Division of Disability and Rehabilitative Services Provider Services
Frequently Asked Questions

Question: **How do I become a Bureau of Developmental Disabilities Services HCBS waiver provider**?

Answer: Information regarding the application process and the qualifications to become a BDDS waiver provider are set forth in 460 IAC 6 The education, experience and professional qualifications required of a provider vary based on the type of service they would like to provide. Individuals and organizations need to determine the services they have interest in and determine if their qualifications meet the requirements. The service definitions are set forth in 460 IAC 6-3.

Question: **Are county background checks needed for the counties of residence or work?**

Answer: In addition to the required state criminal backgrounds checks as set forth in 460 IAC 6-10-5, county background checks are required for any owner, officer, director, employee, contractor, subcontractor or agent involved in the management, administration, or provision of services. The county background check must be for the counties in which the individual resided and worked for the prior three years.

Question: **What is a Supervised Group Living or group home**?

Answer: Supervised Group Living, also known as group homes, is a residential option and alternative to waiver services for eligible individuals with intellectual or developmental disabilities needing services. Typically, there are five to eight individuals in one SGL setting. The setting and services provided in a Supervised Group Living placement can vary depending on the individual's age, support needs and interests. Homes are licensed and governed by state and federal regulations.

Group homes fall into six different categories based on an individual's level of need:

- Intensive Training
- Basic Developmental
- Developmental Training
- Extensive Medical Needs
- Extensive Support Needs
- Comprehensive Rehabilitation Management Needs Facility

The residences are governed by state and federal regulations and are monitored by the Indiana Department of Health. For specific information, reference 460 IAC 9.

Question: **How does an individual or organization apply to become a SGL provider**?

Answer: The Indiana State Department of Health Web page provides valuable information for those interested in learning more about SGL. However, the Division of Disability and Rehabilitative Services Bureau of Developmental Disabilities Services are not approving the addition of new homes.

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Question: What is a Medicaid Waiver?

Answer: The Medicaid Waiver program began in 1981, in response to the national trend toward providing home and community-based services. In the past, Medicaid paid only for institutionally based long-term care services, such as nursing facilities and group homes.

Indiana applies for permission to offer Medicaid Waivers from the Centers for Medicare and Medicaid Services. The Medicaid Waivers make use of federal Medicaid funds, plus state matching funds, for HCBS, as an alternative to institutional care, under the condition that the overall cost of supporting people in the home or community is no more than the institutional cost for those individuals.

The goals of waiver services are to provide to the person meaningful and necessary services and supports, to respect the person's personal beliefs and customs, and to ensure that services are cost-effective.

Specifically, a Medicaid Waiver for an individual with an Intellectual disability or developmental disability would assist the person to:

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

DDRS oversees two waiver programs, the Community Integration and Habilitation Waiver and the Family Supports Waiver.

Community integration and Habilitation Waiver
CIH is a combination of the Autism and the Developmental Disability Waivers and provides services that enable persons to remain in their homes or in community settings and assists transitions from institutions into community settings. This is a needs-based waiver and designed to provide supports for persons to gain and maintain optimum levels of independence and community integration while allowing flexibility in the provision of those supports.

Family Supports Waiver
Formerly the Support Services Waiver, the FSW is designed to provide limited, non-residential supports to persons with developmental disabilities residing with their families or in other settings with informal supports.

Question: I have an extra room in my home. How can I become a home for a developmentally disabled person?

Answer: All providers of services must meet specific standards to be approved as a Medicaid Waiver provider. Provider application guidelines are available on the BDDS Provider Services Web page.

Structured Family Caregiving is a service on the Community Integration and Habilitation waiver.

Structured family caregiving means a living arrangement in which a participant lives in the private home of a principal caregiver who may be a non-family member (foster care) or a family member who is the participants spouse, the parent of the participant who is a minor or the legal guardian of the participant.

Question: If my application is approved by Provider Services, what happens next?

Answer: If the proposal is accepted/approved, the potential provider will complete enrollment with Medicaid. Once a Medicaid waiver billing number has been assigned and confirmed by the state, the provider will be listed on the provider choice list (also known as the picklist). Provider Services will then send the approved provider a Provider Agreement, which must be completed and signed by the provider and returned to Provider Services.

Question: How long does the provider application process take?

Answer: DDRS issues determinations within 60 calendar days of a provider's submission of a completed application.

Question: For services that require national accreditation, what organizations are approved to perform the accreditation?

Answer: The list of approved national accrediting organizations are set forth in Indiana Code 12-11-1.1(j).

Question: What BDDS services require national accreditation?

Answer: The services that require national accreditation are:

- Adult Day Services
- Day Habilitation
- Extended Services
- Facility Based Support Services
- Pre-Vocational
- Residential Habilitation and Support Services
- Case Management

Note: Respite Services may only be provided by an organization that has accreditation for adult day or residential habilitation services.

Question: How often does a provider need to renew its National Accreditation?

Answer: The length of the accreditation is based on the accrediting organization's program and if the provider meets the required standards at the time of accreditation The list of national accrediting organizations are set forth in Indiana Code 12-11-1.1(j)

Question: What is the definition of CERT, Re-approval and DDR?

Answer: The Bureau of Quality Improvement Services monitors provider compliance with established rules, regulations, policies, and requirements (e.g. quality assurance). BQIS also engages provides in quality improvement initiatives. Below explains these processes.

CERT (ended 3/31/20200

The Compliance Evaluation and Review Tool, is a set of standards required by provider to remain approved to provide services through the Bureau of Developmental Disabilities Services. The CERT process ended on March 31, 2020 and is being replaced by the Quality On-site Provider Review.

QOPR (piloted October 2020)

The Quality On Site Provider Review was piloted in the Fall of 2020. It is designed to assess the quality of supports and outcomes of individuals. The review recognizes and promotes the progress a provider has made in aligning their service delivery system with the person-centered values embraced in the Charting the LifeCourse Framework and the requirements of the HCBS Settings Rule. The pilot phase will last through December 2020, with full implementation January 2021.

Re-approval (ended9/30/2019)

Per 460 IAC 6, a BDDS waiver provider must be re-approved at least every three years. The provider re-approval process ended on September 30, 2019 and is being replaced by Provider Reverification.

DDR (ended 12/31/2019)

The Data Driven Review process is an initiative designed to proactively and collaboratively work with BDDS waiver providers to review provider specific data, conduct a root cause analysis, and develop a plan for improvement. Relying on best practices, providers are provided with tools, guidance, and support by BQIS to drive improvement within their organizations. The DDR process ended on December 31, 2019.

PROVIDER REVERIFICATION

Per 460 IAC 6, a BDDS waiver provider must be re-approved at least every three years. The purpose of the provider reverification process is to ensure, on an on-going basis, providers are 'fit for business' by validating basic compliance with statutes, rules, regulations, and requirements.

Question: How do I add a county or a service if I am an existing approved provider?

Answer: The requirements for adding a service are set forth in 460 IAC 6-6-6 and BDDS policy. When an approved provider wishes to add a service, the provider must complete the Request for Add/Update Form. BDDS Provider Services Web page. This form is also used by an existing approved provider to request the addition of a county.

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Question: I am an existing provider and I no longer want to provide one of our services, who do I need to notify and is there a timeframe for notification?

Answer: The notice requirements are set forth in the provider agreement and 460 IAC 6-9-7. If a provider would like to terminate a service it has been approved to provide, the provider must provide 60 days written notice to BQIS and BDDS, any individual currently receiving ongoing services and the individual's legal representative (if applicable) and the individual's case manager.

Question: I am thinking of selling my business or closing the operation. Who do I need to contact and is there a timeframe I need to adhere to?

Answer: The notice requirements are set forth in the provider agreement. If a provider would like to terminate a service it has been approved to provide, the provider must provide 60 days written notice to BDDS, any individual currently receiving ongoing services and the individual's legal representative (if applicable) and the individual's case manager.

Question: How do I find out why a claim is not being paid?

Answer: Providers may submit questions about claims for Waiver services to the JIRA helpdesk. Instructions on how to create JIRA account can be found at https://www.in.gov/fssa/ddrs/files/Jira-Help-Desk-Web-Portal-Instruct-Prov.pdf. Provider should look at denied claims remittance EOB's (the reason why the claim was denied). The request for help should include the name and recipient identification number of the individual along with the dates of service and the service(s) being denied or partially paid. A provider may also contact Provider Customer Assistance at 1-800-577-1278, option 2. Additional information is available at Indiana Medicaid.

Alternatively, the provider may contact the Indiana Medicaid Provider Relations Field Consultants.

Question: I need an educational and experience assessment for a behavior management candidate we would like to hire. What do I need to provide and who performs the assessment?

Answer: A provider may determine if a Level 2 behavior management candidate is qualified without submitting documentation to the Behavior Management Committee. The requirements are set forth in 460 IAC 6-5-4.

Candidates working toward a required degree or are awaiting licensure do not fit the definition outlined in 460 IAC 6-5-4.

Question: What are Case Management Services?

Answer: Case management means services that assist participants in gaining access to needed waiver and other Medicaid State plan services, as well as medical, social, educational, and other services, regardless of the funding source for the services to which access is gained. Case management services include annual planning and assessment as well as ongoing case management support.