excess of, the individual's needs.
  - Three bids must be obtained for items over $1,000.
  - If three bids cannot be obtained, it must be documented to show what efforts were made to secure the three bids and explain why fewer than three bids were obtained (including provider name, dates of contact, response received).
  - For requested items under $1,000, one bid is required, and pricing must be consistent with the fair market price.
  - Bids must be itemized to include a picture of the product and detailed product information, including make/model number of the item as shown in the example in Table 6.

Table 6 – Bid Itemization Example – Specialized Medical Equipment and Supplies

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

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

Service Standards

- Specialized Medical Equipment and Supplies must be of direct medical or remedial benefit to the individual.
- All items shall meet applicable standards of manufacture, design and service specifications.
- Under the FS and CIH waivers, 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 for Specialized Medical Equipment and Supplies include the following:

- The identified direct benefit or need must be documented within all the following:
  - Service authorization
  - Physician prescription and/or clinical evaluation as deemed appropriate
  - PCISP under the FS and CIH waivers
- Indiana Medicaid State Plan prior authorization request and the decision rendered, if applicable
- Signed and approved *Request for Approval to Authorize Services (RFA) (State Form 45750)*
- Signed and approved service authorization
- 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 PCISP/service authorization
- Authorized on the RFA and linked to the PCISP/service authorization
- Included on a state-approved and signed service authorization
- Completed by an approved Medicaid waiver service provider (that is approved to perform this service)

Items – Covered

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

- Communication Devices – Computer adaptations for keyboard, picture boards and so forth.
- The RFA must be accompanied by documentation of Indiana Medicaid State Plan PA request and decision rendered under the Indiana Medicaid State Plan.
- Generators (portable) – When either ventilator, daily use of oxygen via a concentrator, continuous infusion of nutrition (tube feeding), or medication through an electric pump are medical requirements of the individual. The generator is limited to the kilo-wattage necessary to provide power to the essential life-sustaining equipment and is limited to one generator per individual per 10-year period.
- Interpreter service – Provided in circumstances where the interpreter assists the individual in communication during specified scheduled meetings for service planning (for example, waiver case conferences, team meetings) and is not available to facilitate communication for other service provision.

- Self-help devices – Including over the bed tables, reachers, adaptive plates, bowls, cups, drinking glasses and eating utensils that are prescribed by a physical therapist or occupational therapist.
- Strollers – When needed because individual's primary mobility device does not fit into the individual's vehicle/mode of transportation, or when the individual does not require the full-time use of a mobility device, but a stroller is needed to meet the mobility needs of the individual outside of the home setting. The RFA must be accompanied by documentation of Indiana Medicaid State Plan PA request and decision rendered under the Indiana Medicaid State Plan.
- Manual wheelchairs – When required to facilitate safe mobility. The RFA must be accompanied by documentation of Indiana Medicaid State Plan PA request and decision rendered under Indiana Medicaid State Plan.
- Maintenance – Limited to $1,000 annually for the repair and service of items that have been provided through an HCBS waiver:
  - Requests for service must detail parts cost and labor cost.
  - If the need for maintenance exceeds $1,000, the case manager will work with other available funding streams and community agencies to fulfill the need. If service costs exceed the annual limit, those parts and labor costs funded through the waiver must be itemized clearly to differentiate the waiver service provision from those parts and labor provided through a nonwaiver funding source.
- Posture chairs and feeding chairs – As prescribed by physician, occupational therapist or physical therapist. The RFA must be accompanied by documentation of Indiana Medicaid State Plan PA request and decision rendered under Indiana Medicaid State Plan.

Note: While not currently listed as covered items, sensory items, seizure detection devices, GPS tracking devices and other electronic devices not currently specified as items covered or reimbursable in the waiver or current RFA policy may be electronically submitted for consideration under Specialized Medical Equipment and Supplies via the Request for Approval to Authorize Services (RFA) (State Form 45750) as outlined in this section. As an interim step toward RFA policy updates, the BDS will develop a Specialized Medical Equipment and Supplies fact sheet citing things individuals and families may wish to consider prior to submitting a request.

Items – Noncovered

The following items and equipment are not covered:

- Hospital beds, air fluidized suspension mattresses/beds
- Therapy mats
- Parallel bars
- Scale
- Activity streamers
- Paraffin machines or baths
- Therapy balls
- Books, games, toys
- Electronics – such as CD players, radios, cassette players, tape recorders, televisions, VCRs and DVDs, cameras or film, videotapes, and other similar items
- Computers and software
- Adaptive switches and buttons

- Exercise equipment such as treadmills or exercise bikes
- Furniture
- Appliances – such as refrigerator, stove, hot water heater
- Indoor and outdoor play equipment such as swing sets, swings, slides, bicycles adaptive tricycles, trampolines, playhouses, merry-go-rounds
- Swimming pools, spas, hot tubs, portable whirlpool pumps
- Tempur-Pedic mattresses, positioning devices, pillows
- Bathtub lifts
- Motorized scooters
- Barrier creams, lotions, personal cleaning cloths
- Totally enclosed cribs and barred enclosures used for restraint purposes
- Medication dispensers
- Any equipment or items that can be authorized through Indiana Medicaid State Plan
- Any equipment or items purchased or obtained by the individual, the individual's family members or other nonwaiver providers

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

Director of Agency Coordination and Integration
Office of Medicaid Policy and Planning
402 W. Washington Street, Room 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 or designees to render decisions based upon the articles within this policy.
- The designees are responsible for preparing and presenting testimony for all fair hearings.
- The case management entity, working as an agent of the state, shall not attend fair hearings in opposition of the state, unless requested by the individual when there is no other advocate to represent the individual at the hearing. If the case manager does attend the hearing, working as an agent of the state, the case manager must also uphold the established federal, state, local and FSSA standards and the division-specific guidelines and/or policies. Additionally, the case manager must submit a letter in writing to the administrative law judge at the fair hearing, as to what their role is at the hearing.

- Each division shall implement a Quality Assurance Plan. In the event of inappropriate authorizations being granted, any or all of the following actions may be required:
  - A corrective action plan (CAP)
  - Reimbursement to Medicaid
  - Loss of decision-making authority

Section 10.3: Vehicle Modifications RFA Policy (for FS and CIH Waivers)

Waiver Policy Notification

Authority: *42 CFR 441.302*

Policy Topic: Vehicle Modification Policy Clarification

Impacts the following HCBS waivers:

- Community Integration and Habilitation (CIH) Waiver
- Family Supports (FS) Waiver
- Effective Date: Dec. 1, 2007, and replaces all previous policies related to the authorization of Vehicle Modifications.

Description

Vehicle Modifications are the addition of adaptive equipment or structural changes to a motor vehicle that permits an individual with a disability to safely transport in a motor vehicle. Vehicle Modifications, as specified in the person-centered individualized support plan (PCISP) and service authorization, 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. Members needing vehicle modifications to attend post-secondary education or job-related services should be referred to Vocational Rehabilitation (VR).

A cap of $15,000 is available for one vehicle per every 10-year period for an individual's household. In addition to the applicable cap, $1,000 will be allowable annually for repair, replacement or an adjustment to an existing modification that was funded by an HCBS waiver.

Vehicle Ownership

The vehicle to be modified must meet all the following:

- The individual or primary caregiver is the titled owner.
- The vehicle is registered and/or licensed under state law.
- The vehicle has appropriate insurance as required by state law.
- The vehicle is the individual's sole or primary means of transportation.
- The vehicle is less than 10 years old and has less than 100,000 miles on the odometer.
- The vehicle is not registered to or titled by an FSSA-approved provider agency.
- Only one vehicle per an individual may be modified per every 10-year period.

Choice of Provider

The individual chooses which approved/certified providers will submit bids or estimates for this service. The provider with the lowest bid will be chosen, unless there is strong written justification from the case manager detailing why a provider with a higher bid should be selected.

Requirements

- All vehicle modifications must be approved by the HCBS waiver program prior to services being rendered.
- Vehicle modification requests must meet and abide by the following:
  - The vehicle modification is based on, and designed to meet, the individual's specific needs:
    - Only one vehicle per an individual's household may be modified.
    - The vehicle is less than 10 years old and has less than 100,000 miles on the odometer.
- All vehicle modifications 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 needs.
  - The modification is individualized, specific and consistent with, but not in excess of, the individual's needs.
  - Two modification bids must be obtained for all modifications over $1,000.
  - If two bids cannot be obtained, it must be documented to show what efforts were made to secure the three bids and explain why fewer than three bids were obtained (for example, provider name, dates of contact, response received).
  - For modifications under $1,000, one bid is required, and pricing must be consistent with the fair market price for such modifications.
  - All bids must be itemized to include the items as shown in the example in Table 7.

Table 7 – Bid Itemization Example – Vehicle Modification

Make: _____Model: _____Mileage: _____Year: _____		
Scope of Work	**Materials Cost**	**Related Labor**
Lift	$$	$$
Tie down	$$	$$
Total Cost:	$$$$$	

- Many automobile manufacturers offer a rebate for individuals purchasing a new vehicle requiring modifications for accessibility. To obtain the rebate the individual is required to submit to the manufacturer documented expenditures of modifications. If the rebate is available, it must be applied to the cost of the modifications.
- Requests for modifications may be denied if the state division director or state agency designee determines the documentation does not support the service requested.

Service Standards

- Vehicle Modifications must be of direct medical or remedial benefit to the individual.
- All items must meet applicable manufacturer, design and service standards.

Documentation Standards

Documentation standards for Vehicle Modifications include the following:

- The identified direct benefit or need must be documented within all the following:
  - PCISP/service authorization
  - Physician prescription and/or clinical evaluation as deemed appropriate
- Documentation/explanation of service within the *Request for Approval to Authorize Services (RFA) (State Form 45750)* 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 PCISP/service authorization
    - Receipts for all authorized 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 PCISP/service authorization
- Authorized on the RFA and linked to the PCISP/service authorization
- Included on a state-approved and signed service authorization
- Completed by a BDS-approved HCBS Medicaid waiver provider (that is approved to perform this service)

Modifications/Items – Covered

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

- Wheelchair lifts
- Wheelchair tie-downs (if not included with lift)
- Wheelchair/scooter hoist
- Wheelchair/scooter carrier for roof or back of vehicle
- Raised roof and raised door openings
- Lowered floor van conversions
- Wheelchair ramp for vehicle
- Power transfer seat base (excludes mobility base)

- Maintenance is limited to $1,000 annually for repair and service of items that have been funded through an HCBS waiver:
  - Requests for service must differentiate between parts and labor costs.
  - If the need for maintenance exceeds $1,000, the case manager will work with other available funding streams and community agencies to fulfill the need. If service costs exceed the annual limit, those parts and labor costs funded through the waiver must be itemized clearly to differentiate the waiver service provision from those parts and labor provided through a nonwaiver funding source.

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

*Modifications/Items – Noncovered**

Examples/descriptions of modifications/items not covered include, but are not limited to, the following:

- Purchase, installation or maintenance of CB radios, cellular phones, global positioning/tracking devices or other mobile communication devices
- Repair or replacement of modified equipment damaged or destroyed in an accident
- Alarm systems
- Auto loan payments
- Insurance coverage
- Driver's license, title registration or license plates
- Emergency road service
- Routine maintenance and repairs related to the vehicle itself

> **Note: Until policy is updated, sensory items, seizure detection devices, GPS tracking devices and other electronic devices not currently specified as items covered or reimbursable in the waiver or current RFA policy may be electronically submitted for consideration under Specialized Medical Equipment and Supplies via the Request for Approval to Authorize Services (RFA) (State Form 45750).*

Decision-Making Authority

- Each division, with approval from the FSSA Office of the Secretary, shall identify a designee or designees to render decisions based upon the articles within this policy.
- The designees are responsible for preparing and presenting testimony for all fair hearings – see *Section 7: Appeal Process*.
- The case management entity, working as an agent of the state, shall not attend fair hearings in opposition of the state.
- Each division shall implement a Quality Assurance Plan. In the event of inappropriate authorizations being granted, any or all the following actions may be required:
  - A corrective action plan (CAP)
  - Reimbursement to Medicaid
  - Loss of decision-making authority

Section 11: Health and Wellness (H&W) and Traumatic Brain Injury (TBI) Waivers

The Division of Disability, Aging and Rehabilitative Services (DDARS) within the Indiana Family and Social Services Administration (FSSA) supports the Health and Wellness (H&W) and Traumatic Brain Injury (TBI) waivers, in addition to the Family Supports (FS) and Community Integration and Habilitation (CIH) waivers.

> *Note: For information specific to services available under the FS and CIH waivers, see Section 9: Service Definitions and Requirements for FS and CIH Waivers and Section 10: RFA Policies. Sections 1–8 also contain information specific to the FS and CIH waivers, as well as some general information applicable to all four waivers.*

Section 11.1: Eligibility for H&W and TBI Waiver Services

To be eligible for Home- and Community-Based Services (HCBS) under the H&W and TBI waivers, individuals must meet the nursing facility level of care (NF LOC) criteria, as defined by *Indiana Administrative Code 405 IAC 1-3-1* through *405 IAC 1-3-2*.

As of July 1, 2025, the Indiana Family and Social Services Administration (FSSA) has designated Level of Care Assessment Representatives (LCARs) – currently contracted to Maximus – to conduct initial NF LOC assessments and determine functional eligibility for these waivers.

LCAR utilizes the AssessmentPro system and the appropriate interRAI tools for assessment:

- InterRAI Home Care (HC): for individuals age 18 and older
- InterRAI Pediatric Home Care (PEDS): for individuals ages 4–17
- InterRAI Early Years (EY): for individuals ages 0–3

LCAR must issue an official outcome letter within 10 business days of receiving a complete referral. All initial H&W and TBI waiver eligibility assessments must go through LCAR to ensure standardization and compliance.

Eligibility assessment referrals may be submitted by managed care entities (MCEs), Area Agencies on Aging (AAAs) or directly by applicants through AssessmentPro.

> *Note: NF LOC approval is a prerequisite for the development of a service plan, Core Medicaid Management Information System (CoreMMIS) benefit assignment and waiver service authorization. No services may begin prior to LOC determination and official service plan approval.*
>
> *If an individual is denied NF LOC, they have the right to appeal. All appeals are reviewed by the FSSA prior to being finalized.*

Providers have the following responsibilities:

- Must verify NF LOC approval and service authorization prior to initiating any services or submitting claims.
- Must not deliver or bill for waiver services without proper *Core*MMIS authorization.

Nursing Facility Level of Care and LCAR Assessment Process for H&W and TBI Waivers

To be eligible for HCBS waiver coverage, individuals must qualify for an NF LOC and must be enrolled in the IHCP. Additional requirements apply, based on the specific waiver program.

Beginning July 1, 2025, individuals seeking H&W and TBI waivers will be assessed for functional eligibility by an LCAR vendor, contracted to Maximus. Presently, Maximus completes the Preadmission Screening and Resident Review (PASSR) process for those seeking entry into nursing facilities. The FSSA is committed to enhancing the quality and efficiency of assessing eligibility necessary to access specific available support and services. LCAR vendors serve to streamline the eligibility evaluation process determining NF LOC for HCBS waivers and nursing facility admission.

Previously, the AAAs served as the initial entry point for individuals seeking H&W or TBI waivers and determining initial functional eligibility. The LCAR implementation process serves as an expansion of entry points to access waiver services for individuals. Through the process, individuals are able to access an NF LOC assessment through a referral to the LCAR vendor, a case management referral, a state agency/FSSA referral, an AAA/ADRC/ICM/MCE referral, or a referral from the state health insurance plan. This expansion is intended to ensure that individuals are receiving the appropriate supports in a timely manner, while allowing case managers to fully focus their attention to enhancing the coordination of paid and unpaid supports and services.

Additional eligibility criteria following eligibility determinations for H&W or TBI include enrollment in Traditional Medicaid – a fee-for service (FFS) program with full Indiana Medicaid State Plan benefits – and financial eligibility determination criteria. An application, if not previously completed, for Medicaid must be completed, and evaluated by the Division of Family Resources (DRF). This must occur before the waiver benefits plan can be assigned in *Core*MMIS. The individual must first have FFS Traditional Medicaid coverage assigned, which will allow the initial service plan and benefit plan to be approved.

> *Note: The fiscal agent cannot add or correct a waiver benefit plan assignment in CoreMMIS nor terminate a managed care enrollment.*

All service providers must verify IHCP eligibility for each member before initiating services. If a member does not have an active HCBS waiver benefit plan and/or is not enrolled in an appropriate IHCP Medicaid program on the date on which waiver services were provided, any claim submitted for those services may not be paid. Waiver liability and transfer-of-property penalty may also impact waiver claim payment. For more information, see the *Verifying IHCP Member Eligibility for HCBS Waiver Services* section.

Level-of-Care Requirements

Level-of-care (LOC) requirements for the H&W and TBI waivers are as follows:

- To be eligible for the H&W Waiver – Persons must meet the criteria for nursing facility level of care (NF LOC).
- To be eligible for the TBI Waiver – Persons must meet criteria for either NF LOC **or** intermediate care facility for individuals with intellectual disabilities level of care level of care (ICF/IID LOC).

NF LOC Requirements

Indiana law allows reimbursement to nursing facilities for eligible individuals who require skilled or intermediate nursing care. Skilled nursing services, as ordered by a physician, must be required and provided on a daily basis, essentially seven days a week. Intermediate nursing care includes care for patients with long-term illnesses or disabilities that are relatively stable, or care for patients nearing recovery and discharge who continue to require some professional medical or nursing supervision and attention.

An individual is functionally eligible for the H&W Waiver or the TBI Waiver if the need for medical or nursing supervision and attention is determined by any of the following findings from the functional screening:

- Need for direct assistance at least five days per week due to unstable, complex medical conditions
- Need for direct assistance for three or more substantial medical conditions including activities of daily living

All applicants to the H&W Waiver (as well as applicants to the TBI Waiver, as applicable) are screened for NF LOC to evaluate and reevaluate whether an individual needs services through the waiver. The criteria necessary to meet NF LOC are specified in *Indiana Administrative Code* *405 IAC 1-3-1* through *405 IAC 1-3-3*.

NF LOC assessments are conducted by the LCAR contractor, using the interRAI suite of tools to evaluate functional eligibility, using a standardized set of criteria. The interRAI suite of tools is used by the LCAR contractor for initial and annual reassessments, allowing collaboration with AAA/Aging and Disability Resource Center (ADRC)/independent case managers (ICMs), hospitals and nursing facilities to ensure proper documentation for determinations. The LCAR contractor will issue determination recommendation and upon final approval will issue a Determination of Outcomes notice to the individual and/or legally authorized representative.

> *Note: If the individual seeking waiver services has been in a nursing facility for at least 90 days, the individual has established a long-term LOC determination designation. In this event, the previous determination will remain valid and serve as an initial evaluation for the individual. The FSSA will review all initial approvals and verify accuracy prior to service implementation.*

Requests to have an LOC assessment performed should be submitted to the Indiana LCAR – Maximus Help Line at 833-597-2777 or (for registered users) by submitting an Assessment Request form on AssessmentPro. The assessment can take place in a person's home, a hospital, an assisted living facility, a nursing home or any other setting where the person lives.

> *Note: AAAs may submit interRAI data elements through AssessmentPro for individuals they already support in nonwaiver programs, when the individuals' needs change and they begin to seek services that require an NF LOC. However, effective July 1, 2025, AAAs will no longer conduct LOC assessments for the general public and will not be making LOC determinations for any individuals. All LOC assessment data must be submitted to the LCAR for review and determination.*

The LCAR contractor must ensure that the LOC outcome letter is sent to the applicant or participant within 10 business days of the determination.

The final functional LOC determination is documented in AssessmentPro.

ICF/IID LOC Requirements

The criteria necessary to meet ICF/IID LOC are specified in *405 IAC 1-3-1*.

If individuals are applying for a TBI waiver and do not meet NF LOC, they are referred to the BDS office for an ICF/ID LOC.

Individuals performing ICF/IID LOC assessments must be a qualified intellectual disability professional (QIDP) as specified by the standard within *Code of Federal Regulations 42 CFR 483.430(a)*.

Medicaid Eligibility and Disability Determinations

To receive HCBS waiver services, an individual must be enrolled in the IHCP.

If an individual has a disability determination from the Social Security Administration (SSA), the state uses the SSA determination for Medicaid eligibility purposes. Individuals considered disabled by the SSA are considered disabled by the IHCP. However, by law, the IHCP determines eligibility for individuals who apply to Indiana Medicaid without having received SSA disability determination. The following conditions apply:

- For those between 18–64, the IHCP requires an approval, active application or appeal to the SSA on file with the FSSA as part of the eligibility process.
- Individuals 18–64 who are found eligible for the IHCP are required to have an approval, active application or appeal to the SSA on file with the FSSA.
- If the SSA's disability determination differs from the IHCP determination, the SSA determination is considered final. As a 1634 state, Indiana is required to defer to all SSA disability determinations. For example, if the Medicaid agency's MRT deemed an individual to be nondisabled but the SSA later determined that same individual to be disabled and eligible for Supplemental Security Income (SSI), the IHCP would automatically enroll the individual. Individuals later found eligible for Social Security Disability Income (SSDI) would need to reapply, but the SSA disability determination would be accepted, and the member would be eligible if they met the other eligibility requirements.

Service Plan Requirements

AAAs/ADRCs/ICMs, through their qualified care managers, are responsible for preparing a written person-centered service plan for each individual participant. The service plan must describe and include the following:

- Reflect that the setting in which the individual resides is chosen by the individual
- Reflect the individual's strengths and preferences
- Reflect clinical and support needs as identified through an assessment of functional need
- Include individually identified goals and desired outcomes
- Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports
- Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed
- Be understandable to the individual receiving services and supports, and the individual needs as they are important in supporting him or her
- Identify the individual and/or entity responsible for monitoring the plan
- Be finalized and agreed upon, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation
- Be distributed to the individual and other people involved in the plan
- Include those services, the purpose or control of which the individual elects to self-direct and prevent the provision of unnecessary or inappropriate services and supports
- Medical and other services to be furnished, regardless of funding source (such as medical transportation under prior authorization [PA], respite care under HCBS waiver, in-home hospice through the Indiana Medicaid State Plan PA process)

- Frequency of each service the member is receiving
- Type of provider (home health provider under Medicaid PA, waiver provider or family member) that will furnish each service

All services must be furnished pursuant to a written person-centered support plan. The support plan is subject to the approval of the DDARS.

FSSA service plan approval results in an approved authorization. The authorization provides the following details for each waiver-funded service that is approved for the member:

- Number of units to be provided
- Name of the authorized waiver provider
- Approved billing code with the appropriate modifiers

Claims deny if no authorization exists in the database or if a code other than the approved code is billed. Providers are not to render or bill services without an approved authorization. It is the provider's responsibility to contact FSSA Provider Services if there is any discrepancy in the services authorized or rendered on the approved authorization.

Member Eligibility for Health and Wellness Waiver

The H&W Waiver is designed to provide an alternative to NF admission for Medicaid-eligible persons ages 59 and younger with a disability by providing supports to complement and supplement informal supports for persons who would require care in an NF if waiver services or other supports were not available. The services available through this waiver are designed to help members remain in their own homes, as well as to help individuals residing in NFs to return to community settings, such as their own homes, apartments, assisted living or adult family care.

> *Note: The Indiana PathWays for Aging (PathWays) Waiver provides services to eligible participants age 60 and over. Indiana has developed a comprehensive transition plan to facilitate continuity of care as 1915(c) waiver enrollees turn age 60 and transition from the H&W waiver to enrollment with a PathWays managed care entity (MCE).*

Individuals must meet the minimal NF LOC requirements and Medicaid eligibility requirements to be eligible for H&W Waiver services.

Waiting List Considerations

Entry to the waiver may be delayed due to the existence of a waiting list. Priority admittance to the waiver may be made based on criteria outlined in the approved waiver.

Until all general waiver capacity slots for a given year have been utilized, eligible individuals will enter the waiver on first-come, first-served basis by date of application. Eligible individuals who meet reserve capacity criteria will be assigned a priority capacity slot when available. When the general waiver capacity slots are full (excluding reserve capacity slots), applicants are added to the single statewide waiting list until a slot becomes available.

Eligible individuals transitioning off 100% state-funded budgets to the waiver, transitioning from nursing facilities to the waiver, or discharging from in-patient hospital settings are given priority waiting list status by date of application.

Other eligible individuals will enter the waiver first-come, first-served basis by date of application.

Services Available Under H&W Waiver

The following services are available under the H&W Waiver:

- Adult Day Services
- Adult Family Care
- Assisted Living
- Attendant Care
- Case Management
- Caregiver Coaching
- Community Transition
- Home and Community Assistance
- Home-Delivered Meals
- Home Modification Assessment
- Home Modifications
- Integrated Health Care Coordination
- Nutritional Supplements
- Participant-Directed Home Care Service
- Personal Emergency Response System
- Pest Control
- Respite Care Services
- Specialized Medical Equipment and Supplies
- Structured Family Caregiving
- Transportation
- Vehicle Modifications

All services should be compliant with the Centers for Medicare & Medicaid Services (CMS) HCBS final rule settings requirements, as outlined in Indiana's Statewide Transition Plan (STP).

Participants must be authorized for individual services under the waiver, as described in the *Service Plan Requirements* section.

Member Eligibility for Traumatic Brain Injury Waiver

The TBI Waiver's goal is to ensure that individuals with a traumatic brain injury receive appropriate services based on their needs and the needs of their families. The TBI Waiver provides home- and community-based services to individuals who, but for the provision of such services, would require institutional care.

Indiana defines TBI as a trauma that has occurred as a closed- or open-head injury caused by an external event that results in damage to brain tissue, with or without injury to other body organs. Examples of external agents are mechanical or events that result in interference with vital functions. TBI means a sudden insult or damage to brain function that is not degenerative or congenital in nature. The insult or damage may produce an altered state of consciousness and may result in a decrease in cognitive, behavioral, emotional or physical functioning resulting in partial or total disability. Indiana's definition of TBI does not include birth trauma-related injury.

Individuals must meet the minimal NF LOC or ICF/IID LOC requirements and Medicaid eligibility requirements and must have a diagnosis of traumatic brain injury to be eligible for TBI Waiver services.

Waiting List Considerations

Entry to the waiver may be delayed due to the existence of a waiting list.

Priority admittance to the waiver may be made based on criteria outlined in the approved waiver.

Services Available Under TBI Waiver

The following services are available under the TBI Waiver:

- Adult Day Services
- Adult Family Care
- Assisted Living
- Attendant Care
- Behavior Management/Behavior Program and Counseling
- Care Management
- Community Transition
- Home and Community Assistance
- Home-Delivered Meals
- Home Modification Assessment
- Home Modifications
- Integrated Health Care Coordination
- Nutritional Supplements
- Personal Emergency Response System
- Pest Control
- Residential-Based Habilitation
- Respite Care Services
- Specialized Medical Equipment and Supplies
- Structured Day Program
- Structured Family Caregiving
- Supported Employment
- Transportation
- Vehicle Modifications

All services should be compliant with the Centers for Medicare & Medicaid Services (CMS) HCBS final rule settings requirements, as outlined in Indiana's Statewide Transition Plan (STP).

Participants must be authorized for individual services under the waiver, as described in the *Service Plan Requirements* section.

Section 11.2: H&W and TBI Waiver Provider Certification, Enrollment and Responsibilities

The process for becoming a provider of HCBS waiver services for the H&W Waiver and/or the TBI Waiver begins with the FSSA OMPP certification process, as described in *Section 2.2: Provider Certification and Renewal Processes for H&W and TBI Waivers*, and is finalized with the IHCP provider enrollment process, and described in *Section 2.3: IHCP Enrollment as a Medicaid Waiver Provider*.

Section 11.3: Quality Assurance/Quality Improvement

Within the FSSA DDARS, the BDS Quality Assurance Services team and authorized vendors are 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 BDS 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 BDS Quality Assurance Services can be found on the *BDS Quality Assurance* webpage at in.gov/fssa/ddars.

> *Note: The H&W and TBI waivers are governed by 455 IAC 2.*
>
> *The FS and CIH waivers are governed by 460 IAC 6. For quality assurance information specific to the FS and CIH waivers, see Section 8: BDS Quality Assurance for HCBS Waiver Program Services.*

Incident Reports

Indiana Administrative Code 455 IAC 2 requires all providers of Home- and Community-Based Services (HCBS) waiver services, including case manager and service coordinators, submit notifications when specific events occur. The nature of these events is defined as an unusual occurrence affecting the health and safety of an HCBS participant.

Events that must be reported include but are not limited to:

- Alleged, suspected, reported or observed abuse/battery, neglect or exploitation of a participant
- The death of a participant
- Significant injuries to the participant requiring emergent medical intervention
- Any threat or attempt of suicide made by the participant
- Any unusual hospitalization due to a significant change in health and/or mental status that may require a change in service provision
- Participant elopement or missing person
- Inadequate formal or informal support for a participant, including inadequate supervision, which endangers the participant
- Medication error occurring in a 24/7 or day setting
- A residence that compromises the health and safety of a participant
- Suspected or observed criminal activity committed by any of the following:
  - Provider's staff when it affects or has the potential to affect the participant's care

  - A family member of a participant receiving services when it affects or has the potential to affect the participant's care or services
  - The participant receiving services
- Police arrest of the member or any person responsible for the care of that participant
- A major disturbance or threat to public safety created by the participant
- Any use of restraints
- Fall with injury

All waiver service providers, including service coordinators and case managers, with knowledge of a reportable event are required to submit an incident report through the web-based Incident and Follow-Up Reporting (IFUR) tool. If IFUR web access is unavailable, incidents can be reported by email at BDSIncidentReports@fssa.in.gov.

Additionally, *455 IAC 2* requires reporting of known or suspected abuse, neglect, or exploitation of an adult to the Adult Protective Services (APS). A 24-hour hotline connected to the statewide APS system is available for this reporting, or reports can be made to the local APS or county prosecutor's office, APS State Hotline: 800-992-6978. Additional information about APS may be obtained at the *Adult Protective Services* webpage at in.gov/fssa.

Providers are required to suspend from duty any staff suspected, alleged, or involved in incidents of abuse, neglect or exploitation of a participant, pending the provider's investigation of the incident. If needed, the service coordinator coordinates replacement services for the participant. If the service coordinator is the alleged perpetrator, the participant will be given a new pick list from which a new service coordinator will be selected.

Providers of HCBS are required to submit an incident report for any reportable unusual occurrence within 48 hours of the time of the incident or becoming aware of the incident. However, if an initial report involves a participant death, or an allegation or suspicion of abuse, neglect or exploitation, it is required to be submitted within 24 hours of "first knowledge" of the incident.

Incidents are received by the Quality Improvement (QI) staff via a secure web-based reporting system that links to the electronic incident database.

Required actions may include:

- Notification to the APS if the incident involves abuse, neglect or exploitation, and notification is not documented in the report
- Submission of a new report when the first report was inadequate or incomplete

Complaints

Any individual, guardian, family member, service provider or community member has the right to file a complaint on the behalf of an individual receiving supports or services through HCBS waivers.

- The BDS quality vendor is responsible for operating the BDS Complaint System for individuals receiving HCBS waiver services administered by the DDARS.
- 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 DDARS 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 BDS 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 BDS again to file a complaint. When requested, complainants can choose to be anonymous.
- The BDS quality vendor reviews and categorizes all initial complaints as *urgent or critical* and assigns a complaint investigator to investigate the case within specified time parameters. Certain circumstances may require the BDS to contact APS, DCS, local law enforcement and/or the provider to take immediate measures to ensure the individual's health and welfare.
- It should be noted that the BDS 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 BDS 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 *Bureau of Disabilities Services (BDS) Complaints: Medicaid and Stateline Funded Services* at in.gov/fssa.

Currently, complaints can be filed using the online complaint form or through the BDS toll-free telephone number at 800-545-7763.

Mortality Reviews

Apparent cause/unexpected death causes may include:

- Accident (for example, motor vehicle)
- Alleged abuse
- Alleged neglect
- Misuse or use of controlled substances
- Refused care or treatment
- Suicide
- Unknown
  - Care transition prior seven days (for example, hospital or nursing facility to home, home to assisted living or nursing facility, and so on)
  - Choking/aspiration
  - Emergency room (ER) visit and/or hospital admission prior seven days
  - Fall with injury
  - Further information needed
  - Homicide
  - Incident reports prior 90 days
  - Medication error or adverse drug effect
  - Sudden death

Apparent cause/expected deaths may include:

- Medical condition or illness
  - Hospice
  - Known chronic illness
  - Known terminal illness
  - Nursing facility more than seven days
- Natural cause
  - Died in sleep
  - Found deceased in home

The Quality Improvement director or delegated staff prepares the final Mortality Review Committee (MRC) recommendations and presents them at the Quality Improvement Committee. The MRC will:

- Evaluate effectiveness of implemented recommendations to reduce death rate, hospitalizations and critical incidents.
- Review trend analysis of deaths and issue systemic interventions as appropriate.
- Provide public reporting on deaths of individuals receiving services, including the trends and patterns identified by mortality reviews.

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 receive HCBS waiver services.

- Complaints may be submitted to the statewide waiver ombudsman by phone, at the toll-free number 800-622-4484 (Option 2) or 317-232-7134 or via email, as follows:
  - LongTermCareOmbudsman@ombudsman.in.gov – For waiver participants who meet the nursing facility level of care (NF LOC)
  - BDSWaiver.Ombudsman@fssa.in.gov – For waiver participants with an intellectual/developmental disability
- Types of complaints received include complaints initiated by families and/or individuals involving rights or issues of individual choice, and complaints requiring coordination between legal services, administrating agency services and provider services.
- The ombudsman is expected to initiate contact with the complainant as soon as possible after the complaint is received. However, precise timelines for the final resolution of each complaint are not established. Although it is expected that the ombudsman will diligently and persistently pursue the resolution of each complaint determined to require investigation, it is recognized that circumstances surrounding each investigation vary.
- Time frames for complaint resolution vary in accordance with the required research, in the collection of evidence, and in the numbers and availability of persons who must be contacted, interviewed or brought together to resolve the complaint. Although the statewide waiver ombudsman is considered “independent” by statute, the DDARS director is responsible for oversight of the ombudsman.
- With the consent of the waiver individual, the ombudsman must be provided access to the individual records, including records held by the entity providing services to the individual. When it has been determined the individual is not capable of giving consent, the statewide waiver ombudsman must be provided access to the name, address and telephone number of the individual’s legal representative.
- A provider of waiver services or any employee of a provider of waiver services is immune from civil or criminal liability and from actions taken under a professional disciplinary procedure for the release or disclosure of records to the statewide waiver ombudsman.

- A state or local government agency or entity that has records relevant to a complaint or an investigation conducted by the ombudsman must also provide the ombudsman with access to the records. The statewide waiver ombudsman coordinates their activities among the programs that provide legal services for individuals who are elderly and/or who have a physical or intellectual/developmental disability, the administrative agency, providers of waiver services and providers of other necessary or appropriate services and ensures that the identity of the individual will not be disclosed without either the individual's written consent or a court order.
- At the conclusion of an investigation of a complaint, the ombudsman reports the ombudsman's findings to the complainant. If the ombudsman does not investigate a complaint, the ombudsman notifies the complainant of the decision not to investigate and the reasons for the decision.
- The statewide waiver ombudsman prepares a report at least annually (or upon request), describing the operations of the program. A copy of the report is provided to the governor, the legislative council and the director of the DDARS. Trends are identified so that recommendations for needed changes in the service delivery system can be implemented.
- The administrative agency is required to maintain a statewide toll-free telephone line continuously open to receive complaints regarding waiver individuals with intellectual/developmental disabilities. All complaints received from the toll-free line must be forwarded to the statewide waiver ombudsman, who will advise the individual that the complaint process is not a prerequisite or a substitute for a Medicaid fair hearing when the problem falls under the scope of the Medicaid fair hearing process.
- A person who does any of the following commits a Class B misdemeanor:
  - Intentionally prevents the work of the ombudsman
  - Knowingly offers compensation to the ombudsman in an effort to affect the outcome of an investigation or a potential investigation
  - Knowingly or intentionally retaliates against an individual, a client, an employee, or another person who files a complaint or provides information to the ombudsman

Provider Compliance Reviews

FSSA DDARS or its designee or contractor conducts provider compliance reviews for all nonlicensed waiver service providers, as well as licensed providers that also offer services that fall outside the scope of the license. The provider compliance review includes a review of provider policies and adherence to state and federal requirements, as well as the provider's own policies. Site visits are conducted as part of the compliance review for all congregate settings, such as adult day centers, adult family care homes and assisted living facilities.

FSSA DDARS or its designees administer compliance reviews that include an extensive review of provider care coordinator and service coordinator documentation, service delivery records, policies and procedures, and compliance with other waiver and state requirements.

For licensed providers, this review is conducted by the Indiana Department of Health (IDOH). Nonlicensed providers are reviewed by the FSSA DDARS. Both the IDOH and FSSA DDARS have formal review and corrective action procedures submitted by the provider with approval or denial by the FSSA. If denied, the provider is required to resubmit the CAP within a two-week time frame. After it is approved, the FSSA DDARS verifies successful implementation of the CAP. Any provider not successfully completing the corrective action process is decertified as a provider.

A provider's failure to cooperate with the review procedure or to complete the corrective action process results in a referral to the BDS Quality Assurance director or designee as a formal complaint, which may result in sanctions up to and including termination as a waiver provider.

Any provider decertified as a result of noncompliance with the provider agreement or failing to complete corrective actions is notified of the decision, and of the provider's right to appeal. Documentation of all

corrective actions taken with providers is maintained in the OMPP HCBS Certification Portal. Prior to taking action to suspend or terminate a provider, alternative service options will be provided to any affected participants through their case manager.

Section 11.4: Program Integrity and Financial Oversight

The FSSA has expanded its program integrity activities using a multifaceted approach that includes provider self-audits, desk audits and on-site audits. The Program Integrity Unit analyzes claim data, allowing them to identify providers and claims that indicate aberrant billing patterns and other risk factors. Based on this information, audits are completed as needed.

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 Program Integrity Unit also meets with all waiver divisions 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 Program Integrity 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 is available in the *Provider and Member Utilization Review* provider reference module at in.gov/medicaid/providers.

FSSA Audit Oversight

Throughout the entire program integrity process, the FSSA maintains oversight. Although the Fraud and Abuse Detection System (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 Audit Division of the FSSA reviews waiver audit team schedules and findings to reduce redundancy and assure use of consistent methodology.

Medicaid Fraud Control Audit Overview

The Indiana Medicaid Fraud Control Unit (MFCU) is an investigative branch of the Attorney General's Office. 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 on the *Medicaid Fraud & Patient Abuse* webpage at in.gov/attorneygeneral.

Section 11.5: Case Management for H&W and TBI Waivers

For individuals participating in TBI and H&W waivers, case management services are provided by certified case managers, as approved by the FSSA DDARS. After theapplicant has been determined to meet the NF

LOC eligibility criteria (as described in the *Level-of-Care Requirements* section), their local Area Agency on Aging (AAA) will provide necessary documentation for the H&W or TBI waiver.

> *Note: Please see Section 9.6: Case Management for FS and CIH Waivers for information on the similarly named but unique service of case management available under the Family Supports (FS) and Community Integration and Habilitation (CIH) waivers.*

The following are minimum qualifications for case managers (must meet one of these):

- Be an RN or LPN
- Have at least one year of experience serving the program population
- Have bachelor's degree or associate degree with one year of experience
- Delivering healthcare/social services or case management

Case management may not be conducted by any organization, entity or individual that also delivers other in-home and community-based services under the FSSA waiver programs, or any organization, entity, or individual with common ownership or control in any other organization, entity or individual that also delivers other in-home and community-based services under the Medicaid waiver program. The exception is an AAA that has been granted permission by the FSSA to provide direct services to members. The FSSA uses the following definitions in determining common ownership, control or relation:

- *Common Ownership* exists when an individual, individuals or any legal entity possesses ownership or equity of at least 5% in the provider entity, as well as the institution or organization serving the provider.
- *Control* exists where an individual or organization has the power or the ability, directly or indirectly, to influence or direct the actions or policies of an organization or institution, whether or not the control is actually exercised.
- *Related* means associated or affiliated with, or having the ability to control, or be controlled by.

Reimbursement of case management services, as defined in this provider reference module, may not be made unless and until the client becomes eligible for waiver service. Care management service provided to individuals who are not eligible for FSSA waiver services will not be reimbursed as a waiver service.

Case Management Monitoring Standards

Each case manager must meet the following standards to fulfill the FSSA guiding principles:

- Responsive, efficient, effective, quality, and timely service delivery
- Effective communication
- Respect, dignity, integrity and rights for all individuals
- Person-centered planning, informed choice and personal empowerment
- Community-based services
- Fiscal stewardship
- Quality customer services

Case managers are to comply with all applicable FSSA standards. The following section is excerpted from the *Care Management Medicaid Waiver Provider Agreement*.

Ongoing Medicaid HCBS Waiver Care Management Standards

HCBS waiver case managers need to maintain the following standards:

- Maintain the highest professional and ethical standards in the conduct of their business.
- Comply with all FSSA-issued documents, as well as all federal, state and local law as well as all FSSA policy, rules, regulations and guidelines, including the *Health Insurance Portability and Accountability Act* (HIPAA).
- Complete the case management orientation as approved by the FSSA prior to being eligible for Medicaid reimbursement. This orientation is now provided online and can be accessed from the *Case Manager Resources* webpage at in.gov/fssa/da. Completion of the modules is verified through completion of the final certification test. Following completion of the test, case managers are issued a certificate of completion.
- Complete required annual training as follows:
  - The following components of the online orientation must be reviewed annually by all active case managers:
    - LOC modules – general, narrative, skilled needs, and activities of daily living
    - Incident reporting module
    - Service definition module
  - An additional 18 hours of training must be completed annually by all active case managers.
    - These trainings do not have to be preapproved by the FSSA but must be relevant to core care management functions.
    - Training documentation is subject to review in compliance surveys and at the FSSA's request.
    - Relevant topics can include the following:
      - Care coordination
      - Documentation
      - Medical terminology
      - Other public or privately funded long-term services and support programs or benefits
      - Specific diagnosis or treatment topics affecting a broad spectrum of the client base, including but not limited to:
        - Fall prevention
        - Adaptive equipment
        - Chronic obstructive pulmonary disease (COPD)
        - Congestive heart failure
        - Diabetes
        - Traumatic brain injury
        - Kidney disease
        - Alzheimer's disease
        - Seizures
        - Stroke
        - Heart disease
        - Mental health issues
        - Behavioral issues
  - The following will ***not*** be accepted as part of the required training:
    - Care management orientation
    - Required annual retraining
    - Vendor fairs
    - Staff meetings (unless there is an outside speaker or expert speaking on a relevant topic, or someone who attended a state training as a trainer is sharing that information)

  - Presentations related to employment issues; for example, performance appraisal process and retirement
  - Communications that are part of supervisory oversight; for example, reinforcement of or retraining on job requirements, review of state guidelines, informational or training, sessions specific to a case, and so on
- Required training hours are prorated in a case manager's first year and are in addition to new case manager orientation.
- Individuals will choose their service provider, from a list furnished by the state, including their case manager, and have the right to change any provider, including their case manager.
- A maximum response time between implementation of the initial service plan and the first monitoring contact will be no more than 30 calendar days.
- Case managers will have face-to-face contact with each individual a minimum of every 90 days to assess the quality and effectiveness of the service plan. At least two of these face-to-face contacts per year will be in the home setting.
- Case managers will document, in the chronological narrative, each contact with the individual and each contact with providers within seven days of activity.
- Case managers will assist with facilitating and monitoring the formal and informal supports that are developed to support the individual's health and welfare in the community.
- Case managers will provide each individual or guardian with clear and easy instructions for contacting the case manager or case manager agency. The case manager will also provide additional information and procedures for individuals who may need assistance or have an emergency that occurs before or after business hours. This information will be located in the home in a location that is visible from the telephone.
- Case managers will complete face-to-face annual assessments and update the service plan as needed, in collaboration with the individual, in a timely and appropriate manner to avoid gaps in service authorization.
- Case managers will support the individual communicating their needs, strengths and preferences to the support team.
- Case managers will ensure that person-centered planning is occurring on an ongoing basis.
- Case managers will monitor the ongoing services to ensure that they meet the individual's needs and preferences.
- Case managers will base the service plan upon the individual's needs, strengths and preferences.
- Case managers will ensure that the individual and all providers have a current, comprehensive service plan a copy of relevant documentation, including instructions on how to request an appeal.
- Case managers will review and explain to the individual or guardian the services that will be provided, and the individual or their designated representative will sign the service plan to show understanding of, and agreement with, the plan. The service plan will not be implemented prior to receiving state approval.
- Case managers will initiate timely follow-up of identified problems, whether self-identified or referred by others. Critical or crisis issues, including incident reports, will be acted upon immediately, as specified by the FSSA. All follow-up and resolution will be documented in the activities under the case record in the BDS Portal.
- Case managers will comply with all automation standards and requirements as prescribed by the FSSA for documentation and processing of care management activities.
- Case managers will maintain privacy and confidentiality of all individual records. No information will be released or shared with others without the individual or guardian's written consent.
- Case managers will provide to the state upon request, ready access to all case manager documentation, either electronic or hard copy.
- Case manager documentation will demonstrate that the safety and welfare of the individual are being monitored on a regular basis.

Section 11.6: H&W and TBI Waiver Services, Codes and Rates

> *Note: For general information about billing and reimbursement for DDARS HCBS waiver services – including eligibility verification, claim completion and submission, and electronic visit verification requirements – see Section 2.5: Billing and Reimbursement for Waiver Services. Billing guidance specific to assisted living facilities appears in the Special Billing Instructions for Assisted Living Facilities section.*

Table 8 lists services available under the Health and Wellness (H&W) Waiver and/or the Traumatic Brain Injury (TBI) Waiver, and identifies the associated procedure codes and modifiers, as well as the rates or payment methodology, as applicable.

For procedure codes, modifiers and rates related to the Family Supports (FS) and Community Integration and Habilitation (CIH) waivers, see *Section 9.2: FS and CIH Waiver Services, Codes and Rates* of this provider reference module.

Table 8 – Medicaid HCBS Waiver Services, Codes and Rates for H&W and TBI Waivers

Service Description	HCPCS Code	Modifiers	H&W Rate	TBI Rate	Notes
Adult Day Services – Level 1 (Category 1)	S5100	U7 U1 UC	$3.32	$3.32	0.25 Hour
Adult Day Services – Level 2 (Category 1)	S5100	U7 U2 UC	$3.74	$3.74	0.25 Hour
Adult Day Services – Level 3 (Category 1)	S5100	U7 U3 UC	$4.76	$4.76	0.25 Hour
Adult Day Services – Level 1 (Category 2)	S5100	U7 U1	$2.93	$2.93	0.25 Hour
Adult Day Services – Level 2 (Category 2)	S5100	U7 U2	$3.30	$3.30	0.25 Hour
Adult Day Services – Level 3 (Category 2)	S5100	U7 U3	$4.20	$4.20	0.25 Hour
Adult Family Care (Level 1)	S5141	U7 U1	$67.93	$67.93	Per Day
Adult Family Care (Level 2)	S5141	U7 U2	$72.34	$72.34	Per Day
Adult Family Care (Level 3)	S5141	U7 U3	$90.64	$90.64	Per Day
Assisted Living – Level 1 Monthly	T2031	U7 U1 UA	$3,028.81	$3,028.81	Monthly
Assisted Living – Level 2 Monthly	T2031	U7 U2 UA	$3,330.26	$3,330.26	Monthly
Assisted Living – Level 3 Monthly	T2031	U7 U3 UA	$3,922.18	$3,922.18	Monthly
Assisted Living – Level 1 Daily	T2031	U7 U1	$101.98	$101.98	1 Day

Service Description	HCPCS Code	Modifiers	H&W Rate	TBI Rate	Notes
Assisted Living – Level 2 Daily	T2031	U7 U2	$112.13	$112.13	1 Day
Assisted Living – Level 3 Daily	T2031	U7 U3	$132.06	$132.06	1 Day
Attendant Care (Agency)	S5125	U7 UA	$8.59	$8.59	0.25 Hour
Attendant Care (Non-Agency)	S5125	U7	$8.21	$8.21	0.25 Hour
Attendant Care (Nonemergency Medical Transportation/Companion)	S5125	U7 UA UC	$8.59	$8.59	0.25 Hour
Attendant Care (Consumer-Directed)	S5125	U7 U1	$8.21	N/A	0.25 Hour
Attendant Care (Consumer-Directed Overtime)	S5125	U7 U1 TU	$1.81	N/A	0.25 Hour
Behavioral Management/Behavior Program and Counseling – Level 1	H0004	U7 U1	N/A	$18.56	0.25 Hour
Behavioral Management/Behavior Program and Counseling – Level 2	H0004	U7 U2	N/A	$18.56	0.25 Hour
Care Management	T2022	U7	$189.56	$189.56	Monthly
Caregiver Coaching	H0004	U7 U4	$15.75	N/A	0.25 Hour Max 32 quarter hours (8 hours)/ month; cap $320/month per member
Community Transition	T2038	U7	$2,500.00	$2,500.00	Lifetime Cap
Home and Community Assistance (Agency)	S5130	U7 UA	$7.93	$7.93	0.25 Hour
Home and Community Assistance (Non-Agency)	S5130	U7	$7.68	$7.68	0.25 Hour
Home-Delivered Meals	S5170	U7	$7.76	$7.76	Per Meal
Home Modification Assessment	T1028	U7	$628.00	$628.00	Per Project
Home Modifications – Install	S5165	U7 NU	Individual	Individual	$20,000 Lifetime Cap
Home Modifications – Maintenance	S5165	U7 U8	Individual	Individual	$1,000 Per Year
Integrated Health Care Coordination	T2022	U7 U1	$14.21	$14.21	0.25 Hour (16 Hours/Month)
Nonmedical Transportation Nonassisted (Base Trip)	T2003	U7 U1 UB	$12.12	$12.12	Base Trip

Service Description	HCPCS Code	Modifiers	H&W Rate	TBI Rate	Notes
Nonmedical Transportation Nonassisted (Mileage)	T2003	U7 U1	$1.06	$1.06	Mileage
Nonmedical Transportation Assisted (Base Trip)	T2003	U7 U2 UB	$20.19	$20.19	Base Trip
Nonmedical Transportation Assisted (Mileage)	T2003	U7 U2	$1.54	$1.54	Mileage
Nutritional Supplements	B4150	U7	Individual	Individual	$1,200 Per Year
Participant-Directed Home Care – Skilled	S5125	U7 U2 UA	$14.97	N/A	0.25 Hour
Participant-Directed Home Care – Unskilled	S5125	U7 U2 U9	$8.59	N/A	0.25 Hour
Personal Emergency Response System – Install	S5160	U7	$54.41	$54.41	One Time
Personal Emergency Response System – Maintenance	S5161	U7	$54.41	$54.41	Monthly
Pest Control	T2025	U7 U1	Individual	Individual	$4,000 Per Year
Residential-Based Habilitation	97535	U7	N/A	$9.45	0.25 Hour
Respite Care Services, Home Health Aide (HHA)	S5150	U7 UA U9	$9.23	$9.23	0.25 Hour
Respite Care Services, Licensed Practical Nurse (LPN)	T1005	U7 UA TE	$13.69	$13.69	0.25 Hour
Respite Care Services, Registered Nurse (RN)	T1005	U7 UA TD	$17.10	$17.10	0.25 Hour
Specialized Medical Equipment and Supplies – New DME	T2029	U7 NU	Individual	Individual	$15,000 Cap; no limit; subject to review
Specialized Medical Equipment and Supplies – Replacement or Repair	T2029	U7 U8	Individual	Individual	$1,000 Per Year
Structured Day Program – Group Setting	T2021	U7 HQ	N/A	$2.35	0.25 Hour
Structured Day Program – Individual	T2021	U7	N/A	$10.05	0.25 Hour
Structured Family Caregiving (Level 1)	S5140	U7 U1	$77.54	$77.54	Per Day
Structured Family Caregiving (Level 2)	S5140	U7 U2	$99.71	$99.71	Per Day
Structured Family Caregiving (Level 3)	S5140	U7 U3	$133.44	$133.44	Per Day
Supported Employment	H2023	U7	N/A	$11.91	0.25 Hour
Vehicle Modifications	T2039	U7	Individual	Individual	$15,000.00 every 10 Years

Service Description	HCPCS Code	Modifiers	H&W Rate	TBI Rate	Notes
Vehicle Modifications – Maintenance	T2039	U7 U8	Individual	Individual	$1,000 Per Year

The sections that follow lists service definitions and related information for the services currently approved for the H&W Waiver and TBI Waiver. Each service listed includes the following information as appropriate:

- Service definition
- Allowable activities
- Service standards
- Documentation standards
- Limitations if applicable
- Activities not allowed
- Provider qualifications
  - A provider qualifications table identifies the waiver, the license or certification requirements, and any additional standards that apply.

Section 11.7: Adult Day Services for H&W and TBI Waivers

The following subsections provide information and requirements for Adult Day Services for the H&W and TBI waivers.

Service Definition

Adult Day Services are community-based group programs designed to meet the needs of individuals who need structured, social integration through comprehensive and nonresidential programs. The service plan will identify the need through the person-centered assessment (PCA) process and evident through the assessment tool. The purpose for Adult Day Services is to provide health, social, recreational, supervision, support services and personal care. Meals, specifically, and as appropriate, breakfast, lunch, and nutritious snacks are required. Participants attend Adult Day Services on a planned basis. The three levels of Adult Day Services are Basic, Enhanced and Intensive.

Allowable Activities

Basic Adult Day Services (Level 1) services include the following activities:

- Monitoring 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 for those with cognitive impairment in a safe environment
- Initial health assessment conducted by a registered nurse (RN) consultant prior to beginning services at the adult day, and intermittent monitoring of health status
- Monitoring of medication or medication administration

- Minimum staff ratio: One staff for each eight individuals
- RN consultant available

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

- Hands-on assistance with two or more ADLs or hands-on assistance with bathing or other personal care
- Initial health assessment conducted by RN consultant prior to beginning services as well as regular monitoring or intervention with health status
- Medication assistance
- Psychosocial needs assessed and addressed, including counseling as needed for individuals and caregivers
- Therapeutic structure and intervention for participants with mild to moderate cognitive impairments in a safe environment
- Minimum staff ratio: One staff for each six individuals
- RN Consultant available
- Minimum of one full-time licensed practical nurse (LPN) staff person with monthly RN supervision

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

- Hands-on assistance or monitoring with all ADLs and personal care
- One or more direct health interventions required
- Rehabilitation and restorative services, including physical therapy, speech/language 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
- RN consultant available
- Minimum of one full-time LPN staff person with monthly RN supervision
- Minimum of one qualified full-time staff person to address participants' psychosocial needs

Recommended Facility Standards

To promote best practices in facility standards for adult day physical spaces, the FSSA OMPP will provide additional reimbursement for providers that meet the following requirements (Adult Day Services Category 1):

- Each adult day health care program, when it is co-located with another facility, must have its own separate designated space during operational hours.
- The indoor space for an adult day center must be at least 100 square feet per participant including office space for staff and must be 60 square feet per participant excluding office space for staff.

- Each program will need to design and partition its space to meet its own needs, but the following functional areas must be available:
  - A dividable multipurpose room or area for group activities, including dining, with adequate table setting space
  - A kitchen area for refrigerated food storage, the preparation of meals and/or training participants in activities of daily living
  - An examination and/or medication room
  - A quiet room (with at least one bed), which functions to isolate participants who become ill or disruptive, or who require rest, privacy, or observation
    - This room should be separate from activity areas, near a restroom and supervised.
  - Bathing facilities adequate to facilitate bathing of participants with functional impairments
  - Toilet facilities and bathrooms easily accessible to people with mobility problems, including participants in wheelchairs
    - There must be at least one toilet for every 10 participants.
    - The toilets must be equipped for use by persons with limited mobility, easily accessible from all program areas, preferably within 40 feet from the program area, designed to allow assistance from one or two staff, and barrier free.
  - Adequate storage space
    - There should be space to store arts and crafts materials, personal clothing and belongings, wheelchairs, chairs, individual handiwork, and general supplies.
    - Locked cabinets must be provided for files, records, supplies and medications.
  - An individual room for counseling and interviewing participants and family members
  - A reception area
  - An outside space that is used for outdoor activities and is safe, accessible to indoor areas and accessible to those with a disability
    - This space may include recreational space and a garden area.
    - It should be easily supervised by staff.
- Furnishings must be available for all participants. This requirement includes functional furniture appropriate to the participants' needs.

Service Standards

Adult Day Services must follow a written service plan addressing specific needs determined by the client's assessment. The Adult Day Services provider is responsible for sharing the client's service plan with the client's case manager to ensure continuity of care.

Documentation Standards

Case managers must maintain the following documentation:

- Justification for the service is documented.
  - The documented need for the service is to include, but not be limited, to the following:
    - Describe the structure needed for the participant (medical, social, recreational)
    - Types of ADL care the participant may require and level of assistance needed
- Level of service as determined in the PCA, which is given to provider.

> *Note: If applicable, copies of personal record must be:*
>
> - *Placed in a prominent place in the participant's file*
> - *Sent with the participant when transferred for medical care or upon moving from the residence and in accordance with state law*

Limitations

Adult Day Services are allowed for a maximum of 10 hours per day.

Activities Not Allowed

The following activities are not allowed for Adult Day Services:

- Services provided to participants receiving the Assisted Living waiver service
- Therapies that duplicate therapies provided under any other service
- Services provided by the parent of a minor child participant or the spouse of a participant (also known as legally responsible individuals or LRIs)

Provider Qualifications

Provider qualifications for Adult Day Services are presented in Table 9.

Table 9 – Provider Qualifications for Adult Day Services

Waiver	Provider	Licensure/ Certification	Other Standards
H&W/TBI	Adult Day Services provider	All adult-day providers, both new and existing providers, are given the option of receiving accreditation from the Indiana Association of Adult Day Services as part of the adult-day provider credentialing through the FSSA.	Must comply with the Adult Day Services Provision and Certification Standards FSSA approved *455 IAC 2* Provider qualifications: Becoming an approved provider; maintaining approval *455 IAC 2* Provider qualifications: General requirements *455 IAC 2* Provider qualifications: General requirements for direct care staff *455 IAC 2* Procedures for protecting individuals *455 IAC 2* Unusual occurrence; reporting *455 IAC 2* Transfer of individual's record upon change of provider *455 IAC 2* Notice of termination of services *455 IAC 2* Provider organizational chart *455 IAC 2* Collaboration and quality control *455 IAC 2* Data collection and reporting standards *455 IAC 2* Quality assurance and quality improvement system *455 IAC 2* Financial information *455 IAC 2* Liability insurance *455 IAC 2* Maintenance of personnel records *455 IAC 2* Adoption of personnel policies *455 IAC 2* Operations manual *455 IAC 2* Maintenance of records of services provided *455 IAC 2* Individual's personal file; site of service delivery

Section 11.8: Adult Family Care for H&W and TBI Waivers

The following subsections provide information and requirements for Adult Family Care services for the H&W and TBI waivers.

Service Definition

Adult Family Care is a comprehensive service in which a participant resides with an unrelated caregiver. The participant (and up to three other participants who have physical and/or cognitive disabilities and are not members of the provider's or primary caregiver's family) reside in a home that is owned, rented or managed by the Adult Family Care provider.

There are three service levels of Adult Family Care each with a unique rate. The applicable rate is determined through completion of the Adult Family Care/Structured Family Caregiving Level of Service Assessment (AFC/SFC LOS Assessment). Case managers complete this assessment at least annually to accurately reflect the relative support need of the individual. The AFC/SFC LOS Score determines the reimbursement rate to be utilized in the participant's next service plan.

The breakdown is as follows:

- Level 1 – AFC/SFC LOS Assessment Score of 0–35
- Level 2 – AFC/SFC LOS Assessment Score of 36–60
- Level 3 – AFC/SFC LOS Assessment Score of 61+

Adult Family Care is designed to provide options for alternatives to long-term care for individuals who meet nursing facility level of care and whose needs can be met in a home-like environment.

The goal of the service is to provide necessary care while emphasizing the participant's independence. This goal is reached through a cooperative relationship between the participant (or the participant's legal guardian), the participant's HCBS Medicaid waiver case manager, and the Adult Family Care provider. The participant's needs must be addressed in a manner that supports and enables the individual to maximize abilities to function at the highest possible level of independence.

Another goal of this service is to preserve the dignity, self-respect, and privacy of the participant by ensuring high-quality care in a noninstitutional setting. Care is to be furnished in a way that fosters the independence of each participant to facilitate aging in place in a home environment that will provide the participant with a range of care options as their needs change.

Participants selecting Adult Family Care service may also receive the following services through the waiver:

- Care Management
- Adult Day Services
- Specialized Medical Equipment and Supplies
- Integrated Healthcare Coordination

> *Note: Participants living in Adult Family Care settings are entitled to retain at least their personal needs allowances (PNAs) as established by the state of Indiana. The PNA is currently $52.00 per month per Indiana Code IC 12-15-7-2.*
>
> *A provider, after ensuring that the participants retain their PNAs, may bill participants up to the current maximum federal Supplemental Security Income (SSI). Providers may not charge Medicaid waiver participants a room-and-board rate that exceeds the maximum SSI rate.*

Allowable Activities

The following are included in the daily per diem for Adult Family Care:

- Attendant care related to ADLs
- Home and community assistance care related to instrumental activities of daily living (IADLs)
- Medication oversight (to the extent permitted under state law)

Service Standards

These service standards must be followed for Adult Family Care:

- Adult Family Care services must follow a written service plan addressing specific needs determined by the participant's PCA.
- Services must address the participant's level of service needs.

- Provider must live in the Adult Family Care home, unless another provider-contracted primary caregiver, who meets all provider qualifications, lives in the Adult Family Care home.
- Backup services must be provided by a qualified participant familiar with the participant's needs for those times when the primary caregiver is absent from the home or otherwise cannot provide the necessary level of care (LOC).
- Adult Family Care provides an environment that has the qualities of a home, including the following:
  - Privacy
  - Safe place that is free of environmental hazards such as pests
  - Habitable environment
  - Comfortable surroundings
  - Opportunity to modify one's living area to suit one's participant preferences
- Rules managing or organizing the home activities in the Adult Family Care home must be provided to the participant prior to the start of Adult Family Care services and may not be so restrictive as to interfere with a participant's rights under state and federal law; these rules are developed by the provider, the provider-contracted primary caregiver, or both and approved by the Medicaid waiver program.
- Participant-focused activity plans are developed by the provider with the participant or the participant's representative.
- Providers or provider's employees who provide medication oversight, as addressed in the *Allowable Activities* subsection, must receive necessary instruction from a doctor, nurse, or pharmacist on the administration of controlled substances prescribed to the participant.

Documentation Standards

Level of service is determined by person-centered planning process and documented in the person-centered service plan. The case manager must follow these documentation standards:

- Document the medical need for Adult Family Care and types of ADL and IADL care the participant may require.
- Document the expected Adult Family Care activity to meet the individual's needs, which is accurately shown in the intermediate LOC assessment.
- If the participant requires skilled care, the case manager must justify how the skilled-care need will be met and by whom with the required documentation, describing:
  - Reason to use attendant care services
  - Who will be providing this service
  - Activities that are expected to be performed and frequency
- Give the completed person-centered service plan to the provider.

The provider must follow these documentation standards:

- Daily documentation to support services rendered by the Adult Family Care to address needs identified in the PCA:
  - Participant's status, including health, mental health, medication, diet, sleep patterns, social activity
  - Updates, including health, mental health, medication, diet, sleep patterns, social activity
  - Participation in consumer-focused activities
  - Medication management records, if applicable

- Monthly updated service plans provided to the participant's case manager from the Adult Family Care caregiver
  - Notification to the participant's case manager within 48 hours of any changes in the participant's care plan
- Maintenance of participant's personal records to include:
  - Social Security number
  - Medical insurance number
  - Birth date
  - Emergency contacts
  - All medical information available including all known current prescription and nonprescription drug medication
  - Most recent prior residence
  - Hospital preference
  - Primary care physician
  - Mortuary (if known)
  - Religious affiliation and place of worship, if applicable
- Participant's personal records must contain copies of all the applicable documents, which the Adult Family Care caregiver will also provide to the participant's case manager on an ongoing basis if there are changes to these documents:
  - Advance directive
  - Living will
  - Power of attorney
  - Health care representative
  - Do not resuscitate (DNR) order
  - Letters of guardianship

Note: If applicable, copies of personal record must be:

- *Placed in a prominent place in the participant's file*
- *Sent with the participant when transferred for medical care or upon moving from the residence and in accordance with state law*

Activities Not Allowed

The following activities are not allowed or reimbursed under Adult Family Care:

- Services provided in the home of a caregiver who is related by blood or related legally to the participant
- Services provided when the owner of the service organization is one of the following:
  - Parent of a minor child participant
  - Spouse of a participant
  - Attorney-in-fact (POA) of a participant
  - Health care representative (HCR) of a participant
  - Legal guardian of a participant
- Payments for room and board or the costs of facility maintenance, upkeep or improvement
- Personal care services provided to medically unstable or medically complex participants as a substitute for care provided by a registered nurse, licensed practical nurse, licensed physician or other health professional

- Separate payment will not be made for the following services furnished to a participant selecting Adult Family Care services, as these activities are integral to and inherent in the provision of Adult Family Care:
  - Home and Community Assistance
  - Respite Care Services
  - Home Modifications
  - Attendant Care
  - Home-Delivered Meals
  - Pest Control
  - Community Transition
  - Structured Family Caregiving

Provider Qualifications

Provider qualifications for Adult Family Care services are presented in Table 10.

Table 10 – Provider Qualifications for Adult Family Care

Waiver	Provider	Licensure/ Certification	Other Standards
H&W/TBI	Adult Family Care individual	Not required	Provider and home must meet the requirements of the *Indiana Adult Family Care Service Provision and Certification Standards*. FSSA approved *455 IAC 2* Becoming an approved provider; maintaining approval *455 IAC 2* Provider qualifications: General requirements *455 IAC 2* General requirements for direct care staff *455 IAC 2* Procedures for protecting individuals *455 IAC 2* Unusual occurrence; reporting *455 IAC 2* Transfer of individual's record upon change of provider *455 IAC 2* Notice of termination of services *455 IAC 2* Provider organizational chart *455 IAC 2* Collaboration and quality control *455 IAC 2* Data collection and reporting standards *455 IAC 2* Quality assurance and quality improvement system *455 IAC 2* Financial information *455 IAC 2* Liability insurance *455 IAC 2* Transportation of an individual *455 IAC 2* Documentation of qualifications *455 IAC 2* Maintenance of personnel records *455 IAC 2* Adoption of personnel policies *455 IAC 2* Operations manual *455 IAC 2* Maintenance of records of services provided *455 IAC 2* Individual's personal file; site of service delivery

Waiver	Provider	Licensure/ Certification	Other Standards
H&W/TBI	Adult Family Care agency	Not required	Provider and home must meet the requirements of the *Indiana Adult Family Care Service Provision and Certification Standards*. FSSA approved *455 IAC 2* Becoming an approved provider; maintaining approval *455 IAC 2* General requirements *455 IAC 2* General requirements for direct care staff *455 IAC 2* Procedures for protecting individuals *455 IAC 2* Unusual occurrence; reporting *455 IAC 2* Transfer of individual's record upon change of provider *455 IAC 2* Notice of termination of services *455 IAC 2* Provider organizational chart *455 IAC 2* Collaboration and quality control *455 IAC 2* Data collection and reporting standards *455 IAC 2* Quality assurance and quality improvement system *455 IAC 2* Financial information *455 IAC 2* Liability insurance *455 IAC 2* Transportation of an individual *455 IAC 2* Documentation of qualifications *455 IAC 2* Maintenance of personnel records *455 IAC 2* Adoption of personnel policies *455 IAC 2* Operations manual *455 IAC 2* Maintenance of records of services provided *455 IAC 2* Individual's personal file; site of service delivery

Section 11.9: Assisted Living for H&W and TBI Waivers

The following subsections provide information and requirements for Assisted Living service for H&W and TBI waivers.

Service Definition

The Assisted Living service is defined as the following services provided in a congregate residential setting in conjunction with the provision of participant-paid room and board:

- Personal care and services
- Home and community assistance
- Chore, attendant care and companion services
- Medication oversight (to the extent permitted under state law)
- Therapeutic social and recreational programming

This service includes 24-hour, on-site response staff to meet scheduled and unpredictable needs. The participant retains the right to assume risk.

Participants selecting the Assisted Living service may also receive the following services through the waiver:

- Care Management
- Specialized Medical Equipment and Supplies

> *Note: Under 455 IAC 3-1-12, participants living in assisted living facilities are entitled to retain at least their PNAs, as established by the state of Indiana. The PNA is currently $52.00 per month per IC 12-15-7-2.*
>
> *A provider, after ensuring that the participants retain their PNAs, may bill participants up to the current maximum federal SSI. Providers may not charge Medicaid eligible individuals a room-and-board rate that exceeds the maximum SSI amount for a studio apartment. A participant who wishes to select a larger room, may pay extra for any unit exceeding the size of a studio based on the monthly amount determined by the facility.*

Allowable Activities

The following activities are included in the daily per diem for the Assisted Living service:

- Attendant care related to ADLs
- Home and Community Assistance care related to IADLs
- Medication oversight (to the extent permitted under state law)
- Nonemergency nonmedical transportation
- Therapeutic social and recreational programming

Service Standards

The Assisted Living service must follow a written service plan addressing specific needs determined by the participant's PCA.

If the participant requires skilled care, the case manager must justify how the skilled need will be met and by whom. The documentation must describe the reason to use Assisted Living services, who will be providing this service, the activities that are expected to be performed and the frequency.

Documentation Standards

The case manager must follow these documentation standards for the Assisted Living service:

- Document the need for, types of, and frequency of ADL and/or IADL care the participant may require, which is identified in the person-centered individualized support plan (PCISP).
- If the participant requires skilled care, the case manager must justify how the skilled-care need will be met and by whom. The documentation must describe the following:
  - Reason to use the Assisted Living service
  - Who will be providing this service
  - Activities that are expected to be performed and frequency of the activities

The case manager must give the completed PCISP to the Assisted Living provider. The provider must follow these documentation standards:

- Complete and accurate documentation to support daily services rendered by the Assisted Living service to address needs identified in the person-centered service plan:
  - Participant's status, including health, mental health, medication, diet, sleep patterns, social activity
  - Updates, including health, mental health, medication, diet, sleep patterns and social activity
  - Participation in consumer-focused activities
  - Medication management records, if applicable
  - Quarterly updated service plans provided to the participant's case manager from the Assisted Living service
  - Notification to the participant's case manager within 48 hours of any changes in participant's care plan
- Maintenance of participant's personal records to include:
  - Social Security number
  - Medical insurance number
  - Birth date
  - Emergency contacts
  - Available medical information, including known current prescription and nonprescription drug medication
  - Hospital preference
  - Primary care physician
  - Mortuary (if known)
- Participant's personal records must include copies of the following documents, if available, which the Assisted Living caregiver will also provide to the participant's case manager on an ongoing basis if there are changes to these documents:
  - Advance directive
  - Living will
  - Power of attorney
  - Health care representative
  - Do not resuscitate (DNR) order
  - Letters of guardianship
  - Fully executed lease agreement with the Assisted Living service
- Services outlined in the service plan
- Documentation to support service rendered

Note: If applicable, copies of personal record must be:

- *Placed in a prominent place in the participant's file*
- *Sent with the participant when transferred for medical care or upon moving from the residence and in accordance with state law*

Activities Not Allowed

The following activities are not allowed under the Assisted Living service:

- Personal care services cannot be provided to medically unstable or medically complex participants as a substitute for care provided by a registered nurse, licensed practical nurse, licensed physician or other health professional.
- The Assisted Living service per diem or monthly rate does not include room and board.
- Separate payment will not be made for the following services furnished to a participant selecting the Assisted Living service, as these activities are integral to and inherent in the provision of the Assisted Living service:
  - Adult Day Services
  - Adult Family Care
  - Attendant Care
  - Home Modifications
  - Home-Delivered Meals
  - Home and Community Assistance
  - Personal Emergency Response System
  - Pest Control
  - Respite Care Services
  - Structured Family Caregiving
  - Transportation

Provider Qualifications

Provider qualifications for the Assisted Living service are presented in Table 11.

Table 11 – Provider Qualifications for Assisted Living

Waiver	Provider	Licensure/ Certification	Other Standards
H&W/TBI	Licensed Assisted Living Agencies	*IC 16-28-2*	FSSA approved *410 IAC 16.2-5*

Section 11.10: Attendant Care for H&W and TBI Waivers

The following subsections provide information and requirements for Attendant Care services for the H&W and TBI waivers.

Service Definition

Attendant Care services are provided to participants with nursing facility level of care needs. Attendant care services provide direct, hands-on care to participants for the functional needs with ADLs. The participant is the employer for Consumer-Directed Attendant Care or appoints a representative to be the employer on their behalf.

Allowable Activities

Attendant Care includes all nonskilled ADL care as identified in the person-centered service plan, which includes but is not limited to the following:

- Provides assistance with personal care, which includes:
  - Bathing, partial bathing

  - Oral hygiene
  - Hair care including clipping of hair
  - Shaving
  - Hand and foot care
  - Intact skin care
  - Application of cosmetics
  - Dressing
- Provides assistance with mobility, which includes:
  - Proper body mechanics
  - Transfers (including lifting with mechanical assistance with appropriate training)
  - Ambulation
  - Use of assistive devices
- Provides assistance with elimination, which includes:
  - Assistance with bedpan, bedside commode, toilet
  - Incontinent or involuntary care
  - Emptying urine collection and colostomy bags
- Provides assistance with nutrition, which includes:
  - Meal planning
  - Meal preparation
  - Clean-up
- Provides assistance with safety, which includes:
  - Use of the principles of health and safety in relation to self and individual
  - Identification and elimination of safety hazards
  - Practicing health protection and cleanliness by appropriate techniques of hand washing
  - Waste disposal and household tasks
  - Reminding the participant to self-administer medications
  - Providing assistance with correspondence and bill paying
  - Transportation of individuals to nonmedical community activities (*Note: Out-of-state transportation is limited to within 50 miles of state geographic limits. Escorting of participants does not include mileage or other costs that are not associated with the provision of personal care.*)

Service Standards

Attendant Care services may be provided from the following:

- Agency – An agency enrolled in the program is responsible to hire and render services.
- Self-directed – The individual is the employer and acts as the agency directing their own care.

If direct care or monitoring of care is not provided to the participant and the documentation of services rendered for the units billed reflects home and community assistance duties, an entry must be made to indicate why the direct care was not provided for that day. If direct care or supervision of care is not provided for more than 30 days and the documentation of services rendered for the units billed reflects home and community assistance duties, the case manager must be contacted to amend the service plan to do one of the following:

- Add the Home and Community Assistance service and eliminate the Attendant Care service.
- Reduce Attendant Care hours and replace with the appropriate number of hours of Home and Community Assistance service.

Documentation Standards

The case manager must follow these documentation standards:

- Document the medical need for Attendant Care and types of ADL support the participant may require.
- Document the type of Attendant Care (attendant care or participant-directed) determined to meet the needs of the individual or caregiver through the person-centered planning process.
- Document the Attendant Care activity that will meet the participant's needs and ensure it is accurately documented in the LOC assessment.
- If the participant has skilled need, document how the skilled need is being met and by whom. If Attendant Care is being requested for an individual with skilled care, documentation must describe the following:
  - Who will be providing Attendant Care
  - Frequency of care
  - Activities being performed
- If the Attendant Care is participant-directed, documentation must describe the following:
  - Who the employer is
  - Who the employee/direct worker is and their relationship to the participant (include POA, guardian status as well)

Attendant Care providers must follow these documentation standards:

- In addition to electronic visit verification (EVV) when required (see the *Electronic Visit Verification System Required for Personal Care Services* section), providers will record services provided, including:
  - Complete date and time of service (in and out)
  - Specific services/tasks provided
  - Signature of participant verifying the service was provided by agency
  - Signature of employee providing the service (minimally the last name and first initial) *(Note: If the person providing the service is required to be a professional, the title must also be included.)*
- Each staff member providing direct care or supervision of care to the participant must make at least one entry on each day of service.
- Documentation of service delivery is to be signed by the participant or designated participant representative.

> *Note: If applicable, copies of personal record must be:*
>
> - *Placed in a prominent place in the participant's file*
> - *Sent with the participant when transferred for medical care or upon moving from the residence and in accordance with state law*

Claim Note Required for Attendant Care

When billing for Attendant Care services, providers must include a claim note with information about who provided those services, including their relationship to the member receiving the service. The claim note must be accurate and complete for audit purposes. If the individual providing the service is the spouse or parent of the member receiving the service, that relationship status should be reflected in the claim note.

Legally responsible individuals (LRIs) (a spouse or the parent of a minor child) may not provide Attendant Care services to that individual. Knowingly using an incorrect relationship status, such as "Other," for the

spouse or (if the member is a minor) parent of the member receiving services may result in recoupment of these claims; it could also constitute a false claim in accordance with the False Claims Act. The OMPP Program Integrity staff is auditing claims, including the entry of claim notes.

For the structure required in the claim note, see the *Caregiver Name for Attendant Care or Structured Family Caregiving* section in the *Claim Submission and Processing* provider reference module.

Limitations

When provided by a legal guardian of an adult, Attendant Care services are limited to a maximum of 40 hours per week.

Activities Not Allowed

The following activities are not allowed and will not be reimbursed under Attendant Care services:

- Services provided for a participant regarding specialized feeding (such as has difficulty swallowing, refuses to eat or does not eat enough), unless permitted under law and not duplication of Indiana Medicaid State Plan services
- Services provided to a participant requiring management of the following (which must be considered for respite care nursing services unless permitted under law and not a duplication of Indiana Medicaid State Plan services):
  - Uncontrolled seizures
  - Infusion therapy
  - Venipuncture
  - Injection
  - Wound care for decubitus incision
  - Ostomy care
  - Tube feedings
- Services provided as a substitute for care provided by a registered nurse, licensed practical nurse, licensed physician or other health professional
- Setting up and administering medications
- Assisting with catheter and ostomy care
- Services provided to household members other than to the participant
- Services provided by the parent of a minor child participant or the spouse of a participant (also known as LRIs)
- Services provided to participants receiving any of the following waiver services:
  - Adult Family Care
  - Assisted Living
  - Structured Family Caregiving

> *Note: Attendant Care services will not be reimbursed if performed in the same calendar month as Structured Family Caregiving services.*

Provider Qualifications

Provider qualifications for Attendant Care services are presented in Table 12.

Table 12 – Provider Qualifications for Attendant Care

Waiver	Provider	Licensure/ Certification	Other Standards
H&W/ TBI	Licensed Home Health Agency	*IC 16-27-1 IC 16-27-4*	FSSA approved
H&W/ TBI	Licensed Personal Services Agency	*IC 16-27-4*	FSSA approved
H&W/ TBI	Attendant Care individual	*IC 16-27-4*	FSSA approved *455 IAC 2* Provider qualifications: General requirements *455 IAC 2* General requirements for direct care staff *455 IAC 2* Liability insurance *455 IAC 2* Professional qualifications and requirements *455 IAC 2* Personnel records *455 IAC 2-6-1* Provider qualifications: becoming an approved provider; maintaining approval *455 IAC 2-6-2 (a)(1)(B)* Provider qualifications: general requirements *455 IAC 2-11-1* Property and personal liability insurance *IC 12-10-17.1-10* Registration; prohibition *IC 12-10-17.1-11* Registration requirement *IC 12-10-17.1-12* Registration by the division; duties of the division The division may reject any applicant with a conviction of a crime against persons or property, a conviction for fraud or abuse in any federal, state, or local government program, (*42 USC §1320a-7*) or a conviction for illegal drug possession. The division may reject an applicant convicted of the use, manufacture, or distribution of illegal drugs (*42 USC §1320a7*). The division may reject an applicant who lacks the character and fitness to render services to the dependent population or whose background check shows that the applicant may pose a danger to the dependent population. The division may limit an applicant with a criminal background to caring for a family member only if the family member has been informed of the criminal background. Compliance with *IC 16-27-4*, if applicable.

Section 11.11: Behavior Management/Behavior Program and Counseling for TBI Waiver

The following subsections provide information and requirements for Behavior Management/Behavior Program and Counseling provided under the TBI Waiver.

Service Definition

Behavior management includes training, supervision, or assistance in appropriate expression of emotions and desires, assertiveness, acquisition of socially appropriate behaviors, and the reduction of inappropriate behaviors for members who receive TBI services.

Behavior plans must be developed, monitored and amended by a master's level psychologist or a master's in special education, supervised by an individual with a doctor of philosophy (PhD) in behavioral science. Persons providing Behavior Management/Behavior Program and Counseling services who are employed by a qualified agency must be a master's level behaviorist, a certified brain injury specialist (CBIS), a qualified intellectual disability professional (QIDP) or a certified social worker who is supervised by a master's level behaviorist. An individual practitioner providing this service must be a master's level behaviorist.

Allowable Activities

The following activities are allowed under Behavior Management/Behavior Program and Counseling services:

- Observation of the individual and environment for purposes of developing a plan and determining a baseline
- Developing a behavioral support plan and subsequent revisions
- 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 in implementing the behavioral support plan
- Consultation with members
- Consultation with a health service provider in psychology (HSPP)

Service Standards

The following service standards must be met:

- Behavior Management/Behavior Program and Counseling services must follow a written service plan addressing specific needs determined by the individual's assessment.
- The behavior specialist will observe the individual in their own environment and develop a specific plan to address identified issues.
- The efficacy of the plan must be reviewed no 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, waiver case manager, all service providers and other involved entities.

Documentation Standards

The following documentation standards must be met for Behavior Management/Behavior Program and Counseling services:

- Identified need in the service plan
- Services outlined in the service plan
- Identified level clinician in the service plan
- Behavioral support plan
- Data record of clinician service documenting the date and time of service and the number of units of service delivered that day with the service type

> *Note: If applicable, copies of personal record must be:*
>
> - *Placed in a prominent place in the participant's file*
> - *Sent with the participant when transferred for medical care or upon moving from the residence and in accordance with state law*

Activities Not Allowed

The following activities are not allowed or reimbursed under Behavior Management/Behavior Program and Counseling services:

- Aversive techniques
- Any techniques not approved by the individual's person-centered planning team and the FSSA
- Services when provided as an individual provider by any of the following:
  - Parent of a minor child participant
  - Spouse of a participant
  - Attorney-in-fact (or POA) of a participant
  - HCR of a participant
  - Legal guardian of a participant

Provider Qualifications

Provider qualifications for Behavior Management/Behavior Program and Counseling services are presented in Table 13.

Table 13 – Provider Qualifications for Behavior Management/ Behavior Program and Counseling

Waiver	Provider	Licensure/ Certification	Other Standards
TBI	Behavior Management/ Behavior Program and Counseling Individual	Not required	FSSA approved *455 IAC 2* Provider qualifications: General requirements *455 IAC 2* General requirements for direct care staff *455 IAC 2* Liability insurance *455 IAC 2* Professional qualifications and requirements *455 IAC 2* Personnel records An individual practitioner providing this service must be a master's level behaviorist.
TBI	Behavior Management/ Behavioral Program and Counseling Agency	Not required	FSSA approved *455 IAC 2* Provider qualifications: General requirements *455 IAC 2* General requirements for direct care staff *455 IAC 2* Liability insurance *455 IAC 2* Professional qualifications and requirements *455 IAC 2* Personnel records

Section 11.12: Care Management for H&W and TBI Waivers

The following subsections provide information and requirements for Care Management services for the H&W and TBI waivers.

Service Definition

Care Management is a process of assessment, discovery, planning, facilitation, advocacy, collaboration and monitoring of the holistic needs of each individual participant, regardless of funding sources.

Allowable Activities

The following activities are allowed under the Care Management service:

- Person-centered assessment and planning:
  - Includes but is not limited to discovering the participant's strengths, needs, goals and preferences.
  - Appropriate facilitation of the assessment process through utility of person-centered discovery tools and practice engaging the participant and their circle of support. The assessment and planning phase can include, but is not limited to, brokering community resources, action and/or service planning, and eligibility for funded services.
- Development and implementation of a person-centered support plan, including action and/or service plans:
  - Action planning is a process to determine community resources to meet the participant's functional and social needs.
  - Service planning is a process to determine funded services and eligibility to appropriately meet the participant's needs.

- Case managers are required to provide each waiver participant with a link to this provider reference module (*Division of Disability, Aging and Rehabilitative Services (DDARS) HCBS Waivers*), which is a resource document for participants and support teams. When requested by the participant, guardian, and/or family, a paper/hard copy of this provider reference module will be provided by the case manager.

- Monitoring and evaluating all action and/or service plans:
  - Case managers are responsible to monitor progress for all services displayed on the action and/or service plans.
  - The case manager will provide and coordinate high quality services to the participant, while promoting seamless, integrated, coordinated care.
  - The case manager will monitor person-centered support plans in a face-to-face contact every 90 days from the initial service plan activation. When the initial care plan is activated, the case manager will either call or visit the participant within 30 days and no more than 40 days from initial service plan activation to ensure implementation of services.
  - When incidents are reported, the case manager must submit a follow-up report to the Bureau of Disabilities Services (BDS) concerning the incident at the following time frames – within seven days of the date of the initial report; and every seven days thereafter until the incident is resolved.
  - Case managers are responsible for notifying families/guardians of incidents reported and sharing results of the provider's investigation.
  - The case manager is responsible for completing annual person-centered assessments, including eligibility and service planning.
  - The case manager is responsible for coordinating changes in the service plan that include but are not limited to, notifying all providers about the change and when they are to begin or end services, and notifying all providers when a care plan is in terminated or restart status.
  - The case manager will be responsible for evaluating the effectiveness of all services. Evaluation is demonstrated through but not limited to the following:
    - Monitoring the progress from identifying need to meeting goals and/or preferences identified by the participant
    - Direct collaboration and coordination with providers to ensure services are within the participant's preferences
    - Adjusting action and service plans appropriately to identify changing needs that meet the participant's needs

- Termination of plans
  - The case manager will follow the Medicaid nursing facility level of care HCBS waiver's termination procedures when a participant is no longer to receive services under the waiver program. This includes providing a 30-day notice to any participant the case manager is terminating.

- Transition follow-up
  - The case manager must ensure that participants fully understand their ability to make choices concerning all services they receive, including Care Management services.
  - In the event the participant chooses another care management agency, the current care management agency fully assists the participant in their transition to the new agency or individual case manager of choice. The goal is to ensure a seamless transition for the participant.

Service Standards

These service standards must be followed for Care Management:

- Care Management services must be reflected in the participant's service plan.
  - Case managers enhance the participant's functional and social well-being.
  - Case managers broker community resources that align with the participant's unique needs.
- Case managers will engage the participant and their circle of support in all aspects of the Care Management process and tailor the person-centered support plan to the participant's needs, preferences, goals and strengths.
- The case manager is expected to coordinate and collaborate with other case managers, other organizations, community partners and FSSA staff to ensure quality care management is being delivered and options are being discovered and presented to the participant to optimize their overall functioning capability.
- A case manager's maximum Medicaid waiver caseload is not to exceed 65 participants at any time.
- Case managers are responsible for the following:
  - Identifying when a participant is residing in a provider-owned or -controlled setting
  - Monitoring HCBS characteristics
  - Monitoring person-centered modifications to HCBS characteristics and documenting them in the person-centered service plan as such

Documentation Standards

The case manager must follow these documentation standards:

- Person-centered planning – This activity includes but is not limited to discovering the individual's strengths, needs, goals, and preferences. The case manager will appropriately facilitate the assessment process to engage the individual and their circle of support. The assessment and planning phase can include, but is not limited to, brokering community resources, action and/or service planning, and eligibility for funded services. To meet the HCBS settings final rule, case managers must support the person to lead and direct their planning process as much as possible, and to the extent the person wants. The circle of support must include people the participant wishes to include.
- Development and implementation of a person-centered support plan, including action and/or service plans. Action planning is a process to determine community resources to meet the individual's functional and social needs.
- Service planning is a process to determine funded services and eligibility to appropriately meet the participant's needs.
- Monitoring and evaluating all action and/or service plans.
- Case managers are responsible to monitor progress for all services displayed on the action and/or service plans.
- The case manager will provide and coordinate high quality services to the individual, while promoting seamless, integrated and coordinated care.
- The case manager will complete monitor person-centered support plans in a face-to-face contact every 90 days from the initial service plan activation. When the initial care plan is activated, the case manager will either call or visit the individual within 30 days and no more than 40 days from initial service plan activation to ensure implementation of services.
- The case manager is responsible to complete annual service planning.

- The case manager is responsible to complete all assessment tools including but not limited to timely submission of incident reports.
- The case manager will be responsible to evaluate the effectiveness of all services. Evaluation is demonstrated through, but is not limited to, the following:
  - Monitoring the progress from identifying needs to meeting goals/preferences identified by the participant
  - Direct collaboration and coordination with providers to ensure services are within the participant's preferences
  - Adjusting action and service plans appropriately to identify changing needs that meet the participant's needs
- Termination of plans prior to individual reaching maximum age limit. The case manager will follow the Medicaid nursing facility level of care HCBS Waiver termination procedures when an individual is no longer to receive services under the waiver program and has not yet reached the maximum age limit specified in *Appendix B-1-c* of the approved H&W and TBI waivers.
- Assistance with transition to new case manager. It is the responsibility of the case manager to assure the individual fully understands their ability to make choices concerning all services they receive. This includes care management services. In the event the individual chooses another care management agency, the current care management agency is to fully assist the individual in their transition to the new agency or individual case manager of choice. The goal is to ensure a seamless transition for the individual.
- Assistance with transition to the Indiana PathWays to Aging program – As specified in *Appendix B-1-c* "Maximum Age Transition," the case manager is responsible for assisting an individual to transition to the PathWays Waiver. This assistance includes, but is not limited to:
  - Initiating the transition planning process six months in advance of an individual turning age 60
  - Educating the individual on the upcoming waiver transition and the PathWays program
  - Coordinating with the LCAR contractor, Maximus, to transition the individual to the PathWays Waiver

Note: If applicable, copies of personal record must be:

- *Placed in a prominent place in the participant's file*
- *Sent with the participant when transferred for medical care or upon moving from the residence and in accordance with state law*

Activities Not Allowed

The following activities are not allowed under the Care Management service:

- Care Management may not be conducted by any organization, entity, or participant that also delivers other in-home and community-based services, or by any organization, entity, or participant related by common ownership or control to any other organization, entity, or participant who also delivers other in-home and community-based services, unless the organization is an Area Agency on Aging (AAA) that has been granted permission by the FSSA BDS to provide direct services to participants. Prior to billing, a case manager must have completed the care management curriculum to become a Medicaid certified case manager.

> *Note: Common ownership exists when a participant, or any legal entity, possesses ownership or equity of at least 5% in the provider as well as the institution or organization serving the provider. Control exists where a participant or organization has the power or the ability, directly or indirectly, to influence or direct the actions or policies of an organization or institution, whether or not actually exercised. "Related" means associated or affiliated with, or having the ability to control, or be controlled by.*

- Independent case managers and independent care management agencies may not provide initial applications for Medicaid waiver services.
- Reimbursement of Case Management under Medicaid waivers may not be made unless and until the participant becomes eligible for Medicaid waiver services. Care Management provided to participants who are not eligible for Medicaid waiver services will not be reimbursed as a Medicaid waiver service.
- Case Management services will not be reimbursed when the owner of the service organization is one of the following:
  - Parent of a minor child participant
  - Spouse of a participant
  - Attorney-in-fact (or POA) of a participant
  - HCR of a participant
  - Legal guardian of a participant

Provider Qualifications

Provider qualifications for Care Management services are presented in Table 14. Prior to billing, a case manager must have completed the care management curriculum to become a Medicaid certified case manager.

Table 14 – Provider Qualifications for Care Management

Waiver	Provider	Licensure/ Certification	Other Standards
H&W/TBI	Care Management Individual	Not required	FSSA, or its designee, approved *455 IAC 2* Documentation of qualifications *455 IAC 2* Care management liability Insurance Training in the nursing facility LOC process by the FSSA or designee Education and work experience (must meet one of the following): • Be continuously employed as a case manager by an Area Agency on Aging (AAA) since June 30, 2018 • Be an Indiana registered nurse • Have a bachelor's degree in social work, psychology, counseling, gerontology, nursing, or health and human services • Have a bachelor's degree in any field with a minimum of two years full-time, direct service experience with the elderly or disabled (this experience includes assessment, care plan development, and monitoring) • Have a master's degree in social work, psychology, counseling, gerontology, nursing, or health and human services, which may substitute for the required minimum of two full time direct services experience • Have an associate degree in nursing • Have an associate degree in any field with a minimum of four-year full-time, direct service experience with the elderly or disabled (this experience includes assessment, care plan development and monitoring)

Waiver	Provider	Licensure/ Certification	Other Standards
H&W	Care Management Agency	Not required	FSSA, or its designee, approved *455 IAC 2* Provider Qualifications: General requirements *455 IAC 2* Procedures for protecting individuals *455 IAC 2* Unusual occurrence; reporting *455 IAC 2* Transfer of individual's record upon change of provider *455 IAC 2* Notice of termination of services *455 IAC 2* Provider organizational chart *455 IAC 2* Collaboration and quality control *455 IAC 2* Data collection and reporting standards *455 IAC 2* Quality assurance and quality improvement system *455 IAC 2* Financial information *455 IAC 2* Liability insurance *455 IAC 2* Documentation of qualifications *455 IAC 2* Maintenance of personnel records *455 IAC 2* Adoption of personnel policies *455 IAC 2* Operations manual *455 IAC 2* Maintenance of records of services provided *455 IAC 2* Case Management Training in the nursing facility level of care process by the FSSA or designee Education and work experience (one of the following): • An individual continuously employed as a case manager by an AAA since June 30, 2018 • A qualified intellectual disability professional (QIDP) who meets the requirements at *42 CFR 483.430* • A registered nurse, licensed practical nurse, bachelor's degree or associate degree with one year of experience delivering health care/social services or care management, or at least two or more years in care planning, care management or delivering healthcare or social services. *Note: A master's degree in a related field may substitute for the required experience*.

Section 11.13: Caregiver Coaching for H&W Waiver

The following subsections provide information and requirements for Caregiver Coaching for the H&W Waiver.

Service Definition

Caregiver Coaching is a training and support service for unpaid caregivers. The purpose of Caregiver Coaching is to enable the stabilization and continued community tenure of a waiver participant by equipping the participant's unpaid caregivers with the necessary skills to manage the participant's medical conditions and associated behavioral health needs related to a cognitive impairment and/or dementia. This is not a service provided directly to the waiver participant, but to their unpaid caregivers.

This service allows family caregivers who are not eligible to participate in Structured Family Caregiving to access support. This service is available to any and all caregivers who are not served through Structured Family Caregiving. The waiver participant will receive additional waiver services outside of what the unpaid caregiver delivers. The goal of the caregiver coach and behavior management service is to address the caregiver's needs as far as training and education on how to best support the person. If the unpaid caregiver raises issues about service delivery, the concern is documented in the caregiver's service plan with the caregiver coach and case manager.

Technology will be used between the agency performing caregiver coaching and behavior management, and the unpaid caregivers. If the unpaid caregiver needs assistance with the technology, the assigned caregiver coach will visit with the unpaid caregiver to provide a tutorial. Caregiver coaching is a service targeted toward the unpaid caregiver to support their needs in order for the unpaid caregiver to continue supporting the waiver participant.

The caregiver coach will assess strengths and goals as well as any health and safety risks of the unpaid caregiver, such as burnout or compassion fatigue, or that the unpaid caregiver is concerned about, related to the waiver participant. These strengths, goals, health and safety concerns will be documented in the person-centered service plan along with interventions to ensure health and safety. The interventions will be assessed during each biweekly visit between caregiver coach and unpaid caregiver, and modified as needed as well as updates to the case manager about health and safety concerns and interventions.

Through additional guidance to providers and case managers, the BDS will clarify that the emergency/crisis plan should be developed among all parties (waiver case manager, participant, caregiver, caregiver coach and behavior management provider). This way, the participant and the participant's circle of support will have the same knowledge and understanding of the participant’s backup plan and emergency plan, and will support the participant in implementing that plan if needed. If there are modifications to the plan, all parties shall be involved in the plan changes as well as aware of the changes. The BDS will provide an example plan to both case managers and providers in guidance.

Because the waiver participant receives services through the Health and Wellness (H&W) waiver as well as the Indiana Medicaid State Plan, the medically complex needs will be addressed through those services. Additionally, there are often times when unpaid caregivers render those services (if the provider is not available). The caregiver coach will identify with the unpaid caregiver the supports being rendered on an informal basis, by the unpaid caregiver to support the waiver participant. These services will be documented in the unpaid caregiver’s person-centered service plan.

The caregiver coach will review the services with the unpaid caregiver and case manager on a biweekly basis (or as communicated by the unpaid caregiver if more than biweekly). If the unpaid caregiver has questions or concerns about service delivery, the caregiver coach will provide training and education about delivery and/or connect with the participant, participant’s waiver case manager, and other providers to ensure services are rendered as specified by the participant.

Covered Services

The following services are covered under Caregiver Coaching:

- Initial consultation for assessment of the caregiver to determine initial coaching needs, and understand the caregiver’s goals, values, needs and strengths.
- Caregiver Coaching provided in the community of the participant, virtually or telephonically, or other identified location meaningful to the unpaid caregiver and through HIPAA secure communication platforms that allow for real-time and asynchronous communication between caregivers and caregiver coaches and collaboration with waiver case managers.

Service Standards

These service standards must be followed for Caregiver Coaching:

- Caregiver Coaching services are family centered, individualized to the needs of the participant and caregiver, and informed by an assessment of each caregiver's goals, values, needs and strengths.
- A caregiver coach with expertise working with unpaid caregivers will conduct a caregiver assessment developed by the FSSA and deliver ongoing education and coaching that is informed by the assessment.
- Caregiver Coaching services may be delivered telephonically and through HIPAA secure electronic communication platforms that enable a caregiver coach and a caregiver to communicate efficiently and, in a manner, convenient to the caregiver.
- Provider agencies must capture any caregiver communications received through an electronic communication platform, such as an app or email, to facilitate the sharing of relevant information with case managers. Providers will communicate with case managers through traditional means to share any relevant information. The service does not require any specific percentage of in-person visits versus virtual visits.
- The service is designed to equip the participant's unpaid caregivers with the skills to manage the participant's medical conditions and associated behavioral health needs related to a cognitive impairment and/or dementia. Part of the caregiver assessment rendered by the caregiver coach will address areas of the caregiver's life that promote socialization and involvement within the community, but ultimately, the decision is based on where the caregiver needs support. If community integration is an area important to the participant, the caregiver coach will support the caregiver in ensuring the participant's goals with regards to community integration are met. Additionally, a caregiver's community integration and supporting a participant's community integration may change over time and will be consistently modified as necessary.
- A caregiver coach engages with a caregiver on a biweekly basis to understand the evolving needs of the participant and caregiver and deliver content, strategies and tools related to the management of the participant's needs and behaviors and the caregiver's self-care needs.
- Caregiver training will include how to address necessary precautions to prevent COVID-19 infections/spread in the home and address anxiety that participants may experience related to the crisis; behavior and triggering events; effective verbal and nonverbal communication strategies; strategies for managing challenging behaviors; and how to address home safety concerns. Coaching will also support a caregiver to apply stress reduction techniques and reduce caregiver isolation.
- A caregiver coach will assist the caregiver and participant in creation of a crisis management/emergency plan to address the person and environment. The plan will be reviewed and updated on a monthly basis (and more often as needed) and provided to the case manager and waiver/Indiana Medicaid State Plan/hospice providers as well as emergency contacts and backup caregiver. The plan shall include but is not limited to the following:
  - Health conditions
  - Advanced directives, will planning, physician orders for life sustaining treatment
  - Medications and medication management/assistance to prevent medication errors
  - Fall prevention interventions
  - Sundowning interventions
  - Healthcare providers including contact information
  - Emergency contacts
  - Identification and contact information for backup caregiver
  - Contact information for caregiver coach and waiver case manager
  - Caregiver resources available within the caregiver's/participant's community of choice.

Limitations

The following restrictions are made for Caregiver Coaching:

- Medicaid participating Structured Family Caregiving agencies may be service providers; agencies must employ caregiver coaches with the experience and qualifications appropriate to the needs of each family.
- Educational content delivered by provider agencies to caregivers and delivery methods must be appropriate to the needs of lay caregivers.

Note: Maximum billable quarter hour units per month is 32.

Activities Not Allowed

The following activities are not allowed or reimbursed under Caregiver Coaching:

- Caregiver coaching services will not duplicate services provided under the Indiana Medicaid State Plan or any other waiver service.
- Separate payment will not be made for Structured Family Caregiving.
- Caregiver Coaching service will not be reimbursed when provided by a parent of a minor child participant or the spouse of a participant (also known as LRIs).

Provider Qualifications

Provider qualifications for Caregiver Coaching services are presented in Table 15.

Table 15 – Provider Qualifications for Caregiver Coaching

Waiver	Provider	Licensure/ Certification	Other Standards
H&W	Structured Family Caregiving Provider	Not required	FSSA approved *455 IAC 2*
H&W	Adult Day Provider	Not Required	FSSA approved *455 IAC 2*

Section 11.14: Community Transition for H&W and TBI Waivers

The following subsections provide information and requirements for Community Transition services for the H&W and TBI waivers.

Service Definition

Community Transition services include reasonable, setup expenses for participants who make the transition from an institution to their own home where the person is directly responsible for their own living expenses in the community. Community Transition services will not be reimbursable on any subsequent move.

> *Note: "Own home" is defined for this service as any dwelling – including a house, an apartment, a condominium, a trailer or other lodging – that is owned, leased or rented by the participant.*

Items purchased through Community Transition are the property of the participant receiving the service, and the participant takes the property with them when moving to another residence. For participants receiving this service under the waiver, approved Community Transition expenditures are reimbursed through the local Area Agency on Aging (AAA) or OMPP-approved provider that maintains all applicable receipts and verifies the delivery of services.

Allowable Activities

The following activities are allowed under Community Transition services:

- Security deposits and application fees that are required to obtain a lease on an apartment or home
- Essential (not luxury) furnishings and moving expenses required to occupy and use a community domicile, including a bed, table and chairs, assembly of flat-packed furniture when it is not included as part of the furniture purchase cost, window coverings, one land-line telephone, eating utensils, housekeeping supplies, food preparation items, microwave, and bed or bath linens
- Setup fees or deposits for utility or service access including telephone, electricity, heating, internet and water
- Health and safety assurances, including pest eradication, allergen control that would be used in instances where the participant is allergic to certain things that need to be removed from the residence (like animal hair), or one-time cleaning prior to occupancy

> *Note: If the participant lacks the required government-issued identification items to secure housing or utilities (including but not limited to birth certificate, Social Security card, state ID and state driver's license), costs related to obtaining these items are also covered under Community Transition services.*

Service Standards

Community Transition services must follow a written service plan addressing specific needs determined by the person-centered planning process.

Documentation Standards

The case manager must follow these documentation standards:

- Document the need for Community Transition services and reasonable furnishings or set-up expenses being requested by the participant (determined through the person-centered planning process) in the service plan.
- Maintain receipts for all expenditures, showing the amount and what item or deposit was covered.
- If a case manager requests the full $1,500 lifetime cap (described in the *Limitations* section) and not all funds are used, the case manager must complete a service plan update to reduce the amount to ensure Medicaid is not over-reimbursing for these services.

Note: If applicable, copies of personal record must be:

- *Placed in a prominent place in the participant's file*
- *Sent with the participant when transferred for medical care or upon moving from the residence and in accordance with state law or upon moving from the residence and in accordance with state law*

Limitations

The following restrictions are made for Community Transition services:

- Reimbursement for Community Transition is limited to a single use and lifetime cap for setup expenses of up to $2,500.
- When the participant is discharged from the facility, the Community Transition service must be identified, ordered, delivered and reimbursed within three months.
- The state will not bill for federal financial participation (FFP) until after the individual departs the institution and meets waiver eligibility.
- Community Transition services are furnished only to the extent that they are reasonable and necessary as determined through the service plan development process, clearly identified in the service plan, and the person is unable to meet such expense or when the services cannot be obtained from other sources.

Activities Not Allowed

The following activities are not allowed through Community Transition services:

- Apartment or housing rental or mortgage expenses
- Food
- Regular utility charges
- Household appliances or items that are intended for purely diversional/recreational purposes
- Allergen control to fund the mitigating or removal of items that would be the responsibility of the landlord or homeowner
- Service provided by the parent of a minor child participant or the spouse of a participant (also known as LRIs)

Provider Qualifications

Provider qualifications for Community Transition services are presented in Table 16.

Table 16 – Provider Qualifications for Community Transition Services

Waiver	Provider	Licensure/ Certification	Other Standards
H&W/TBI	Community Transition Service Agency	Not required	FSSA approved *455 IAC 2* Becoming an approved provider; maintaining approval *455 IAC 2* Provider qualifications: General requirements *455 IAC 2* Transfer of individual's record upon change of provider *455 IAC 2* Financial information *455 IAC 2* Liability insurance *455 IAC 2* Transportation of an individual *455 IAC 2* Professional qualifications and requirements; documentation of qualifications *455 IAC 2* Maintenance of personnel records *455 IAC 2* Adoption of personnel policies *455 IAC 2* Operations manual *455 IAC 2* Maintenance of records of services provided *455 IAC 2* Individual's personal file; site of service delivery

Section 11.15: Home and Community Assistance for H&W and TBI Waivers

The following subsections provide information and requirements for Home and Community Assistance services for the H&W and TBI waivers.

Service Definition

Home and Community Assistance services provide instrumental activities of daily living (IADL) for participants in their home. The services are provided when participants are unable to meet their needs or when their informal caregiver or helper is unable to perform these needs for the participant.

Allowable Activities

The following activities are allowed under the Home and Community Assistance services:

- IADL care that may include but are not limited to the following:
  - Dusting and straightening furniture
  - Cleaning floors and rugs by wet or dry mop and vacuum sweeping
  - Cleaning the kitchen, including washing dishes, pots and pans; cleaning the outside of appliances and counters and cupboards; cleaning ovens; and defrosting and cleaning refrigerators
  - Maintaining a clean bathroom, including cleaning the tub, shower, sink, toilet bowl and medicine cabinet; and emptying and cleaning commode chair or urinal

  - Laundering clothes in the home or laundromat, including washing, drying, folding, putting away, ironing, and basic mending and repair
  - Changing linen and making beds
  - Washing insides of windows
  - Removing trash from the home
- Assistance with meal planning and preparation, including special diets under the supervision of a registered dietitian or health professional
- Completing essential errands and/or unassisted transportation for nonmedical, community activities
- Assistance with correspondence and bill paying
- Simple pet care *(Note: This activity may be allowed at the discretion of the agency.)*
- Assistance with outdoor tasks including raking leaves, snow removal, lawn mowing and weeding

Service Standards

These service standards must be followed:

- The case manager will document through the PCISP the need for Home and Community Assistance, the frequency of need, the required type of Home and Community Assistance activities.

Documentation Standards

The case manager will document the following through the PCISP:

- Need for Home and Community Assistance
- Frequency of need
- Required type of Home and Community Assistance activities

Home and Community Assistance providers are responsible for the following documentation standards:

- Data record of services provided must include the following:
  - Complete date and time of service (in and out)
  - Specific services/tasks provided
  - Notification to the participant's case manager within 48 hours upon any changes in the participant's person-centered service plan
  - Time spent traveling and completing the errand as well as the specific tasks and necessity of the task being completed (for errands such as using a laundromat due to there not being a washer or dryer in the participant's home)

    Note: If Home and Community Assistance services take place outside the participant's home (such as errands being required due to no washer/dryer in home, or travel for other allowable tasks), travel expenses beyond the time spent on the errand are the responsibility of the agency providing Home and Community Assistance services.
  - Signature of employee providing the service (minimally the last name and first initial) *(Note: If the person providing the service is required to be a professional, that title must also be included.)*
- Each staff member providing direct care or supervision of care to the participant must make at least one entry on each day of service. All entries should describe an issue or circumstance concerning the participant.

- Documentation of service delivery is to be signed by the participant or designated participant representative.

> *Note: If applicable, copies of personal record must be:*
>
> - *Placed in a prominent place in the participant's file*
> - *Sent with the participant when transferred for medical care or upon moving from the residence and in accordance with state law*

Activities Not Allowed

The following services are not allowed under Home and Community Assistance services:

- Assistance with ADL hands-on care (*Note: Specifically, Home and Community Assistance services do not include any ADL assistance, such as eating, bathing, dressing, personal hygiene, or medication setup and administration.*)
- Hands-on and/or assisted transportation of participants to community activities or errands
- Home and Community Assistance services provided to household members other than to the participant
- Home and Community Assistance services when the owner of the service organization is one of the following:
  - Parent of a minor child participant
  - Spouse of a participant
  - Attorney-in-fact (or POA) of a participant
  - HCR of a participant
  - Legal guardian of the participant
  - Any member of the participant's household
- Service provided by the parent of a minor child participant or the spouse of a participant (also known as LRIs)
- Services provided to participants receiving any of the following waiver services:
  - Adult Family Care
  - Assisted Living
  - Structured Family Caregiving

> *Note: Home and Community Assistance services will not be reimbursed if performed in the same calendar month as Structured Family Caregiving services.*

Provider Qualifications

Provider qualifications for Home and Community Assistance services are presented in Table 17.

Table 17 – Provider Qualifications for Home and Community Assistance Services

Waiver	Provider	Licensure/ Certification	Other Standards
H&W/TBI	Licensed Personal Services Agency	*IC 16-27-4*	FSSA approved
H&W/TBI	Homemaker Individual	*IC 16-27-4*	FSSA approved *455 IAC 2* Provider qualifications: becoming an approved provider; maintaining approval *455 IAC 2* Provider qualifications: general requirements *455 IAC 2* Liability insurance *455 IAC 2* Professional qualifications and requirements *455 IAC 2* Personnel records Compliance with *IC 16-27-4*, if applicable

Section 11.16: Home-Delivered Meals for H&W and TBI Waivers

The following subsections provide information and requirements for Home-Delivered Meals for the H&W and TBI waivers.

Service Definition

A Home-Delivered Meal is a nutritionally balanced meal. This service is essential in preventing institutionalization because the absence of proper nutrition in individuals with frail and disabling conditions presents a severe risk to health. No more than two meals per day will be reimbursed under the waiver.

Allowable Activities

The Home-Delivered Meals service may include but is not limited to:

- Diet and nutrition counseling provided by a registered dietician
- Nutritional education based on needs of each participant
- Diet modification according to a physician's order, as required, meeting the individual's medical and nutritional needs

Service Standards

These service standards must be followed:

- Home-Delivered Meals services must follow a written service plan addressing specific needs determined by the participant's PCISP.
- Home-Delivered Meals services will be provided to persons who are unable to prepare their own meals and for whom there are no other persons available to do so or where the provision of a Home-Delivered Meal is the most cost-effective method of delivering a nutritionally adequate meal and it is not otherwise available through other funding sources.

- All meals must meet state, local, and federal laws, and regulations regarding the safe handling of food. The provider must also hold adequate and current Servsafe certification.
- All Home-Delivered Meals provided must contain at least one-third of the current daily recommended dietary allowance (RDA) as established by the Food and Nutrition Board of the National Academy of Sciences, National Research Council, including but not limited to the following foods:
  - A variety of vegetables (dark green, red, and orange), legumes (beans and peas), and starchy and other vegetables
  - Fruits, especially whole fruit
  - Grains, at least half of which are whole grain
  - Fat-free or low-fat dairy, including milk, yogurt, cheese and/or fortified soy beverages
  - A variety of protein foods, including seafood, lean meats and poultry, eggs, legumes (beans and peas), soy products, and nuts and seeds
  - Oils, including those from plants: canola, corn, olive, peanut, safflower, soybean, and sunflower. Oils also are naturally present in nuts, seeds, seafood, olives and avocados
- Meals shall contain less than 10% daily calories from added sugars unless prior FSSA or registered dietitian approval is received.
- Meals shall contain less than 10% of daily calories from saturated fats unless prior FSSA or registered dietitian approval is received.
- Meals shall contain less than 2,300 mg of sodium per day unless prior FSSA or registered dietitian approval is received.

Documentation Standards

These documentation standards must be followed:

- The case manager is responsible for documenting the need for Home-Delivered Meals and the amount being requested.
- The provider is responsible for the following:
  - Documenting the date of delivery, how many meals are included and the name of the care professional or case manager that involved the participant
  - Documenting any food allergies, food preferences, or gluten sensitivity for waiver participants
  - Ensuring date of expiration is included on all meals
  - Written or oral instruction for:
    - Appropriate storage of meal
    - Preparing meal

Note: If applicable, copies of personal record must be:

- *Placed in a prominent place in the participant's file*
- *Sent with the participant when transferred for medical care or upon moving from the residence and in accordance with state law*

Activities Not Allowed

The following activities are not allowed or reimbursed under Home-Delivered Meals:

- More than two meals per day

- Services provided to participants receiving either of the following waiver services:
  - Adult Family Care
  - Assisted Living
- Service provided by the parent of a minor child participant or the spouse of a participant (also known as LRIs)

Provider Qualifications

Provider qualifications for Home-Delivered Meals services are presented in Table 18.

Table 18 – Provider Qualifications for Home-Delivered Meals

Waiver	Provider	Licensure/ Certification	Other Standards
H&W/TBI	Home-Delivered Meals Agency	Not required	FSSA approved *455 IAC 2* Becoming an approved provider; maintaining approval *455 IAC 2* Provider qualifications: General requirements *455 IAC 2* Maintenance of records of services provided *455 IAC 2* Liability insurance *455 IAC 2* Maintenance of records of services provided Must comply with all state and local health laws and ordinances concerning preparation, handling and serving of food.

Section 11.17: Home Modification Assessment for H&W and TBI Waivers

The following subsections provide information and requirements for Home Modification Assessment services under the H&W and TBI waivers.

Service Definition

The service will be used to objectively determine the specifications for a home modification that is safe, appropriate, and feasible to ensure accurate bids and workmanship. All participants must receive a Home Modification Assessment with a certified waiver provider selected by the participant prior to any subsequent home modifications as well as a home modification inspection upon completion of the work. A home modification will not be reimbursed until the final inspection has been completed.

The Home Modification Assessment will assess the home for physical adaptations to the home, that, as indicated by the individual's service plan, are necessary to ensure the health, welfare, and safety of the individual and enable the individual to function with greater independence in the home. Without the modifications, the individual would require institutionalization.

The assessor will be responsible for writing the specifications, review of feasibility and the post-project inspection:

- Upon completion of the specifications and a review of feasibility, the assessor will prepare and submit the project specifications to the case manager and the participant for the bidding process. The assessor will be paid first installment for the completion of the home specifications.

- After the project is complete, the assessor, participant, and case manager will each be present on an agreed upon date and time to inspect the work and sign-off indicating that it was completed per the agreed-upon bid and be paid the final installment of the home modification work. In the event the participant, provider, assessor and/or case manager become aware of discrepancies for complaints about the work being completed, the provider shall stop work immediately and contact the case manager and the FSSA for further instruction. The FSSA also has the ability to request additional assessment visits to help resolve a disagreement between the Home Modifications provider and the participant. This payment is not included in the actual home modification cost category and shall not be subtracted from the participant's lifetime cap for Home Modifications. The care management provider entity will be responsible for maintaining related records that can be accessed by the state.

Allowable Activities

The Home Modification Assessment service includes the following activities:

- Evaluation of the current environment, including the identification of barriers underneath the home, electrical and plumbing, which may prevent the completion of desired modifications
- Nonfeasible assessments
- Drafting of specifications
- Preparation and submission of specifications
- Examination of the modification (inspection/approval)
- Contacting county for code enforcement

Service Standards

These service standards must be followed for the Home Modification Assessment:

- The need for Home Modifications must be indicated in the participant's plan of care.
- The modification must address the participant's level-of-service needs.
- Proposed specifications for the modification must conform to the requirements and limitations of the current approved service definition for Home Modifications.
- The assessment should be conducted by an approved, qualified individual who is independent of the entity providing the Home Modifications.
- The appropriate authority must be contacted regarding potential code violations.

Documentation Standards

These documentation standards must be followed:

- The need for Home Modifications must be indicated in the participant's plan of care.
- The modification must address the participant's level-of-service needs.
- Any discrepancy noted by the provider, case manager and/or participant shall be detailed in the final inspection and addressed by the assessor.

Note: If applicable, copies of personal record must be:

- *Placed in a prominent place in the participant's file*
- *Sent with the participant when transferred for medical care or upon moving from the residence and in accordance with state law*

Limitations

An annual cap of $628 is available for Home Modification Assessment services, unless the FSSA requests an additional assessment to help mediate disagreements between the home modification provider and the participant.

Activities Not Allowed

The following activities are not allowed:

- Home Modification Assessment services shall not be performed by the same provider that performs the subsequent Home Modifications.
- This service must not be used for living arrangements that are owned or leased by providers of waiver services.
- Payment will not be made for Home Modifications under this service.
- Service provided by the parent of a minor child participant or the spouse of a participant (also known as LRIs)

Provider Qualifications

Provider qualifications for Home Modification Assessment services are presented in Table 19.

Table 19 – Provider Qualifications for Home Modification Assessment

Waiver	Provider	Licensure/ Certification	Other Standards
H&W/TBI	Home Modification Assessment Individual	One of the following: • License: *IC 2520.2* Home Inspector • Certified Aging-In-Place Specialist (CAPS Certification – National Association of Home Builders) • Executive Certificate in Home Modifications (University of Southern California) Verification required every three years	FSSA approved *455 IAC 2* Becoming an approved provider; maintaining approval *455 IAC 2* Provider qualifications: General requirements *455 IAC 2* Financial information *455 IAC 2* Liability insurance *455 IAC* 2 Professional qualifications and requirements; documentation of qualifications *455 IAC* 2 Warranty required Compliance with applicable building codes and permits

Waiver	Provider	Licensure/ Certification	Other Standards
H&W/TBI	Architect	*IC 25-4*	FSSA approved *455 IAC 2* Becoming an approved provider; maintaining approval *455 IAC 2* Provider qualifications: General requirements *455 IAC 2* Financial information *455 IAC 2* Liability insurance *455 IAC 2* Professional qualifications and requirements; documentation of qualifications *455 IAC 2* Warranty required Compliance with applicable building codes and permits

Section 11.18: Home Modifications for H&W and TBI Waivers

The following subsections provide information and requirements for Home Modifications for the H&W and TBI waivers.

Service Definition

Home Modifications are physical adaptations to the home, as required by the participant's service plan, which are necessary to ensure the health, welfare, and safety of the participant, and which enable the participant to function with greater independence in their home. Without these Home Modifications, the participant would require institutionalization. Incidental structural repairs to facilitate modifications may be included in this service.

Home Ownership

Home Modifications are considered when the participant owns a home. Rented homes or apartments or family-owned homes are allowed to be modified only when a signed agreement from the property owner is obtained. The signed agreement must be submitted along with all other required documentation. Disputes between different parties may not be within the scope of the Bureau of Disabilities Services to be able to intervene in a resolution.

Choice of Provider

The participant chooses the certified providers to submit bids for the Home Modifications. If the participant chooses to continue with the Home Modifications after receiving the bids, then the lowest bid that meets the minimum requirements shall be chosen, such as, time frame to start service. There is a minimum requirement to gather two bids for any expected amount over $5,000.

Allowable Activities

Modifications allowed under the Home Modifications service may include but are not limited to the following:

- Adaptive door openers and locks
- Bathroom modification – including but not limited to:
  - Removal of existing bathtub, toilet and/or sink
  - Installation of roll-in shower, grab bars, toilet and sink
  - Installation of replacement incidental items (such as flooring, storage space and cabinets) that are necessary due to the bath modification
- Home 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.
- Kitchen modification, including but not limited to:
  - Removal of existing cabinets and sink
  - Installation of sink and cabinet
  - Installation of replacement incidental items (such as flooring, storage space and cabinets) if necessary due to kitchen modification
- Home safety devices such as:
  - Door alarms
  - Anti-scald devices
  - Hand-held shower head
  - Grab bars for the bathroom
- Ramp – including but not limited to portable (considered for rental property only) and permanent
- Single room air or portable conditioners/single room air purifiers:
- Vertical lift and/or stair lift
- Widening of doorways, including:
  - Exterior or interior bedroom, bathroom, kitchen door or any internal doorway as needed to allow for access. Pocket doors may be requested.
- Windows – replacement of glass with Plexi-glass or other shatterproof material when there is a documented medical or behavioral reason
- Matching interior – Upon completion of the modification, the room being modified will be matched to the previous color/style/design to the degree possible with the same paint, wall texture, wall coverings, doors, trim, flooring and so on.

Items requested that are not listed in this section must be reviewed and a decision rendered by the state FSSA director or state agency designee. Requests for modifications at two or more locations may only be approved at the discretion of the BDS director or designee. Requests for modifications may be denied if the state BDS director or state agency designee determines the documentation does not support residential stability and/or the service requested.

Service Standards

The case manager must follow these service standards:

- Document the need for Home Modification Assessment.
- Share expected modification requests identified by the participant determined through the PCISP with the assessor.
- All home modifications must be approved by the waiver program prior to services being rendered.
- Collect two bids if the cost is over $5,000.
- If only one bid is obtained, the case manager must document the date of contact, the provider name and why a bid was not obtained from another provider.
- Notify the FSSA of any discrepancies or complaints about the work while it is being completed. Notice must be provided to the FSSA within 48 hours upon learning of the issues.
- Ensure that before and after drawings are submitted for bathroom, kitchen and ramps.
- Ensure that bid contains warranty information.
- If a home assessor is available in the county where the participant lives, then all participants must receive a Home Modification Assessment with a certified waiver provider selected by the participant prior to any subsequent home modifications as well as a home modification inspection upon completion of the work.

The provider must meet these standards:

- The need for home modification must be indicated in the participant's service plan.
- Proposed specifications for modification must conform to the requirements and limitations of the current approved service definition for Home Modifications service.
- Providers are required to provide a written warranty for a new product or service in the form of a binding document stating that, for a period of not less than one year, the service provider shall replace or repair any product or installation.
- If the state agency determines the provider is at fault for poor and/or incorrect work during the home modification, then the provider is responsible for correcting work at the cost of the provider.
- Bid must contain warranty information.
- Before and after drawings are required for bathroom, kitchen and ramps.
- Bid must be itemized with cost for each major component of the modification.
- Prohibited from placing residential liens.
- All Home Modifications must be approved by the waiver program prior to services being rendered.
- Home modification requests must be provided in accordance with applicable state and/or local building codes. Home modifications must be compliant with applicable building codes.
- A land survey may be required when exterior modifications approach the property line.
- Providers of services must maintain receipts for all incurred expenses related to the modification; must be in compliance with FSSA and FSSA-specific guidelines and/or policies.
- Notification to the participant's case manager and BDS of any discrepancies or complaints about the work while it is being completed. Notice must be provided to the BDS within 48 hours upon learning of the issues.

Documentation Standards

The case manager must provide documentation/explanation of the service within the *Request for Approval to Authorize Services (RFA) (State Form 45750)* including the following:

- Property owner of the residence where the requested modification is proposed
- Property owner's relationship to the participant
- What, if any, relationship the property owner has to the waiver program
- Written agreement of landlord or homeowner for modification, including agreement about items purchased during the modification, such as a bathtub, upon participant moving from the property or eviction.

> *Note: If applicable, copies of personal record must be:*
>
> - *Placed in a prominent place in the participant's file*
> - *Sent with the participant when transferred for medical care or upon moving from the residence and in accordance with state law*

Limitations

The following limits apply for the Home Modifications service:

- A lifetime cap of $20,000 is available for Home Modifications – Installation (procedure code and modifier S5165 U7 NU); however, the cap on any single project is $15,000. The cap represents a cost for basic modification of a participant's home for accessibility and safety and accommodates the participant's needs for housing modifications.
- The cost of a home modification includes all materials, equipment, labor and permits to complete the project. No parts of a home modification may be billed separately as part of any other service category (such as Specialized Medical Equipment and Supplies).
- In addition to the $20,000 lifetime cap, $1,000 is allowable annually for the repair, replacement or an adjustment to an existing home modification that was funded by an HCBS waiver.
- Home Modifications – Maintenance (procedure code and modifier S5165 U7 U8) is limited to $1,000 annually for the repair and service of home modifications that have been provided through an HCBS waiver. The following apply for these home modification maintenance services:
  - Requests for service must detail parts cost and labor cost.
  - If the need for maintenance exceeds $1,000, the case manager will work with other available funding streams and community agencies to fulfill the need. If service costs exceed the annual limit, those parts and labor costs funded through the waiver must be itemized clearly to differentiate the waiver service provision from those parts and labor funded through a nonwaiver funding source.
- Items requested that are not listed in the *Allowable Activities* section must be reviewed and decision rendered by the state FSSA director or state agency designee.
- Requests for modifications at two or more locations may only be approved at the discretion of the FSSA director or designee.
- Requests for modifications may be denied if the state FSSA director or state agency designee determines the documentation does not support residential stability and/or the service requested.

The services under Home Modifications are limited to additional services not otherwise covered under the Indiana Medicaid State Plan, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) but consistent with waiver objectives of avoiding institutionalization.

Activities Not Allowed

Activities not allowed under Home Modifications include but are not limited to the following:

- Adaptations or improvements that are not of direct medical or remedial benefit to the participant, such as:
  - Central heating and air conditioning
  - Routine home maintenance
  - Roof repair
  - Structural repair that is not incidental to the original modification
  - Driveways, decks, patios, publicly owned sidewalks and household furnishings
  - Swimming pools, spas or hot tubs
  - Outside storage spaces
  - 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 on)
- Modifications that will add non-incidental square footage to the home
- Home Modifications services for participants living in foster homes, group homes, assisted living facilities or homes for special services (any licensed residential facility)
  (*Note: The responsibility for Home Modifications rests with the facility owner or operator.*)
- Home Modifications services for participants living in a provider-owned or -controlled residence (*Note: The responsibility for Home Modifications rests with the facility owner or operator.*)
- Completion of, or modifications to, new construction or significant remodeling/reconstruction are excluded, unless there is documented evidence of a significant change in the participant's medical or remedial needs that now require the requested modification
- The services under Home Modifications are limited to additional services not otherwise covered under the Indiana Medicaid State Plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.
- Home Modifications services will not be reimbursed when the owner of the service organization is one of the following:
  - Parent of a minor child participant
  - Spouse of a participant
  - Attorney-in-fact (or POA) of a participant
  - HCR of a participant
  - Legal guardian of a participant
- Service provided by the parent of a minor child participant or the spouse of a participant (also known as LRIs)

Provider Qualifications

Provider qualifications for Home Modifications are presented in Table 20.

Table 20 – Provider Qualifications for Home Modifications

Waiver	Provider	Licensure/ Certification	Other Standards
H&W/TBI	Home Modifications Individual	Any applicable licensure must be in place	FSSA approved *455 IAC 2* Becoming an approved provider; maintaining approval *455 IAC 2* Provider qualifications: General requirements *455 IAC 2* Maintenance of records of services provided *455 IAC 2* Liability insurance *455 IAC 2* Professional qualifications and requirements; documentation of qualifications *455 IAC 2* Warranty required Compliance with applicable building codes and permits
H&W/TBI	Home Modifications Agency/Contractor	Any applicable licensure *IC 25-20.2* Home inspector *IC 25-28.5* Plumber *IC 25-4* Architect	FSSA approved *455 IAC 2* Becoming an approved provider; maintaining approval *455 IAC 2* Provider qualifications: General requirements *455 IAC 2* Maintenance of records of services provided *455 IAC 2* Liability insurance *455 IAC 2* Professional qualifications and requirements; documentation of qualifications *455 IAC 2* Warranty required Compliance with applicable building codes and permits
H&W/TBI	Plumber	*IC 25-28.5*	FSSA approved *455 IAC 2* Becoming an approved provider; maintaining approval *455 IAC 2* Provider qualifications: General requirements *455 IAC 2* Financial information *455 IAC 2* Liability insurance *455 IAC 2* Professional qualifications and requirements; documentation of qualifications *455 IAC 2* Warranty required Compliance with applicable building codes and permits

Waiver	Provider	Licensure/ Certification	Other Standards
H&W/TBI	Architect	*IC* 25-*4*	FSSA approved *455 IAC 2* Becoming an approved provider; maintaining approval. *455 IAC 2* Provider qualifications: General requirements *455 IAC 2* Financial information *455 IAC 2* Liability insurance *455 IAC 2* Professional qualifications and requirements; documentation of qualifications *455 IAC 2* Warranty required Compliance with applicable building codes and permits

Section 11.19: Integrated Health Care Coordination for H&W and TBI Waiver

The following subsections provide information and requirements for Integrated Health Care Coordination services for the H&W and TBI waiver.

Service Definition

Integrated Health Care Coordination is to promote improved health status and quality of life, delay/prevent deterioration of health status, manage chronic conditions in collaboration with the physicians, and integrate medical and social services.

Allowable Activities

Integrated Health Care Coordination may include the following activities:

- Development and oversight of a healthcare support plan that includes coordination of medical care and proactive care management of both chronic diseases and complex conditions such as recurring falls, depression and dementia (*Note: Skilled nursing services are provided within the scope of the Indiana State Nurse Practice Act.*)
- Collaboration across all service providers: waiver, Indiana Medicaid State Plan, mental health, dental and medical
- Collaboration across social supports: housing, food, Medicare/Medicaid system navigation, finances and transportation
- Medication review
- Transitional support from hospital or nursing facility to home/assisted living
- Advance care planning

Service Standards

These service standards must be followed for Integrated Health Care Coordination:

- Weekly consultations or reviews

- Face-to-face visits with the participant; including a minimum of one face-to-face visit per month
- No duplication of services provided under the Indiana Medicaid State Plan or under any other waiver service
- Services must address needs in the plan of care
- Current Indiana RN license for each nurse.
- Current Indiana license for each LPN.
- Current Indiana license for social worker (LSW) with master's degree in social work with additional documentation of at least two years of experience providing health care coordination.

The case manager is expected to coordinate and collaborate with the participant's Integrated Health Care Coordination provider; review all updates about the participant from the health care coordination provider including interventions and follow up with the participant about changes in medical and social services as well as interventions implemented by the health care coordinator provider to ensure the member's needs are being met. The case manager shall communicate information learned in these follow-up meetings with the integrated health care coordination provider and shall work together to resolve any unmet needs identified.

Documentation Standards

These documentation standards must be followed for Integrated Health Care Coordination:

- Evidence of a consultation, including complete date and signature (*Note: Consultation can be with the participant, informal caregivers, other staff, other professionals, as well as healthcare professionals.*)
  - Weekly consultations or reviews
  - Minimum of one face-to-face visit with the participant per month.
- Services required to address needs identified in the plan of care or PCISP
- Written report provided to pertinent parties at least quarterly by the Integrated Health Care Coordination provider (*Note: Pertinent parties include the participant, guardian, waiver case manager, all waiver service providers including mental health providers, Indiana Medicaid State Plan services and physicians.*)

Note: If applicable, copies of personal record must be:

- *Placed in a prominent place in the participant's file*
- *Sent with the participant when transferred for medical care or upon moving from the residence and in accordance with state law*

Limitations

Integrated Health Care Coordination services will not duplicate services provided under the Indiana Medicaid State Plan or any other waiver service.

Integrated Health Care Coordination services are:

- A minimum of one face-to-face visit per month
- Not to exceed 16 hours of healthcare coordination per month, including travel time

Activities Not Allowed

The following activities are not allowed under Integrated Health Care Coordination:

- Skilled nursing services that are available under the Indiana Medicaid State Plan
- Any other service otherwise provided by the waiver

Provider Qualifications

Provider qualifications for Integrated Health Care Coordination are presented in Table 21.

Table 21 – Provider Qualifications for Integrated Health Care Coordination

Waiver	Provider	Licensure/ Certification	Other Standards
H&W/TBI	Adult Day Facility	*IC 25-23-1* RN *IC 25-23-1* LPN *IC 25.23.6* LSW	FSSA approved *455 IAC 2* Provider qualifications: General requirements for direct care staff
H&W/TBI	Assisted Living Facility	*IC 25-23-1* RN *IC 25-23-1* LPN *IC 25.23.6* LSW	FSSA approved *455 IAC 2* Provider qualifications: General requirements for direct care staff
H&W/TBI	Physician Practice	*IC 25-23-1* RN *IC 25-23-1* LPN *IC 25.23.6* LSW	FSSA approved *455 IAC 2* Provider qualifications: General requirements for direct care staff

Section 11.20: Nutritional Supplements for H&W and TBI Waivers

The following subsections provide information and requirements for the Nutritional Supplements service for H&W and TBI waivers.

Service Definition

Nutritional (dietary) supplements include liquid supplements, such as Boost or Ensure, to support people in maintaining an individual's health, so they are able to remain in the community.

Supplements must be ordered by a physician, physician assistant or nurse practitioner.

Approved Nutritional Supplements expenditures are reimbursed through the local AAA or an approved FSSA provider that maintains all applicable receipts and verifies the delivery of services. Providers can directly relate with the state Medicaid agency at the provider's election.

Allowable Activities

The Nutritional Supplements service includes enteral formulae, category 1, such as Boost or Ensure.

Service Standards

Nutritional Supplements services must follow a written service plan addressing specific needs determined by the individual's PCISP.

Documentation Standards

The case manager must complete these documentation tasks:

- Document the need for Nutritional Supplements and amount being requested.
- Identify the amount requesting from the annual cap of $1,200 for Nutritional Supplements services.

The provider must document the following:

- Date of delivery
- How many meals were provided
- Care professional or case manager that involved the participant

> *Note: If applicable, copies of personal record must be:*
>
> - *Placed in a prominent place in the participant's file*
> - *Sent with the participant when transferred for medical care or upon moving from the residence and in accordance with state law*

Limitations

The following limits apply for Nutritional Supplements services:

- An annual cap of $1,200 is available for Nutritional Supplements services.
- The services under Nutritional Supplements are limited to additional services not otherwise covered under the Indiana Medicaid State Plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.
- The meals provided as part of these services shall not constitute a full nutritional regimen.

Activities Not Allowed

The following activities are not allowed under Nutritional Supplements:

- Services available through the Indiana Medicaid State Plan (an Indiana Medicaid State Plan PA denial is required before reimbursement is available through the Medicaid waiver for this service)
- Service provided by the parent of a minor child participant or the spouse of a participant (also known as LRIs)

Provider Qualifications

Provider qualifications for the Nutritional Supplements service are presented in Table 22.

Table 22 – Provider Qualifications for Nutritional Supplements

Waiver	Provider	Licensure/ Certification	Other Standards
H&W/TBI	Nutritional Supplements Agency	Not required	FSSA approved *455 IAC 2* Becoming an approved provider; maintaining approval. *455 IAC 2* Provider qualifications: General requirements *455 IAC 2* Transfer of individual's record upon change of provider *455 IAC 2* Maintenance of records of services provided *455 IAC 2* Liability insurance

Section 11.21: Participant-Directed Home Care Service for H&W Waiver

The following subsections provide information and requirements for Participant-Directed Home Care Service under the H&W Waiver.

Service Definition

The Participant-Directed Home Care Service is a health-related service under the H&W Waiver that can be performed by either licensed medical or trained nonmedical personnel, and is provided for the primary purpose of meeting the chronic personal needs of the participant to maintain a level of function that will allow for a participant to avoid unnecessary institutionalization. This service can provide skilled or attendant care activities or both. In conjunction with the Indiana Medicaid State Plan, the Participant-Directed Home Care Service may be provided 24 hours per day, seven days a week.

> *Note: The Participant-Directed Home Care Service has a limit of five slots, and services must be approved by the FSSA.*

Service Standards

The Participant-Directed Home Care Service has the following service standards:

- A participant shall hire either a licensed professional through a home health agency, an independent, licensed professional or a nonclinical competency trained unlicensed profession.
- Home care service requires individual and continuous services when there is no person available outside of these services to assume the role of caregiver.
- The Participant-Directed Home Care Service requires a participant to be diagnosed with a chronic medical condition that may require up to 24 hours of continuous care, as evidenced through a physician's order that can be safely provided outside of an institution. The participant must also receive Indiana Medicaid State Plan home health services.
- Home care attendant service is provided according to the participant's service plan/plan of care which documents the participant's specific health-related need for individual and continuous care.
- Participant must be willing to accept risks and responsibilities associated with employing the caregiver and directing their own care.

Limitations

The Participant-Directed Home Care Service has the following limitations:

- Is offered to individuals in a noncongregate setting.
- Is offered to individuals living alone without family or other informal supports willing and able to be trained to care for the participant and assume a portion of the participant's care.
- Is offered to individuals residing in postal codes 46260, 46143, 46202 and 46204
- Does not include administration of level II, III, IV and V medications.

Documentation Standards

Case managers are an integral part of the success of the Participant-Directed Home Care Service. The case manager must maintain these documentation standards:

- Provide oversight and monitoring of the service plan of the participant.
- Assess the participant for participation in the Participant-Directed Home Care Service and complete the participant-directed checklist before the service may be added to the service plan and at the initial, quarterly review, annual and reentry assessments.
- Assist the participant in directing care in evaluating whether the Participant-Directed Home Care Service is appropriate for meeting the participant's needs.
- Assess the needs of the participant through a person-centered planning process and establish an annual cost limit based on the authorized plan of care. For waiver participants, annual cost per participant is determined by an algorithm established by the FSSA. The case manager will develop a person-centered plan that aligns with all setting rule requirements and meets those needs and service requests, and a dollar amount will be assigned to the plan using the FSSA's algorithm. The case manager must document the budget process and review with the participant.
- Document the medical need for a skilled service and types of skilled care the participant may require.
- Document the frequency, duration and types of appropriate skilled activities that will meet the participant's needs and ensure it is accurately documented in the skilled LOC assessment.
- Have the participant sign a waiver liability form.
- Document who is the employer, who is the employee/direct worker and their relationship to the participant.
- Document the backup plan for the participant for when the direct worker is unavailable to deliver skilled care.
- Monitor the enrollment process for the participant and their employee/direct worker.
- Collect all training paperwork containing signatures for the file.
- Monitor the service delivery every month. The case manager will coordinate service delivery (frequency, activities) with the employee/direct worker and also contact the fiscal intermediary agency to verify.

Note: If applicable, copies of personal record must be:

- *Placed in a prominent place in the participant's file*
- *Sent with the participant when transferred for medical care or upon moving from the residence and in accordance with state law*

Activities Not Allowed

The following activities are not allowed under Participant-Directed Home Care Service:

- Home care service shall not be reimbursed when provided by any of the following:
  - Parent of a minor child participant
  - Spouse of a participant
- Participant must be able to direct their own care.

Provider Standards

The caregiver applicant must enter into the IHCP agreement to become a paid caregiver. The caregiver authorized to provide home care attendant services to participants if the caregiver:

- Either meets the personnel qualifications specified in *IC.16-27-1* or successfully completed at least one of the following, as applicable (verified by the fiscal intermediary):
  - If applicable, a competency evaluation program or training and competency evaluation program approved or conducted under section 10.2.2 of the American Association of Respiratory Care (AARC) Clinical Practice Guideline
  - A program that includes cardiopulmonary resuscitation (CPR), basic first aid and any applicable durable medical equipment (DME) training
- Identifies and documents participant need in the provider service plan:
  - Services must be outlined in the provider service plan.
  - Data record of services must be provided and maintained, including:
    - Complete date and time of service (in and out)
    - Specific services or tasks provided
    - Signature of paid caregiver providing the service (minimally the last name and first initial)
  - Each paid caregiver providing direct care or supervision of care to the participant must make at least one entry on each day of service. All entries must describe an issue or circumstance offered to the individual.
  - Daily documentation of service delivery is to be signed by the participant. If the participant cannot sign, then the paid caregiver must self-attest and sign in lieu of the participant.
  - The paid caregiver is required to coordinate information about the participant's care, including backup plan, with any and all other providers and case manager rendering services to the participant. Provider coordination shall occur among providers/paid caregivers during shift changes for the participant and at any other time where the participant experiences a healthcare change.

Provider Qualifications

Provider qualifications for the Participant-Directed Home Care Service are presented in Table 23.

Table 23 – Provider Qualifications for Participant-Directed Home Care Service

Waiver	Provider	Licensure/ Certification	Other Standards
H&W	Aide/Paid Caregiver	Not required	FSSA approved
H&W	Home Health agency	*IC 16-27-1*	FSSA approved provider

Section 11.22: Personal Emergency Response System for H&W and TBI Waivers

The following subsections provide information and requirements for the Personal Emergency Response System under the H&W and TBI waivers.

Service Definition

Personal Emergency Response System is an electronic device that enables certain participants at high risk of institutionalization to secure help in an emergency. The participant may also wear a portable help button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center after a button is activated. The response center is staffed 24 hours a day, seven days a week by trained professionals.

Allowable Activities

The following activities are allowed under the Personal Emergency Response System service:

- Device installation
- Ongoing monthly maintenance of the device
- Electronic service that is usually a portal help button; however, it can also be an electronic device that includes, but is not limited to, Global Positioning System (GPS) or video monitoring service (*Note: Remote monitoring will not be placed in participant bedrooms or bathrooms.*)

Service Standards

The Personal Emergency Response System service must follow a written service plan addressing specific needs determined by the individual's assessment.

The case manager is required to contact the waiver participant if contacted by the Personal Emergency Response System provider that waiver participant experienced a fall.

Documentation Standards

The case manager is responsible for documenting the following:

- The need for Personal Emergency Response System
- The need for Personal Emergency Response System maintenance
- Whether the person is residing alone or alone for significant parts of the day without a caregiver present

The provider is responsible for documenting the following:

- Date of installation
- Expense for installation
- Monthly rental fee
- Ongoing monthly maintenance of device
- Monthly written notification to case managers of any participant who experienced a fall within a one-month time frame

The monitor positions would be determined during the person-centered service planning process.

Persons responsible for monitoring would be determined during the person-centered service planning process.

The mainframe location would be determined by the provider.

The state confirms there is a backup plan in the event of equipment failure.

The care manager is the central vehicle for the state to provide information to the participant, their family and the entire circle of support. This is part of the person-centered planning process, which would include the provider.

Note: If applicable, copies of personal record must be:

- *Placed in a prominent place in the participant's file*
- *Sent with the participant when transferred for medical care or upon moving from the residence and in accordance with state law*

Activities Not Allowed

The following activities are not allowed under the Personal Emergency Response System service:

- Replacement cost of lost or damaged equipment
- Services provided to participants receiving the Assisted Living or Adult Family Care waiver services
- Remote monitoring in participant bedrooms or bathrooms

Service provided by the parent of a minor child participant or the spouse of a participant (also known as LRIs)

Provider Qualifications

Provider qualifications for the Personal Emergency Response System service are presented in Table 24.

Table 24 – Provider Qualifications for Personal Emergency Response System

Waiver	Provider	Licensure/ Certification	Other Standards
H&W/TBI	Personal Emergency Response System Agency	Not required	FSSA approved *455 IAC 2* Becoming an approved provider; maintaining approval *455 IAC 2* Provider qualifications: General requirements *455 IAC 2* Maintenance of records of services provided *455 IAC 2* Liability insurance *455 IAC 2* Professional qualifications and requirements; documentation of qualifications *455 IAC 2* Warranty required Compliance with applicable building codes and permits

Section 11.23: Pest Control for H&W and TBI Waivers

The following subsections provide information and requirements for Pest Control services under the H&W and TBI waivers.

Service Definition

Pest Control services are designed to prevent, suppress or eradicate anything that competes with humans for food and water, injures humans, spreads disease to humans, or annoys humans, and is causing or is expected to cause more harm than is reasonable to accept. Pests include but are not limited to insects such as roaches, mosquitoes, bed bugs and fleas; insect-like organisms, such as mites and ticks; and vertebrates, such as rats and mice.

Services to control pests are services that prevent, suppress or eradicate pest infestation.

Reimbursement for approved Pest Control expenditures is through the local AAA or other approved FSSA provider, which maintains all applicable receipts and verifies the delivery of services. Providers can directly communicate with the state Medicaid agency at the provider's election.

Allowable Activities

Pest Control services are added to the service plan when the case manager determines – either through direct observation or by participant report – that a pest is present and is causing or is expected to cause more harm than is reasonable to accept.

Services to control pests are services that prevent, suppress or eradicate pest infestation.

Service Standards

Pest Control services must follow a written service plan addressing specific needs determined by the individual's PCISP.

Documentation Standards

The case manager is responsible for documenting the following through the PCISP:

- Need for Pest Control
- Types of pests to eradicate through the PCISP

> *Note: If applicable, copies of personal record must be:*
>
> - *Placed in a prominent place in the participant's file*
> - *Sent with the participant when transferred for medical care or upon moving from the residence and in accordance with state law*

Limitations

An annual cap of $4,000 is available for Pest Control services.

Activities Not Allowed

The following activities are not allowed under the Pest Control service:

- Services used solely as a preventative measure (*Note: There must be documentation of a need for this service either through the case manager's direct observation or participant report that a pest is causing or is expected to cause more harm than is reasonable to accept.*)
- Services provided to participants receiving either of the following waiver services:
  - Adult Family Care
  - Assisted Living
- Preventive measures or ongoing need for service
- Eradication or prevention of mold or mold-like substances
- Service provided by the parent of a minor child participant or the spouse of a participant (also known as LRIs)

Provider Qualifications

Provider qualifications for Pest Control services are presented in Table 25.

Table 25 – Provider Qualifications for Pest Control

Waiver	Provider	Licensure/ Certification	Other Standards
H&W/TBI	Pest Control Agency	*IC 15-3-3.6*	FSSA approved *455 IAC 2* Becoming an approved provider; maintaining approval *455 IAC 2* Provider qualifications: General requirements *455 IAC 2* Maintenance of records of services provided *455 IAC 2* Liability insurance *455 IAC 2* Professional qualifications and requirements; documentation of qualifications *455 IAC 2* Warranty required Pesticide applicators must be certified or licensed through the Purdue University Extension Service and the Office of the Indiana State Chemist.

Section 11.24: Residential-Based Habilitation for TBI Waiver

The following subsections provide information and requirements for Residential-Based Habilitation services under the TBI Waiver.

Service Definition

Residential-Based Habilitation service provides training to regain skills that were lost secondary to the traumatic brain injury (TBI).

Allowable Activities

The following activities are allowable under the Residential-Based Habilitation service:

- Goal-oriented training and demonstration with:
  - Skills related to activities of daily living:
    - Personal grooming
    - Bed making and household chores
    - Planning meals, the preparation of food
  - Skills related to living in the community:
    - Using the telephone
    - Learning to prepare lists and maintaining calendars of essential activities and dates, and other organizational activities to improve memory
    - Handling money and paying bills
    - Shopping and errands
    - Accessing public transportation

Service Standards

Residential-Based Habilitation services must follow a written service plan addressing specific measurable goals and objectives to help with the acquisition, retention or improvement of skills that were lost secondary to the TBI.

Residential-Based Habilitation services must be monitored monthly.

As authorized under DDARS BDS policy, Residential-Based Habilitation services may be provided to an individual in an acute care hospital when such services are:

- Identified in an individual's person-centered service plan (or comparable plan of care)
- Provided to meet needs of the individual that are not met through the provision of hospital services
- Not a substitute for services that the hospital is obligated to provide through its conditions of participation or under federal or state law, or under another applicable requirement
- Designed to ensure smooth transitions between acute care settings and home and community-based settings, and to preserve the individual's functional abilities.

Documentation Standards

Documentation standards under Residential-Based Habilitation services include the following:

- Identified need must be documented in the service plan.
- Services must be outlined in the service plan.
- Data must be recorded of services provided, including the following:
  - Complete date and time of service (in and out)
  - Specific services/tasks provided
  - Monthly documentation of progress toward identified goals
  - Signature of employee providing the service (minimally the last name and first initial) (*Note: If the person providing the service is required to be a professional, the title of the individual must also be included.*)

- Each staff member providing direct care or supervision of care to the individual must make at least one entry on each day of service. All entries should describe an issue or circumstance concerning the individual.
- Documentation of service delivery is to be signed by the participant or designated participant representative.

> *Note: If applicable, copies of personal record must be:*
>
> - *Placed in a prominent place in the participant's file*
> - *Sent with the participant when transferred for medical care or upon moving from the residence and in accordance with state law*

Activities Not Allowed

The following activities are not allowed under Residential-Based Habilitation:

- Payments for residential based habilitation are not made for room and board.
- This service will not be reimbursed when provided by the parent of a minor child participant or the spouse of a participant (also known as LRIs).
- Payments will not be made for the routine care and supervision.
- Residential-Based Habilitation services to participants receiving Adult Family Care waiver service, or Structured Family Caregiving waiver service will not be reimbursed.
- The HCBS provided in an acute care hospital must not be duplicative of services available in the acute care hospital setting.

Provider Qualifications

Provider qualifications for Residential-Based Habilitation services are presented in Table 26.

Table 26 – Provider Qualifications for Residential-Based Habilitation

Waiver	Provider	Licensure/ Certification	Other Standards
TBI	Residential Based Habilitation Agency	N/A	FSSA approved *455 IAC 2* Provider Qualifications; General requirements *455 IAC 2* General requirements for direct care staff *455 IAC 2* Liability insurance *455 IAC 2* Professional qualifications and requirements *455 IAC 2* Personnel Records Habilitation services must be performed by persons who are supervised by a certified brain injury specialist (CBIS); a qualified intellectual disability professional (QIDP); or a physical, occupational or speech therapist licensed by the state of Indiana and have successfully completed training or have experience in conducting habilitation programs.

Section 11.25: Respite Care Services for H&W and TBI Waivers

The following subsections provide information and requirements for Respite Care Services under the H&W and TBI waivers.

Service Definition

Respite Care Services are those services that are provided temporarily or periodically in the place of the usual caregiver. Respite can occur in home- and community-based settings.

Allowable Activities

The following activities are allowed under Respite Care Services:

- Home health aide services
- Respite care nursing services

Service may be provided in home- and community-based settings.

Service Standards

If Respite Care Services occur in an HCBS-certified facility targeting children and young adults 22 years and younger, staff-to-participant ratio cannot be greater than one staff per two participants. When Respite Care Services are provided in this environment, the intent is to provide support to families in an effort to avoid institutionalization of their children.

The level of professional care provided under Respite Care Services depends on the needs of the participant and caregiver determined in the PCISP. The service standards under Respite Care Services are as follows:

- Agency providing Respite Care Services is responsible for tracking participant's respite hours and notifying participant and case manager of hours used as well as hours remaining.
- RHHA: A participant who is eligible for Indiana Medicaid State Plan home health services (HOHE) should be considered for respite home health aide (RHHA) services under the supervision of a registered nurse.

  RHHA-authorized hours will roll over month-to-month through the duration of the annual service plan. If a request for an increase in RHHA during the annual care plan is needed, the case manager must coordinate with the agency to verify unused hours before requesting the additional hours. If there are unused hours, those hours must be used first before requesting additional hours.
- RNU: A participant who is eligible for Indiana Medicaid State Plan nursing services (SKNU) must be considered for respite care nursing services (RNU) provided by an RN or LPN.

  RNU authorized hours will roll over month to month through the duration of the annual service plan. If a request for an increase in RHHA during the annual care plan is needed, the case manager must coordinate with the agency to verify unused hours before requesting the additional hours. If there are unused hours, those hours must be used first before requesting additional hours.

Documentation Standards

The case manager is responsible for the following documentation standards:

- Identify the primary caregiver being relieved; identify that the primary caregiver is not being paid by the agency to respite themselves during this time.
- Document needs and activities that require skilled respite.

The provider is responsible for the following documentation standards:

- Complete a data record of staff to participant service, documenting the complete date and time in and time out, and the number of units of service delivered that day.
- Ensure that each staff member providing direct care or supervision of care to the participant makes at least one entry on each day of service describing an issue or circumstance concerning the participant.
- Include date and time, and at least the last name and first initial of the staff person making the entry in documentation. *(Note: If the person providing the service is required to be a professional, include that title - for example, if a nurse is required to perform the service, the RN or LPN title would be included with the name.)*
- Document any significant issues involving the participant that require intervention by a healthcare professional; also document the case manager that involved the participant.
- Include the following elements: the reason for the respite and the type of respite rendered.
- Specify applicable (if any) limits on the amount, frequency or duration of this service.
- Provide notification to the participant's case manager and other unskilled provider within 48 hours upon changes to the participant's person-centered service plan.

Note: If applicable, copies of personal record must be:

- *Placed in a prominent place in the participant's file*
- *Sent with the participant when transferred for medical care or upon moving from the residence and in accordance with state law*

Activities Not Allowed

The following activities are not allowed under Respite Care Services:

- Replacing services that should be provided under the Indiana Medicaid State Plan
- Provided when the owner of the service organization is one of the following:
  - Parent of a minor child participant
  - Spouse of a participant
  - Attorney-in-fact (or POA) of a participant
  - HCR of a participant
  - Legal guardian of a participant
- Duplication of any other service being provided under the participant's service plan
- Services provided to participants receiving any of the following waiver services:
  - Adult Family Care
  - Assisted Living
- Service provided by the parent of a minor child participant or the spouse of a participant (also known as LRIs)

Provider Qualifications

Provider qualifications for Respite Care Services are presented in Table 27.

Table 27 – Provider Qualifications for Respite Care Services

Waiver	Provider	Licensure/ Certification	Other Standards
H&W/TBI	Licensed Home Health Agency	*IC 16-27-1*	FSSA approved

Section 11.26: Specialized Medical Equipment and Supplies for H&W and TBI Waivers

The following subsections provide information and requirements for Specialized Medical Equipment and Supplies under the H&W and TBI waivers.

Service Definition

The Specialized Medical Equipment and Supplies service includes medically prescribed items required by the participant's service plan, which assist the participant in maintaining their health, welfare and safety, and enable the participant to function with greater independence in the home. The Specialized Medical Equipment and Supplies service provides therapeutic benefits to a participant in need, because of certain medical conditions and/or illnesses. Specialized Medical Equipment and Supplies primarily and customarily are used to serve a medical purpose and are not useful to a person in the absence of illness or injury.

All Specialized Medical Equipment and Supplies must be approved by the waiver program prior to the service being rendered:

- Participants requesting authorization for this service through an HCBS waiver must first exhaust eligibility of the desired equipment or supplies through the Indiana Medicaid State Plan, which may require PA. The BDS will deny any provider claim that did not follow the correct Medicaid billing practices:
  - There should be no duplication of services between the HCBS waiver and Indiana Medicaid State Plan.
  - The refusal of a Medicaid vendor to accept the Medicaid reimbursement through the Indiana 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. The Indiana Medicaid State Plan often covers similar equipment but may not cover the specific brand requested. When this occurs, the participant is limited to the service/brand covered by the Indiana Medicaid State Plan.
  - Reimbursement is limited to the Indiana Medicaid State Plan fee schedule if the requested item is covered under the Indiana Medicaid State Plan.
  - All requests for items to be purchased through a Medicaid waiver must be accompanied by documentation of Indiana Medicaid State Plan PA request and decision, if requested item is covered under Indiana Medicaid State Plan.
- Requests will be denied if the FSSA director or designee determines the documentation does not support the service requested.

Allowable Activities

The services under Specialized Medical Equipment and Supplies are limited to additional services not otherwise covered under the Indiana Medicaid State Plan (including EPSDT), but consistent with waiver objective of avoiding institutionalization.

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

The following are allowable activities under Specialized Medical Equipment and Supplies:

- Lift chairs – The HCBS program will cover the chair. The Indiana Medicaid State Plan should be pursued first for prior approval of the lift mechanism.
- Medication dispensers

> *Note: Filling the medication dispenser is not currently an allowable activity. If a participant needs assistance with the filling of medication dispensers, Indiana Medicaid State Plan prior authorization services could be sought, and this task could be completed by a registered nurse (RN). Participants could also use informal supports if available. As a reminder, "pill packs," where the pharmacy is packaging together an individual's medications, is not a medication dispenser. Any service plans that include pill packs will not be approved. If a member is receiving pill packs, work with them to update their service plan. Case managers can use their local Aging and Disability Resource Center (ADRC) and options counselors to identify pharmacies that may offer pill packs through other resources.*

- Toileting and/or incontinence supplies that do not duplicate Indiana Medicaid State Plan Services
- Slip-resistant socks
- Self-help devices – Including over-the-bed tables, reachers, adaptive plates, bowls, cups, drinking glasses and eating utensils
- Strollers – When needed because participant's primary mobility device does not fit into the participant's vehicle/mode of transportation, or when the participant does not require the full-time use of a mobility device, but a stroller is needed to meet the mobility needs of the participant outside of the home setting
- Voice active smart devices
- Interpreter service – Provided in circumstances where the interpreter assists the individual in communication during specified scheduled meetings for service planning (such as waiver case conferences or team meetings) and is not available to facilitate communication for other service provision.

> *Note: Items requested that are not listed in this section will be submitted in the service plan and reviewed by the state FSSA director.*

- Maintenance – Limited to $1,000 annually for the repair and service of items that have been provided through an HCBS waiver

Service Standards

The following service standards must be met for the Specialized Medical Equipment and Supplies service:

- All items must be of direct medical or remedial benefit to the participant.
- All items must meet applicable standards of manufacture, design, and service specifications.

Documentation Standards

The case manager is responsible for the following documentation standards:

- Document the need for medical specialized equipment.
- Describe how the equipment is expected to improve the participant's quality of ADL.
- Collect two bids if over $1,000; if only one bid is obtained, the case manager must document the date of contact, the provider name and why the bid was not obtained from another provider.
- Ensure that bid contains warranty information and picture of the equipment.
- Submit Indiana Medicaid State Plan denial information for the equipment and/or supplies.

The provider must follow these document standards:

- Document date of installation.
- Document expense for installation.
- Document the identified direct benefit or need within the following:
  - Person-centered service plan
  - Physician prescription and/or clinical evaluation as deemed appropriate
- Obtain Indiana Medicaid State Plan PA request and the decision rendered, if applicable.
- Obtain signed and approved *Request for Approval to Authorize Services (RFA) (State Form 45750)*.
- Obtain signed and approved person-centered service plan.
- Maintain receipts for all incurred expenses related to this service.
- Must be in compliance with FSSA and FSSA-specific guidelines and/or policies.
- At the time of renewal or when this section of the waiver is opened/edited in an amendment prior to the renewal, the state will create a separate, standalone interpreter service.

Note: If applicable, copies of personal record must be:

- *Placed in a prominent place in the participant's file*
- *Sent with the participant when transferred for medical care or upon moving from the residence and in accordance with state law*

Limitations

Maintenance is limited to $1,000 annually for the repair and service of items that have been provided through an HCBS waiver:

- Requests for service must detail parts and labor costs.
- If the need for maintenance exceeds $1,000, the case manager works with other available funding streams and community agencies to fulfill the need. If service costs exceed the annual limit, parts and labor costs funded through the waiver must be itemized clearly to differentiate parts the waiver service provision from parts and labor provided through a nonwaiver funding source.
- The services under Specialized Medical Equipment and Supplies are limited to additional services not otherwise covered under the Indiana Medicaid State Plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Activities Not Allowed

The following activities are not allowed under Specialized Medical Equipment and Supplies:

- Unallowable items including, but not limited to the following:
  - Hospital beds or air fluidized suspension mattresses/beds
  - Therapy mats
  - Parallel bars
  - Scales
  - Paraffin machines or baths
  - Therapy balls
  - Books, games, or toys
  - Electronics such as CD players, radios, cassette players, tape recorders, television, VCRs/DVDs, camerasor film, videotapes, and other similar items
  - Computers and software
  - Exercise equipment such as treadmills or exercise bikes
  - Furniture
  - Appliances such as refrigerator, stove or hot water heater
  - Indoor and outdoor play equipment such as swing sets, swings, slides, bicycles adaptive tricycles, trampolines, playhouses or merry-go-rounds
  - Swimming pools, spas, hot tubs, or portable whirlpool pumps
  - Adjustable mattresses (such as, but not limited to, Tempur-Pedic), positioning devices or pillows
  - Motorized scooters
  - Barrier creams, lotions, or personal cleaning cloths
  - Essential oils
  - Totally enclosed cribs and barred enclosures used for restraint purposes
  - Manual wheelchairs
  - Vehicle modifications
- Any equipment or items that can be authorized through the Indiana Medicaid State Plan
- Any equipment or items purchased or obtained by the participant, their family members or other nonwaiver providers
- Service provided by the parent of a minor child participant or the spouse of a participant (also known as LRIs)

Provider Qualifications

Provider qualifications for Specialized Medical Equipment and Supplies are presented in Table 28.

Table 28 – Provider Qualifications for Specialized Medical Equipment and Supplies

Waiver	Provider	Licensure/ Certification	Other Standards
H&W/TBI	Licensed Home Health Agency	*IC 16-27-1*	FSSA approved *455 IAC 2-18* Warranty required
H&W/TBI	Specialized Medical Equipment and Supplies Agency	*IC 25-26-21 Certification IC 6-2.5-8-1*	FSSA approved *455 IAC 2* Becoming an approved provider; maintaining approval *455 IAC 2* Provider qualifications: general requirements *455 IAC 2* Maintenance of records of services provided *455 IAC 2* Liability insurance *455 IAC 2* Professional qualifications and requirements; documentation of qualifications *455 IAC 2* Warranty required

Section 11.27: Structured Day Program for TBI Waiver

The following subsections provide information and requirements for Structured Day Program services covered under the TBI Waiver.

Service Definition

The Structured Day Program provides assistance with acquisition, retention or improvement in self-help, socialization, and adaptive skills that takes place in a nonresidential setting, separate from the home in which the individual resides. Services will normally be furnished four or more hours per day on a regularly scheduled basis, for one or more days per week, unless provided as an adjunct to other day activities included in an individual's service plan.

Service Standards

The following service standards must be met for the Structured Day Program:

- Must follow a written service plan addressing specific needs determined by the individual's assessment.
- Shall focus on enabling the individual to attain or maintain their functional level.
- May serve to reinforce skills or lessons taught in school, therapy, or other settings.

Documentation Standards

The following service standards must be met:

- Identified need in the service plan
- Services outlined in the service plan
- Data record of services provided, including:
  - Complete date and time of service (in and out)
  - Specific services/tasks provided

- Signature of the employee providing the service (minimally the last name and first initial) (*Note: If the person providing the service is required to be a professional, the title of the individual must also be included.*)

- At least one entry on each day of service from each staff member providing direct care or supervision of care to the individual (*Note: All entries should describe an issue or circumstance concerning the individual.*)

> *Note: If applicable, copies of personal record must be:*
>
> - *Placed in a prominent place in the participant's file*
> - *Sent with the participant when transferred for medical care or upon moving from the residence and in accordance with state law*

Limitations

Services provided through Structured Day Programs should not duplicate any services provided under the Indiana Medicaid State Plan or other waiver service.

Provider Qualifications

Provider qualifications for Structured Day Program are presented in Table 29.

Table 29 – Provider Qualifications for Structured Day Program

Waiver	Provider	Licensure/ Certification	Other Standards
TBI	Structured Day Program Agency	Not required	FSSA approved *455 IAC 2* Provider Qualifications: General requirements *455 IAC 2* General requirements for direct care staff *455 IAC 2* Liability insurance *455 IAC 2* Professional qualifications and requirements *455 IAC 2* Personnel Records Habilitation services must be performed by persons who are supervised by a CBIS; QIDP; or a physical, occupational, or speech therapist licensed by the state of Indiana and have successfully completed training or have experience in conducting habilitation programs.

Section 11.28: Structured Family Caregiving for H&W and TBI Waivers

The following subsections provide information and requirements for Structured Family Caregiving services under the H&W and TBI waivers.

Service Definition

Structured Family Caregiving means a caregiving arrangement in which a participant lives with a primary caregiver who provides daily care and support to the participant based on the participant's daily care needs. The person responsible for providing day-to-day support (hereafter known as primary caregiver) may be a nonfamily member or a family member (except as limited below) who lives with the participant in the private home of the participant or the primary caregiver. Structured Family Caregiving agencies (hereafter known as provider agencies) are the Medicaid provider of this service and are responsible for identifying primary caregivers and substitute caregivers as needed, assessing the home setting, and providing ongoing oversight and support.

Necessary support services are provided by the primary caregiver as part of Structured Family Caregiving. Primary caregivers must be qualified to meet all federal and state regulatory guidelines and be able to provide care and support to a participant based on the participant's assessed needs. Primary caregivers receive training based on the participant's assessed needs and are paid a per diem stipend for the care and support they provide to participants.

Structured Family Caregiving preserves the dignity, self-respect and privacy of the participant by ensuring high-quality care in a noninstitutional setting. The goal of this service is to provide necessary care while fostering and emphasizing the participant's independence in a home environment that will provide the participant with a range of care options as the needs of the participant change. The goal is reached through a cooperative relationship between the participant (or the participant's legal guardian), the primary caregiver, the waiver case manager and the provider agency. Participant needs shall be addressed in a manner that supports and enables the individual to maximize abilities to function at the highest level of independence possible while primary caregivers receive initial and ongoing support so they can provide high-quality care. The service is designed to provide options for alternative long-term care to persons who meet nursing facility level of care and whose needs can be met in Structured Family Caregiving.

Only agencies may be Structured Family Caregiving providers, with the home settings being assessed and accessible, and all paid caregivers (including primary caregivers) being qualified as able to meet the participant's needs. The provider agency must conduct a minimum of two quarterly home visits. Additional home visits and ongoing communication with the primary caregiver is based on the assessed needs of the participant and the primary caregiver. Home visits are conducted by a registered nurse and/or a caregiver coach as determined by a person-centered plan of care. The provider agency must make a substitute caregiver available to allow opportunities for primary caregiver wellness and skill development in alignment with the needs of the primary caregiver as identified by the caregiver coach, up to 15 days per year. The provider agency must capture daily notes that are completed by the primary caregiver in an electronic format, and use the information collected to monitor participant health and primary caregiver support needs. The agency provider must make such notes available to waiver case managers and the state, upon request.

There are three service levels of Structured Family Caregiving each with a unique rate. The applicable rate is determined through completion of the Adult Family Care/Structured Family Care Level of Service Assessment (AFC/SFC LOS Assessment). Case managers complete this assessment at least annually to accurately reflect the relative support need of the individual. The AFC/SFC LOS Score determines the reimbursement rate to be utilized in the participant's next service plan.

The breakdown is as follows:

- Level 1 – AFC/SFC LOS Assessment Score of 0 - 35
- Level 2 – AFC/SFC LOS Assessment Score of 36 - 60
- Level 3 – AFC/SFC LOS Assessment Score of 61+

Additional Information:

NOTE REGARDING PROVISION OF PERSONAL CARE OR SIMILAR SERVICES BY LEGALLY RESPONSIBLE INDIVIDUALS AS APPROVED BY CMS:

In accordance with the federal description, legally responsible individuals (LRIs) include ONLY the parent of a minor child or a spouse of a participant. LRIs DO NOT include the parent of an adult participant (including a parent who also may be a legal guardian) or other types of relatives.

LRIs may be paid by an FSSA-approved provider for the provision of ONLY Structured Family Caregiving (SFC) services and ONLY when the following conditions are met:

- *The SFC services are provided as "extraordinary care." Extraordinary care in the provision of Structured Family Caregiving means the day-to-day care or support activities provided by a legally responsible individual primary caregiver (spouse or parent who meet the established waiver provider qualifications) that exceed the daily care that a legally responsible individual ordinarily would provide or perform in the household on behalf of a person of the same age without a disability or chronic illness.*
- *The SFC services are provided in alignment with the SFC waiver service definition and limitations found in Appendix C of the H&W and TBI waivers.*
- *The LRI is qualified to provide SFC services in alignment with the qualifications found in Appendix C of the waivers.*
- *The LRI is employed by or contracts with an DDARS-approved provider agency. Payment for SFC services provided by an LRI is only made to an OMPP-approved provider agency, and payment for such SFC services is never made directly to the LRI.*

The state tracks service plans that include the provision of SFC by an LRI for monitoring purposes. Additionally, provider agencies and their employed/contracted LRIs who receive payment for the provision of SFC services will be subject to service plan monitoring by the case manager. These practices will ensure that services delivered will continue to meet the needs and goals as well as the best interest of the participant. For more information about the waivers, see the Medicaid HCBS Waivers webpage at in.gov/fssa/ddars.

As with all other waiver-funded services, SFC service delivery is authorized via the service authorization issued by the state upon approval of the participant's service plan. Provider agencies are required to ensure that waiver services are provided as authorized and to document service delivery, allowing access to that documentation at any time by the state or its agents, including the case manager. The state uses a billing validation process to ensure claims are paid only for necessary services that were properly authorized and actually provided to the participant within the authorized time frame. Billing is subject to audit by the state in looking at efforts of BDS and FSSA OMPP Program Integrity staff.

Allowable Activities

Structured Family Caregiving includes the following activities (Levels 1-3):

- Services provided by a primary caregiver who is the spouse of the participant or the parent of the minor participant (also known as LRIs)
- Home and Community Assistance care services related to needed IADLs
- Attendant Care services related to needed ADLs
- Medication oversight (to the extent permitted under state law)
- Escorting to necessary appointments, whenever possible, such as transporting individuals to doctor. (*Note: When provided, such transportation is incidental and not duplicative of any other Indiana Medicaid State Plan or waiver service.)*
- Appointments and community activities that are therapeutic in nature or assist with maintaining natural supports
- Other appropriate supports as described in the individual's service plan

Service Standards

These service standards must be followed for Structured Family Caregiving:

- Structured Family Caregiving provider agencies must demonstrate three years of delivering services to older adults and adults with disabilities, and their caregivers must be in Indiana or be a Medicaid participating provider in another state or have a national accreditation.
- Structured Family Caregiving must be reflected in the participant's service plan and address specific needs determined by the participant's person-centered planning process.
- Structured Family Caregiving provider agencies develop, implement and provide ongoing management and support of a person-centered service plan that addresses the participant's level of service needs.
- The supports provided within the home are managed and completed by the primary caregiver throughout the day based on the participant's daily needs.
- Structured Family Caregiving is provided in a private residence and affords all the rights, dignity and qualities of living in a private residence including privacy, comfortable surroundings, and the opportunity to modify one's living area to suit one's individual preferences.
- Provider agencies must conduct, at a minimum, two home visits per quarter based on the participant's assessed needs and caregiver coaching needs, but the actual frequency of visits should be based on the participant's assessed needs and caregiver coaching needs.
- The provider agency must identify the skill development and wellness needs of the primary caregiver and provide access to a qualified substitute caregiver as needed for up to 15 days per year.
- Primary caregivers receive a minimum of eight hours in-person annual training that reflects the participant's and primary caregiver's assessed needs. Training may be delivered during quarterly home visits, or in another manner that is flexible and meaningful for the caregiver.
- Provider agencies must work with participants and primary caregivers to establish backup plans for emergencies and other times when the primary caregiver is unable to provide care.
- Structured Family Caregiving emphasizes the participant's independence in a setting that protects and encourages the participant's dignity, choice, and decision-making while preserving self-respect.

- Provider agencies that provide medication oversight, as addressed in the *Allowable Activities* subsection, must receive necessary instruction from a doctor, nurse or pharmacist regarding medications prescribed to the participant.

Documentation Standards

These documentation standards must be followed for Structured Family Caregiving.

The waiver case manager must document the following:

- Identified need for Structured Family Caregiving in the service plan
- Services outlined in the service plan performed by the primary caregiver
- Caregiver assessment findings

The case manager must give the completed person-centered service plan and caregiver assessment to the Structured Family Caregiving provider.

The provider agency is responsible for the following:

- Documentation to support service rendered, including:
  - Training outlined in the service plan that provider agency will provide to the primary caregiver
  - Electronic caregiver notes that record and track the participant's status, and updates or significant changes in the participant's health status or behaviors and participation in community-based activities and other notable or reportable events
  - Medication management records, if applicable
- Regular review of caregiver notes by provider agency to:
  - Understand and respond to changes in the participant's health status and identify potential new issues in an effort to better communicate changes with the participant's doctors or healthcare providers and avoid unnecessary hospitalizations or emergency room use
  - Document, investigate and refer reportable events to the waiver case manager
- Documentation of home visits conducted by the provider agency
- Documentation of education, skills training and coaching conducted with the primary caregiver
- Documentation demonstrating collaboration and communication with other service providers and healthcare professionals (as appropriate), waiver case managers and other caregivers or individuals important to the participant regarding changes in the participant's health status and reportable events
- Documentation of all qualified caregivers (including paid substitute caregivers)

> *Note: If applicable, copies of personal record must be:*
>
> - *Placed in a prominent place in the participant's file*
> - *Sent with the participant when transferred for medical care or upon moving from the residence and in accordance with state law*

Claim Note Required for Structured Family Caregiving

When billing for Structured Family Caregiving services, providers must include claim notes with information about who provided those services, including their relationship to the member receiving the service. The claim note must be accurate and complete for audit purposes. This requirement helps the IHCP obtain better information on the legally responsible individuals (LRIs) providing services to a member.

When completing the claim note, providers should ensure that the most accurate relationship status is being used. If the individual providing the service is an LRI (parent [if the individual is a minor child] or spouse

of the member receiving services), that relationship status should be reflected in the claim note. Knowingly using the incorrect relationship status, such as "Other" for the spouse or parent of the member receiving services may result in recoupment of these claims if an LRI received payment for services when they otherwise should not have; it could also constitute a false claim in accordance with the *False Claims Act*. OMPP Program Integrity staff is auditing claims, including the entry of claim notes.

For the structure required in the claim note, see the *Caregiver Name for Attendant Care or Structured Family Caregiving* section in the *Claim Submission and Processing* provider reference module.

Activities Not Allowed

Separate payment will not be made for any of the following waiver services furnished to a participant receiving Structured Family Caregiving services:

- Adult Family Care
- Assisted Living
- Attendant Care
- Home and Community Assistance

> *Note: Attendant Care or Home and Community Assistance services will not be reimbursed if performed in the same calendar month as Structured Family Caregiving services.*

Provider Qualifications

Provider qualifications for Structured Family Caregiving are presented in Table 30.

Table 30 – Provider Qualifications for Structured Family Caregiving

Waiver	Provider	Licensure/ Certification	Other Standards
H&W/TBI	Structured Family Caregiving Agency	Not required	Provider and home must meet the requirements of the Indiana Adult Family Care Service Provision and Certification Standards. FSSA approved *455 IAC 2* Becoming an approved provider; maintaining approval *455 IAC 2* Provider qualifications: general requirements *455 IAC 2* General requirements for direct care staff *455 IAC 2* Procedures for protecting individuals *455 IAC 2* Unusual occurrence; reporting *455 IAC 2* Transfer of individual's record upon change of provider *455 IAC 2* Notice of termination of services *455 IAC 2* Provider organizational chart *455 IAC 2* Collaboration and quality control *455 IAC 2* Data collection and reporting standards *455 IAC 2* Quality assurance and quality improvement system *455 IAC 2* Financial information *455 IAC 2* Liability insurance *455 IAC 2* Transportation of an individual

Waiver	Provider	Licensure/ Certification	Other Standards
			455 IAC 2 Documentation of qualifications *455 IAC 2* Maintenance of personnel records *455 IAC 2* Adoption of personnel policies *455 IAC 2* Operations manual *455 IAC 2* Maintenance of records of services provided *455 IAC 2* Individual's personal file; site of service delivery

Section 11.29: Supported Employment for TBI Waiver

The following subsections provide information and requirements for Supported Employment services under the TBI Waiver.

Service Definition

Supported Employment services consist of paid employment for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting. Supported Employment is conducted in a variety of settings, particularly worksites where persons without disabilities are employed. Supported Employment includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training.

Service Standards

The following service standards must be met:

- Supported Employment services must follow a written service plan addressing specific needs determined by the individual's assessment.
- When Supported Employment services are provided at a worksite where persons without disabilities are employed, payment will be made only for the adaptation, supervision, and training required by individuals receiving waiver services as a result of their disabilities and will not include payment for supervisory activities rendered as a normal part of the business setting.
- Supported Employment services furnished under the waiver must be services that are not available under a program funded by either the *Rehabilitation Act of 1973* or *Public Law PL 94-142*.

Documentation Standards

The following documentation standards must be met for Supported Employment services:

- Identified need in the service plan
- Services outlined in the service plan
- Data record of services provided, including:
  - Complete date and time of service (in and out)
  - Specific services /tasks provided
  - Signature of employee providing the service (minimally the last name and first initial) (*Note: If the person providing the service is required to be a professional, the title of the individual must also be included.*)

- At least one entry on each day of service made by each staff member providing direct care or supervision of care to the individual (*Note: All entries should describe an issue or circumstance concerning the individual.*)
- Documentation must be maintained in the file of each individual receiving this service, showing that the service is not otherwise available under a program funded under the *Rehabilitation Act of 1973* or *PL 94-142*.

> *Note: If applicable, copies of personal record must be:*
>
> - *Placed in a prominent place in the participant's file*
> - *Sent with the participant when transferred for medical care or upon moving from the residence and in accordance with state law*

Limitations

When Supported Employment services are provided at a worksite where persons without disabilities are employed, payment will be made only for the adaptation, supervision and training required by individuals receiving waiver services as a result of their disabilities.

Activities Not Allowed

The following activities are not allowed under the Supported Employment service:

- Services funded under the *Rehabilitation Act of 1973* or *PL 94-142*
- Reimbursement for supervisory activities rendered as a normal part of standard business procedures in a business setting where persons without disabilities are also employed
- Reimbursement for incentive payments, subsidies, or unrelated vocational training expenses for the following:
  - Incentive payments made to an employer to encourage or subsidize the employer's participation in a Supported Employment program
  - Payments that are passed through to users of Supported Employment programs
  - Payments for vocational training that are not directly related to an individual's employment program
- Service provided by the parent of a minor child participant or the spouse of a participant (also known as LRIs)

Provider Qualifications

Provider qualifications for the Supported Employment service are presented in Table 31.

Table 31 – Provider Qualifications for Supported Employment

Waiver	Provider	Licensure/ Certification	Other Standards
TBI	Supported Employment Agency	Certification from the Commission on Accreditation of Rehabilitation Facilities (CARF)	FSSA approved *455 IAC 2* Provider qualifications: general requirements *455 IAC 2* General requirements for direct care staff *455 IAC 2* Liability insurance *455 IAC 2* Professional qualifications and requirements *455 IAC 2* Personnel records
TBI	Community Mental Health Center	Not required	FSSA approved *455 IAC 2* Provider qualifications: general requirements *455 IAC 2* General requirements for direct care staff *455 IAC 2* Liability insurance *455 IAC 2* Professional qualifications and requirements *455 IAC 2* Personnel records *IC 12-7-2-38(1)* Community Mental Health Center

Section 11.30: Transportation for H&W and TBI Waivers

The following subsections provide information and requirements for nonmedical Transportation services for the H&W and TBI waivers.

Service Definition

Transportation services are offered to enable participants served under the waiver to gain access to waiver and other nonmedical community services, activities, and resources, specified by the service plan.

Allowable Activities

The following activities are allowed for Transportation waiver services:

- Attendance at Adult Day Services
- Visits to community centers or senior centers
- Participation in volunteer work or employment
- Trips to grocery stores, pharmacies and other essential errands
- Social outings, such as visiting friends or family, attending religious services, or participating in community events

Service Standards

These service standards must be followed for nonmedical Transportation waiver services:

- Transportation services must follow a written service plan addressing specific needs determined by the participant's PCISP.
- This service is offered in addition to medical transportation required under *42 CFR 431.53* and transportation services under the Indiana Medicaid State Plan, defined at *42 CFR 440.170(a)* (if applicable), and shall not replace them.
- Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge will be used.

Transportation services are reimbursed as the following types of service:

- Level 1 - Nonassisted Transportation: The participant does not require mechanical assistance to transfer in and out of the vehicle.
- Level 2 - Assisted Transportation: The participant requires mechanical assistance to transfer into and out of thevehicle.
- Adult Day Service Transportation – The participant requires round-trip transportation to access Adult Day Services.

Documentation Standards

These documentation standards must be followed for Transportation waiver services:

- Identified need in the service plan
- Services outlined in the service plan
- Documentation, maintained by the provider or its agent, that the provider meets and maintains the requirements for providing services under *455 IAC 2*
- Specify applicable (if any) limits on the amount, frequency, or duration of this service.

Note: If applicable, copies of personal record must be:

- *Placed in a prominent place in the participant's file*
- *Sent with the participant when transferred for medical care or upon moving from the residence and in accordance with state law*

Limitations

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

Activities Not Allowed

The following activities are not allowed under the Transportation waiver service:

- Services available through the Indiana Medicaid State Plan *(Note: An Indiana Medicaid State Plan prior authorization [PA] denial is required before reimbursement is available through the Medicaid waiver for this service.)*

- Services provided to participants receiving any of the following waiver services:
  - Adult Family Care
  - Assisted Living
- Services provided by the parent of a minor child participant or the spouse of a participant (also known as LRIs)

Provider Qualifications

Provider qualifications for Transportation waiver services are presented in Table 32.

Table 32 – Provider Qualifications for Transportation

Waiver	Provider	Licensure/ Certification	Other Standards
H&W/TBI	Licensed Home Health Agency	*IC 16-27-1*	FSSA approved Compliance with applicable vehicle/driver licensure for vehicle being utilized
H&W/TBI	Transportation Agency	Not required	FSSA approved *455 IAC 2* Becoming an approved provider; maintaining approval *455 IAC 2* Provider qualifications: general requirements *455 IAC 2* Procedures for protecting individuals *455 IAC 2* Unusual occurrence; reporting *455 IAC 2* Transfer of individual's record upon change of provider *455 IAC 2* Notice of termination of services *455 IAC 2* Provider organizational chart *455 IAC 2* Collaboration and quality control *455 IAC 2* Data collection and reporting standards *455 IAC 2* Quality assurance and quality improvement system *455 IAC 2* Financial information *455 IAC 2* Liability insurance *455 IAC 2* Transportation of an individual *455 IAC 2* Documentation of qualifications *455 IAC 2* Maintenance of personnel records *455 IAC 2* Adoption of personnel policies *455 IAC 2* Operations manual *455 IAC 2* Maintenance of records of services provided Compliance with applicable vehicle/driver licensure for vehicle being utilized

Section 11.31: Vehicle Modifications for H&W and TBI Waivers

The following subsections provide information and requirements for Vehicle Modifications under the H&W and TBI waivers.

Service Definition

Vehicle Modifications are the addition of adaptive equipment or structural changes to a motor vehicle that will empower a participant to have safe transportation in a motor vehicle.

Allowable Activities

Justification and documentation are required to demonstrate that the modification is necessary to meet the participant's identified needs.

The following are allowable under the Vehicle Modifications service:

- 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

Maintenance is limited to $1,000 annually for repair and service of items that have been funded through an HCBS waiver:

- Requests for service must differentiate between parts and labor costs.
- If the need for maintenance exceeds $1,000 the case manager will work with other available funding streams and community agencies to fulfill the need. If service costs exceed the annual limit, those parts and labor costs funded through the waiver must be itemized clearly to differentiate the waiver service provision from those parts and labor provided through a nonwaiver funding source.

> *Note: Items requested that are not listed in this section, must be reviewed and decision rendered by the state division director or state agency designee.*

Service Standards

These service standards must be followed:

- The vehicle to be modified must meet all the following:
  - The participant 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 participant's sole or primary means of transportation.
  - The vehicle is not registered to or titled by an FSSA-approved provider.
  - Only one vehicle per a participant's household may be modified.

- Many automobile manufacturers offer a rebate of up to $1,000 for participants purchasing a new vehicle requiring modifications for accessibility. To obtain the rebate, the participant 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 FSSA director or designee determines the documentation does not support the service requested.
- All Vehicle Modifications must be approved by the waiver program prior to services being rendered.

Documentation Standards

The case manager is responsible for the following documentation standards:

- Document the medical need for Vehicle Modifications determined to meet the needs of the participant through the PCISP.
- Describe the specific modification being requested to the vehicle.
- Collect two bids if over $1,000; if only one bid is obtained, the case manager must document the date of contact, the provider name and why the bid was not obtained from another provider.
- Submit warranty information from the provider to the FSSA.
- Ensure that a picture of vehicle modification is included with the bid.

The provider is responsible for the following documentation standards:

- Maintain receipts for all incurred expenses related to the modification.
- Itemize all bids.
- Be in compliance with FSSA and FSSA-specific guidelines and/or policies.

Note: If applicable, copies of personal record must be:

- *Placed in a prominent place in the participant's file*
- *Sent with the participant when transferred for medical care or upon moving from the residence and in accordance with state law*

Limitations

A lifetime cap of $15,000 is available for one vehicle per every 10-year period for a participant's household. In addition to the applicable lifetime cap, $1,000 will be allowable annually for repair, replacement or an adjustment to an existing modification that was funded by an HCBS waiver.

Activities Not Allowed

Examples or descriptions of modifications or items not covered under this service include but are not limited to, the following:

- Repair or replacement of modified equipment damaged or destroyed in an accident
- Alarm systems
- Auto loan payments
- Insurance coverage
- Driver's license, title registration, or license plates

- Emergency road service
- Routine maintenance and repairs related to the vehicle itself
- Specialized Medical Equipment and Supplies or Home Modifications items
- Leased vehicles

This service will not be reimbursed when provided by the parent of a minor child participant or the spouse of a participant (also known as LRIs).

Provider Qualifications

Provider qualifications for Vehicle Modifications are presented in Table 33.

Table 33 – Provider Qualifications for Vehicle Modifications

Waiver	Provider	Licensure/ Certification	Other Standards
H&W/TBI	Vehicle Modification Agency	Not required	FSSA approved *455 IAC 2* Becoming an approved provider; maintaining approval *455 IAC 2* Provider qualifications: general requirements *455 IAC 2* Liability insurance *455 IAC 2* Professional qualifications and requirements; documentation of qualifications *455 IAC 2* Maintenance of records of services provided *455 IAC 2* Warranty required

Section 11.32: Provider Help

This section provides websites, contact information and publications for providers to use.

Helpful Websites

Consult the following websites for more information:

- FSSA homepage – Find information by type of person in need: children, seniors, families, those with intellectual disabilities (ID) and so forth. All programs and services available are listed on this site.
- Medicaid HCBS webpage – Find information about how to become a provider of FSSA services.
- Indiana Level of Care Assessment Representative (LCAR) website – Find information about requesting a level of care (LOC) assessment for individuals seeking a nursing facility level of care (NF LOC) determination.
- Incident And Follow-Up Reporting (IFUR) Tool – Submit initial incident reports and case manager follow-up reports for waiver and Money Follows the Person (MFP) services via the IFUR Tool.
- IHCP Providers website – Find Indiana Health Coverage Programs (IHCP) provider bulletins and the IHCP provider reference modules. Telephone contact information for providers is also available on this website.

Helpful Contact Numbers

Contact Indiana LCAR – Maximus Help Line at 833-597-2777 to request an NF LOC assessment, register for the AssessmentPro web-based assessment platform, or find out more information about the LCAR process.

Contact the DDARS BDS at 800-545-7763 for questions related to ICF/IID LOC or send email to BDSProviderServices@fssa.in.gov.

See *Indiana's Area Agencies on Aging* for information on local Area Agency on Aging (AAA) offices. To contact your local AAA office toll-free, call 800-713-9023.

Communications

The IHCP publishes IHCP bulletins and provider reference modules for providers, which are accessible from the *Bulletins and Reference Modules* webpage at in.gov/medicaid/providers.

Providers may also subscribe to the Email Notification Service, accessible from the homepage at in.gov/medicaid/providers. This service sends emails to subscribers when new communications are posted on the IHCP website.