IN-ABC

Indiana Association of Behavioral Consultants
www.inabc.org

Through professional advocacy, support and development, IN-ABC promotes effective, ethical and quality behavioral services.

6/22/12 IN-ABC Meeting Minutes

2012 Board Members present:

President: Gail Kahl
Vice President: Fritz Kruggel
Director: CJ Gallihugh
Director: Kelly Howard
Treasurer: Rob Westcott
Secretary: Sue Bauer

Call to order:

Introductions:

President's Report:

- **Logo presentation:**

  Designed by Molly Lang, Noble of Indiana

- **Conference update:**

  IN-ABC 5th Annual State Wide Conference

  Oct 24th and 25th Hilton North

  Rooms are ready to be booked and you can do it online. Book early! If you wait, rate may not be guaranteed. Wireless is free, ask for code at check-in.

The special room rate will be available until September 24th or until the group block is sold-out, whichever comes first.

Make room reservations at:

http://www.hilton.com/en/hi/groups/personalized/I/INDINHF-ABC-20121024/index.jhtml?WT.mc_id=POG

There will be twelve 90 minute sessions available. Can attend three.

Some of the presenters: Dr. Ralph Ankenman (Hope for the Violently Aggressive Child), Chris Tullis (Data Analysis, Interpretation), Steve Gundy (ADHD), Dr. Dallas Mulvaney (Evolution of services), Brad Mitchell (SIB), Heather Myers (Nurtured Heart-2 sessions), Kristin Loflin (Communication Aps)

- **DDRS Updates**

(see DDRS power point attachment)

- **Community Integration and Habilitation Waiver**

DDRS Q & A from Webinar

(see CIH Waiver attachment)

Treasurer Report: Rob Westcott

(see Treasurer Report attachment)

Secretary Report: Sue Bauer

We continue to grow! As of 7/22/12 we have 266 Members.

Membership numbers since 2008:

2011- 215
2010- 189
2009 -191
2008- 166

Liaison Report: Kelly Hartman

- As far as our sector, things are fairly quiet at a policy level.

- The combining Autism and DD waivers have been submitted to CMS.

- The state is still planning to go forth with the plan that if you are not a BCBA or HSPP you will have to have a contract on file with a licensed person. Contact Kelly and Gail with concerns.

- This is going to be the year of accountability. RHS services will require national accreditation. Increased accountability to do our jobs. When complaints are involved, BQIS is investigating in person.

- Focus on best practices, using least restrictive interventions, client rights, not using prohibited interventions.

- Rumor BCBA's going after licensure, could not call yourself a behavior analyst unless you are one.

- NEW 90 day check list (contact Kelly with concerns).

- Health homes---federal movement toward health home. Intent of this is that some will meet a certain medical criteria that they get comprehensive health care. Put's an ICF/MR group home spin on waiver folks. Medicaid costs higher on the waiver than the group home. More preventative, tightly monitored health care coordination. Provider's that meet guidelines for a health home would get paid a certain dollar amount per person per month so that provider can pay for services from physician, dietician, etc. On top of medicaid fees there will be a stipend to help make sure medical needs are met.

  (see Health Home attachment)

- The industry is changing rapidly.

- Roommate Questionnaire:

  Answer the questions and get very thorough answers. The people at the state do not know about previously failed placements. Put history on paper and write good

justifiers. Be deliberate, client centered. They want to know how this will impact progress.

- Jim Hammond, President of IN-ARF, is resigning at the end of this calendar year. IN-ARF is conducting a nation wide search. Targeted announcement of new president is September 2012.

- First Steps: They do not have behaviorists but have developmental therapists. There is not a requirement that they are masters level clinician's. Behaviorists in First Steps are a possibility in the future.

Vice President's Report:

Fritz Kruggel

District Networks are a go. Everyone we approached is on board. Have the initial phase completed. Fritz is continuing to organize and this is now in the launching phase. May be converting our internet stuff to google/gmail. Possible twitter accounts.

Committee Reports:

Ethics Committee:

Mari Shawcroft

No complaints submitted for review.

Professional Credentialing Committee:

Autumn Brown new RBC
Two applications and possibly more in progress.

Professional Development Committee:

No updates

Risk Management:

No updates

Marketing committee:

No updates

Respectfully submitted by: Sue Bauer, Secretary

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June 20, 2012

Treasurer Report

Current Balance / Funds as of 6/20/12:

Checking:	**$ 6332.16**
Savings 1:	**$ 3028.35**
Savings 2:	**$ 5375.00**

Total Funds: $ 14,735.51

and for reference:

Total Funds at this point last year: $20,733

- **however, $5000 more in Liaison Stipend has been paid out this year than last year at this time**
- **the 2011 $$ reference also appears much higher than 2012 given that $2200 in advance conference expenses have been paid out that had not yet been paid out last year at this time**
- **the lower 2012 figure also is affected by the high cost of last year's conference**

Membership Revenue:

Membership Revenue 2012 = $17,441

and for reference:

Membership Revenue 2011 = $10,924
Membership Revenue 2010 = $11,033
Membership Revenue 2009 = $11,776
Membership Revenue 2008 = $10,968
Membership Revenue 2007 = $ 9,450
Membership Revenue 2006 = $ 6,782

Health Home Background

One of the many focuses of healthcare reform is that of integration and improved coordination of care. In support of that focus, the Affordable Care Act authorized a health home provision [Sec. 2703 & Sec. 19459(e)] that enables states to build a person-centered care system to improve outcomes for beneficiaries and ensure better services and value for state Medicaid and other programs.[1] Health homes can be an enhancement to already existing medical homes within primary care practices but because of their emphasis on serving individuals with chronic conditions, they offer an opportunity for specialty providers to enhance care coordination for the populations they serve. An evolution of the medical home model, health homes are intended for individuals with chronic conditions with care coordination efforts incorporating all the medical, behavioral health, and social supports and services needed by a beneficiary. Additional emphasis is placed on the use of health information technology (HIT) to enhance care coordination efforts.

States can elect to provide the health home option through a state plan amendment. In defining the population to be served, it must consist of individuals eligible under the State plan or "under a waiver of such plan" who have: at least two chronic conditions, as listed in section 1945(h)(2) of the Act; one chronic condition and be at risk for another; or one serious and persistent mental health condition. Services which may be provided by the health home are:

- Comprehensive care management;
- Care coordination and health promotion;
- Comprehensive transitional care from inpatient to other settings, including appropriate follow-up;
- Individual and family support, which includes authorized representatives; and
- Referral to community and social support services, if relevant.

CMS also encourages the use of HIT to link services, as feasible and appropriate.

Indiana DDRS Health Home Initiative

In partnership with the Indiana Office of Medicaid Policy and Planning, Indiana's Division of Disability and Rehabilitative Services (DDRS) proposes a health home initiative to serve persons with intellectual and developmental disabilities (ID/DD). DDRS believes care should be less fragmented and more holistic (i.e., in addressing physical and behavioral health care needs and in considering both medical as well as social needs), and there should be greater communication across settings and

[1] http://www.integration.samhsa.gov/integrated-care-models/person-centered-healthcare-homes

providers. In addition, DDRS believes Consumers should have greater involvement in their care management. With these primary goals in mind, outcomes of this enhanced care management model would include improvements in functional status, clinical status, and client satisfaction, adherence to the treatment plan, cost savings, and enhanced quality of life.

Needs Statement

According to the World Health Organization (WHO):

- People with disabilities report seeking more health care than people without disabilities and have greater unmet needs. For example, a recent survey of people with serious mental disorders, showed that between 35% and 50% of people in developed countries, and between 76% and 85% in developing countries, received no treatment in the year prior to the study.
- Health promotion and prevention activities seldom target people with disabilities. For example, women with disabilities receive less screening for breast and cervical cancer than women without disabilities. People with intellectual impairments and diabetes are less likely to have their weight checked. Adolescents and adults with disabilities are more likely to be excluded from sex education programs.
- People with disabilities are particularly vulnerable to deficiencies in health care services. Depending on the group and setting, persons with disabilities may experience greater vulnerability to secondary conditions, co-morbid conditions, age-related conditions, engaging in health risk behaviors and higher rates of premature death.
- Secondary conditions occur in addition to (and are related to) a primary health condition, and are both predictable and therefore preventable. Examples include pressure ulcers, urinary tract infections, osteoporosis and pain.
- Co-morbid conditions occur in addition to (and are unrelated to) a primary health condition associated with disability.
- Some studies have indicated that people with disabilities have higher rates of risky behaviors such as smoking, poor diet and physical inactivity.

In addition, the WHO identified that people with disabilities encounter a range of barriers when they attempt to access health care. Affordability of health services and transportation are two main reasons why people with disabilities do not receive needed health care in low-income countries, 32-33% of non-disabled people are unable to afford health care compared to 51-53% of people with disabilities. In addition, there is a lack of appropriate services and an inadequately trained workforce of health care workers. People with disabilities were more than twice as likely to report finding health

care provider skills inadequate to meet their needs, four times more likely to report being treated badly and nearly three times more likely to report being denied care.[2]

In providing enhanced care coordination services for individuals with developmental disabilities, the proposed health homes are consistent with a framework developed by the World Health Organization referred to as Community-Based Rehabilitation (CBR). CBR programs support people with disabilities in attaining their highest possible level of health, working across five key areas: health promotion, prevention, medical care, rehabilitation and assistive devices. Both CBR and health homes shifts the focus beyond the historical model of pathology and limitations, to achieving optimal functioning as a goal for everyone. These models also recognize the important tenets of person-centered, community-based care and well planned care.

Proposed Population

DDRS is proposing a statewide implementation of health home services for individuals with a co-occurring developmental disability (DD) who are at risk for developing another chronic health condition or currently have a co-occurring mental illness. The state defines developmental disabilities as persons with intellectual disability (ID) and/or other developmental disabilities (DD) as defined in Indiana Code [IC 12-7-2-61], such as cerebral palsy, epilepsy, and autism. The ID/DD must have an onset prior to age 22 and be expected to continue. The ID/DD must also result in substantial functional limitations in at least three (3) of the following areas of major life activities:

a. Self-care.

b. Understanding and use of language.

c. Learning.

d. Mobility.

e. Self-direction.

f. Capacity for independent living.

When an individual enrolled in a health home is also receiving case management services through a waiver program, the health home will also serve as a link between the waiver program and the enrollee's health care providers to ensure that clients are receiving preventive, holistic and coordinated health care services.

Proposed Providers

[2] WHO website; http://www.who.int/mediacentre/factsheets/fs352/en/index.html

Designated Providers must have training, expertise and experience in providing care management and care coordination services for individuals with developmental disabilities and behavioral health needs. Specifically these providers must demonstrate an understanding of the types of barriers that adults with physical, sensory, communication disabilities, developmental or mental health needs face in the health care industry and the resulting access and accommodation needs. The health home's care coordinators will work in partnership with Primary Medical Providers (PMPs) and other caregivers to ensure that each enrolled individual's care is coordinated and well managed. Designated Providers shall be any Medicaid enrolled provider that meet health home provider standards including being enrolled as a Rehabilitation Service Provider with DDRS. The health home will develop and use a multidisciplinary team to manage and coordinate the care of the complex populations of persons with intellectual and developmental disabilities. These providers will establish health home teams that must, at a minimum, consist of a RN or LPN to serve as care coordinator, a nutritionist to review dietary needs, and a pharmacist to review medication regimes. The team may also include a peer support specialist, behavioral specialist, employment specialist, substance abuse counselor, and/or mental health therapist or other specialists necessary to meet the individual needs of each client. Designated providers must have a written agreement with a physician to consult and support the health team. Providers serving persons with ID/DD/MI must have a behavioral health specialist assigned to the health team.

In addition to being enrolled as a provider in the Indiana Medicaid program and complying with all Medicaid program requirements, health homes must meet the following requirements which are subject to approval, changes, and updates by the State:

- Be an approved Residential Habilitation and Support Services Provider under 460 IAC 6-5-24.
- Provide a designated Care Management Manager responsible for oversight of the health home program.
- Designate health teams that at minimum include: an RN or LPN to serve as the Care Coordinator, a nutritionist, and a licensed Pharmacist. For the ID/DD/MI population the care coordinator may be a Licensed Mental Health Counselor (LMHC), Licensed Clinical Social Worker (LCSW), or Qualified Behavioral Health Professional (QBHP) under the Medicaid Rehabilitation Option Program.
- Provide documentation of written agreement with a physician or physician group to serve the primary care needs of the population.

- Provide written agreement with local hospitals to provide referrals of eligible individuals to the health home following emergency room (ER) contacts or inpatient admissions; as well as how the health home intends to provide transitional services to individuals already enrolled in the health home when admissions or ER visits occur.

- Provide documentation of a written agreement with local behavioral health providers to ensure access and coordination of behavioral health prevention and treatment services.

- Provide plan to ensure the environment, care, and materials for clients are culturally competent.

- Provide written assurances that the health home has established relationships with local advocacy and support resources for clients and their families.

- When developing the care plan, in addition to working with a multidisciplinary team of qualified health care professionals, the health home must ensure that there is a mechanism for members and their families and advocates to be actively involved in care plan development. The health home will develop a process for reviewing and updating the care plans with members on an as-needed basis, but no less often than every rolling 12 months.

- Provide a written plan for the provision of health promotion services.

- Provide written plan for continuous quality improvement program, including how the health home provider will collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.

- Provide written plan for staff training and ongoing supervision, including competency with person centered planning approaches.

- Demonstrate a capacity to use health information technology and other technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate.

- Demonstrate the ability to report required data for both state and federal monitoring of the program.

The health home will design and implement care management services that are dynamic and change as members' needs change. The health home will address the

medical, psychological, functional and social domains of health care for its membership. The health home will be responsible for linking the member to the services that will address these four domains and for coordinating care, as needed, between these services.

Goals

The health home will empower individuals with developmental disabilities to reach their optimum level of wellness, self-management and functional capability by:

- **Prevention and/or early treatment of secondary conditions** – For example, decubiti in people with cerebral palsy or urinary tract infections in people with spina bifida;
- **Decreasing preventable chronic conditions** – For example, adults with disabilities are at increased risk to have inadequate emotional support and to lack regular physical activity. They remain at the same or greater risk as the general population to be overweight or obese and also to use tobacco. They are at increased risk of cardiovascular disease, arthritis and chronic pain;
- **Improving access to clinical preventive services** – For example, adults and children with disabilities are at increased risk to lack routine dental care and women's health preventive services. People with disabilities often require additional preventive or guideline recommended screenings and services (i.e., thyroid screening for individuals with Down Syndrome or flu shots for individuals with chronic obstructive pulmonary disease); and
- **Planning beyond the physical needs of the person with disabilities to improve health and quality of life**, (i.e., functioning, activities and participation in work and school) – People with disabilities not only need education about their conditions, but also activities to acquire life skills to manage their own care and opportunities to participate in their communities to foster healthy physical, mental and social lifestyles.

Use of Health Information Technology

DDRS currently uses the Developmental Disabilities Automated Resource Tool (DART) and INsite systems for management of both provider and client information. INsite provides support for multiple, program-specific case management business processes. Major business processes include recording client demographics, client contact information, case/progress notes, assessments, eligibility determinations, service planning, fiscal management, and outcome measurement. INsite also manages case managers and provider databases. DART is the client server based application to support case management for DDRS. The application houses client demographic and status information, eligibility, placement information, State Line budget and claims

information and provider management, along with other information to support DDRS. The capabilities and functions of both of these systems will be combined into a single integrated case management system (ICMS) scheduled for implementation on July 1, 2013.

ICMS's goal is to increase the quality and coordination of care for DDRS's clients. Currently, clients from different service-delivery programs are served by several systems, including INsite and DART, which do not share client or provider data. ICMS will provide a single web-based application to integrate multiple case-management programs and, at the same time, present program-specific workflows to assist case managers in delivering goal-based services. Because care coordinators and case managers will have access to the system, information regarding services from multiple sources can be accessed when developing and monitoring service plans. This information can assist the care coordinator in assuring clients are accessing needed services while also eliminating duplication. In addition this platform will facilitate information sharing among all providers.

Evaluation

States operating a health home SPA are required to have a quality program that evaluates whether the program design is meeting identified goals. CMS expects the quality metrics to include measures that assess individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes. Until CMS releases a core set of measures, states are expected to define their own.

In addition to the CMS required tracking of emergency room contacts, hospital admissions, and skilled nursing facility admissions, DDRS proposes where possible to utilize existing quality measures that are being tracked for the current DD waiver or by OMPP for the Care Select population. The majority of these measures will use claims data as a source. However, it may be necessary to look beyond claims to other sources in order to identify measurable data that aligns with DDRS program goals.

Payment Methodology

Health Homes meeting State and federal standards will be paid a per member per month care management fee. All payments are contingent on the Health Home meeting the requirements set forth in their Health Home applications, as determined by the State of Indiana. Failure to meet such requirements is grounds for revocation of Health Home status and termination of payments. The payment methodology for Health Homes is in addition to the existing fee-for-service payments for direct services. Health Homes do not serve beneficiaries enrolled in managed care.

This reimbursement model is designed to fund only Health Home services that are not covered by any of the currently available Medicaid funding mechanisms. Health Home services, as described above (Comprehensive Care Management, Care Coordination, Health Promotion, Comprehensive Transitional Care, Individual and Family Support, and Referral to Community and Social Supports) may or may not require face-to-face interaction with a Health Home beneficiary. However, when these duties do involve such interaction, they are not traditional clinic treatment interactions that meet the requirements of currently available billing codes. Indiana recognizes that health home transformation requires financial support to clinic leadership and administrative functions so that beneficiaries receive services in a data driven, population focused, and person centered environment.

All Health Home providers will receive the same single PMPM rate. The PMPM management fee is not risk-adjusted or based on patient functional status.

Full-time PMPM funded staff will not be permitted to bill for any other Medicaid services. Staff for whom PMPM funding covers only a part of their total work time are required to document their time funded by and dedicated to Health Home services to assure that no other billing to Medicaid occurs during that time

Financing

DDRS will provide the matching funds for the Health Home Services. The Health Homes initiative provides a 90/10 FMAP for the first eight quarters of the program. Cost savings to the state are anticipated through decreased ED/inpatient utilization and decreased health care costs due to improved health outcomes.

Community Integration and Habilitation Waiver
Q&A's from Webinar:

The ultimate goals of the conversion of the Autism and Developmental Disabilities waivers to the Community Integration & Habilitation (CIH) waiver are to:

- Provide the Family Supports Waiver (FSW) to more people,
- Enable families to intervene earlier in the care for their family member with a Developmental Disability, including Autism,
- More rapidly reduce the wait time to receive funding from the state for services upon diagnosis.

Important facts about the Waivers:

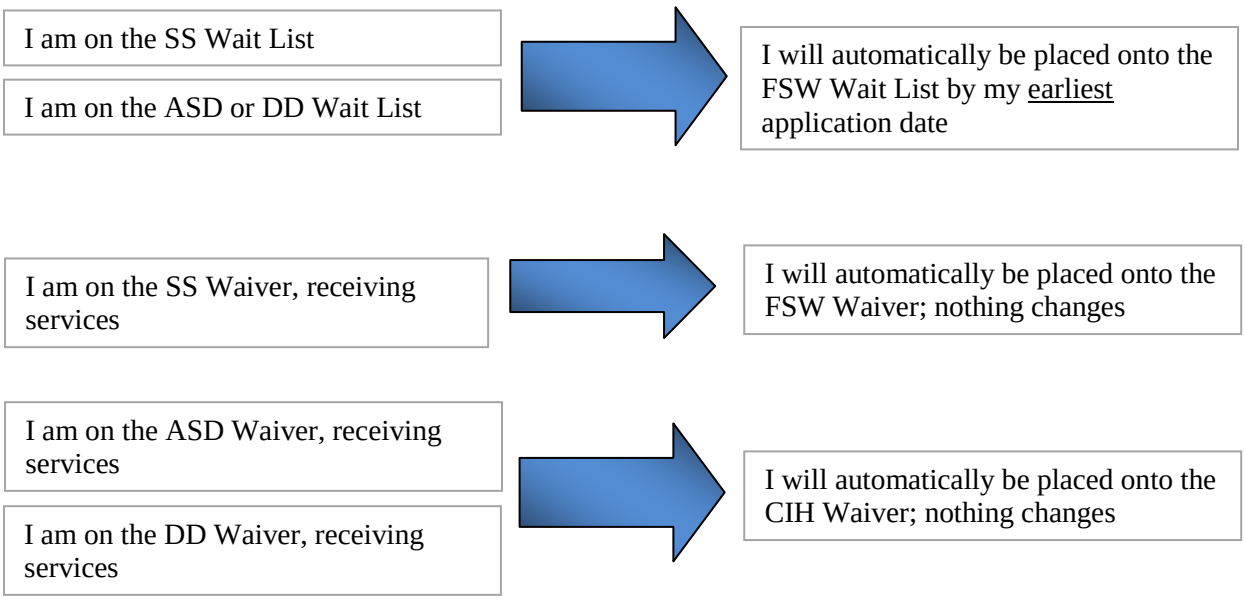
1. If a person is currently on the wait list for any of DDRS' waivers - Autism (ASD), Developmental Disabilities (DD), or Support Services (SS), he/she will be moved to the FSW wait list and targeted for the FSW by the earliest application date that he/she has submitted. They will not have to re-apply for any waiver, and their position on the list will be the same as it was on the Autism, DD, or SS wait lists.

2. If a person is currently on the Support Services (SS) waiver he/she will automatically begin receiving services through the Family Supports Waiver (FSW). These individuals will receive the same services and benefits as they were on the Supports Services waiver, as the new waiver is exactly the same, only named differently and includes two more services and an increased cap. They will not need to do anything.

3. If a person is on the Autism or the DD Waiver, he/she will automatically begin receiving services through the Community Integration & Habilitation (CIH) waiver. These individuals will receive the same services and benefits as they were on the Autism or DD waivers, as the new waiver is exactly the same, only named differently. They will not need to do anything.

4. An application has been submitted for the increase in funding (from $13,500 to $16,250) on the Family Supports Waiver. BDDS is waiting for approval, and has an estimated effective date of September 1, 2012.

5. The FSW is a capped waiver, but soon will be expanding to cover direct care service for in-home support.



Definitions for information in the Question/Answer section

Acronym	Full Meaning
ASD Waiver	Autism Waiver
BDDS	Bureau of Developmental Disabilities Services Community
CIH Waiver	Integration & Habilitation Waiver
CMS	Centers for Medicare and Medicaid Services
DD Waiver	Developmental Disabilities Waiver
DDRS	Division of Disability and Rehabilitative Services
FSW Waiver	Family Supports Waiver
ICF/ID	Intermediate Care Facility/Intellectual Disability
IPMG	Indiana Professional Management Group
SS Waiver	Support Services Waiver

Questions and Answers

Waiting List

If I am on another waiver, like the Aged and Disabled (A&D) Waiver, can I move to the FSW or CIH waivers?

If you are receiving services through another waiver, you can move to the FSW only if you are currently on a wait list for the Autism, Developmental Disabilities, or Support Services waivers. To move onto the CIH waiver, an individual must meet specific priority criteria, which include:

- Eligible individual in other setting whose health and welfare is threatened
- Eligible individuals transitioning to the community from nursing facilities, extensive support needs homes, and state operated facilities.
- Eligible individuals determined to no longer need/receive active treatment in group home
- Eligible individuals transitioning from 100% state funded services
- Eligible individuals with loss or incapacitation of the primary caregiver
- Eligible individuals with an aging primary caregiver
- Eligible individuals aging out of Department of Education, Department of Child Services, or Supported Group Living
- Emergency Placement
- Eligible individuals requesting to leave a Large Private Intermediate Care Facility/Intellectual Disabilities (ICF/ID)

Eligible individuals transitioning from Crisis Management and meet certain other criteria

What do you mean by "needs based" when referring to being placed on a waiver?

"Needs-based" refers to meeting the eligibility and/or priority criteria that are required for that waiver's services.

Eligibility Criteria

What are the criteria for the FSW?

The criteria for the FSW are the same that are required for receiving any services through DDRS' waiver program. Individuals meeting the state criteria for a developmental disability and meeting the criteria for an ICF/ID level of care determination are eligible to receive waiver services. "Developmental Disability" means a severe, chronic disability of an individual.

- Is attributable to intellectual disability, cerebral palsy, epilepsy, or autism; or
- any other condition (other than a sole diagnosis of mental illness) found to be closely related to intellectual disability,
- Is manifested before the individual is twenty-two (22) years of age.
- Is likely to continue indefinitely.
- Results in substantial functional limitations in at least three (3) of the following areas of major life activities:
  - Self-care.
  - Understanding and use of language.
  - Learning.

- Mobility.
- Self-direction.
- Capacity for independent living.

What are the criteria for the CIH?
The CIH waiver is a needs-based waiver, which means that an individual must meet one of the following priority criteria:

- Eligible individual in other setting whose health and welfare is threatened
- Eligible individuals transitioning to the community from nursing facilities, extensive support needs homes, and state operated facilities.
- Eligible individuals determined to no longer need/receive active treatment in group home
- Eligible individuals transitioning from 100% state funded services
- Eligible individuals with loss or incapacitation of the primary caregiver
- Eligible individuals with an aging primary caregiver
- Eligible individuals aging out of Department of Education, Department of Child Services, or Supported Group Living
- Emergency Placement
- Eligible individuals requesting to leave a Large Private Intermediate Care Facilities/Intellectual Disabilities (ICFs/ID)
- Eligible individuals transitioning from Crisis Management and meet certain other criteria

What do you mean by "emergency placement?" Can you please define "emergency?"
Emergency is defined as a situation in which the health and welfare of an individual is threatened, and alternative placement in a supervised group living setting is not available or is determined by the division to be an inappropriate option.

- Eligible individual in other setting whose health and welfare is threatened
- Eligible individuals transitioning to the community from nursing facilities, extensive support needs homes, and state operated facilities.
- Eligible individuals determined to no longer need/receive active treatment in group home
- Eligible individuals transitioning from 100% state funded services
- Eligible individuals with loss or incapacitation of the primary caregiver
- Eligible individuals with an aging primary caregiver
- Eligible individuals aging out of Department of Education, Department of Child Services, or Supported Group Living
- Emergency Placement
- Eligible individuals requesting to leave a Large Private Intermediate Care Facilities/Intellectual Disabilities (ICFs/ID)
- Eligible individuals transitioning from Crisis Management and meet certain other criteria

I have been deemed "ineligible" by BDDS, but I have a diagnosis of autism. What should I do?

Individuals meeting the state criteria for a developmental disability and meeting the criteria for an ICF/ID level of care determination are eligible to receive waiver services. "Developmental Disability" means a severe, chronic disability of an individual.

- Is attributable to intellectual disability, cerebral palsy, epilepsy, or autism; or
- any other condition (other than a sole diagnosis of mental illness) found to be closely related to intellectual disability,
- Is manifested before the individual is twenty-two (22) years of age.
- Is likely to continue indefinitely.
- Results in substantial functional limitations in at least three (3) of the following areas of major life activities:
  - Self-care.
  - Understanding and use of language.
  - Learning.
  - Mobility.
  - Self-direction.
  - Capacity for independent living.

If you have been deemed ineligible as not meeting one of these criteria, you have the right to appeal the decision within 33 calendar days of the date of the notice. Instructions about this process can be found at http://www.in.gov/fssa/ddrs/4312.htm.

I didn't receive a "targeting letter". What should I do?

DDRS realizes that many individuals currently on the Medicaid Waiver wait list have application dates for more than one waiver – possibly with different dates. A targeting letter is sent to individuals who are on a wait list for a DDRS waiver when his/her application date is being targeted. DDRS targets individuals on the DDRS Medicaid Waiver wait list in order of application date, starting with the oldest.

Moving forward, individuals will be targeted for the FSW – no matter what DDRS Medicaid waiver wait list he/she is on – by the earliest application date that he/she has submitted. For example, if you applied for the DD Waiver on January 1, 2001, and the ASD Waiver on March 3, 2001, you will be targeted for the FSW based on your January 1, 2001, application date.

It is the responsibility of an individual or his/her legal guardian to contact his/her local BDDS office once a year to (1) update any changes to contact information, and (2) indicate preference for remaining on the DDRS Medicaid Waiver wait list. As long as your contact information is updated, a targeting letter will reach you upon DDRS' targeting of your Medicaid waiver application date.

I am currently on the DD or the Autism Waiver, but don't meet the new CIH criteria. What will happen?
If a person is on the Autism or the DD Waiver, he/she will automatically begin receiving services through the Community Integration & Habilitation (CIH) waiver. These individuals will receive the same services and benefits as they were on the Autism or DD waivers, as the new waiver is exactly the same, only named differently.

Only individuals who do not currently receive the Autism or DD waivers will be required to meet priority criteria.

What are the Level of Care requirements for BDDS eligibility? Specifically.
An applicant/participant must meet three of six substantial functional limitations and each of four basic conditions (listed below) in order to meet LOC.
The basic conditions are:

- intellectual disability, cerebral palsy, epilepsy, autism, or condition similar to intellectual disability,
- the condition identified above is expected to continue,
- the condition identified above had an age of onset prior to age 22, and
- the applicant needs a combination or sequence of services.

The substantial functional limitation categories, as defined in 42 CFR 435.1009, are:

- self-care,
- learning,
- self direction,
- capacity for independent living,
- receptive and expressive language, and
- mobility.

Timeline

When will the FSW replace the SS Waiver?
The expected effective date of the FSW wavier is September 1, 2012, pending approval by the Centers for Medicare and Medicaid Services.

When will the Autism and DD Waiver be converted to the new CIH waiver?
The expected effective date of the CIH wavier is September 1, 2012, pending approval by the Centers for Medicare and Medicaid Services.

How long will people have to continue to wait on the FSW?
As quickly as the system can bring them into the waiver. Right now, 200 individuals on the waiting list are being targeted every 2-3 weeks (5,200/yr).

Residential Supports

Can I live outside of the home (not with family) and still be on the FSW?
Yes! If your physical, emotional, behavioral, social, and medical needs can be met while pursuing your goals within the budget of the capped waiver, you are encouraged to live outside of the family home.

DDRS realizes, however, the cost associated with some individuals living independently will negatively affect the Division's ability to put more people onto the FSW and decrease the Waiver wait list. In many cases, it is less expensive for an individual to remain in the family home than to live independently.

Further, there is a current societal shift occurring in which individuals – both with and without disabilities - tend to stay at home longer or are moving in with roommates rather than living on their own. The Division hopes to refrain from separating people with developmental disabilities from the mainstream, and rather, work within the current national trends of economic stability.

What do I do if the cap on the FSW is not enough for me to live independently?
If you're unable to live alone because of the cap on the waiver, alternatives such as living in your family home, another family member's home, or in a house with housemates are all options.

How do I get on the CIH waiver if I am currently on the FSW?
To move onto the CIH waiver, an individual must meet specific priority criteria, which include:

- Eligible individual in other setting whose health and welfare is threatened
- Eligible individuals transitioning to the community from nursing facilities, extensive support needs homes, and state operated facilities.
- Eligible individuals determined to no longer need/receive active treatment in group home
- Eligible individuals transitioning from 100% state funded services
- Eligible individuals with loss or incapacitation of the primary caregiver
- Eligible individuals with an aging primary caregiver
- Eligible individuals aging out of Department of Education, Department of Child Services, or Supported Group Living
- Emergency Placement
- Eligible individuals requesting to leave a Large Private Intermediate Care Facilities/Intellectual Disabilities (ICFs/ID)
- Eligible individuals transitioning from Crisis Management and meet certain other criteria

If I am currently an adult in a group home, what will happen?
If you are currently in a group home and are on the waiting list for the ASD, DD or SS waivers, you will be targeted for the FSW waiver when DDRS targets your Medicaid waiver application date. At that time, you can choose to accept the waiver placement, or remain in the group home. Once you decline the waiver placement, however, you will be unable to access it again unless you meet priority criteria for the CIH.

If you are not on the DDRS Medicaid waiver wait list, you will remain in the group home setting, unless you meet priority criteria for the CIH. Should this occur, you will be automatically placed onto the CIH waiver.

Lastly, group home providers are being given the option to voluntarily convert to waiver homes, as addressed in the Section 144 report. Should your group home provider choose to convert to waiver homes, you will have the choice to receive waiver services through the CIH waiver, or not receive waiver services and remain in a group home setting. Ultimately, this conversion would allow individuals the opportunity to have more choices in which providers serve their needs, but not in their service delivery.

If I am a child in a group home, what will happen when I become an adult?
You will transition into an adult group home. However, if you have been on the DDRS Medicaid waiver wait list and are targeted for the FSW prior to becoming an adult, you will have the option to receive waiver services through the FSW waiver, or not receive waiver services and remain in a group home setting.

What is the difference between a group home and a waiver home?
A group home is considered a small institutionally based long term care facility that provides services for 4 or more individuals living in the same home. The group home provider may work with a limited number of other providers to deliver your services.

A waiver home is your family home, a home with housemates, or your own home. You have greater choice in which providers deliver your services.

Both, however, are considered placements within the community setting.

If I am in a group home, will I be on the FSW or on the CIH waiver?
Group homes and waiver services are two different things. You will not be on a waiver if you live in a group home.

If you are currently in a group home and are on the waiting list for the ASD, DD or SS waivers, you will be targeted for the FSW waiver when DDRS targets your Medicaid waiver application date. At that time, you can choose to accept the waiver placement, or remain in the group home. Once you decline the waiver placement, however, you will be unable to access it again unless you meet priority criteria for the CIH.

If you are not on the DDRS Medicaid waiver wait list, you will remain in the group home setting, unless you meet priority criteria for the CIH. Should this occur, you will be automatically placed onto the CIH waiver.

Lastly, group home providers are being given the option to voluntarily convert to waiver homes, as addressed in the Section 144 report. Should your group home provider choose to convert to waiver homes, you will have the choice to receive waiver services through the CIH waiver, or not receive waiver services and remain in a group home setting. Ultimately, this conversion would allow individuals the opportunity to have more choices in which providers serve their needs, but not in their service delivery.

Questions Specific to the CIH Waiver

Will there still be the "buckets" that the budget will be based on? If so, what are they?
The procedures that are currently used for evaluating an individual's needs and budgets will remain the same.

Questions Specific to the FSW Waiver

When can I receive the increased budget amount? How do I apply for that?
Initially, the cap for the FSW will be $16,250 per year, and will take effect as soon as CMS approves our SSW amendment. An announcement will be made when the date becomes effective and individuals can begin utilizing services up to the cap.

However, if an individual does not need an increased budget, he/she should not request one. When and if he/she needs increased services, an increase in budget can occur.

Providers who service individuals who are currently on the SS waiver in their homes, will they be able to continue to provide that service?
Yes. Services through the FSW will be no different than what was on the SSW, except that two are being added:

(1) Participant Assistance and Care (PAC), which is a residential service
(2) Case Management

Providers

Will providers have to re-apply to qualify as waiver providers?
No, you will not have to re-apply to provide services through either the Family Supports Waiver or Community Integration & Habilitation Waiver.

Will the state increase the reimbursement rate for any of the types of direct care workers to encourage the retention of good employees?
DDRS will be implementing its Quality and Outcome Based Provider Reimbursement Methodology in the next year which "raises the bar" on provider service delivery and outcomes for consumers. The Residential Habilitation and Supports (RHS) rate providers receive would be contingent upon performance as measured by five quality indicators, each measured at varying degrees of difficulty. Providers meeting or exceeding all five indicators will be rewarded by a higher RHS rate for the year following the evaluation. Raising standards for service providers will also promote employment of more qualified staff, which in turn, will result in higher quality services for waiver consumers.

Is IPMG the only provider of case management services?
Currently, IPMG is the only case management company that provides services to individuals receiving DDRS Medicaid Waiver services. However, the contract between this entity and the State expires on August 31, 2012. To provide more choice to individuals and families regarding individual case managers, case management has been added to the SSW and DD waiver amendments that create the FSW and CIH waivers, respectively.

The expected effective date of the case management as a waiver service is September 1, 2012, pending approval by the Centers for Medicare and Medicaid Services.

Starting July 18, 2012, DDRS will accept proposals from new case management companies interested in providing case management services through the Waiver program. Prospective providers should follow the instructions for becoming a BDDS approved provider outlined on the Provider Relations webpage located at http://www.in.gov/fssa/ddrs/2644.htm.

Case Management

Will I be able to select my own case manager?
Individuals receiving waiver services have always been able to choose their individual case manager.

Existing waiver participants will have greater choice in individual case managers as soon as the service is made available on the waiver and other case management providers are approved to provide the service. Pending CMS approval, it is anticipated that the date by which theses choices can be made by waiver participants is September 1, 2012.

For individuals transitioning onto the waiver after September 1, 2012, they will able to choose an individual case manager from as many case management providers are approved by DDRS at that time.

Where is a list of case managers?
A list of approved case management providers will be made available on DDRS' website on September 1, 2012.

When will CMS determine if multiple providers can be case management vendors?
Pending approval from the Center for Medicare and Medicaid Services (CMS), the effective date for providing case management as a waiver service is expected to be September 1, 2012.

How is the new waiver being funded?
The new FSW will be funded through federal Medicaid funding and a match contributed by the State. In addition, savings from other waiver initiatives will also fund the Family Supports Waiver (FSW). This waiver is intended to reduce the per capita cost of residential placements on the DD Waiver resulting in more financial resources being available for the new Family Supports Waiver. An annual cap and strong emphasis on identification and utilization of natural supports will provide greater certainty in individual Family Supports Waiver budgets.

The Community Integration and Habilitation (CIH) waiver will continue to be funded through federal Medicaid funding and a match contributed by the State.

How will these changes affect the state budget?
The cost of the DD and Autism Waivers has remained relatively flat as budgets established for individuals varied little from year to year. As a result of the addition of a residential service component onto the Support Services Waiver and giving it a new name, the new Family Supports Waiver can be included in the per capita cost calculation. These changes will result in a dramatic decrease in per capita spending as more individuals are transitioned onto this waiver.

General

How will the change in the DSM5 diagnostic criteria affect eligibility?
This change will not affect the Intermediate Care Facility/Intellectual Disability (ICF/ID) level of care.

Individuals meeting the state criteria for a developmental disability and meeting the criteria for an ICF/ID level of care determination are eligible to receive waiver services. "Developmental Disability" means a severe, chronic disability of an individual.

- Is attributable to intellectual disability, cerebral palsy, epilepsy, or autism; or
- any other condition (other than a sole diagnosis of mental illness) found to be closely related to intellectual disability,
- Is manifested before the individual is twenty-two (22) years of age.
- Is likely to continue indefinitely.
- Results in substantial functional limitations in at least three (3) of the following areas of major life activities:
  - Self-care.
  - Understanding and use of language.
  - Learning.
  - Mobility.
  - Self-direction.
  - Capacity for independent living.

Will families who earn "a little bit more" have to make co pays? If so, how will that be determined?
No. Medicaid eligibility (which is required to receive Medicaid waiver services) for minors seeking Medicaid waiver services disregards parental income.

How do I know where we are on the waiting list?
To determine what application date is currently being targeted, please contact your local BDDS office.

You can find the phone number for your local BDDS office here http://www.in.gov/fssa/ddrs/4088.htm.
Simply click on the map where your county is located to view contact information and location addresses.

The BDDS helpline number is another resource: 1-800-545-7763.

Finally, you can also access the Waiver Waiting List online portal (http://www.in.gov/fssa/ddrs/4328.htm) where you can see your contact information and you're your application. You also have the capability of sending an email to update any information that is incorrect.

While none of these options will give you an indication about how many individuals are "in front of you," you will better understand the proximity of your targeting based upon the date DDRS is targeting at the time of your call.

Will Applied Behavior Analysis (ABA) be funded under the CIH waiver? Will it be funded under the FSW?
Intermediate Behavior Intervention (IBI), which is currently available on the DDW and ASW, will remain on the new CIH Waiver and FSW. The definition for this service can be found at http://www.in.gov/fssa/files/Part_10_-_Service_Definitions_and_Requirements.pdf.

As DDRS rolls out these new waivers and assesses needs of individuals moving onto the FSW and CIH, discussions and analysis about ABA will continue.

What will happen to children on any of the waivers who are a part of the DCS system?
DDRS has a Memorandum of Understanding (MOU) with DCS to work through any situations in which a child with ASD or DD is placed onto Waiver services.

Will people who have co-morbid conditions (Mental Health and Developmental disability qualify for either waiver?
For both the FSW and CIH waivers, individuals meeting the state criteria for a developmental disability and meeting the criteria for an ICF/ID level of care determination are eligible to receive waiver services. "Developmental Disability" means a severe, chronic disability of an individual.

- Is attributable to intellectual disability, cerebral palsy, epilepsy, or autism; or
- any other condition (other than a sole diagnosis of mental illness) found to be closely related to intellectual disability,
- Is manifested before the individual is twenty-two (22) years of age.
- Is likely to continue indefinitely.
- Results in substantial functional limitations in at least three (3) of the following areas of major life activities:
  - Self-care.
  - Understanding and use of language.
  - Learning.
  - Mobility.
  - Self-direction.
  - Capacity for independent living.

Further, priority criteria must be met for placement onto the CIH waiver. These criteria are:

- Eligible individual in other setting whose health and welfare is threatened
- Eligible individuals transitioning to the community from nursing facilities, extensive support needs homes, and state operated facilities.

- Eligible individuals determined to no longer need/receive active treatment in group home
- Eligible individuals transitioning from 100% state funded services
- Eligible individuals with loss or incapacitation of the primary caregiver
- Eligible individuals with an aging primary caregiver
- Eligible individuals aging out of Department of Education, Department of Child Services, or Supported Group Living
- Emergency Placement
- Eligible individuals requesting to leave a Large Private Intermediate Care Facilities/Intellectual Disabilities (ICFs/ID)
- Eligible individuals transitioning from Crisis Management and meet certain other criteria

What is the process for applying for a FSW?
Pending approval from CMS, an individual or his/her guardian may apply for the Family Supports Services Medicaid waiver program through the local Bureau of Developmental Disabilities Services (BDDS) office. Individuals (or their guardians) have the right to apply without questions or delay.

The Bureau of Developmental Disabilities Services District Offices can provide an application for the Family Supports Waiver, as well as assist in researching additional services.

To apply for the Family Supports Services Waiver, the individual or guardian must complete, sign, and date an Application for Long Term Care Services (State Form 4594) including the time of day that the application is signed. An individual who has not already applied for waiver services may also need to complete, sign, and date a DDRS Referral and Application (State Form 10057) located at http://www.in.gov/fssa/ddrs/3349.htm. Other individual or agency representatives may assist the individual or guardian in completing the application form and forward it to the BDDS office service the county in which the individual currently resides. The application may be submitted in person, by mail or by fax.

Upon receiving the waiver application, the BDDS staff must contact the individual and/or his/her guardian and discuss the process for determining eligibility for the waiver (documentation of a developmental disability, diagnosis within the Autism Spectrum, Medicaid eligibility, and level of care). If the applicant is not a Medicaid recipient, he/she will be referred to the local Division of Family Resources to apply for Medicaid. Once it has been determined that an individual meets the criteria for developmental services, that individual will be placed on the Waiver wait list. Once a waiver slot becomes available based upon the individual's application date, he/she will be "targeted", or offered a waiver placement.

More specific information about applying for DDRS Medicaid waiver services can be found in the 2011 DDRS Waiver Manual http://www.in.gov/fssa/files/Part_5_-_Application_and_Start_of_Waiver_Services.pdf.

How do I get on the CIH? Do I have to be on the FSW first, and then moved? That seems to take a long time.
No, an individual will not go onto the FSW first, necessarily. The Family Supports Waiver is not meant to be a "placeholder waiver" for the CIH Waiver.

To be placed onto the CIH waiver, which is a needs-based waiver, an individual must meet one of the priority criteria for emergency access, which are listed below:

- Eligible individual in other setting whose health and welfare is threatened
- Eligible individuals transitioning to the community from nursing facilities, extensive support needs homes, and state operated facilities.
- Eligible individuals determined to no longer need/receive active treatment in group home
- Eligible individuals transitioning from 100% state funded services
- Eligible individuals with loss or incapacitation of the primary caregiver
- Eligible individuals with an aging primary caregiver
- Eligible individuals aging out of Department of Education, Department of Child Services, or Supported Group Living
- Emergency Placement
- Eligible individuals requesting to leave a Large Private Intermediate Care Facility/Intellectual Disabilities (ICF/ID)
- Eligible individuals transitioning from Crisis Management and meet certain other criteria

How will people receiving VR services be handled? Will they be put on a waiver or receive state funded employment services? Do they need a waiver?
Individuals receiving VR services will continue to do so as they are now. It will not be necessary for them to go onto the waiver to continue to receive services through VR. Further, if an individual does not successfully complete VR services, he/she is still able to access Supported Employed Follow Along (SEFA) through State funding.

How will high-need individuals be addressed? What will the waiver amendment address these higher cost individual's needs?
To help ensure the unique needs of high-cost/high-needs individuals are met, a new service definition will be created in which specific services that accommodate this population will be defined. Affixed to this service definition will be a rate that can support the increased responsibility placed on providers to care for this population. This rate will allow providers to pay quality staff to provide safe and effective services.

DDRS Updates
June 22, 2012

Residential Habilitation Re-Approval Process

- Effective July 1, 2012
- Grant re-approval on terms of either 6, 12, or 36 months
- RHS providers that have the oldest original approval date will be reviewed first
- Goal is to re-approve all 150 RHS providers prior to Dec. 31, 2012

RHS Re-Approval Process

- RHS Providers will be contacted by BQIS indicating that their review process is beginning
- BQIS will review recent, standardized data using T-Scores to compare providers with other providers
- BQIS will develop a Provider Review Profile (PRP)

Provider Review Profile (PRP)

- BQIS will conduct remediation activities for providers with trends outside of their expected range.
- BQIS will develop its recommendations to DDRS Provider Relations for a re-approval of 6, 12, or 36 months.
- A signed provider agreement will be required to be on file with DDRS to complete the Re-approval process.

PRP Risk Categories
(providers will be compared against each other)

- Numbers of complaints BQIS received about the provider
- Number of issues identified in complaints
- Percent of complaint issues substantiated

- CERT/Accreditation Review

PRP Risk Categories

- Number of incidents filed to BDDS Incident Reports
- Number of sentinel events
- Percent of incidents made sentinel

PRP Risk Categories

- Number of behavioral incidents
- Number of incidents of behavioral failures (i.e., use of PRN medications, restraints)
- Number of medical incidents

PRP Risk Categories

- Numbers of incidents reported late (>24 hours)
- Number of incidents closed (>30 days)
- Number of sentinel events closed late (>3 days)

PRP Risk Categories

- Number so allegations of abuse, neglect, or exploitation by staff
- Percent of substantiated allegations of abuse, neglect, or exploitation by staff
- Percent of staff suspended from duty pending investigations of allegations of abuse, neglect, or exploitation by staff

BDDS Incident Reporting per email from Barb Bearman, BQIS

- Medication Errors – Please include the following information when submitting an incident report regarding a medication error:
- · Was there any negative outcome as a result of the medication error?
- · Was the prescribing physician notified? If so, what was the physician's recommendation(s)?
- · How will future medication errors be prevented?
- · Will the staff member be retrained prior to administering medications on his/her own again?
- · How will the agency monitor medication administration to identify further medication errors?
- · In the case of multiple medication errors within the last several months, please clarify how future errors are being prevented, including any systemic actions/changes.

BDDS Incident Reporting per email from Barb Bearman, BQIS

- Allegations of Abuse, Neglect, Exploitation –

If an allegation of abuse, neglect or exploitation involves multiple staff, an incident report must be submitted for each alleged perpetrator.

Community Integration and Habilitation Waiver

- Upon approval from CMS, DD Waiver and Autism Waiver will be folded into the CIH Waiver
- Current NOA's will be automatically approved to rename the waiver type at time of annual CCB
- Currently, the DD Waiver is serving 4X more people with autism diagnosis than those being served on the Autism Waiver

Family Supports Waiver

- Upon approval by CMS, the currently named Support Services Waiver will be renamed Family Supports Waiver
- Annual cap will increase to $16, 250
- Will add direct care service for in-home support (Participant Assistance and Care Service)

Waiver Wait Lists

- Family Support Waiver will be the sole entry point as an individual is awarded a waiver
- Regardless of how many waiver types an individual is currently on waiting lists, being targeted for the FSW will place that person on wait list order by the earliest application date that he/she has submitted

Emergency Placement in Waiver Services

Emergency is defined as a situation in which the health and welfare of an individual is threatened, and alternative placement in a supervised group setting is not available or is determined by the division to be an inappropriate option.

Emergency Waiver (must meet definition of "emergency")

- Health and welfare in other setting is threatened
- Transitioning to community from nursing facilities, extensive support needs homes, and state operated facilities
- Determined to no longer need/receive active treatment in group home.
- Transitioning from 100% state funded services

Emergency Waiver
(must meet definition of “emergency”)

- Loss or incapacitation of the primary caregiver
- Aging out of Department of Education, Department of Child Services, or Supported Group Living
- Alternative emergency placement that threatened health and safety
- Requesting to leave a Large Private Intermediate Care Facilities/Intellectual Disabilities
- Transitioning from Crisis Management and meet certain other criteria