December 16, 2015

CIH Amendment Public Comment
c/o Division of Disability and Rehabilitative Services
402 W. Washington St., #W453
P.O. Box 7083, MS26
Indianapolis, IN 46207-7083

COMMENT RE: Community Integration and Habilitation Waiver Amendment #2

Thank you for the opportunity to comment and provide feedback to the Indiana Family and Social Services Administration (FSSA) and the Division of Disability and Rehabilitative Services (DDRS) on the proposed second amendment to the Community Integration and Habilitation Waiver (CIHW). INARF appreciates the state agency's efforts to obtain public input from a wide range of stakeholders in response to the proposed Waiver amendment. As you consider how to proceed with the Amendment, we hope our feedback proves beneficial and is constructive to the process.

INARF is the principal statewide trade association representing agencies that serve Hoosiers with intellectual and developmental disabilities. INARF and its members are committed to ensuring Indiana's system of services and supports for individuals with intellectual and developmental disabilities offer maximum options, access, and choice. To that end, we appreciate the opportunity to provide comment on the proposed second amendment to the Community Integration and Habilitation (CIH) Waiver. INARF has also encouraged its member agencies to submit comments in response to the Administration's request. We appreciate in advance your thorough review and consideration of our collective feedback.

Overall, INARF is opposed to the proposed second amendment to CIH Waiver. As demonstrated by the extensive comments that follow, INARF believes that submission of the draft Waiver amendment is premature and has significant potential to result in unintended consequences that have the possibility of negatively impacting persons served and the system, as a whole. Given the Amendment's proposed effective date of October 1, 2016, we believe that a more reasonable and rational pathway is to fully develop and test the proposed service definitions, rate structure and related policies and then submit the full service model and rate structure to CMS for approval. In this way, we believe the Division is able to focus on its long-term goal, avoid any unintended consequences of an untested model, and demonstrate that the model accomplishes the goals that the Division has identified.

In addition to our overall position, INARF offers comments on a few key areas that should be addressed. Please note, where appropriate we have offered some recommendations in terms of alternatives. However, in many instances our comments

either raise questions to better understand the proposed changes or raise issues that require broader policy discussion with all stakeholders to identify appropriate solutions.

- Throughout the document, there are numerous references to specific provisions in Indiana Administrative Code. We understand that the Division plans to update and make changes to the current Indiana Administrative Code to reflect the changes proposed in the draft Waiver amendment. While we appreciate this effort to harmonize service definitions and provider requirements with administrative code, we are concerned that those changes may render those specific references obsolete or inaccurate, creating more confusion as to what administrative code provisions apply in which instances.
- Transition Plan for Individuals Potentially Adversely Affected
    - The provisions for Personal Emergency Response (PER) refer to that service being included in Electronic Monitoring. It is our understanding that Electronic Monitoring is being replaced with Remote Support Technology. If this is accurate, this excerpt should be corrected and a provision should be inserted regarding how individuals currently receiving Electronic Monitoring will be transitioned to Remote Support Technology.
    - In the provisions for Residential Habilitation and Support (RHS-D), it states that for individuals not in a shared staffing home will have the option of using Residential Habilitation and Support – Hourly (RHS-H) as a replacement to the same level the individual would have received under RHS-D. This provision is confusing as RHS-D does not include a rate or service level for individuals living in non-shared staffing homes. More information is needed to understand the impact of the transition and how to determine the level of service the individual can expect to receive.
    - Also, under the RHS-D provision, it indicates that the Individualized Support Team (IST) will be asked to review the replacement service plan, make corrections or adjustments, and submit the plan for review and approval by the State. Based on this information, is it correct to assume that the individual's budget will not be changed until the replacement service plan is approved?
    - Under the provisions for Structured Family Caregiving:
        - It is our understanding that Structured Family Caregiving is being replaced by Adult Family Living. If this is accurate, this excerpt should be corrected and the provision should discuss how individuals will be transitioned to the new service.
        - Also, the provision references a clarification that the service is intended for individuals 18 years of age and older and that to the extent anyone currently receiving Structured Family Caregiving is under 18 years of age, they will be allowed to retain the service if they choose. This provision is appreciated. In light of the new service definitions preference for single person settings, we would recommend this provision of the Transition Plan include similar language allowing individuals who are currently receiving Structured Family Caregiving in settings with more than one individual to retain the service in that setting, if they choose.
    - Under the provisions for Wellness Coordination and Transportation:
        - It states that these services are included in IRS-B and IRS-M. It was our understanding that these services were also to be included in Enhanced

Residential Living. If this is accurate, this excerpt should be corrected and addressed.

- It also states that Wellness Coordination and Transportation are included in the new services and will not limit access to these services. We do not agree with this statement. As a first matter, in the Rate Methodology section of this Amendment, it states that "some components of wellness" were being included in Enhanced Residential Living, which suggests that not all current components of Wellness Coordination will be available to the individual. Second, we believe that because wellness and transportation were accounted for in the proposed Enhanced Residential Living rate as a flat percentage regardless of individual need, the rate does not accurately reflect the cost to provide this service for individuals with high support needs, creating a disincentive to serve them and potentially negatively impacting their access to these services.

  - We note that there are no provisions discussing transitioning individuals who qualify from Case Management to Intensive Support Coordination, particularly the impact if the individual's current case manager is not able or eligible to serve as the Intensive Support Coordinator. We believe this should be more clearly addressed.
  - We also note that there are no provisions discussing transitioning related to Residential Habilitation and Support – Hourly. In our review, there are many substantive changes to the service definition and we believe the potential impact to individuals currently receiving the service should be addressed in this section.

- Case Management
  - Reimbursable Activities
    - In terms of cultivating and strengthening informal and natural supports for each participant, how is this measured / defined? In other words, how will we know when the case manager is successful in meeting this standard?
    - In reference to face-to-face contacts at least once every 90 calendar days, we would recommend changing this to at least every quarter to be consistent with the current monitoring system and schedule through Advocare. The quarterly requirement is consistent with other services, like ERL and Wellness that require quarterly reporting or Intensive Support Coordination that requires monthly contact.
    - Also with reference to face-to-face contacts, is the expectation that these face-to-face contacts are distinct from the team meetings?
    - In reference to convening team meetings no less than every 90 calendar days and as needed, based on feedback from individuals and families, we believe – particularly in light of the quarterly face-to-face requirement - that frequency of team meetings should be dictated by the IST and reflected in the ISP, based on the needs of the individual, with no minimum requirement beyond an annual meeting.
    - In regards to monitoring claims through the approved MMIS, our members report that this this system is often not accurate and we believe case managers should not be held responsible until it is accurate.
    - In reference to the note regarding timeframes specified in the DDRS Waiver Manual, we are not sure what provision of the manual is being

referenced and would recommend that this information should be included in the definition.

- Service Standards
  - Because these seem duplicative of previously described reimbursable activities, we would like to see greater clarification on how the service standards differ from reimbursable activities, as well as how these should be documented and monitored, particularly activities like “spend sufficient time”?
- Documentation Standards
  - We have no objection to the requirement for including the complete date and time entry (including a.m. or p.m.) on the data record for case management activities. However, we believe to implement this would require a modification to the Advocare system, which automatically imbeds the date the note was entered and the name of the note's author when the note is saved. This is the part that should be modified to reflect time stamp and credentials.
  - Given the inclusion of wellness coordination within many services, it is not clear when it would be appropriate for the Case Manager who is a licensed nurse to sign off with their title. Given there is no requirement for Case Managers to be licensed nurses, and if they are acting in their capacity as a case manager and not as a licensed nurse, this requirement could be confusing and misleading.
  - In terms of requiring documentation of contact/communication with the participant and a RN or LPN and any recommendations, is the case manager required to document any time the participant communicates with a RN or LPN and any recommendations? If this is so in the context of an individual receiving wellness supports, this seems like a very difficult standard to meet as the case manager is most likely not involved or even aware of every interaction between the participant and a RN or LPN. This would be even more difficult if this requirement extended to other services and funding sources involving a RN or LPN.
  - In terms of documenting contact/communication with any behavior professional, psychiatrist, or pharmacist, we are not clear why the documentation requirements are separated for these professionals and not others that they may contact. Shouldn’t all contacts that case managers have with these and any professional or individual related to an individual served be documented? In addition, the heavy emphasis on contact with medical providers may confuse the role / responsibilities with the wellness coordinator.
- Agency Training Requirements – Outside Waiver Amendment
  - We would recommend that the Division work with Case Management Organizations to develop the curriculum that meets the training requirements, so that all case managers are trained consistently and in a manner consistent with the Division’s expectations.
- Provider Qualifications – Inside Waiver Amendment
  - It is our understanding that Indiana Code (IC12-11-1.1-1) requires National accreditation for day habilitation, including facility based or community based habilitation, prevocational services, employment

services, and residential habilitation and support services, but not for Case Management.

- Provider Qualifications – Outside Waiver Amendment
  - Consistent with requirements in Enhanced Residential Living, Intensive Residential Support – Behavioral, and Intensive Residential Support – Medical, we recommend that Case Management Companies are given the discretion to either employ OR contract with a Registered Nurse to provide consultation and guidance, as needed.
  - We recommend that the requirement to ensure criminal background checks cites to the appropriate administrative code and policy guidance on criminal history checks. Please note, as to on-going background checks, Indiana Code (IC 10-13-3-27) only allows employers to secure a limited criminal history on employees upon hire. (see DDARS Bulletin #69, April 7, 2005). To use limited criminal history information otherwise is considered a Class A misdemeanor. (IC 10-13-3-27(c)).

- Residential Habilitation and Support – Hourly
  - As an overall comment, we note that the service definition no longer includes reference to 460 IAC 13, which provides guidance as to service hours available to an individual based on their assessed level of need or Algo. Without this as a reference, how does the Division intend to identify how many hours an individual is eligible to receive? If it is at the discretion of the Individualized Support Team, what type of guidance or framework will they be provided for making such determinations? What policies or guidance will be offered when the IST does not agree with the appropriate amount of support? What about when the individual and/or their family/guardian does not agree with the IST's determination?
  - We also note that the Reimbursable Activities section has changed significantly. In particular, we note that references to direct supervision and monitoring, assistance with personal care, assurance that direct service staff are aware of and actively participate in the development and implementation of the ISP, Behavior Support Plan, and Risk Plans; coordination and facilitation of medical and non-medical services to meet health care needs when not receiving Wellness Coordination; and collaboration with wellness coordinator when receiving Wellness Coordination are not included. Are these no longer considered part of the service definition/expectations?
  - We note the addition of the provision of transportation to fully participate in social and recreational activities as a reimbursable activity. Does this prohibit the provision of non-medical transportation services, as a separately billable service? If the provider is able to provide non-medical transportation services, would they be restricted to only billing for transportation that was non-social or recreational, given the services definition's specificity? If the provider is not able to provide non-medical transportation as a separate billable service or is only able to provide non-medical transportation for non-social and non-recreational activities, has the rate been evaluated to accommodate for this additional service component?
  - In the Documentation Standards in the separately published service definition, there is a requirement for documentation to include transportation provided throughout the day. If this service is separately billable, this documentation standard seems duplicative and unnecessary.

- Can individuals use the newly proposed Participant Care and Assistance, in addition to Residential Habilitation and Support – Hourly, assuming they were not being provided concurrently? If not, what would be the basis of the prohibition? How would individuals be supported in deciding which service best fit their unique needs? What if there is disagreement among the IST or between the IST and the individual as to which service is most appropriate? What criteria will the Division use to determine which individuals are eligible for which service? If the individual can use both services, non-concurrently, given the similarities between the services, what differences in service experience and outcomes are anticipated?
- In the Documentation Standards in the separately published service definition, there is a requirement that the Individualized Support Team (IST) must provide documentation at least annually demonstrating that all options for Remote Support Technology have been explored and provide written justification when it is determined Remote Support Technology is not a viable option for the individual. Who on the IST is responsible for ensuring the team completes this requirement? What information or criteria should the IST use to demonstrate what options have been explored? What information or criteria should be included in the written justification if it is not a viable option? Should this information be submitted to the Division? If so, how? If not, where should it be recorded or stored?

- Adult Family Living
  - In terms of the exception process to the preference to limit Adult Family Living to one adult participant per home, how would an individual seek an exception, meaning is there a standard format, specific justification required, etc? What criteria will the Division use to evaluate these requests? If the Division does not grant the exception, what recourse does the individual have to appeal the decision?
  - In the Adult Family Living member provider requirements, we are unfamiliar with a "Hiring Agreement"? Is this a new requirement for the service? Who authors the agreement? Who are the parties to the agreement? What should be included in the agreement? Where is the agreement kept? How often is it reviewed / updated? Who is responsible for storage, maintenance, and ensuring it is completed?
  - Also, in that section, the first bullet indicates that Adult Family Living member must meet the requirements set forth by the AFL provider through which the family member provides services. Is the reference to family member intentional? If so, how does that comport with the latter limitation that family members will not be reimbursed for any time in excess of 40 hours per individual per seven-day period? Further, how is the 40 hour limitation to be applied when the agency provider is paid a daily rate and the individuals with whom the agency provider contracts with are usually paid as a monthly stipend?
  - We note that Participant Care and Assistance is not listed as a service "not available" to participants receiving Adult Family Living. Was this omission intentional? If so, how does the Division anticipate the two services being used by the same individual?
- Enhanced Residential Living
  - Individuals Eligible for ERL Services

- In reference to the requirement to establish eligibility through a determination that the individual needs the service based on assessment criteria defined by the State, who is responsible for ensuring a determination is made? What entity is tasked with completing the assessment? How frequently should the determination be considered / updated? What is the assessment criteria that will be used in making the determination? What recourse will individuals have if they are not determined eligible for the service?
- In reference to the requirement that the IST must demonstrate that available Medicaid State Plan benefits are not available to meet an individual's needs, who on the IST is responsible for ensuring the team completes this requirement? What information or criteria should the IST use to demonstrate what options have been explored? How and where is the determination captured? Should the determination information be submitted to the Division? If so, how? If not, where should it be recorded or stored?
- In reference to the requirement that enrolled individuals must be able to live independently with supports, this seems like an oxymoron – how can the individual live independently, but require supports. How is this demonstrated or determined? By whom? And, how is it recorded?
- In reference to the requirement that participants must demonstrate that 1:1 staffing is not required at all times during the day, that they are able to be in the community with minimal supports, and are able to demonstrate this through the application of independent living skills, including community access, and/or employment, how does the participant demonstrate this requirement? Who is responsible for determining whether they meet the requirement? What criteria are used for making this determination? What recourse does the individual have if they do not meet that criteria? Also, what does the term "minimal support" mean? How is this determined or assessed?
- In reference to the requirement that the IST must provide justification in the ISP that Remote Support Technology is not appropriate to meet the individual's needs before other residential services and supports are recommended.
    - Does this mean that Enhanced Residential Living is not available until this justification is provided? If that is the case, then how would any ERL recipient be able to use RST, as allowed in the Reimbursable Activities section? Perhaps, it would be more helpful to state that ". . .Remote Support Technology [alone] is not appropriate . . . "
    - Who on the IST is responsible for ensuring the team completes this requirement? What information or criteria should the IST use to demonstrate what options have been explored? What information or criteria should be included in the written justification if it is not a viable option? Should this information be submitted to the Division? If so, how? If not, where should it be recorded or stored?

- Reimbursable Activities

- In reference to services based on the ISP, including goals that are identified through the Person Centered Planning process, we believe this is important and should be the practice, however, actual practice seems far from this standard. The process does not always produce "clear outcomes" and it is believed that many current PCP's would not be in alignment with this standard. Is the Division planning to provide clearer guidance and expectations for Person Centered Planning? What supports are being considered to improve the process and make it more meaningful to the individual and while assuring their needs and goals are adequately addressed.
- In reference to including "training and support that would allow opportunities for integrated employment", we believe this may be interpreted along a broad continuum of supports from providing residential supports to ensure successful employment like reinforcing the work schedule at home and providing transportation to work, all the way to providing active supported employment supports. Clarity is needed as to the Division's intent, particularly in light of later provisions that prohibit concurrent provision of two authorized services for the exact time period in a day.
- In reference to the provision of transportation necessary to implement the goals in the ISP, we note that not all transportation provided is in support of specific goals. Does that mean that transportation is not included in the service and accompanying rate?
- Also, in reference to transportation, while the idea of including transportation in ERL is intriguing, we are concerned that the proposed rate structure is not Person Centered in that it does not appropriately recognize the unique needs of those with higher transportation needs either due to geography or accessibility needs nor does it recognize the costs to provide this higher level of service. As a result, we believe this may create a disincentive to serving these individuals, which will impact their ability to access needed services.
- Likewise for Wellness, we believe the proposed rate structure is not Person Centered in that it does not appropriately recognize the unique needs of those with higher medical needs nor does it recognize the costs to provide this higher level of service.
- Also for Wellness, what guidance/direction will ISTs be provided in determining the frequency of face to face consultations with the Wellness Coordinator? What if the ERL provider believes the frequency is too low to provide quality care? What if they believe it is too high and inconsistent with the individual's needs? What if the individual doesn't agree with the IST's assessment? What recourse do they have for reconsideration?
- Lastly for Wellness, how is "active involvement" at all team meetings defined? Does that require physical participation in every team meeting? If not, what other types of involvement would be considered "active"?

- Limitations
  - In reference to the prohibition of concurrent provision of two authorized services for the exact time period in a day, we are concerned that read literally this would result in no other service being provided to individuals

receiving ERL, as the service is offered at a "daily" rate up to 24 hours a day. Clarification would be appreciated about how other services like extended support, and community habilitation can be provided to individuals receiving ERL and other "daily" services not hindered by this limitation.

- We note that Participant Care and Assistance is not listed as a service "not available" to participants receiving Enhanced Residential Living. Was this omission intentional? If so, how does the Division anticipate the two services being used by the same individual?

- Training Requirements
  - As an overarching comment, we understand from prior conversations with the Division that the minimum hours of training requirement is meant to refer to all training activities, not just training in the participant's home. With this in mind, we recommend the following re-wording:
    - "The BDDS requires that each employee in a direct support position complete a minimum 20 hours of training that includes the following components (reference to #1, 2, 3, and 4). Documentation that these components have been met must be maintained and able to be produced at the request of the state or its contracted agents:"
    - Then, eliminate #3 as it could be considered in conflict with earlier provisions (i.e. it is not clear whether designated co-workers or supervisors must meet the "essential knowledge, skills, and abilities" and years' experience to qualify as a trainer) and documentation of training is addressed in greater detail earlier in the requirements.
  - The designation of "one or more staff positions" seems to suggest a dedicated FTE or more. This could be a large hurdle for smaller providers, in particular. As a result, we recommend changing the phrase to "sufficient staff."
  - Will there be additional guidance on determining what "essential knowledge, skills, and abilities" a staff member should have to be qualified to implement a staff training program? What are the criteria for making this determination? How should it be documented?
  - In order to promote flexible and consistent training, INARF recommends that computer based training provided under supervision of the staff responsible for implementing staff training can be utilized to deliver any and all training requirements.
  - We would recommend defining the term "orientation" to ensure clarity in terms of the Division's expectations for what information/training is to be provided through orientation.
  - While person-specific training is important, we are concerned that for on call or emergency staff who may be required to work at any of an agency sites, completing an orientation at each site is not practical or workable. Logistically, it would be difficult to provide orientation to all staff "just in case" but also it would be virtually impossible to keep staff updated on changing support plans. It would be practical to require staff hired to support a specific site to participate in some orientation at the site, while

requiring that all substitute staff have completed all agency orientation training including specific training like insulin administration if germane to the site at which substitute staff are working.

- Documentation
  - Much like our comments on case management, if a nurse provides direct support that is not medical or wellness based and any qualified staff can deliver the service, why is there a requirement for professionally licensed staff to include their title?
  - What type of documentation is needed to document transportation?
  - What type of documentation is needed to document face to face contact with the participant and a RN or LPN and any recommendations provided by that professional? Does this apply to any RN or LPN or only those who are delivering components of Wellness Coordination?
  - INARF is concerned that the Division is giving less guidance to providers on expectations around wellness services when recent audits suggested more guidance and clarification of expectations is needed.
  - In terms of the requirement that the Individualized Support Team (IST) must provide documentation at least annually demonstrating that all options for Remote Support Technology have been explored and provide written justification when it is determined Remote Support Technology is not a viable option for the individual. Who on the IST is responsible for ensuring the team completes this requirement? What information or criteria should the IST use to demonstrate what options have been explored? What information or criteria should be included in the written justification if it is not a viable option? Should this information be submitted to the Division? If so, how? If not, where should it be recorded or stored?
- Provider Specifications
  - How do providers demonstrate that an RN is available to the individual and the IST of individuals receiving ERL 24 hours a day? What evidence / activities would demonstrate this standard as met? Where would this be documented?
  - It is our understanding that Indiana Code (IC12-11-1.1-1) requires National accreditation for day habilitation, including facility based or community based habilitation, prevocational services, employment services, and residential habilitation and support services, but not necessarily for Enhanced Residential Living. Will the Division be addressing this with the legislature to expand the requirements in Indiana Code to include ERL and the Intensive Residential Support services?

- Intensive Residential Supports – Behavioral
  - Service Definition
    - The service is described as “all inclusive of the individual’s needs.” We believe this could be misperceived to mean that the IRS-B provider is responsible for all needs, including employment, community habilitation, facility habilitation, etc…
    - In terms of the requirement that the individual must demonstrate a temporary need, how is temporary defined? Some individuals with significant and persistent behavioral challenges could require this level of

service for several years. Would that be permissible under the Division's definition of "temporary"?

- In terms of the requirement that the endorsement of the behavior support plan shall be done by the DDRS Clinical Review Team (CRT), what criteria will the CRT use to determine whether to endorse the plan? What are the timeframes for submitting a plan for review and for the CRT's response to that plan? What happens if the CRT does not endorse the plan?
- In terms of the requirement that the CRT, or any member of the team, shall make recommendations in writing to the IST and Intensive Support Coordinator as appropriate:
    - Is the reference to "any member of the team", mean any member of the CRT or any member of the IST?
    - What happens if the CRT makes a recommendation and then a member of the CRT makes an individual recommendation that contradicts or is in conflict with the CRT recommendation, which should the IST consider and respond to?
    - Is the IST required to respond or address the recommendations made by the CRT or member of the team? If so, within what timeframe? How is the response to be captured and communicated to the CRT?
    - What happens if the IST does not accept and/or modifies the recommendation? What if the individual and their family/guardian do not accept the recommendation? How will this be resolved timely? What recourse does the individual have to resolve the matter?

- Individuals Eligible for Intensive Residential Supports – Behavioral
    - How do individuals or teams make referrals for individuals that may be eligible for this service? While it would seem the Intensive Support Coordinator would be responsible for compiling information for CRT review on an on-going basis, who is responsible for compiling and submitting the documentation, prior to the person being determined eligible for IRS-B or Intensive Support Coordination?
    - Who is responsible for obtaining the required clinical and functional assessment of the individual's psychological and behavioral condition? What types of professionals are expected to complete these assessments?
    - In describing the standards for documentation submitted there is a reference to 460 IAC 6-18-2, which refers to the Behavior Support Plan Standards. It is unclear how some of these standards would apply to submitting documentation to demonstrate need for this intensive service and their readiness/ability to benefit from intervention. For instance, these standards include requirements to include written guidelines of teaching the individual functional and useful behaviors to replace the individual's maladaptive behavior and include documentation that each person implementing the plan has received specific training on the plan and techniques and procedures required for implementing the behavior support plan. It may be more appropriate to identify the standards

expected for documentation to demonstrate the individual meets the eligibility criteria for this service.
    - Consistent with Intensive Residential Support – Medical, we believe that IRS-B should include a requirement that referrals should include recommendations for regarding the number of staff necessary to deliver the specified interventions.
- Reimbursable Activities
    - Please see our Enhanced Residential Living (ERL) comments above regarding the need for:
        - additional guidance/expectations for person-centered planning;
        - clarification on employment as a reimbursable service
    - We would also offer the same comments as offered above for ERL in regard to bundling transportation and wellness with the residential components.
    - Also, in regard to transportation, unlike the ERL definition, there is no clarifying language included to indicate that the provision of transportation to community employment and employment activities and/or community volunteerism will be reimbursable under Community Employment Transportation. Was this omission intended? If so, why?
    - In regard to including components of Wellness coordination, unlike the ERL definition, there are no specific reimbursable activities providing guidance on wellness expectations. Was this omission intended? If so, why?
    - Please note, immediately following the limitations section, it appears that the Individuals Eligible of Intensive Residential Supports – Behavioral is repeated
- Limitations – please see our ERL comments regarding Participant Access and Care not being referenced as a service that may not be authorized concurrently on the individual's plan of care.
- Activities Not Allowed – please see our ERL comments regarding the concurrent provision of two authorized services for the exact time period in a day.
- Provider Qualifications
    - Please see our ERL comments regarding Indiana Code requirements for National Accreditation.
    - Please note, it appears that the accreditation requirements section is duplicated in this section.
    - In terms of the requirements for behavior consultant, psychiatric services, and HSPP services, we believe this seems like an extraordinary amount of support for an individual. Assuming these are patterned after the Extensive Support Need's homes referenced in the rate methodology, those are shared staff settings where four individuals share the staffing and ancillary service resources. Under that system, requirements like 15 hours per week of behavior services would seem more appropriate, although the actual ESN requirement for four individuals is at least 10 hours per week. In addition, it is unclear whether and to what extent the rate appropriately accommodates the related costs being absorbed by an individual in a non-shared staff setting. We would recommend these requirements be reconsidered.

- Agency Qualifications
  - In the third sentence, end of the fourth line, it appears that the word "not" is missing.
  - In terms of using the DDRS CRT to evaluate any agency applying to provide this service, what criteria will they use to evaluate the prospective provider? Would an interested provider go first through DDRS Provider Relations? Would Provider Relations facilitate the review with the CRT and communicate their decision to the DDRS Director?
  - Since this is a new service, what is the Division's implementation plan to review and approve prospective provider applications to ensure a sufficient pool of willing and qualified providers when the service is implemented?
- Direct Support Professional Qualifications – understanding that the Division's separately published service definition for this service includes extensive guidance on DSP training, it may make sense to either remove the limited guidance offered in this section or to replace it with the more extensive guidance referenced above.
- In reference to the guidance included on direct support training in the separately published service definition, please see our ERL comments on direct support training requirements. As with the recommendation above, we would recommend eliminating the "Direct Support Professional Qualifications" section and incorporating these requirements in with the training requirements.
- Documentation Standards
  - Please see our ERL comments regarding demonstrating that Remote Support Technology is not a viable option for the individual.
  - Please see our ERL comments regarding documentation standards
  - In terms of documenting contact / communication with the HSPP, behavior professional, psychiatrist, or pharmacist, is this contact / communication with any member of the team and these identified professionals? If so, how will that be monitored or verified? If not, to whom do these requirements apply? Any member of the IRS-B provider organization? Only the direct service staff?

- Intensive Residential Supports – Medical
  - Service Definition – please see our IRS-B comments above regarding how temporary is defined. Particularly for the individuals likely to be eligible for IRS-M, they are likely to be experiencing persistent and chronic conditions that may require long-term and/or lifelong intensive intervention.
  - Individuals Eligible for Intensive Residential Supports – Medical
    - Please see our IRS-B comments regarding making referrals for this service.
    - We would recommend including criteria noting the individual is experiencing a significant increase in food intake, elimination of stool, and elimination of urine.
    - In terms of the requirement that "the DSP shall be awake and available at all times in the person's home," would this include only the time the person is at home or was it intended to say staff should be present in the home regardless of whether the individual is in the home?

- In terms of providing recommendation for the number of staff necessary to deliver the specified interventions, what happens if the recommendation exceeds what the published rate provides in terms of resources?

- Reimbursable Activities
  - In terms of the functional and clinical assessment to use in developing the plan, who is responsible for ensuring these assessments are completed? What are the types of professionals who should be completing these assessments? Are there specific assessments or tools that are expected / required?
  - In terms of requirement for "Active involvement of all ISP team members at all team meetings," how is active defined? Is it face to face involvement only? If not, what other involvement would be considered 'active'? Who is responsible for ensuring ISP team members are actively involved?
  - Please see our Enhanced Residential Living (ERL) comments above regarding the need for:
    - additional guidance/expectations for person-centered planning;
    - clarification on employment as a reimbursable service
  - We would also offer the same comments as offered above for ERL in regard to bundling transportation and wellness with the residential components.
  - Please see our ISR-B comments regarding adding clarifying language regarding the provision of Community Employment Transportation.
  - In terms of permitting the use of remote support technology, we believe this is inconsistent with an earlier requirement requiring direct support professionals to be awake and available at all times in the person's home.
- Limitations – please see our ERL comments regarding Participant Access and Care not being referenced as a service that may not be authorized concurrently on the individual's plan of care.
- Activities Not Allowed – please see our ERL comments regarding the concurrent provision of two authorized services for the exact time period in a day.
- Provider Qualifications - please see our ERL comments regarding Indiana Code requirements for National Accreditation.
- Agency Qualifications
  - In the third sentence, it appears that the word "not" should be inserted before the word currently.
  - Please see our IRS-B comments regarding DDRS CRT evaluation of prospective providers and questions regarding on-boarding prospective providers to ensure a pool of willing and qualified providers when the service is implemented?
- Direct Support Professional Qualifications – please see our IRS-B comments regarding this section.
- In reference to the guidance included on direct support training in the separately published service definition, please see our ERL comments on direct support training requirements. As with the recommendation above, we would recommend eliminating the "Direct Support Professional Qualifications" section and incorporating these requirements in with the training requirements.
- Documentation Standards

  - We note that there is not a requirement to demonstrate that Remote Support Technology is not a viable option for the individual. Was this omission intended?
  - Please see our ERL comments regarding documentation standards
  - In terms of documenting contact / communication with the pharmacist, is this contact / communication with any member of the team and these identified professionals? If so, how will that be monitored or verified? If not, to whom do these requirements apply? Any member of the IRS-B provider organization? Only the direct service staff?

- Intensive Support Coordination
  - In terms of the differing educational requirements depending on whether the Intensive Support Coordinator is supporting an individual receiving IRS-B or IRS-M, is the Intensive Support Coordination provider responsible for documenting this or is there any requirement to share this with DDRS Provider Relations to seek approval?
  - For those who do not meet the educational requirements, what is the process for seeking the Division Director's approval to provide ISC based on their degree and years of experience? What is the criteria that will be used to evaluate individuals seeking this approval? What recourse, if any, is available if the individual is not given approval?
  - We note that Education and Special Education are not listed as meeting ISC minimum qualifications. Knowing that Special Education is referenced as other disciplines that might be engaged in the DDRS Clinical Review Team for either IRS-B or IRS-M and the prevalence of this degree among case managers, we would recommend adding these degrees to the minimum qualification list.
  - In reference to the conflict-free case management reference, should this be included in the Case Management definition, as well?
  - Please see our case management comments regarding reimbursable activities and service standards.
  - Under Activities Not Allowed, should the prohibitions regarding ownership of multiple agencies and/or of other waiver service providers reference Intensive Support Coordination agency instead of Case Management agency? Otherwise, it could seem that an ISC agency was not prohibited from these arrangements. Also, should the prohibition that owners of one Case Management agency may not be a stakeholder of any other waiver service agency, include an exception for Intensive Support Coordination and vice versa?
  - Please see our Case Management comments regarding National accreditation requirements in Indiana Code and on-going criminal background checks.
  - We note that the separately published Case Management definition requires case managers to complete the DDRS/BDDS approved case management curriculum with a score no lower than 95%. However, the ISC definition included in the Waiver amendment indicates that Intensive Support Coordinators complete the curriculum with a score no lower than 80%. Is this difference intended? If so, why? We also note that this activity is required initially and annually for ISCs and presumably initially only for CMs – what is the rationale behind the different frequencies?
  - In the training requirements included in the separately published ISC service definition, there is a requirement for the ISC to have a minimum of 5 hours of

person-specific training before beginning work independently on a participant's case. In conversations with the Division on this requirement, we understand that this training would include meeting/visiting the participant, completing a file/history review, talking with IST members, reviewing documentation submitted to the DDRS Clinical Review Team, and time working with the ISC's supervisor or co-worker to discuss the case, demonstrate what has been learned, and how they intend to approach ISC services for the participant. If this is correct, we would recommend including language clarifying this intent, so that the expectations are clear.

- Non-Medical Transportation and Community Employment Transportation
    - In terms of documenting use and availability of natural supports, who is responsible for ensuring this is documented in the plan?
    - In terms of the Non-Medical Transportation Services Exclusions, what is community access group or individual services? What is an Individuals with Developmental Disabilities Service Center?
    - In terms of the requirement that drivers must have the required training and skills needed to work with waiver service recipients, we would recommend that transportation brokers (i.e. the City bus) not be required to comply with this requirement, as it would be difficult to require or demonstrate that the requirement is met.
- Participant Access and Care - Under the Family Support Waiver, the service definition includes language indicating that the service can be delivered individually or in a group (up to 4). Will this be permissible under the CIH Waiver? If not, why?
- Remote Support Technology
    - As an overarching comment, we would recommend that Electronic Monitoring and other Support Technologies be reflected in two different service definitions. While we appreciate the Divisions move toward flexibility, we believe by combining such a broad scope of support technologies under a single service definition may dilute the safeguards that are currently in place for Electronic Monitoring.
    - To that end, the Electronic Monitoring service definition included in the current DDRS Waiver Manual includes a host of requirements and service standards that serve as important safeguards for individuals served. Will these standards still apply for services provided under Remote Support Technology?
    - Additionally, because of the breadth of services that could be provided under the definition, how does the Division intend to set a consistent rate for providing the service?
    - Under the Service Definition, do all individuals need to provide consent in situations where the service is being utilized by a single housemate in common areas of the home, but only when the other housemate(s) are not in the home?
    - In the description of individuals who may be appropriate for the service, what does minimal support mean? What criteria are used to ascertain whether someone is able to be in the community with minimal support?
    - Also, how do participants demonstrate these requirements? What information is needed? Who is responsible for gathering the information? Who makes the determination? Based on what criteria? Is this reviewed / submitted to DDRS?
    - Under Reimbursable Activities, what are the caps for device installation service and ongoing monthly maintenance of device, including equipment rental or

purchase? How do the caps impact the availability to access other service options under the service?
    - What is the process for receiving the approval of the Director for remote support technology? How can it be ascertained whether approval has already been provided? What recourse is available if approval is not granted? Do all remote support technologies require Director approval?
    - What is the Remote Support Technology Oversight Committee? Who are members of the Committee? What are their roles and responsibilities? What background or expertise are they required to have to participate in the Committee?
    - Note, we believe Additional Provider Qualifications is duplicated in the amendment.
- Wellness Coordination
    - We believe the Tier requirements for face to face contact and consultation be reframed as minimum number of consultations within a month versus the current weekly requirement, to provide greater flexibilities when individuals are absent from services due to hospitalizations or other activities. It is also more consistent with the monthly billing unit.
    - We believe the requirement that the nurse provide DSP training on risk plans be modified to permit the RN/LPN to use their professional judgment in determining when it is appropriate to use a train-the-trainer approach to training on a risk plan or when direct training by the RN/LPN is warranted.
    - Under Reimbursable Activities, how is "active involvement" defined? Does it mean face-to-face involvement only? If not, what other type of involvement would qualify as active?
    - Under Professional Standards, the BDDS Policy reference refers to the Maintenance of Service Records policy, this doesn't seem like an appropriate reference for the section.
    - Under Wellness Assessment, Plan, and Risk Plan, if the IST is responsible for completing these activities who is ultimately responsible for ensuring they are complete and entering into Advocare?
    - Please note, under Wellness Plans it likely should read "within 14 days" not with.
    - Under the Documentation Requirements, it may be helpful to differentiate what documentation is required from a service note perspective and what the Wellness Coordination provider is required to design as a result of providing the service and often involves documentation requirements by other providers. For instance, med refusal must be documented by the provider attempting the medication administration, not by the Wellness Coordination provider, who is required to review the refusal with the physician and IST.
- Appendix I-2 Rates, Billing, and Claims
    - Enhanced Residential Living
        - As currently designed, we believe the proposed setting-based rate structure does not adequately reflect the unique needs of the individual's residing within the setting. Specifically, it appears to take a one-size fits all approach to funding services by assigning individual residential resources as an equal portion of the household rate regardless of need.
        - Also, providing for a flat percentage add-on to the rate for wellness coordination and transportation does not adequately reflect individual

need. As result, this approach has the potential to inhibit operationalizing person-centered planning.

- We also believe this approach creates a disincentive to serve individuals with higher support needs, particularly if those needs exceed the available add-on, thus impacting their ability to access appropriate supports. For example, a non-ambulatory individual with significant healthcare needs classified as Level 2 for accessible transportation and Level 2 for wellness will see a significant reduction in resources available to meet their health and transportation needs. Under this structure, the alternatives available to address the limitations posed by the equal distribution of resources and add-on are to serve the individual based on their needs but without appropriate reimbursement provided, to serve the individual at a service level less than their needs but in keeping with the reimbursement level, or to not serve individuals whose needs exceed the available reimbursement. For INARF and its members, none of these alternatives represent tenable solutions.
- Additionally, bundling wellness coordination and transportation into the ERL rate creates a lack of transparency and accountability in ensuring an individual receives needed service levels to ensure their health and safety and to promote their independence. As a result, we believe the proposed rate structure creates an incentive for providers to limit or lower service levels for all individuals, in order to reduce cost since reimbursement would be unaffected by a reduction in service. While we understand the proposed service definitions would require service levels to be detailed in the Individual Support Plan, we do not believe this is a sufficient safeguard, given currently available policy guidance.

- Intensive Residential Supports
  - In regard to the proposed intensive support services, we are concerned that individuals will be unable to access these services as the proposed rates appear insufficient to attract a pool of willing and qualified providers.
  - Both proposed intensive residential services are premised on the individual having support needs that require one to one support plus ancillary services. However, the proposed rates for Intensive Residential Support – Medical ($250/day) and for Intensive Residential Support – Behavioral ($350/day) are based on costs experienced by existing extensive support needs group homes, which are delivered in a shared staff model that spread the costs for services across four individuals. Because of this difference in approach, we believe the proposed rate model does not provide sufficient resources to cover the required services and supports.
  - As an example, the Intensive Residential Support – Behavioral service definition requires
    - one to one residential support
    - behavior consultant support for 15 hours/week;
    - health care coordination with access to 24 hour consultation and support;
    - psychiatric services and HSPP services both available for up to 10 hours per month with 24 hour availability; and

- access to regular pharmacy review.

- Under current service rates, this would be the equivalent of at least $558/day – calculated based on
  - 138 hours/week of 1:1 residential support at $20.42/hour or $402/day
  - Tier 2 wellness coordination at $111.96/month
  - 15 hours/week of Behavior Support at $18.20/quarter hour or about $156/day
  - plus transportation
  - plus the cost to retain a psychiatrist, HSPP, and pharmacist – far in excess of the proposed rate.
- Given the apparent misalignment between the required level of service and support and the proposed rate, we are concerned that no matter how needed the services may be, access to these services will be negatively impacted as there will be no willing providers to offer the service under these conditions.
- Additionally, we would appreciate more information whether and to what extent the DDRS Clinical Review team will be involved in decisions related to an individual's budget. In the service definition for IRS-M, there is a reference to the IST including recommendations for staffing requirements based on identified interventions to the DDRS CRT as part of the referral for the service. If that staffing exceeds the published rate, can the DDRS CRT make a recommendation to increase the individual's budget to support the increased staff? Also, in a recent waiver amendment webinar, the Division indicated in response to one question that the IST and CRT would evaluate needs and develop a budget around those needs. However, in a subsequent question about the DDRS CRT performing a cost control function, the Division indicated that the CRT are not being engaged for purposes of the budget. Any additional guidance / clarification would be appreciated.

- Intensive Support Coordination
  - We believe the proposed rate does not accurately reflect the increased time and responsibilities required under the Intensive Support Coordination. It is estimated to be a near tripling of current responsibilities, but without a commensurate increase in the rate.
  - We are also concerned as the proposed rate is based on the current Case Management rate, which we believe does not accurately compensate for the work related to annual level of care determinations, person-centered planning, and related budget development.
  - As with the Intensive Residential Services, we are concerned that the misalignment between the rate and responsibilities will not attract a sufficient pool of qualified and willing providers creating a barrier to accessing these services.

In addition to comments related to the amendment, we also wanted to raise questions related to guidance published in support of the Amendment. In relation to the Service Definition Matrix, the Division indicates that the current "buckets" used to reserve certain portions of an individual's allocation would now be given as a "total allocation" for

the individual and their IST to determine how to utilize based on the individual's needs. Currently, Indiana Administrative Code dictates how the "buckets" are determined based on an individual's Algo score. Under this proposed change, how will the total allocation be determined? What happens when the team wishes to use the allocation in a way that the individual does not support? What about when the individual wishes to use the allocation in a manner the team does not support?

Related to this change, how will Division implement its plan to allocate funds for residential supports based on the total needs of the home, separate from the "total allocation" referenced above and not based on the individual's unique needs? More specifically, how will an individual's residential allocation be determined? How will the site allocation be determined? In addition, given the direction that residential support planning by the IST would need to be done holistically and in conjunction with the other individuals and ISTs in the site, how will the Division ensure, support, and enforce teams working together to achieve the desired result? What if there is disagreement within or among teams about how supports are to be used – how will that be negotiated and resolved?

Thank you, again, for the opportunity to offer comment on the proposed second amendment to the CIH Waiver. We hope you find that they are constructive and will assist you in planning and implementing a quality and coordinated program for Hoosier with disabilities.

Sincerely

Kimberly A. Opsahl, J.D.
President/CEO