

To: Kylee Hope, Director, DDS  
From: Steve Cook, President/CEO, INARF  
RE: Family Supports and Community Integration and Habilitation Waiver Renewals  
Date: December 12, 2019

Thank you for the opportunity to comment on the proposed renewals of the Community Integration and Habilitation (CIHW) Waiver and the Family Supports (FSW) Waiver. INARF applauds the state agency for the importance it places upon obtaining public input from a wide range of stakeholders in developing the waiver renewals, and is confident that the feedback received will be carefully considered in the final development of the renewal applications prior to submission. Please know that beyond our written comments, INARF is dedicated to assisting the state agency in any way appropriate to improve systems and services to individuals with disabilities.

INARF is the principal statewide trade association representing agencies that serve Hoosiers with intellectual and developmental disabilities. INARF Members often play a lifelong role in the lives of those they serve by providing a continuum of services that in many instances stretches from birth to death and across all facets of life in their chosen community. Further, INARF and its members are committed to ensuring Indiana's system of services and supports for individuals with intellectual and developmental disabilities offers maximum options, access, and choice.

The renewals of the CIH and FS waivers are vital to reflect DDS' person-centered philosophy and the LifeCourse Framework and to enable individuals to have more flexibility in using their services, supports, and budgets to achieve their visions for a good life in all domains of their lives.

INARF thanks DDS for its inclusion of elements of INARF's recommended revisions to the waivers, including addition of Environmental Modifications and Remote Supports to the FSW, renaming Electronic Monitoring to Remote Supports, and combining Facility Habilitation and Community Habilitation into a single Day Habilitation service.

INARF does, however, have the concerns outlined below, and we request that the Division of Disability and Rehabilitative Services address them in the waiver renewals prior to submission to the Centers for Medicare and Medicaid Services (CMS). Our concerns include the following:

#### **40 Hour Rule for Relative Caregivers**

It is INARF's understanding that DDS' intent is to limit the number of hours of waiver services each relative caregiver can provide to 40 hours per week in accordance with 1102 Task Force recommendation 3.4: That adults who participate in Medicaid HCBS waiver services be allowed, through informed choice, to receive direct services and supports from one or more family members to meet their assessed needs; and that no individual family member be allowed to provide more than 40 hours of support, within a seven day period.

Limiting each relative caregiver to 40 hours per week across all waiver services received by related participants will likely result in loss of services for some individuals. The top issue INARF hears from our members is their inability to recruit and retain direct care staff. Many waiver participants depend on relative caregivers to provide the majority of their hours of services. The proposed change would require providers to find additional FTEs to provide the hours of

services these family caregivers could no longer provide. Otherwise, waiver participants would experience a loss of hours of service. See Attachment A for additional information on additional FTEs needed and potential hours of service lost.

We urge DDRS to eliminate the language limiting each relative caregiver to 40 hours per week and to maintain the current policy, which applies the 40 hour limit only when an individual is receiving Residential Habilitation or PAC and does not apply the limit to other services, in order to avoid loss of services for participants prior to submission of the waiver renewals to CMS.

### **Behavioral Support Services**

INARF appreciates modifications to the service definition that elucidate the intent of the service and expand upon the reimbursable activities, particularly the clarification regarding concurrent service delivery. However, INARF requests the following additional clarification and policy guidance:

- Regarding developing a comprehensive behavioral support plan and subsequent revisions, how often, at a minimum, should restrictive techniques be reviewed by the Human Rights Committee?
- Clarify that, in accordance with concurrent service delivery being allowable, observation and environmental assessment should be completed in individuals' typical setting, activities, and routine in order to identify targeted behaviors when and where they typically occur.
- Clarify that: When delivery of Behavioral Support Services will require the individual to be absent for a period of time from their typical setting and/or activities, Behavioral Consultants should make appointments with the individuals and inform the other service providers of the appointments in advance.

### **Case Management**

In 2018, the State added a payment point specifically for annual person-centered planning to assure individuals received high quality person centered planning. INARF appreciates that the change to combine the annual AISP rate with the CMGT rate will be less administratively burdensome; simplify service delivery for Case Management companies (CMCO); and eliminate questions regarding billing of the AISP service when there are plan interruptions, re-entries, changes in Case Management companies, and transitions between waiver types. However, we are concerned that the focus on person-centered planning may be lost without a rate designated specifically for this critical activity.

INARF encourages the State to issue guidance regarding expectations for documentation of person-centered planning activities within the broader Case Management service to assure annual person-centered planning activities remain at the forefront of the Case Management service. INARF requests that the guidance specifically address individuals' transitions from one CMCO to another CMCO.

INARF recommends that the FSW annual cost limit/spending cap per individual be adjusted to include the increased monthly CMGT rate to avoid any unintended consequences of individuals close to the cap losing services. Currently, the AISP rate falls outside of the annual FSW cap but the CMGT rate does not.

INARF urges DDRS to assure that the Case Management rate is sufficient to support delivery of high quality annual person-centered planning activities and ongoing Case Management activities by qualified and skilled Case Managers.

INARF recommends that DDRS consider allowing FSW recipients who only need Case Management services to add additional hourly units of Case Management services to assure they receive the supports they need.

### **Day Habilitation**

INARF thanks DDRS for combining Facility Habilitation and Community Habilitation into a single Day Habilitation service to allow more flexibility to waiver participants and providers for the service to be delivered in the community or in a facility operated by a DDRS-approved provider. We believe this change is one small but critical step that will assist providers in achieving compliance with the HCBS Settings Rule.

INARF encourages DDRS to consider the following recommendations:

- The Day Habilitation rates are not sufficient to support service delivery in the community, particularly for the individual and small group ratios. To incentivize service delivery in the community, these rates should be increased.
- Eliminate the ratio-based service model and rate reimbursement system as it is counter to HCBS Rule and person-centered approaches and creates significant administrative burden related to hourly billing and ratio tracking.
- Establish a Daily or Half-day rate for Day Habilitation service provision, which would allow providers the ability to offer more choices to individuals and to monitor their progress towards positive outcomes with less administrative burden related to hourly billing and ratio tracking. INARF provided proposals previously, most recently in 2016.
- A Medium Group of up to 10 individuals to one direct care staff is not consistent with best practices, particularly in community settings or with individuals with more significant support needs. Consider modifying the ratio sizes to assure individuals' needs can be adequately met within the ratios in both community and facility settings.
- Work with FSSA audit to provide guidance regarding expected documentation for the 11:1 to 16:1 being allowable only in facility settings. For example, should the notes for this ratio always specify that the service was delivered in a facility setting?

### **Environmental Modifications**

INARF thanks DDRS for the addition of Environmental Modifications to the FSW. INARF encourages DDRS to conduct outreach to recruit additional Environmental Modifications providers to assure the service is available.

### **Intensive Behavioral Intervention**

- Remove recommended 20 hour minimum and required submission of justification explaining why the IST feels a number less than the recommended minimum is acceptable. This minimum is difficult to maintain and expensive in an individual's budget
- Clarify differences between IBI level one and level two
- Increase reimbursement rates, particularly for level 2, to allow providers to recruit and retain qualified clinicians

### **Prevocational Services**

As INARF communicated in July in our comments to the proposed service definition modifications, prevocational services are expected to help people develop general skills that lead to competitive and integrated employment, an individual should not be disqualified from prevocational services based on their productivity and average wage for a quarter. Regardless of an individual's productivity or average wage, individuals can benefit from services to assist them to develop

general, non-job-task specific skills that will contribute to employability in an integrated, competitive workplace.

We recommend that the language regarding the appropriateness of prevocational services being determined by the average hourly wage for the previous quarter falling below 50% of the Federal minimum wage be removed and that the prevocational services core service definition from the CMS 1915C HCBS Waiver Instructions and Technical Guide be adopted in the CIH and FS waivers.

Additionally, the service definition in the waiver renewals specifies that participants receiving prevocational services must have employment-related goals in their PCISP. INARF requests clarification regarding the deadline by which the employment related goals should be included in the individual's plan after the individual begins prevocational services.

### **Residential Habilitation**

Allow reimbursement (at a different rate) for time when direct care staff is asleep, as do other states.

### **Remote Supports**

INARF thanks DDRS for renaming Electronic Monitoring to Remote Supports, for adding Remote Supports as a service on the FS waiver, and for designating an additional \$500 for Remote Supports to be accessed outside of the FSW's \$17,300 annual cost limit/spending cap.

Recommended revisions to the service definition in the renewals:

- Move references to “surveillance” and types of sensors under reimbursable activities rather than in the first sentence describing the service. INARF believes reading these words in the first sentence of the service description may create a negative first impression and deter some individuals and families from selecting this service.
- Regarding “Assure that the stand-by intervention (float) staff meet the qualifications for direct support professionals as set out in DDRS BDDS policy on requirements and training for direct support professional staff”, INARF recommends that DDRS expand this to allow a trained and qualified family member, friend, or natural support to provide the stand-by intervention.

INARF requests that DDRS encourage Remote Supports providers to provide Remote Supports during daytime hours to assure availability of the service when individuals need it, particularly if the IST identifies the need for additional safeguards/supports during individuals' alone time.

INARF also recommends that DDRS issue policy guidance regarding the required safeguards for participants receiving Remote Supports services (e.g. how often continued use of RS should be assessed; required backup systems; minimum audio communication capabilities for monitoring base staff to effectively interact with participants; protocols for response to individual's needs, including physical response for on-site support; etc.). See Attachment B for additional information.

INARF urges DDRS to identify strategies to add a service or broaden existing service definitions to encourage the use of technology and meet the unique needs of individuals at all levels (from artificial intelligence to use of sensors and cameras) to support participants to maximize independence and community integration, including in transportation. INARF recommends that DDRS encourage use of enabling technology for items such as communication devices, cell phone/tablet allowances and supportive applications, technical assistance training throughout the state including training for self-advocates and families, and inclusion of non-direct tele-service (telemedicine, telepsychiatry, and telepharmacy) on a more widespread basis.

## **Structured Family Caregiving**

In accordance with the DDRS Shared Living/SFC Workgroup recommendations

- Change the name of the service to Shared Living and limit Shared Living sites to no more than 2 or 3 individuals receiving DDRS-funded HCBS waiver services, unless clearly for the benefit of the individual(s) and approved by BDDS.
- For current sites with more than 2 or 3 individuals receiving DDRS-funded HCBS waiver services, if BDDS does not waive the requirement for these sites, a transition plan and target date should be established.

## **Transportation Services**

To ensure transportation is not a barrier for individuals to access the community:

- Specify that alternate methods of transportation includes vehicle and ride sharing systems
- Increase the 2 trips per day limit and annual limits to ensure transportation is not a barrier for individuals to access the community

## **Wellness Coordination**

- For documentation purposes, clarify that a week is defined as Sunday-Saturday and each week's service and documentation will be attributed to the month in which the last day of the calendar week falls.
- Allow Wellness Coordination services to be provided via telemedicine
- The Wellness Coordination rates are not sufficient to recruit and retain licensed and registered nurses, to support travel to face to face visits, and to complete the extensive required documentation. The rates revised and the rate structure should create incentives for providers that assist individuals in achieving desired outcomes (e.g. ensuring wellness/cancer/screening, managing chronic conditions, etc.)

## **Appendix J**

INARF is concerned about the cost neutrality calculations in Appendix J. In the CIHW renewal, rates for group homes seem low. For Year 4 (10/1/17 – 9/30/18), the calculated costs per recipient are at \$87,292.42 per year or \$239.16 per recipient per day. However, Myers & Stauffer has indicated that the average cost per recipient per day is closer to \$250. INARF is concerned that the cost neutrality calculations may not accurately reflect the calculated costs per recipient for individuals served in group homes, therefore artificially decreasing the cost neutrality calculation. INARF recommends that DDRS review the cost neutrality calculation to assure that the cost per recipient for individuals served in group homes are accurately reflected.

Thank you very much for your consideration of our comments on the renewals of the CIH and FS waivers. We hope you find that they are constructive as you draft the final version of the waiver renewals.

Attachment A: 40 Hour Rule Change Scenarios

Current guidance issued 2/22/2019: The rule applies only when an individual is receiving Residential Habilitation or PAC and is not applied to other services.

Current Situation	Participant Family Member 1		Total hours per relative caregiver	Participant Family Member 2		Total hours per relative caregiver	Grant total hours per caregiver	Total hours per relative caregiver
Relative 1	40 hours RHS	10 hours of other services	50	40 hours PAC	10 hours of other services	50	100	40 hours of RHS/PAC per relative caregiver per participant, plus additional hours of other services
Relative 2	40 hours RHS	10 hours of other services	50	40 hours PAC	10 hours of other services	50	100	
Total hours of family caregiving per participant			100	Total hours of family caregiving per participant		100		
Total hours of family caregiving across participants						200		

The proposed renewal language would limit each relative caregiver to 40 hours per week across all waiver services for all relative participants.

For example, if Relative 1 and Relative 2 are providing services to two family members (Participant Family Member 1 and Participant Family Member 2), Relative 1 would be limited to 40 hours across both Participant Family Member 1 and Participant Family Member 2 and Relative 2 would be limited to 40 hours across Participant Family Member 1 and Participant Family Member 2. Participants would lose services unless additional caregivers were identified.

Scenario 1	Participant Family Member 1	Participant Family Member 2	Total hours per relative caregiver	If each participant or the combination of relative participants is currently receiving more than 40 hours from an individual relative caregiver, additional relative or non-relative caregivers would need to be identified
Relative 1	40	hours	40	
Relative 2	40	hours	40	
Total hours of family caregiving per participant		80	Difference between Scenario and Current per participant: 20 hours	
Total hours of family caregiving across participants: 80 hours			Difference between Scenario and Current across participants: 120 hours	
Number of Additional FTEs needed to avoid loss of hours of service across participants: 3				



Attachment B: Remote Supports Participant Safeguards Policy Guidance Recommendations

- Annual assessment updates: At least annually, the IST must assess and determine that continued usage of the remote support system will ensure the health and welfare of the participant. The results of this assessment must be documented in the PCISP and in the DDRS Case Management system. A review of all incident reports and other relevant documentation must be part of this assessment.
- The remote supports provider must have safeguards and/or backup system, such as battery and generator for the electronic devices, in place at the monitoring base and the participant's residential living sites in the event of electrical outages.
- The remote supports provider must have backup procedures for system failure (e.g. prolonged power outage), fire or weather emergency, participant medical issue, or personal emergency in place and detailed in writing for each site utilizing the system as well as in each participant's PC/ISP. This plan should specify the staff person or other supports to be contacted by the remote supports staff who will be responsible for responding to these situations and traveling to the participant's living site.
- Remote Supports must include the capabilities to allow monitoring base staff to effectively interact with and address the needs of participants in each living site, including emergency situations when the participant may not be able to use the telephone.
- A secure (compliant with the Health Insurance Portability and Accountability Act [HIPAA]) network system must be in place when using remote supports technology.
- At the time of monitoring, the monitoring base staff may not have duties other than the oversight and support of participants at remote living sites. Oversight of a participant's home must be done in real time by an awake-staff at a remote location (monitoring base).
- The remote support staff must have detailed and current written protocols for responding to the needs of each participant at each remote living site, including contact information for a person who can physically respond to the site ("Responder") (e.g. float staff, family member, natural support etc.) to supply onsite support at the participant's residential living site, when necessary.
- Residential providers must ensure the Responder is able arrive at the participant's residential living site within a reasonable time as determined by the IST.
- The Responder will assist the participant in the home as needed to ensure the urgent need/issue that generated an intervention response has been resolved. Relief of Responder, if necessary, must be provided by the residential provider.
- Documentation Standards
  - Documentation must include the following:
    - Services outlined in the PCISP
    - Informed consent documents (BDDS should develop a standard document)
    - Reports of activity must be available upon request from to the provider or other authorized person on an IST from the remote supports provider.