Application for

Section 1915(b) (4) Waiver
Fee-for-Service
Selective Contracting Program

June, 2012

v1.0

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Application for Section 1915(b) (4) Waiver
Fee-for-Service (FFS) Selective Contracting Program

Facesheet

The **State** of Indiana requests a waiver/amendment under the authority of section 1915(b) of the Act. The designated Medicaid agency will directly operate the waiver.

The **names of the waiver programs are:** 1) Community Integration and Habilitation (CIH); and 2) Family Supports (FSW).
(List each program name if the waiver authorizes more than one program.).

Type of request. This is:
_x_ an initial request for new waiver. All sections are filled.
___ a request to amend an existing waiver, which modifies Section/Part ____
___ a renewal request

Section A is:
- ___ replaced in full
- ___ carried over with no changes
- ___ changes noted in **BOLD**.

Section B is:
- ___ replaced in full
- ___ changes noted in **BOLD**.

Effective Dates: This waiver/renewal/amendment is requested for a period of _5_ years beginning 1/1/2022 and ending 12/31/2026.

State Contact: The State contact person for this waiver is Brian Gilbert and can be reached by telephone at (317)-233-3340, or fax at (317)-232-7382, or e-mail at brian.gilbert@fssa.in.gov.

Section A – Waiver Program Description

Part I: Program Overview

Tribal Consultation:
Describe the efforts the State has made to ensure that Federally-recognized tribes in the State are aware of and have had the opportunity to comment on this waiver proposal.

Indiana has one Federally recognized tribe, the Pokagon Band of Potawatomi Indians. The Medical Director and Chief for the tribe was provided a letter and official notice. The 1915(b)(4) document was posted for tribal notice on July 28, 2021 at least 60 days before the anticipated submission date as provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

Program Description:
Provide a brief description of the proposed selective contracting program or, if this is a request to amend an existing selective contracting waiver, the history of and changes requested to the existing program. Please include the estimated number of enrollees served throughout the waiver.

Indiana has two Medicaid Home and Community Based Services (HCBS) 1915(c) waivers serving individuals with intellectual and developmental disabilities (IDD)– the Family Supports Waiver (FSW) and the Community Integration and Habilitation Waiver (CIH). Both waivers provide services to participants in a range of community settings as an alternative to care in an intermediate care facility. The waiver requested is limited to the case management services in these existing 1915(c) waivers. These waivers provide services, including case management, to persons with developmental disabilities or related conditions ages zero and above who meet the Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) Level of Care.

The Family Social Services Administration (FSSA) is the single state Medicaid agency authorized to administer Indiana's FSW and CIH waivers. The waivers are operated by FSSA's Division of Disability and Rehabilitative Services (DDRS), Bureau of Developmental Disability Services (BDDS) a division and bureau under the single State Medicaid agency.

Under this 1915 (b)(4) authority, the State will waive the freedom of choice of providers for case management services offered under the 1915(c) authority to those case management companies (CMCO) identified through the selective contracting process. This arrangement will limit the number of entities providing this service thereby allowing DDRS to engage in more robust oversight and monitoring activities related to the provision of this pivotal service. Using the tools afforded through this 1915(b)(4) waiver authority will enable the state to leverage existing infrastructure, ensure sustained and exceptional knowledge of local resources, will allow proximity to enrollees and providers to arrange and monitor services and will provide the state with the tools necessary to ensure consistently high caliber case management through its own employees and its selected vendor(s). A move to a contractual relationship will further enhance

the collaborative working relationship between FSSA and selected CMCOs in order to provide quality case management services for waiver participants across the state.

Over the course of the current waiver periods an estimated 11,000 participants will be served through the CIH waiver and approximately 32,000 will be served on the FSW waiver.

Waiver Services:

Please list all existing State Plan services the State will provide through this selective contracting waiver.

The State will be offering case management services covered in the State's two 1915(c) HCBS waivers for people with IDD:

- Community Integration and Habilitation Waiver
- Family Supports Waiver

STATE RESPONSE

A. Statutory Authority

1. **Waiver Authority.** The State is seeking authority under the following subsection of 1915(b):

   _x_ **1915(b) (4) - FFS Selective Contracting program**

Sections Waived. The State requests a waiver of these sections of 1902 of the Social Security Act:

a.___ **Section 1902(a) (1) - Statewideness**
b.___ **Section 1902(a) (10) (B) - Comparability of Services**
c._x__ **Section 1902(a) (23) - Freedom of Choice**
d.___ **Other Sections of 1902** – (please specify)

B. Delivery Systems

1. **Reimbursement.** Payment for the selective contracting program is:

   __x__ the same as stipulated in the State Plan
   ___ is different than stipulated in the State Plan (please describe)

   STATE RESPONSE

2. **Procurement**. The State will select the contractor in the following manner:

   _x_ **Competitive** procurement
   ___ **Open** cooperative procurement
   ___ **Sole source** procurement

___ **Other** (please describe)

C. Restriction of Freedom of Choice

1. **Provider Limitations**.

__ _ Beneficiaries will be limited to a single provider in their service area.
__x_ Beneficiaries will be given a choice of providers in their service area.

(NOTE: Please indicate the area(s) of the State where the waiver program will be implemented)

The CIH and FSW waiver programs are both implemented statewide and this waiver will apply to all case management services provided under either of those programs. CMCOs will complete a competitive procurement process which will result in multiple CMCOs receiving contracts to provide case management services. All CMCOs will be required to provide services statewide within 6 months of being awarded a contract. Each individual will then be given the choice of CMCOs to provide their service, however, each individual may only receive this service from one provider at a given time.

2. **State Standards**

Detail any difference between the state standards that will be applied under this waiver and those detailed in the State Plan coverage or reimbursement documents.

There will be no difference in the state standards that will be applied under this waiver and those detailed in the State Plan.

D. Populations Affected by Waiver

(May be modified as needed to fit the State's specific circumstances)

1. **Included Populations**. The following populations are included in the waiver:

___ Section 1931 Children and Related Populations
___ Section 1931 Adults and Related Populations
_x_ Blind/Disabled Adults and Related Populations
_x_ Blind/Disabled Children and Related Populations
___ Aged and Related Populations
___ Foster Care Children
___ Title XXI CHIP Children
___ Other

2. **Excluded Populations.** Indicate if any of the following populations are excluded from participating in the waiver:

___ Dual Eligibles
___ Poverty Level Pregnant Women
___ Individuals with other insurance
___ Individuals residing in a nursing facility or ICF/MR
___ Individuals enrolled in a managed care program
___ Individuals participating in a HCBS Waiver program
___ American Indians/Alaskan Natives
___ Special Needs Children (State Defined). Please provide this definition.
___ Individuals receiving retroactive eligibility
_x__ Other (Please define): [This waiver will only be applicable to participants served through CIH or FSW]

Part II: Access, Provider Capacity and Utilization Standards

A. Timely Access Standards

Describe the standard that the State will adopt (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State has adopted) defining timely Medicaid beneficiary access to the contracted services, *i.e.,* what constitutes timely access to the service?

1. How does the State measure (or propose to measure) the timeliness of Medicaid beneficiary access to the services covered under the selective contracting program?

The state of Indiana ensures timely intake of eligible individuals and aids the individual in the selection of a CMCO entity. The state further monitors timely access related to timely development and submission of the initial and annual PCISPs, timely completion of the annual level of care screening instrument (LOCSI), timely completion of the annual budget in support of the PCISP, meeting requirements, semi-annual Individualized Support Team meetings, and face-to-face meetings with the individual at least every 90 days, and monthly case notes which demonstrate meaningful activity with or on behalf of the individual to address issues, monitor the plan, and make adjustments to the PCISP as needed. DDRS utilizes its IT systems to monitor if initial and annual PCISPs, annual budgets, and annual LOCSIs are done in a timely manner.

DDRS also utilizes National Core Indicator data to monitor timely access through questions such as "Can contact Case Manager/Service Coordinator when wants to" and "Case managers are accessible, responsive, and support the person's participation in service planning." DDRS reviews these select NCI data to monitor timely access for the system holistically, as NCI data are not linked to specific individuals.

To be awarded a contract CMCOs must show evidence of written policies and procedures which ensure timely access to appropriate disability services, supports, and assessments. These policies are provider specific, however, each provider is responsible for ensuring that policies and procedures meet or exceed DDRS timely access standards. Through regular case record reviews, review of quarterly reporting submitted by CMCOs, and QTIPs (detailed below) state staff will evaluate the agency's compliance with their

documented policies and procedures. The specific expectations for this reporting will be delineated in provider contracts.

DDRS will utilize a series of tools to complete all monitoring specific to the CMCO selective contracting program. These methods of monitoring will be aimed at ascertaining timely access, as well as appropriate utilization, compliance with Indiana's quality standards, and compliance with contractual requirements:

- Case Record Reviews (CRR)- On a quarterly basis Bureau of Quality Improvement Services (BQIS) staff review a statistically valid sample of case files for waiver participants for case manager compliance with Indiana Code, 460 IAC 6 & 7 and Community Integration and Habilitation and Family Supports waivers. For any item reviewed that is not in compliance, a corrective action plan (CAP) is required (see remedies section below).
- Quarterly Performance Reports- Specific requirements for quarterly performance reports will be outlined in CMCO contracts under this selective contracting agreement. These reports will be due 15 business days following the close of the previous quarter.
- Quality Tracking Improvement Process (QTIPs)- A panel of reviewers will examine documentation which details the case management service being provided by each contracted entity. Information reviewed includes both that which is provided by the CMCO and information pulled from DDRS data systems to evaluate the quality of the services being provided. Information obtained during QTIPs feeds directly into the content of the subsequent Semi-Annual Collaborative Touchpoints.
- Semi-Annual Collaborative Quality Touchpoints- All contracted entities must participate in semi-annual meetings with DDRS to build shared understanding and support provision of quality case management services.
- Annual Summary Reports – Specific requirements for annual review and reverification will be outlined in the CMCO contracts under this selective contracting agreement.
- Individual and Family Satisfaction Survey – Specific requirements will be outlined in CMCO contracts under this selective contracting agreement. Reports will be due annually.

2. Describe the remedies the State has or will put in place in the event that Medicaid beneficiaries are unable to access the contracted service in a timely fashion.

The state has a variety of remedies available, both those outlined within Indiana Code, Indiana Administrative Code and those delineated within the applicable provider contract. General concerns regarding timely access may initially be addressed through informal actions, such as obtaining an explanation of the circumstances surrounding the event, or verification that remediation actions have been taken, and may act as a sufficient remedy. Such communication will occur on an as needed basis. Discussion of areas where improvements or adjustments to practice are needed, prior to the necessity for a corrective action plan (CAP), will be a focal point of conversation during QTIPs and the Semi-Annual Collaborative Quality Touchpoints. In the event that lack of access

poses risk of harm to an individual, the state will intercede and facilitate alternative case management for the individual.

When monitoring processes show a failure to meet compliance with the requirements as outlined in Indiana Code, 460 IAC, and BDDS/BQIS service standards, guidelines, policies and manuals, BDDS or its designee will issue a report documenting the findings of monitoring activities, identifying the necessary CAP, and identifying the time period in which a CAP must be submitted to BDDS or its designee and the timeframe by which the CAP must be fully implemented.

In the event a provider does not comply with the requirements as outlined in IAC, as well as any requirement laid out within the contract itself, and does not complete a timely corrective action plan to the reasonable satisfaction of BDDS or its designee, BDDS will identify additional remedial actions permitted under the contract and/or within IAC. This may include withholding authorization for providing services to new individuals until which time the CAP has been satisfied. BDDS also has the ability to revoke the contract award as detailed within the provider contract and will do so in circumstances where the failure to comply with contract requirements are particularly egregious and persistent.

B. Provider Capacity Standards

Describe how the State will ensure (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State has ensured) that its selective contracting program provides a sufficient supply of contracted providers to meet Medicaid beneficiaries' needs.

1. Provide a detailed capacity analysis of the number of providers (e.g., by type, or number of beds for facility-based programs), or vehicles (by type, per contractor for non-emergency transportation programs), needed per location or region to assure sufficient capacity under the selective contracting program.

In order to plan and receive other services available through the FSW and CIH waivers, all individuals served by DDRS through either waiver must utilize case management. As of March 2021, BDDS served just under 32,000 individuals with a workforce of 715 case managers across 10 case management companies (CMCOs). Of these 715 case managers, the average number of individuals served per case manager was 40.

DDRS's transition to case management under a selective contracting program is not anticipated to impact the necessary supply of providers for the case management service as this change will not impact enrollment in the larger CIH and FSW waiver programs. Annual growth in the FSW waiver averages will be monitored and the potential changes from this average will be confirmed by DDRS as they are directly tied to the number of additional funded waiver slots approved by the legislature. All new enrollees to the CIH waiver must meet one of the reserve capacity criteria, with available slots reserved and utilized for each criterion reviewed by DDRS regularly. Should the growth in either of these waivers exceed expected rates, DDRS will have the ability to notify each of the contracted CMCOs of such, thereby allowing them to increase their workforce of case managers as warranted.

To ensure case managers have the necessary capacity to provide high caliber case management services to program participants, caseload size limits of an average of 45 across full time case managers will be imposed as part of CMCO contracts. This limit will ensure case managers have adequate capacity to absorb increased utilization amongst the people they are serving, if necessary. Because case management is paid at a monthly per diem, changes in utilization associated with this new caseload limit would not have an immediate corresponding cost to account for. CMCOs are also allowed to develop their own independent means of further managing caseload sizes within the caseload limit.

CMCOs are aware of this new limit and will be contractually required to ensure a sufficient amount of case managers are employed to provide statewide coverage while maintaining the maximum caseload size.

The state's data reporting system allows for reports to be pulled which identify the total number of participants at both the district and county level, thereby indicating the varying case management capacities necessary down to the county level. While DDRS does not require that case managers be located in the same county as those they serve, and in fact, most case managers currently serve more than one county, physical proximity between the case manager and service recipient is preferable to facilitate timely access and availability of the service. As service recipients move or new individuals are targeted for waiver services, their location information is updated or captured, allowing DDRS to analyze trends indicating changes in case management capacity requirements.

While DDRS intends to limit the total number of CMCOs to approximately 5 through the competitive procurement process, the state anticipates requiring more or less the same total workforce of individual case managers. Award of this contract will be contingent upon the CMCO offering services statewide within 6 months of being notified of their selective contract award to facilitate choice of providers in even rural or sparsely populated areas of the state. Each respondent to the forthcoming RFS will be evaluated on the description of their current capacity, and detailed plan for building capacity within the designated roll-in time frame. Respondents will be asked to detail the location and targeted caseload sizes of their case managers. They will also explain their strategy for recruiting additional case managers in regions of the state where the agency is not currently represented, as well as in areas where additional case managers will be needed to meet capacity.

In addition to being evaluated and scored on the individual responses, proposals will be reviewed as a group regarding capacity to ensure the cohort of awarded contractors have adequate ability to scale as needed to serve all individuals receiving services under CIH or FSW waivers. The state will routinely monitor provider capacity, including caseload size and ratios of case managers to case management supervisors to ensure that provider capacity does not, in any event, cause access issues.

2. Describe how the State will evaluate and ensure on an ongoing basis that providers are appropriately distributed throughout the geographic regions covered by the selective contracting program so that Medicaid beneficiaries have sufficient and timely access throughout the regions affected by the program.

Award of this contract will be contingent upon the CMCO offering services statewide within 6 months of being awarded the contract, thereby ensuring coverage by multiple entities in all areas of the state. Providers will be required to submit as part of their contract, the process they have put into place to ensure caseload sizes per case manager appropriately address the geographical and complex needs of individuals. Information submitted by CMCOs as part of their quarterly performance reports will be used alongside information entered and maintained within the BDDS Gateway online portal to evaluate appropriate distribution of providers and identify areas where adjustments may be needed. Issues around timely access and distribution of providers will be broadly discussed during the Semi-Annual Collaborative Quality Touchpoints and addressed with individual CMCOs during their QTIPs as needed.

C. Utilization Standards

Describe the State's utilization standards specific to the selective contracting program.

The state of Indiana expects that each service recipient receives the amount of case management services necessary to build a robust Person-Centered Individualized Support Plan (PCISP) and help to coordinate those supports necessary to facilitate the individual achieving their vision of a preferred life. This includes coordinating all services provided through the applicable 1915(c) waiver, Medicaid state plan benefits, as well as identification of and connection with resources regardless of funding source as needed to achieve the aims defined in the PCISP, and activities to perform necessary quality monitoring activities pursuant to the services defined.

Case management is paid on a monthly unit of service, with necessary contact minimums in place to ensure permissibility of billing. This will ensure entities perform to minimum utilization standards.

1. How will the State (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State) regularly monitor(s) the selective contracting program to determine appropriate Medicaid beneficiary utilization, as defined by the utilization standard described above?

DDRS specifically monitors utilization of the case management service through the submission of plans, documentation of quarterly face-to-face visits with the individual within their home and service setting, and review of case notes which detail additional interaction with and support of the individual. These monitoring activities allow DDRS to identify how well the provider is supporting the full implementation of the individual's PCISP, ascertaining satisfaction with the waiver services and addressing issues or concerns that have arisen—all key elements of the case management service.

More generally, DDRS will utilize a series of tools to complete all monitoring specific to the CMCO selective contracting program. These methods of monitoring will be aimed at ascertaining appropriate utilization, as well as timely access, compliance with Indiana's quality standards, and compliance with contractual requirements:

- Case Record Reviews (CRR)- On a quarterly basis Bureau of Quality Improvement Services (BQIS) staff review a statistically valid sample of case files for waiver participants for case manager compliance with Indiana Code, 460 IAC 6 & 7 and Community Integration and Habilitation and Family Supports waivers. For any item reviewed that is not in compliance, a corrective action plan (CAP) is required (see remedies section below).
- Quarterly Performance Reports- Specific requirements for quarterly performance reports will be outlined in CMCO contracts under this selective contracting agreement. These reports will be due 15 business days following the close of the previous quarter.
- Quality Tracking Improvement Process (QTIPs)- A panel of reviewers will examine documentation which details the case management service being provided by each contracted entity. Information reviewed includes both that which is provided by the CMCO and information pulled from DDRS data systems to evaluate the quality of the services being provided. Information obtained during QTIPs feeds directly into the content of the subsequent Semi-Annual Collaborative Touchpoints.
- Semi-Annual Collaborative Quality Touchpoints- All contracted entities must participate in semi-annual meetings with DDRS to build shared understanding and support provision of quality case management services.
- Annual Summary Reports – Specific requirements for annual review and reverification will be outlined in the CMCO contracts under this selective contracting agreement.
- Individual and Family Satisfaction Survey – Specific requirements will be outlined in CMCO contracts under this selective contracting agreement. Reports will be due annually.

2. Describe the remedies the State has or will put in place in the event that Medicaid beneficiary utilization falls below the utilization standards described above.

The state has a variety of remedies available, both those outlined within Indiana Code and Indiana Administrative Code and those that will be delineated within the applicable provider contract. Areas of concern, including concerns regarding utilization which falls below the standards DDRS has outlined by rule and within forthcoming provider contracts, are regularly addressed through written and/or verbal communications to ensure timely remediation. In some cases, informal actions, such as obtaining an explanation of the circumstances surrounding the event, or verification that remediation actions have been taken, may be sufficient to deem the problem resolved. Such communications will occur on an as needed basis and areas where improvements or adjustments to practice are needed will be a focused point of conversation during QTIPs and the Semi-Annual Collaborative Quality Touchpoints. In other situations, more formal actions may be taken.

When monitoring processes show a failure to meet compliance with the requirements as outlined in 460 IAC or those additionally detailed within the provider contract itself,

BDDS or its designee will issue a report documenting the findings of monitoring activities, identifying the necessary CAP, identifying the time period in which a CAP must be submitted to BDDS or its designee, and the timeframe by which the CAP must be fully implemented.

In the event a provider does not comply with the requirements as outlined in Indiana Code, IAC, BDDS/BQIS policy and guidance, as well as any requirement laid out within the contract itself, and does not complete a timely corrective action plan to the reasonable satisfaction of BDDS or it's designee, BDDS will identify additional remedial actions permitted under the contract and/or within Indiana Code and IAC. This may include withholding authorization for providing services to new individuals until which time the CAP has been satisfied. BDDS also has the ability to revoke the contract award as detailed within the provider contract and will do so in circumstances where the failure to comply with contract requirements are particularly egregious and persistent.

Part III: Quality

A. Quality Standards and Contract Monitoring

1. Describe the State's quality measurement standards specific to the selective contracting program.

All providers will be required to meet the case management service delivery requirements as outlined in Indiana State Statute and Administrative Code as well as those requirements detailed within BDDS/BQIS policy, guidance and the contracts developed following the competitive procurement process. Required responses to the Request for Services as part of this procurement will include providing detail as to how the entity will meet state expectations related to methods and measures related to quality. The specific elements outlined in these responses will be incorporated into the expectations for reporting as detailed within the subsequently developed contracts.

Case management service quality is measured via the development of a timely, annual PCISP, development of an annual budget in support of the PCISP, timely determination of continued eligibility for services, convening of IST meetings at least semi-annually, meeting with the individual and/or guardian at least every 90 days, or as requested by the individual, and regularly reviewing and updating the PCISP as needed due to changes in circumstances or at the request of the individual and/or guardian. In addition, the state will monitor individual satisfaction of case management performance through multiple mechanisms of engagement with individuals and families, including valid and reliable surveys such as the National Core Indicators.

a. Describe how the State will (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State):

i. Regularly monitor(s) the contracted providers to determine compliance with the State's quality standards for the selective contracting program

DDRS monitors compliance with the State's quality standards for case management through review of documentation that identifies all elements outlined above have been met. While much of this information is tracked and documented within the DDRS IT systems, within the confines of this selective contracting program, providers are also expected to affirmatively supplement that documentation through the submission of quarterly reports detailing their own measurement of compliance with all policies, procedures, and service expectations. The state will also use post-payment audits and reviews to ensure that proper documentation of service delivery is present.

More generally, DDRS will utilize a series of tools to complete all monitoring specific to the CMCO selective contracting program. These methods of monitoring will be aimed at ascertaining compliance with Indiana's quality standards, as well as timely access, adequate utilization, and compliance with contractual requirements:

- Case Record Reviews (CRR)- On a quarterly basis Bureau of Quality Improvement Services (BQIS) staff review a statistically valid sample of case files for waiver participants for case manager compliance with Indiana Code, 460 IAC 6 & 7 and Community Integration and Habilitation and Family Supports waivers. For any item reviewed that is not in compliance, a corrective action plan (CAP) is required (see remedies section below).
- Quarterly Performance Reports- Specific requirements for quarterly performance reports will be outlined in CMCO contracts under this selective contracting agreement. These reports will be due 15 business days following the close of the previous quarter.
- Quality Tracking Improvement Process (QTIPs)- A panel of reviewers will examine documentation which details the case management service being provided by each contracted entity. Information reviewed includes both that which is provided by the CMCO and information pulled from DDRS data systems to evaluate the quality of the services being provided. Information obtained during QTIPs feeds directly into the content of the subsequent Semi-Annual Collaborative Touchpoints.
- Semi-Annual Collaborative Quality Touchpoints- All contracted entities must participate in semi-annual meetings with DDRS to build shared understanding and support provision of quality case management services.
- Annual Summary Reports – Specific requirements for annual review and reverification will be outlined in the CMCO contracts under this selective contracting agreement.
- Individual and Family Satisfaction Survey – Specific requirements will be outlined in CMCO contracts under this selective contracting agreement. Reports will be due annually.

ii. Take(s) corrective action if there is a failure to comply.

When monitoring processes show a failure to meet compliance with the requirements as outlined in Indiana Code, 460 IAC, BDDS/BQIS policy and guidance, or those additionally detailed within the provider contract itself, BDDS or its designee will issue a report documenting the findings of monitoring activities, identifying the necessary CAP, identifying the time period in which a CAP must be submitted to BDDS or its designee and the timeframe by which the CAP must be fully implemented.

In the event a provider does not comply with the requirements as outlined in IAC, as well as any requirement laid out within the contract itself, and does not complete a timely corrective action plan to the reasonable satisfaction of BDDS or its designee, BDDS will identify additional remedial actions permitted under the contract and/or within IAC. This may include withholding authorization for providing services to new individuals until which time the CAP has been satisfied. In particularly egregious circumstances BDDS also has the ability to revoke the contract award as detailed within the provider contract and will do so in circumstances where the failure to comply with contract requirements are particularly egregious and persistent. Additionally, the state may utilize claims adjudication procedures and post payment reviews to ensure that payments were appropriately made.

2. Describe the State's contract monitoring process specific to the selective contracting program.

   a. Describe how the State will (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State):

      i. Regularly monitor(s) the contracted providers to determine compliance with the contractual requirements of the selective contracting program.

      The multi-step monitoring approach outlined in the response to Part 1 of this question was specifically designed to expand beyond compliance with Indiana State statute and administrative code to incorporate review of those expectations defined under the specific contracts developed following this competitive procurement process. The information submitted as part of quarterly reporting will be defined within the provider contacts and will incorporate both standard measures and those measures detailed by providers in their responses to the request for services. The specific reporting requirements as well as the subsequent QTIPs and Quality Touchpoints are specifically aimed at ensuring compliance with the contractual requirements, including those that go beyond the case management service requirements outlined elsewhere.

      ii. Take(s) corrective action if there is a failure to comply.

      - If the vendor fails to comply with any of the requirements of the contract, the State may impose civil monetary penalties for poor performance.

- Ultimately, if the violations are considered egregious and persistent, the contract may be terminated and a new contractor sought for service delivery.

When monitoring processes show a failure to meet compliance with the requirements as outlined in 460 IAC or those additionally detailed within the provider contract itself, BDDS or its designee will issue a report documenting the findings of monitoring activities, identifying the necessary CAP, identifying the time period in which a CAP must be submitted to BDDS or its designee and the timeframe by which the CAP must be fully implemented.

In the event a provider does not comply with the requirements as outlined in IAC, as well as any requirement laid out within the contract itself, and does not complete a timely corrective action plan to the reasonable satisfaction of BDDS or its designee, BDDS will identify additional remedial actions permitted under the contract and/or within IAC. This may include withholding authorization for providing services to new individuals until which time the CAP has been satisfied. In particularly egregious circumstances BDDS also has the ability to revoke the contract award as detailed within the provider contract and will do so in circumstances where the failure to comply with contract requirements are particularly egregious and persistent.

B. Coordination and Continuity of Care Standards

Describe how the State assures that coordination and continuity of care is not negatively impacted by the selective contracting program.

The selective contracting program will ensure the highest quality and continuity of care is delivered by all selected CMCOs. Currently, not all CMCOs serve individuals statewide. All respondents to the RFS will be required to state how they plan to expand to provide statewide coverage within their technical proposal. All contracted CMCOs will have demonstrated their ability to serve individuals statewide within 6 months of the contract award. In addition to demonstrating the ability to absorb additional case managers and associated caseloads, CMCOs will need to develop protocols for situations where an individual may be required to change case manager or CMCO with an aim of ensuring minimal interruption to care continuity.

All CMCOs must develop plans to ensure adequate coverage, high-quality services, and regular oversight and accountability, which are tantamount to ensuring continuity of care. These plans, plus strategies for ensuring continuity of care due to structural changes brought about by the shift in procurement process must be provided in each CMCOs application materials for the state to review. If awarded a contract, providers will be expected to use these same, or similar, standards as part of ongoing quality monitoring.

Part IV: Program Operations

A. Beneficiary Information

Describe how beneficiaries will get information about the selective contracting program.

DDRS will initiate a communications plan that includes sending personalized letters to individuals who will experience a change to their case management company or individual case manager. Individuals will be fully supported during the transition.

In addition, during the transition several resources will be used to provide regular updates to waiver participants and their families regarding any anticipated changes to case management services. These sources may include the DDRS listserv, written material such as FAQ's, web copy, virtual information sessions, and individual meetings with select stakeholder groups such as family-advocacy and self-advocacy organizations.

DDRS will regularly make comprehensive information available to individuals regarding the CMCO providers available to them upon their approval for 1915 (c) HCBS waivers. The providers identified through the competitive solicitation will also be responsible for providing information to enrollees as outlined in their contracts.

Waiver participants will continue to receive information on their rights at any time a service is denied, terminated, or reduced. If recipients are concerned with their services, they may request a fair hearing (to dispute a denial or limitation) or file a formal grievance with DDRS.

B. Individuals with Special Needs.

_x__ The State has special processes in place for persons with special needs (Please provide detail).

All participants who are enrolled the two HCBS 1915 (c) waivers relevant to this application would meet this designation based on their disability. A Person-Centered Individualized Support Plan (PCISP) is a requirement of waiver services. Therefore, by virtue of its operation, the programs, through the PCISP, meet the unique and specific needs of 1915(c) participants.

All case management entities will be required to provide services in a manner fully accessible to individuals served.

Section B – Waiver Cost-Effectiveness & Efficiency

Efficient and economic provision of covered care and services:

1. Provide a description of the State's efficient and economic provision of covered care and services.

Project the waiver expenditures for the upcoming waiver period.

Year 1 (partial) from: _1/2022___ to _12/2022__

Trend rate from current expenditures (or historical figures): ____7____%

Projected pre-waiver cost _$62,228,844_____
Projected Waiver cost _$62,228,844_
Difference: _$0_

Year 2 from: 1/2023___ to __12/2023__

Trend rate from current expenditures (or historical figures): ____5____%

Projected pre-waiver cost _$67,167,236_____
Projected Waiver cost _$67,167,236_
Difference: _$0_

Year 3 (if applicable) from: _1/2024__ to 12/2024__
(*For renewals, use trend rate from previous year and claims data from the CMS-64*)

Projected pre-waiver cost _$72,083,942_____
Projected Waiver cost _$72,083,942_
Difference: _$0

Year 4 (if applicable) from: 1/2025__ to _12/2025__
(*For renewals, use trend rate from previous year and claims data from the CMS-64*)

Projected pre-waiver cost _$76,990,141_____
Projected Waiver cost _$76,990,141_
Difference: _$0_

Year 5 (if applicable) from: _1/2026__ to _12/2026__
(*For renewals, use trend rate from previous year and claims data from the CMS-64*)

Projected pre-waiver cost _$80,835,148_____
Projected Waiver cost _$_80,835,148

Difference: _$0_

Year 5 (partial) (if applicable) from: _ to ___
(*For renewals, use trend rate from previous year and claims data from the CMS-64*)

Projected pre-waiver cost _$0_____
Projected Waiver cost _$_
Difference: _$_