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FAQ: BDDS temporary policy changes related to COVID-19

Incident reporting guidance

Please clarify the temporary timing changes for when incidents should be reported as an incident report to BQIS.

BDDS has extended the timeline for reporting incidents to 48 hours from incident occurrence or point reporter becomes aware of occurrence, except in the following circumstances:

1. Incidents related to alleged abuse, neglect or exploration must still be reported within 24 hours from incident occurrence or point reporter becomes aware of the occurrence.
2. Incident reports should be filed within 24 hours when participant tests positive for COVID or if their healthcare provider has indicated that it should be presumed that the individual is COVID positive.

Please clarify what should be reported relating to an individual and COVID-19.

If an individual tests positive for COVID or if their healthcare provider has indicated that it should be presumed that the individual is COVID positive, an incident report should be submitted. BDDS is requesting incident reports be filed within 24 hours when a participant is presumed positive with COVID-19.

Incident reports are not required when a person has symptoms of COVID-19, unless another incident report category applies (such as an emergency intervention or event with the potential for causing significant harm or injury and requiring medical or psychiatric treatments or services). Incident reports are not required for COVID-19 related service/site closures/suspensions, visitor restrictions, quarantine measures without a COVID-19 positive test, or other changes in service delivery.

Even though these are not required to be reported as incident reports, BDDS and BQIS are requiring providers to inform and update everyone who is a part of the individualized support team of any situation involving an individual, including quarantine measures, restrictions, etc., as well as document all changes.

Please continue to submit IRs as appropriate for non-related COVID-19 incidents.

Are nursing facilities required to complete incident reports for COVID related issues?

Nursing facilities are not required to complete incident reports in the BDDS/BQIS system. Nursing facilities are responsible for reporting COVID+ cases to ISDH.

Reporting in congregate residential settings

Is the COVID reporting process the same for individuals in Waiver and ICF?

Yes. The reporting process for individuals is the same for individuals in waivers and ICF—these have been identified as required due to their designation as congregate residential settings. Congregate residential settings



include Medicaid home- and community-based waiver settings serving two or more individuals and community residential facilities for persons with developmental disabilities (ICF/IDDs and SGLs), as defined in 460 IAC 9-1-2. Providers will continue using BDDS's Incident Management System to report COVID-19 individual information, though are asked to provide additional information in the narrative. Please review [“Update: COVID-19 reporting in congregate residential settings supported by BDDS,”](#) issued on April 21, for additional details on these requirements.

An individual in services was exposed to COVID-19 but was unable to get tested without a doctor's order. How can I get him tested?

There are approximately 50 sites throughout the state operated by Optum. These sites are open for anyone who lives or works in Indiana. To learn more, including how to register to access testing, please visit <https://www.coronavirus.in.gov/2524.htm>. Also, healthcare workers are prioritized at those sites, including those staff in congregate settings. If you have workers with symptoms who need testing and cannot get it rapidly done by their primary care doctor, please have them register to access testing through Optum using the following: <https://lhi.care/covidtesting>.

Recently, ISDH Long Term care reported that CDC is now requiring positive tests be reported to them as well. Will BQIS be reporting to CDC based on our BDDS reports and online employee reporting form?

ICF/IDD and waiver services provided through the Bureau of Developmental Disabilities are considered “congregate living settings.” BDDS providers should continue with the established reporting process and BDDS/BQIS will submit the report to ISDH as required by the [State Health Commissioner's order](#). ISDH reports the data to the CDC as required.

A DSP supporting an individual has been confirmed as COVID-19 positive. The individual has been tested and the results are pending. Do I need to report the DSP as having COVID-19? How do I do that?

All congregate residential settings supported by BDDS are required to report any employee who tests positive for COVID-19. Employee-specific reporting shall be submitted using our [online COVID-19 Employee Reporting Form](#).

Is employee COVID-19 positive testing required only for staff working in residential settings? What if the employee has worked in day services in the last two weeks?

BDDS is not aware of a mandated requirement for employee testing. Mandatory reporting is only for staff working in congregate residential settings, which has been defined as group homes/CRMNFs and HCBS residential settings with 2 or more people. Staff who do not have contact/interaction with individuals are not to be reported. Information for any additional settings in which the employee has worked should be included in the additional information question on the report.

Regarding the online form (for employees): does it matter if the employee was not involved with individuals in service? Also, part of the information is the address/county in which the person worked. What timeframe do you need? Some staff work in multiple sites over time. Also, is anyone able to report an employee or are you interested in having a ‘point person’ to submit?

Mandatory reporting is only for staff working in congregate residential settings, which has been defined as group homes/CRMNFs and HCBS residential settings with two or more people. Staff who do not have contact/interaction

with individuals are not to be reported. Information for any additional settings in which the employee has worked should be included in the additional information question on the report. ISDH has not mandated a timeframe; however, the last 14-21 days is recommended. Anyone is able to use the link to report an employee.

What if the employee has suspected COVID-19 but cannot get tested?

There are approximately 50 sites throughout the state operated by Optum. Healthcare workers are prioritized at those sites, including those staff in congregate settings. If you have workers with symptoms who need testing and cannot get it rapidly done by their primary care doctor, please have them register to access testing through Optum using the following: <https://lhi.care/covidtesting>. Additional information about testing can be found at <https://www.coronavirus.in.gov/2524.htm>.

In regards to the info required for employees, should we be concerned about privacy of the employee's health information?

As established in the [State Health Commissioner's order](#), the Indiana State Department of Health is operating under authority granted in Ind. Code 16-19-3-9 to "do what is reasonable and necessary for the prevention and suppression of disease", Ind. Code 16-41-2-14 requiring the reporting of communicable disease information; and Executive order 20-02. Healthcare providers and local officials are required to cooperate with the Indiana State Department of Health in its response to a declared public health emergency.

Do we need to report if employees who work at our office test positive for COVID?

Mandatory reporting is only for staff working in congregate residential settings, which has been defined as group homes/CRMNFs and HCBS residential settings with two or more people. Staff who do not have contact/interaction with individuals are not to be reported.

Staff has been tested COVID positive. Requirements for reentry to work—retesting with a negative result?

Providers are encouraged to review the following resource from CDC: ["Return to Work Criteria for HCP with Suspected or Confirmed COVID-19."](#)

What if a staff for Medicaid PA/home health was tested, so not waiver provider. Who is responsible to notify everyone? RHS/waiver provider?

Medicaid PA/home health is not responsible for reporting to BDDS. Best practice would be for the RHS/waiver provider to notify the team of the potential exposure to ensure communications.

How about a guardian refusing a COVID test for person supported with symptoms of COVID-with doctor's order?

If a guardian refuses to consent to allowing an individual to have a COVID test, it is recommended that a provider staff or case manager talk with the guardian to gain a better understanding of any concerns the guardian may have regarding testing. Ultimately, if a guardian continues to refuse testing it is recommended that the physician be consulted. If appropriate and directed by physician, precautions should be put in place that may mimic situations of a positive COVID-19 test result.



When a consumer has been exposed to a COVID-19 positive individual they must isolate for 14 days. Is it also required that the consumer be tested prior to resuming day programming? If not, can the provider require this in their policy even if the state does not?

Providers are encouraged to follow CDC guidelines related to [“Discontinuing Home Isolation for Persons with COVID-19.”](#)

Can you please clarify what we are supposed to be doing as far as staff and COVID? My understanding is we are required to do a 14-day quarantine if they are exposed to someone who tests positive.

Healthcare workers that, in a healthcare setting, have been potentially exposed to patients with confirmed COVID-19 should follow CDC guidance linked below. This guidance includes considerations for managing healthcare workers with exposure who are asymptomatic. <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assessment-hcp.html>.

If an individual has been exposed to COVID, is the individual required to get tested?

While there is no mandated requirement, it is recommended that a provider staff or case manager talk with the individual/guardian to gain a better understanding of any concerns they may have regarding testing. Ultimately, if an individual continues to refuse testing it is recommended that the physician be consulted. If appropriate and directed by physician, precautions should be put in place that may mimic situations of a positive COVID-19 test result.

Will the “When to quarantine” sheet be updated to reflect the updated CDC quarantine guidance?

The resources of when to quarantine/when to isolate are a product developed by the Indiana Department of Health. You can visit the Indiana Department of Health COVID website for their most up to date information and resources.

Have these documents been updated based on the new guidance issued by the CDC today on quarantine timelines?

The resources of when to quarantine/when to isolate are a product developed by the Indiana Department of Health. You can visit the Indiana Department of Health COVID website for their most up to date information and resources.

What if a guardian indicates they have been told by another guardian of a positive case at a day program site? And they know their loved one may have been exposed but says that the provider did not contact all possible parties noting they do not share a home? Besides the CM, who does the guardian report their concern to?

Contacting the individual’s case manager is a first step. The case manager can convene a team meeting, virtual or otherwise, to discuss the concerns of the guardian. If the guardian wishes to file a complaint, they can do so by [contacting BQIS](#).

If a provider is not notifying people that they have been exposed to COVID-19 what is the policy?

Per [BDDS provider COVID-19 policy guidance](#), as of 09/01/20, providers should have policies and procedures in place that describe how to:

- Keep individuals, their families, and staff informed of your agencies plans for addressing COVID related needs.
- Keep individuals, their families, other providers, and staff informed of the COVID status in the home. All should be informed if there are new COVID positive or presumed positive cases. This communication should include actions that are being taken to prevent further spread of COVID-19 and how to reach a staff person if they have questions.
- Document any outside visitors to the home (including the date of visit, visitor name, and visitor contact information). Any visitor who was present in the home within 48 hours of when an individual or staff who is confirmed COVID positive was tested, or who was present in the home within 48 hours of a staff or resident developing symptoms that are confirmed or presumed to be from COVID-19 should be notified of the possible exposure, as soon as possible.
- Monitor individuals, staff, and visitors (when it is determined that visitors are permissible in the setting) for [symptoms of COVID-19](#), including fever, respiratory or other symptoms like loss of taste and smell. Providers should also consider adding questions about whether the individuals, staff, and visitors live with a current COVID positive individuals. Visitors or staff with symptoms should be restricted from entry.
- Support hand and respiratory hygiene, as well as cough etiquette by individuals, visitors and staff, including having hand washing and/or alcohol hand rub available at the setting entry and supplies of alcohol hand rub for staff to use before and after resident interactions.
- Continue to follow social distancing requirements within the setting, particularly during meals or other times when individuals may be engaging in common activities or areas.
- Consider how individuals are storing toothbrushes to minimize exposure. Consider utilizing disposable toothbrushes for COVID positive individuals.
- Require daily deep cleaning of the home using [CDC guidance](#) and approved cleaning solutions
- Require all staff having direct contact with individuals should wear a mask for the duration of their shift. Hospital/surgical masks are recommended, however if such masks are not available, providers are encouraged to follow CDC [“Strategies for Optimizing the Supply of Facemasks.”](#)
- Provide infection control training (including cleaning and disinfecting protocols for high touch areas), supplies, and ensure easy and correct use of PPE.
- Identify strategies to:
 - Quickly respond if an individual or staff presents with COVID-19.
 - Care for individuals with COVID-19 while protecting others in the setting.

What is the provider responsibility with communication when there has been an exposure/potential exposure and notifying families/teams?

Providers should notify all team members when an individual has been exposed to/or is suspected of having COVID-19; is being tested for COVID-19; or has tested positive for COVID-19. All team members are encouraged to openly communicate with each other on a regular basis on symptoms, possible exposures and testing being done or completed.

What is the link for reporting to BQIS if staff are not wearing a mask?

<https://www.in.gov/fssa/ddrs/quality-improvement/>

Do you have suggestions for safe ways for DSPs to take a break from wearing a mask? We are writing clearer policies and would love BDDS input to ensure that it does not result in a BQIS complaint if our DSPs work 8-12 hours and need to take safe breaks from mask usage.

Governor Holcomb's [Executive Order 20-48](#) addresses requirements for all businesses and entities in Indiana. This includes minimum safeguards including:

- Instituting an employee health screening process;
- Employing enhanced cleaning and disinfecting protocols for the workplace, including regularly cleaning high-touch surfaces;
- Enhancing the ability of employees, customers and clients to wash hands or take other personal hygiene measures such as use of hand sanitizer;
- Complying with social distancing requirements established by the CDC, including maintaining six-foot social distancing for both employees and members of the general public when possible and/or employing other separation measures such as wearing face coverings or using barriers.

Many individuals supported by BDDS are considered high risk with regard to COVID-19. As a result, all staff should wear a mask for the duration of their shift. Hospital/surgical masks are recommended, however if such masks are not available, providers are encouraged to follow CDC [“Strategies for Optimizing the Supply of Facemasks.”](#)

Direct support staff may briefly remove their mask if they are outside and appropriately social distanced from individuals they are supporting. They may also briefly remove their mask when in a room of the home alone such as the bathroom. DSPs should follow all hygiene and cleaning recommendations including how to safely handle a used mask.

I thought masks were worn to protect others from yourself. Does the mask also protect you?

Wearing a mask protects other people from infected droplets, and it offers you some protection, too, according to recent studies. [“Wear a Mask to Protect Yourself and Others.”](#)

If CM in the home—DSPs not wearing mask—do they go ahead and file an IR or “only” call the provider leadership and tell them?

IST members are encouraged to communicate frequently during this unprecedented time. CMs are encouraged in this situation to contact the provider leadership to share their observation. CMs can also contact BQIS who will contact the provider and offer technical assistance.

What should be done when residential provider staff refuse to wear masks when working with high-risk individuals in waiver homes and residential provider management do not ensure that staff wear masks?

Notification to the residential provider and BQIS-help.fssa@state.in.us of the staff's refusal to wear a mask should be completed.



So if we hear of a day program/workshop not following CDC guidelines, we just let BQIS know so they can follow up, correct?

Correct. BQIS will contact the provider and offer technical assistance.

A local provider is not making DSPs wear masks because they are in the clients' homes and say they aren't required to by the state. Is that accurate?

Governor Holcomb's [Executive Order 20-48](#) states that every individual within the state of Indiana shall wear a face covering over the nose and mouth when:

1. Inside a business, a public building, or other indoor place open to the public. This does not extend, however, to private offices, private workspaces or meetings in which six (6) feet of social distancing can be achieved and maintained between individuals not in the same household;
2. In an outdoor public space wherever it is not feasible to maintain six (6) feet of social distancing from another person not in the same household; or
3. Using public transportation or while in a taxi, private car service or ride-sharing vehicle;

Unless an exemption, the [Executive Order 20-48](#) (3.f.) applies or when in a private residence.

The DSP is working when in the individual's residence to the DSP is required to wear a mask and is not exempted because they are in a private residence.

Suspension of new providers

Does the information indicating no new service provider refer to adding a new provider for an individual? Such as individual wants a new RHS provider?

No. An individual with the FSW or CIH can choose a new currently enrolled provider at any time. BDDS has temporarily suspended enrollment of new HCBS Medicaid service providers for the FSW and CIH waivers.

As of Sept. 1, 2020, BDDS has re-opened enrollment of new HCBS Medicaid service providers for the FSW and CIH waivers.

For new FSW provider enrollment is the application submission address the same as it was prior to March and pre-COVID times?

No, both FSW and CIH waiver applications are to be sent to BDDSPROVIDERSERVICES@FSSA.IN.GOV.



Suspension of provider reverification

We were scheduled for CARF survey in May/June 2020. We are considering an extension, as we do not think it is feasible for an “onsite” review just as the Pandemic will be slowing. If we request an extension of current accreditation through 12/31/2020; our survey may be held in September/October—but, it could be pushed beyond that due to CARF backlog. Will this cause any problems for providers?

Extensions granted for a provider’s current accreditation by one of the approved accreditation entities is acceptable. If a provider receives an extension, the provider must forward the extension documentation to BQIS.

When will the reverification process start again?

There is no date set for resuming the reverification process. Advance notice will be provided when a date is determined.

The reverification process has resumed effective September 1 and the pilot will begin in September.

On provider reverification is BQIS going to pilot the new process before broader rollout?

Yes. Please see the DDRS Announcement Page for the BQIS announcement on 2/12/2020

(https://www.in.gov/fssa/ddrs/files/Provider-reverification-process-rollout-announcement_FINAL_02.12.2020.pdf). Furthermore, the BQIS webpage

(<https://www.in.gov/fssa/ddrs/quality-improvement/>) contains detailed information regarding provider reverification.

Is the new provider verification process taking the place of an outside survey agency? It seems that the new process is the same thing that agencies are spending thousands of dollars on.

Yes. Please see the DDRS announcement page for the BQIS announcement on 2/12/2020

(https://www.in.gov/fssa/ddrs/files/Provider-reverification-process-rollout-announcement_FINAL_02.12.2020.pdf). Furthermore, the BQIS webpage

(<https://www.in.gov/fssa/ddrs/quality-improvement/>) contains detailed information regarding provider reverification.

Reopening efforts and individual restrictions

I have read some providers provisions for their plan of reopening, and their phases. One stated they would allow higher functioning individuals to return in the first phase, and then the individuals who need more supports would then be allowed to return in a later phase. As I understand their reasoning to a degree, couldn’t this be taken as discrimination?

Providers are encouraged to follow the guidance and recommendations of all local, state and federal authorities such as the local health department, Family and Social Services Administration, Indiana State Department of Health, Governor Holcomb’s Back on Track, and the Centers for Disease Control and Prevention.



What are providers' rights with respect to client behavior outside the home? For example, if an individual wants to return to work but the provider prefers that he/she not do so due to the potential to bring the virus home, how do we navigate scenarios like this? Or where an individual wants a "porch visits" from family and other team members, etc.?

Individuals are the ultimate decision makers in their life and home. Teams should meet and work together to allow the individual to make an informed choice and determine what supports are necessary and available to them. The entire team should work to facilitate strategies and resolutions in congregate settings where each individual living in the home may want and/or need something different but also have to consider the health and safety of everyone in the home. Resources that may be helpful during these conversations include: ["The Integrated Supports Conversation Starter,"](#) the ["Center for Disease Control and Prevention Guidance for Direct Service Providers,"](#) Governor Holcomb's ["Back on Track Plan"](#) and our most recent [guidance for BDDS providers.](#)

What do we do when providers are prohibiting visitors or normal socialization between peers that don't live together?

Providers should work with the individual, their family, case manager and other team members to identify whether and to what extent to implement restrictions on visitors and/or activities outside of the home based on balancing what is important for the individual relative to their health, their household structure, and related issues with what is important to the individual. These discussions should support the individual in informed decision-making by providing them with information about what is currently permissible under the Executive Order and what risks are represented in those activities.

Can a provider restrict a client from going back to work? Or restrict them from going on an interview?

Individuals are the ultimate decision makers in their life and home. Teams should meet and work together to allow the individual to make an informed choice and determine what supports are necessary and available to them.

If the providers set their own plan to "re-open," what happens if the plan is not in line with the wants of the individuals or families? With the misinformation in the media many believe there is no reason to not fully re-open and with no guidance it puts providers in a difficult spot between the safety of individuals and staff and BQIS.

The state's Bureau of Developmental Disabilities Services issued guidance on May 21 to support providers in the successful reopening of day service settings and to inform individuals and families on the recommendations and considerations for their day program. Day service providers are strongly encouraged to develop and share their specific plan and procedures with their staff, individuals accessing their services, and families.

Thinking about safety... Can providers require consumers to wear a mask while in common areas of their home?

It is up to the individual(s) on how they would like to address exposure risk within their own home.

These settings are their homes and individuals should have the support, information, and resources needed for them to be an active decision-maker in the discussion.

Can BDDS provide some additional information about how Governor Holcomb's most recent [Executive Order 20-26](#), Roadmap to Reopen Indiana for Hoosiers, Businesses and State Government, impacts providers of services?

Executive Order 20-26 provides a measured and staggered approach to reopening businesses and entities over five stages. It is important to note that all counties were permitted as of May 4 to advance to Stage 2 except Cass, Lake and Marion counties. As with any Indiana business, providers are expected to adhere to the safeguards and guidance contained in the Executive Order. Additional guidance will be forthcoming from BDDS with regard to the re-opening of day service sites.

How can we know that a DSP is practicing social distancing when not at work?

A provider will set expectations for their employees while they are at work. However, there is no manner by which an employer can control someone's behavior when they are not at work. If there are concerns regarding DSPs not practicing social distancing or other recommended precautions while providing support, the provider should be contacted or the IST may choose to convene to problem solve.

As a provider, must I mandate that DSPs wear masks when working with individuals?

Governor Holcomb's [Executive Order 20-26](#) addresses requirements for all businesses and entities in Indiana in item #4 of the order. This includes minimum safeguards including:

- Instituting an employee health screening process;
- Employing enhanced cleaning and disinfecting protocols for the workplace, including regularly cleaning high-touch surfaces;
- Enhancing the ability of employees, customers and clients to wash hands or take other personal hygiene measures such as use of hand sanitizer;
- Complying with social distancing requirements established by the CDC, including maintaining six-foot social distancing for both employees and members of the general public when possible and/or employing other separation measures such as wearing face coverings or using barriers.

Many individuals supported by BDDS are considered high risk with regard to COVID-19. As a result, all staff should wear a mask for the duration of their shift. Hospital/surgical masks are recommended, however if such masks are not available, providers are encouraged to follow CDC ["Strategies for Optimizing the Supply of Facemasks."](#)

Providers must consider this when reviewing their policies around the mandates within the Executive Order. In recognition of the varying needs of individuals supported, ISTs are encouraged to convene if there are outstanding issues or questions related to a particular individual's needs and how they are being addressed as they relate to COVID-19.

Has there been any discussion on the mask mandate and procedures when it comes to people who have a trach who breathes through that trach and not necessarily through their nose or mouth.

The mask mandate allows for exemptions for persons who cannot wear a mask. Please reference [Executive Order 20-37](#). It is recommended that the individual's physician be contacted for further guidance.



Should all providers be wearing a mask now that there is the mandate? This has been very inconsistent between services.

Per [Executive Order 20-37](#), Hoosiers are expected to wear a face covering over the nose and mouth until 8/26/20 when:

- Inside a business, public building, or other indoor place open to the public. This does not extend, however, to private offices, private workspaces or meetings in which six feet of social distancing can be achieved and maintained between people not in the same household;
- In an outdoor public space, wherever it is not feasible to maintain six feet of social distancing from another person not in the same household; or
- Using public transportation or while in a taxi, private car service, or ride-sharing vehicle;

Unless in a private residence or an exemption as indicated in the Executive Order.

Exemptions are included in the Executive Order.

Are all BDDS service providers and case managers considered ‘healthcare workers’ or ‘essential workers’ at this time?

[Executive Order 20-08, paragraph #10](#) identifies that workers providing FSSA and/or Medicaid funded services as being an essential worker.

How can individuals and their residential waiver provider address visitors, daily routines, and agreement on the household’s response to COVID-19 social distancing, isolating recommendations from the Centers for Disease Control and Indiana State Department of Health, as well as the Governor’s executive order declaring a public health emergency?

CIH Waiver housemates (and as applicable, their guardians) are encouraged to discuss household expectations in relation to visitors, and the general coming and going from their home during the COVID-19 implemented recommendations for social distancing or isolating measures practiced as a result of the Governor’s emergency declaration. CIH Waiver housemates are encouraged to include their waiver residential provider and DSP staff in these discussions. Housemates will need to determine their comfort level with imposing restrictions and how this may impact availability and impact to staffing supports. CIH residential settings are to be treated similarly to households of people who do not receive Medicaid waiver services; therefore, it is expected that housemates receive the necessary support and facilitation from their teams to assist in making informed decisions about their risk of exposure to COVID-19. It is strongly encouraged that individuals, case managers, and residential providers are proactively addressing the needs and implementing appropriate preventative measures to prevent the exposure of COVID-19.

If an individual’s employer is open for business and the individual wants to work but the RHS provider is indicating they cannot go to work due to the concern that they could be exposed to COVID-19 at work and possibly bring it home to others, what guidance does the state recommend?

Despite the current public health crisis, all parties should continue to be person centered. The individual needs to be provided information on risks associated with leaving their home and trained on social distancing and other disease mitigating activities. The IST should meet (by phone or virtually) to discuss and find a resolution.



Individualizing practices is certainly important, but many (perhaps most) clients with residential supports live in a congregate setting (whether group home or congregate waiver setting). It may be perfectly appropriate for Client A to go out but that impacts housemates. If it presents too high a risk for housemates, what does the department recommend?

Providers are encouraged to have no blanket restrictions and teams should work together to develop a plan that supports individuals in living their best life.

A local provider says if a consumer goes to a Thanksgiving dinner that includes anyone outside their normal circle of individuals, that the person would have to quarantine for 14 days afterwards, even if no one has any symptoms of COVID, based on LTC facility recommendations. Do we consider waiver homes to be long term care facilities in this instance?

ISTs are encouraged to discuss these situations before the holidays arrive so that everyone is aware of the expectations of all involved.

Day service guidance

When day programs open up, does the consumer have to go back and attend if they are a high risk or their caregiver is high risk? Will their place be held at the day program for a certain period of time?

Individuals in services always have the freedom of choice in the services they choose to utilize and participate in. Teams should work together to develop a transition plan back into services that is appropriate for the individual. It is up to each provider to communicate and determine their policy and practices as it relates to their services.

Should individuals who are out of work (workshop) because their day program closed file for unemployment?

The Department of Workforce Development has developed a COVID-19 page with information and resources that include who is eligible for unemployment insurance benefits. You can find that information by visiting <https://www.in.gov/dwd/19.htm>.

How should we handle concerns related to risk of exposure to COVID-19 in services where families drop off individuals and pick up on a regular basis?

Considerations should be made on an individualized basis regarding participants that are in the high-risk category or those who present other vulnerabilities and individualized adjustments should be made. Implementing the practice of checking the temperature of the individual when they arrive and before their caregiver leaves is recommended. Social distancing and frequent handwashing practices should continue. Participants and staff should be encouraged to stay home when sick. CDC has published guidance for [cleaning/disinfecting your facility](#).

Will the closing of a day services program have any effect on the individual's waiver going forward, since they won't be able to totally use all the funds this year?

An individual's inability to receive all authorized services in a year will not affect their budget for the following year.

Is BQIS considering requiring masks at day services (unless documented by a doctor that individual cannot) to be a blanket restriction?

Per our [previously published guidance](#), providers are expected to develop policy on their COVID response utilizing resources available through the Indiana State Department of Health and the CDC. Additionally, providers need to account for local requirements due to changing conditions in their community.

Individuals, when not prohibited by medical reasons, are encouraged to wear masks when social distancing is not possible. This is a precautionary measure for everyone; not only individuals receiving services.

#MaskUpIndiana

What if Jim, when able to return, refuses to wear the mask? I've got at least two individuals I serve that are convinced this whole thing is a "Democrat hoax" and refuse to go along with any protocols.

ISTs are encouraged to utilize resources available to the individual, such as BMAN, to help prepare an individual for changes related to COVID-19, such as social distancing and wearing a face mask. This includes education, training, and increasing tolerance of wearing a facemask. In addition, if Jim chooses to not wear a mask then the IST should work collaboratively with Jim to find alternate activities that he can participate in.

For those that have sensory issues, respiratory concerns, or are unable to independently remove the mask, does BDDS have suggestions for ways to mitigate risks of exposure? We have focused on outdoor sessions, implementing social distancing, air purifiers in each room, and other solutions, but we were wondering if there are other options we have not explored that BDDS may be aware of?

The Centers for Disease Control and Prevention has information and guidance for direct service providers as well as [considerations for wearing cloth face coverings](#) that may be helpful.

If there is an outbreak or exposure at a day program, how are other providers being notified of the potential exposure?

Per our [previously published guidance](#), providers are expected to have a policy outlining how situations such as exposure to COVID-19 will be addressed. Providers are encouraged to review resources available through the CDC such as ["Businesses and Workplaces | COVID-19 | CDC."](#)

Are day programs required to follow the CDC's guidelines for leaving the area untouched for 24 hours before cleaning?

Per our [previously published guidance](#), providers are expected to have a policy outlining how it will address infection control practices, including actions to take when an individual or staff member presents with symptoms during the course of the day. Providers are encouraged to review CDC guidelines for ["Businesses and Workplaces | COVID-19 | CDC"](#) and develop policy to ensure the health and safety of individuals and staff.



We, as everyone else, are trying to figure out the mask executive order. I interpret it to state that masks are required in public places and only when individuals are outdoors and can socially distance they are not. I was prepared to send out a letter with our workshop consumers to state that they would have to wear a mask unless outside. Others are stating that is not the case that if they can social distance inside they do not have to wear a mask. Staff are wearing mask when consumers are present already—they will just now have to wear them unless they are in their office with the door shut. Also, just to confirm, individuals with disabilities are not exempt—only if there is medical reason would an exemption be considered?

Per [Executive Order 20-37](#), Hoosiers are expected to wear a face covering over the nose and mouth until 8/26/20 when:

- Inside a business, public building, or other indoor place open to the public. This does not extend, however, to private offices, private workspaces or meetings in which six feet of social distancing can be achieved and maintained between people not in the same household;
- In an outdoor public space wherever it is not feasible to maintain six feet of social distancing from another person not in the same household; or
- Using public transportation or while in a taxi, private car service or ride-sharing vehicle;

Unless in a private residence or an exemption as indicated in the Executive Order. Exemptions include any person with a medical condition, mental health condition or disability which prevents wearing a face covering. You can find the full list of exemption in [Executive Order 20-37](#).

Do day habilitation hours roll over from month to month like CHIO and facility hab did or are they specific to the month budgeted like PAC? PAC is on the quarter, isn't it?

The PA length for day habilitation remains the same as it was for CHIO and facility habilitation.

Guidance for visitors

In waiver homes, are there any restrictions from individuals being able to visit with guardians/family inside of the individual's home or being able to go with the guardian/family out within the community?

Individuals are the ultimate decision makers in their life and home. Teams should meet and work together to allow the individual to make an informed choice and determine what supports are necessary and available to them. Using the [“Integrated Supports Conversation Starter”](#) may be helpful as teams work through these types of scenarios. In addition, the team should refer to [“Guidance for BDDS Providers”](#) for specific recommendations on visitors.

For the visitor guidance, is that for just group homes or will there be guidance for waiver settings as well coming out?

The BDDS provider COVID-19 policy guidance, as of 05/21/20, includes guidance for visitors for both SGL and waiver settings.



These “visitor” restrictions continue to be a blanket decision solely by several residential providers. Our emancipated clients are asking to see their therapists, services they have requested, and residential is saying “our restrictions are still in place. We’re thinking about loosening up starting June.” Clients haven’t been allowed out of their homes or to see their therapists for 10 weeks already. There hasn’t been any team discussion.

Providers should work with the individual, their family, case manager, and other team members to identify whether and to what extent to implement restrictions on visitors and/or activities outside of the home based on balancing what is important for the individual relative to their health, their household structure, and related issues with what is important to the individual. These discussions should support the individual in informed decision-making by providing them with information about what is currently permissible under the Executive Order and what risks are represented in those activities.

What are some ways we can keep individuals in services safe, while also keeping provider staff/service providers safe in residential settings where both individuals and staff are leaving the home and coming back?

There are current restrictions for visitors in facilities, including SGLs, or group homes. SGLs and CRMNFs should follow the guidelines established by CMS regarding visitors found at:

<https://www.cms.gov/files/document/3-13-2020-nursing-home-guidance-covid-19.pdf>.

For CIH waiver residential locations, it is recommended that housemates and staff review/train on best practices related to universal precautions and social distancing as well as discussing household expectations for individuals who live in the home and those coming into the home.

For Family Support Waiver family homes, it is up to the family how they would like to address exposure risk and visitors or staff coming and leaving the home.

According to the CDC, households should practice everyday preventive actions to help reduce your risk of getting sick and remind everyone in your home to do the same. These actions are especially important for older adults and people who have severe chronic medical conditions:

- Avoid close contact with people who are sick.
- Stay home when you are sick, except to get medical care.
- Cover your coughs and sneezes with a tissue and throw the tissue in the trash.
- Wash your hands often with soap and water for at least 20 seconds, especially after blowing your nose, coughing, or sneezing; going to the bathroom; and before eating or preparing food.
- If soap and water are not readily available, use an alcohol-based hand sanitizer with at least 60% alcohol. Always wash hands with soap and water if hands are visibly dirty.
- Clean and disinfect frequently touched surfaces and objects (e.g., tables, countertops, light switches, doorknobs, and cabinet handles).
- Launder items, including washable plush toys, as appropriate and in accordance with the manufacturer’s instructions. If possible, launder items using the warmest appropriate water setting for the items and dry items completely. Dirty laundry from an ill person can be washed with other people’s items.



Did you mention when nursing homes will lift visitation restrictions?

The Indiana State Department of Health provides guidance regarding long term care facilities through [2020 Long Term Care Newsletters](#).

I'm working with an individual in which she has two housemates with compromised health, so the provider has stated that the individual cannot have her mother in the home and allows her to see her only outside of her house and just recently has allowed her to see Mom in the community with staff. The provider is not permitting the individual to go home with her mother due to the housemates, even though the team felt that Mom would follow guidelines by wearing mask, etc. Where is the policy that states that there is no blanket policies and is there anything else that could be discussed or done? Mom is not happy about the situation...

Providers are empowered to determine whether and to what extent to apply restrictions similar to those being utilized in nursing facility settings for visitors; attendance at work and/or day program; and other activities (including travel) outside the home on a setting-by-setting basis. This allows appropriate application of restrictions based on the needs and circumstances of the individuals living in the setting. It also helps to avoid the application of blanket restrictions that may be overly broad and restrictive.

In making these determinations, providers should consider the following:

- Individuals residing in the setting should be engaged in discussions related to making these determinations to the greatest extent possible. These settings are their homes and these individuals should have the support, information, and resources needed for them to be an active decision-maker in the discussion.
- If individuals residing in the setting (and/or their families and guardians) do not agree on restrictions on visitors, all individuals' support teams should convene as a group to discuss and make these determinations.
- If the majority of individuals in a setting are in the CDC's [high-risk category](#) (e.g., age 65+ and/or people who have severe underlying medical conditions like heart or lung disease or diabetes), the setting should follow restrictions similar to those being utilized in nursing facility settings: https://www.coronavirus.in.gov/files/IN_COVID-19_LTC_04.29.20.pdf.
- If there are active cases of COVID-19 in the setting (involving staff or individuals), restrictions on visitation should be considered to prevent community spread. In addition, measures should be implemented to mitigate how many homes staff work in to decrease spread across settings. If staff work in a COVID positive home, consider having staff only work in that home. Also, providers should encourage any staff who have additional employment outside your agency to notify their other employers regarding exposure.

Providers have said that they make the final decision if an individual can have a visit. I thought it was a team decision.

Providers should work with the individual, their family, case manager, and other team members to identify whether and to what extent to implement restrictions on visitors and/or activities outside of the home based on balancing what is important for the individual relative to their health, their household structure, and related



issues with what is important to the individual. These discussions should support the individual in informed decision-making by providing them with information about what is currently permissible under the Executive Order and what risks are represented in those activities

Guidance for personal protective equipment

I am a provider of residential hab and need additional PPE. What resources does the state have that can be shared?

Providers may contact the local health department and explain what PPE (masks, gloves, gowns, eye protection) is needed. Providers may explore grant opportunities through local resources, as well as the AWS Foundation and United Way. It is recommended that providers explore community resources such as [Sew and Serve](#), local businesses, churches, community foundations, etc. Providers may also choose to sign up to access supplies through Amazon at: [Medical Supplies – Coronavirus Supplies | Amazon Business](#). Providers may also want to check the following website: [Back On Track Indiana: PPE Marketplace](#). The Indiana Small Business Personal Protective Equipment Marketplace is an additional resource and can be found at: <https://appengine.egov.com/apps/in/ppemarketplace>.

What is the link to the PPE interest form?

Interested providers were asked to complete the [DDRS Provider PPE Interest Form](#) as soon as possible but no later than close of business on Dec. 4th.

Contingency plans

What are the expectations for residential providers to provide backup staff to ensure individuals have needed supports to stay in their homes when the staff for one shift tests positive for COVID? How do we ensure safety and adequate support for individuals with high support needs when this occurs?

- Providers should review the flexibilities outlined in Appendix K to address temporary staffing concerns.
- Case managers are having monthly check-ins with all individuals residing in provider owned or controlled settings and who require 24/7 support. Providers should work with case managers, individuals and families to develop plans for support when traditional staffing or day service options are not available. Providers should communicate early and often with case managers, individuals and families when staffing and/or other typical support options are not available. BDDS has developed a Rapid Response toolkit for teams to develop alternate plans for if or when staff are unavailable due to COVID-19. This toolkit is located on the [COVID-19 guidance for DDRS stakeholders web page](#).
- In partnership with the Indiana Department of Health and the Bowen Center for Health Workforce Research and Policy, DDRS/BDDS has added congregate residential direct support needs in the Call to Action for Hoosier Healthcare Heroes and the newly launched Students Rise Up 2 Serve. If you are experiencing a COVID-19 related workforce need of an urgent nature, you are encouraged to complete the Indiana COVID-19 Reserve Workforce Needs Request Form [Indiana COVID-19 Reserve Workforce Needs Request Form](#).



Upon receipt of your completed form, the Bowen Center team will identify whether there are any healthcare reservists or students that match your request using an established process.

- Providers should have an emergency/crisis plan in place to assist in addressing staffing concerns. As you continue to review and update your emergency / crisis plan, you may find a new training from the Federal Emergency Management Agency, called [Organizations Preparing for Emergency Needs](#), useful. It is available as both a web-based, self-guided training, and a downloadable instructor kit that will guide participants on how to identify risks, locate resources, and take preparedness actions.

I have completed my first rapid response conversation regarding one of my individuals. The brother is willing to have the individual come stay with him if needed but the brother lives in an adjacent state. The brother works and would need services to assist with care during his working hours. Does the waiver cover services provided in this situation?

Appendix K flexibilities allow for telehealth services which may be appropriate in this situation. In addition, the [“DDRS Policy: Reimbursement of out-of-state home- and community-based waiver services policy”](#) outlines situations where a provider can be reimbursed for the provision of services outside of Indiana.

Are CMs to have these conversations with FSW families also?

Case managers are to complete the COVID-19 Rapid Response Check-in with all individuals in provider owned or controlled settings and those who require 24/7 supports.

Policy changes applying to all BDDS programs

Do you have any guidance on extended services support for individuals working in the community?

Guidance for extended services is included in our [“Updated Guidance for BDDS Providers on Temporary Policies Changes Related to COVID-19”](#) and Appendix K and in our [“Updated FAQ on COVID-19 Policy Changes.”](#)

Additional COVID-19 guidance from BDDS can be found on the [DDRS COVID-19 webpage](#). BDDS encourages stakeholders to follow the recommendations of the [Indiana State Department of Health](#) and the [Centers for Disease Control and Prevention](#).

What should a provider do if an individual being supported does not understand the importance of social distancing and aggressively invades the space of others when that individual is COVID-19 positive?

IST’s are encouraged to meet (by phone or virtually) early and often to ensure plans are in place to address the needs of those supported. Teams should work proactively on educating and modeling proper social distancing and exploring options to address each individual’s situation. If the individual has behavior support services, the BC would be an integral part of addressing these issues. Teams may find these resources helpful:

- [“COVID-19 Information by and for People with Disabilities”](#)
- [“IIDC Social Narratives”](#)
- [“DSP Toolkit”](#)
- [“Hands in Autism Social Narratives on COVID-19 and Staying Healthy”](#)



Do you have suggestions for providers with clients who are high behavior and test positive and will not isolate in their rooms? Our concern is that putting them in a hotel may not help with containing and then we have to be able to provide 24/7 for the client in the hotel. Which is another concern as staffing is already delicate.

Teams should work together to build in strategies and supports that ensure everyone's safety and well-being. Working closely with and/or bringing in behavior consultants to identify and adapt specific approaches that have been successful with the individual should be explored. Approaches the team can consider includes but are not limited to: social narratives, visual schedules, sensory activities, communication strategies, opportunities for movement/physical exercise, anxiety reducing activities, and/or activities for entertainment.

What is the status of EVV policy updates?

Recently, IHCP announced EVV policy updates, which are available here:

<http://provider.indianamedicaid.com/ihcp/Bulletins/BT202060.pdf>. In addition to important policy updates, the bulletin includes additional training opportunities related to the state-sponsored Sandata solution. It is important to note that the implementation date for requiring use of an EVV system for personal care services is Jan. 1, 2021. Providers are strongly encouraged to continue taking steps now to be ready by January. If they have not done so already, providers need to determine whether they would like to utilize the state's EVV solution, Sandata, or an alternative EVV solution. For more information, please visit <https://www.in.gov/medicaid/providers/1005.htm>.

Do BDDS providers have statutory immunity from civil liability during the public health emergency as outlined in ISDH's "Guidance Concerning Liability and Health Care Facilities" (April 3, 2020)?

For HCBS providers and staff, whether they may have immunity from civil liability for care provided in response to the public health emergency created by COVID-19 depends on whether the health care services are provided by a licensed professional. For ICF/IDDs, facilities may be protected to the extent that the health care services are provided by professional licensed providers in response to and during the COVID-19 emergency declaration. This response does not constitute legal advice. Individuals and facilities are encouraged consult independent legal counsel and/or the appropriate licensing authority regarding questions about their licensure and liability.

How can individualized support teams address quarantine needs for individuals who may now need additional supports?

For individuals receiving support on the Family Supports Waiver: In-home quarantine measures should be implemented based on the individualized needs of the individual in their family home or residence. Teams may need to discuss interruptions to routines or services for a period of time, and develop alternate means or ways to get an individual's needs met while in quarantine. Additional information on in-home isolation can be found at <https://www.cdc.gov/coronavirus/2019-ncov/if-you-are-sick/care-for-someone.html>.

For individuals receiving support on the Community Integration and Habilitation Waiver: In-home quarantine measures should be implemented based on the individualized needs of the individual in their home or residence. Short-term changes to service needs may be addressed via a budget modification request, as appropriate.



For SGLs/ICFs: Recommended controls for institutional settings can be found at:

<https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spread-in-long-term-care-facilities.html>.

If person is admitted to nursing home for rehab after a hospital stay, does CM interrupt waiver?

Yes, if a person is admitted to a nursing facility, the waiver should be interrupted.

Modifications to direct support professional qualifications and requirements

Is the TB test extension for waiver and group home staff?

The extension applies to DSPs in waiver and group homes.

Please clarify rules around TB testing for DSPs working in ICF's and HCBS waiver settings.

BDDS has temporarily waived the requirement for a provider to conduct a tuberculosis test on potential staff prior to hire. BDDS instead requires that new staff and existing staff whose annual screening is due shall be screened for tuberculosis within one hundred and eighty (180) days of hire and/or the expiration of their annual screening.

For DSPs working in HCBS waiver settings, the requirement for TB testing is a negative tuberculosis screening prior to providing services and updated in accordance with [recommendations of Centers for Disease Control](#) as outlined in [460 IAC 6-15-2, Maintenance of personnel files](#). The requirement for DSPs working in ICF's is prior to assuming residential job duties and annually thereafter. [460 IAC 9-3-3, Facility staffing](#).

Many places are still not allowing TB tests to be performed. If someone is coming due and have already received the 180-day extension, what are our options as a provider?

BDDS will temporarily waive the requirement for a provider to conduct a tuberculosis test on potential staff prior to hire. BDDS will instead require that new staff and existing staff whose annual screening is due shall be screened for tuberculosis within one hundred and eighty (180) days of hire and/or the expiration of their annual screening. Providers should contact their local health department for assistance in exploring options in your area to obtain the test.

What is the timeline for DSPs to complete all required training under the current modifications allowed by Appendix K?

BDDS has temporarily waived the requirement that direct care staff complete the list of training detailed in 460 IAC 6-14-4 and 460 IAC 6-15-2 prior to working with participants. Instead, training requirements for direct care staff that must be completed prior to working with participants include the following:

- Individual specific (risk plans, behavior plans, modified diets, lifting, etc.)
- Infection control
- Signs and symptoms of medical issues
- Medication administration (if DSP will be administering medication)
- Cardiopulmonary resuscitation/Choking: Heimlich Maneuver

- Individual rights/abuse, neglect, exploitation/incident reporting
- Emergency procedures/on-call support
- Crisis intervention/de-escalation (if DSP will support an individual with a known history of challenging behaviors)

The temporary essential training will be authorized only while the Executive Order remains in effect, plus any additional time afterward that FSSA deems necessary to facilitate providers' orderly resumption of normal staffing. Providers have 60 calendar days from the date of hire for DSPs to complete the remaining required trainings as outlined in 460.

These training requirements can be met if staff can provide:

- Documentation that they were employed by another BDDS approved provider within the last six (6) months; and
- Documentation from that BDDS approved provider for each training topic satisfactorily completed by the staff.

For additional details and guidance, please review the Temporary DSP Essential Training outline.

Is there a waiver for staff who need a three-year follow-up county check?

Not at this time.

Are staff required to have first aid and CPR?

BDDS will continue to accept documentation of successfully completed cardio-pulmonary resuscitation and/or First Aid. In addition, BDDS will temporarily allow DSPs to continue working ninety (90) days past the expiration of their CPR/First Aid. The hands-on component of training is not required. DSPs completing CPR certification during COVID will need to complete the hands-on component, when it is safe and appropriate to do so.

As part of the temporary policy changes related to COVID-19, only the online CPR/First Aid portion is required before the first day of work. The hands-on component of training is not required but will need to be completed when it is safe and appropriate to do so.

Use of telemedicine to support service delivery

Are there any updates on extending telehealth past August 31? (We are a behavioral support and music therapy provider.)

The Appendix K flexibilities are updated and many original flexibilities are extended to Feb. 28, 2021 (including the flexibilities around telemedicine).

Any updates on telemedicine approval timelines?

The Appendix K flexibilities are updated and many original flexibilities are extended to Feb. 28, 2021, (including the flexibilities around telemedicine).

Are there any resources available to help families secure technology necessary to more fully participate in telehealth or virtual activities they may need until provider agencies and community supports open?

Case managers and providers can contact statewide organizations such as 211, Self-Advocates of Indiana or The Arc of Indiana to find national, state and local resources that may be available. First Steps has developed a [resource guide for COVID-19](#) that includes phone and data carriers who may be providing some assistance. Many technology resources may have been available for a limited time or with limited availability therefore you should work directly with any resource provided for the most current information and availability.

Can CHIO be provided via telemedicine?

CHIO could be provided via telemedicine, in limited situations, as a last resort. The Office of Medicaid Policy and Planning has issued guidance permitting broad use of telemedicine to support service delivery, highlights include:

- Appropriate consent from the member must be obtained by the provider prior to delivering services.
- Documentation must be maintained by the provider to substantiate the services provided and that consent was obtained.
- Documentation must indicate that the services were rendered via telemedicine, clearly identify the location of the provider and the individual, and be available for post-payment review.
- The provider and/or individual may be located in their home(s) during the time of these services.
- Telemedicine services may be provided using any technology that allows for real-time, interactive consultation between the provider and the individual.
- This includes, but is not limited to, the use of computers, phones, or television monitors. This policy includes voice-only communication, but does not include the use of non-voice communication such as emails or text messages.

Under this guidance, the following home- and community-based services, when appropriate, should be explored and utilized as telemedicine options:

- Case management
- Behavior management
- Therapies, including PT, OT, speech, psychological, music and recreational
- Extended services
- Wellness coordination
- Family and caregiver training

For all other HCBS services, such as CHIO, telemedicine should be a last resort option, only with individuals who need only verbal prompting and guidance, and must relate to an individualized need or interest. When utilized, some element of the underlying service definition must be provided and documented.

We serve individuals who live in their family home and some of the parents aren't allowing staff to come to the home to provide services in order to protect their high risk loved one from possible exposure to COVID-19. What options should the team explore to address the individuals support needs?

The Office of Medicaid Policy and Planning has issued guidance permitting broad use of telemedicine to support service delivery. The following Home and Community Based Services, when appropriate, should be explored and utilized as telemedicine options: Case management, behavior management, therapies (speech, occupational, physical, psychological, music and recreational), extended services, wellness coordination, and family and caregiver training.

For other HCBS services, telemedicine should be a last resort option, only with individuals who need only verbal prompting and guidance, and must relate to an individualized need or interest. When utilized, some element of the underlying service definition must be provided and documented.

ISTs are encouraged to utilize tools such as the [Integrated Supports Star](#) to identify other appropriate alternatives that are available to support the individual including other HCBS services, natural supports, technology, etc.

Appendix K states: “For all other HCBS services, telemedicine should be a last resort option, only with individuals who need only verbal prompting and guidance, and must relate to an individualized need or interest. When utilized, some element of the underlying service definition must be provided and documented.” What is considered a last resort? If staff or the consumer doesn’t feel comfortable with services being delivered face- to-face, even though staff nor consumer have been confirmed to be exposed to COVID-19, would this be an allowable reason for virtual PAC or RH services?

Case Management, Behavior Management, Therapies (speech, occupational, physical, psychological, music, and recreational), Extended Services, Wellness Coordination and Family and Caregiver Training can be utilized and delivered via the telemedicine option. For other HCBS services, such as RHS and PAC, telemedicine should be a last resort option. RHS and PAC should only be delivered via telemedicine with individuals who need only verbal prompting and guidance, and it must relate to an individualized need or interest. When utilized, some element of the underlying service definition must be provided and documented. A last resort is when there is no other option available.

Are video chat and phone calls acceptable for billable time?

For information on the delivery of telemedicine services, providers are encouraged to refer to [IHCP Bulletin BT202022](#) issued on March 19 for additional details on billing and documentation requirements and [IHP Bulletin BT202034](#) issued on April 2 addressing frequently asked questions.

Can you talk about PAC services? Can we do telehealth for under stay-at-home orders or for those that don’t want to meet in person?

DSP’s are considered essential staff and can continue to provide services even during a stay at home order. The provision of PAC services via telemedicine should be a last resort option only with individuals who need only verbal prompting and guidance, and must relate to an individualized need or interest. When utilized, some element of the underlying service definition must be provided and documented.

Will there be fact sheets for the other services? PAC?

Additional fact sheets on other HCBS services are forthcoming.

Can the fact sheets about the CIH and FSW waiver be in Spanish as well?



The fact sheets are currently available in English, Spanish and Burmese.

Can adult day services be provided via telemedicine?

This service may be provided via telemedicine as a last resort option, only with individuals who need only verbal prompting and guidance, and must relate to an individualized need or interest. When utilized, some element of the underlying service definition must be provided and documented.

Electronic monitoring (also known as remote supports) remains available on the CIH waiver and should be explored as an alternative option, as appropriate.

How is the delivery of behavior management and billing different as it relates to the approval of telemedicine for the delivery of this service? We have traditionally billed for various modes of communication with teams. Is this still allowable?

The recent approval of telemedicine options via the [IHCP Bulletin BT202022](#) allows for direct service delivery via telemedicine. For Behavior Support services, this is related to the component of the service related to the monitoring, training, education, demonstration, support, etc., that is provided directly to the participant receiving the service, not the secondary communications taking place with other team members or other associated activities. Those direct, face to face activities were not previously approved to be delivered via telemedicine.

The PCISP and/or CCB does NOT need to be updated in order to deliver services via telemedicine. The key issue is to ensure documentation is consistent with OMPP and BDDS guidance.

To view the Office of Medicaid Policy and Procedure webinars on telemedicine and other topics, please visit <https://www.in.gov/medicaid/providers/1014.htm>.

Can RHS, PAC and CHIO be provided via telemedicine if the participant only needs verbal prompts?

The recent approval of telemedicine options via the [IHCP Bulletin BT202022](#) allows for direct service delivery via telemedicine. For RHS, PAC and CHIO, telemedicine should be a last resort option, only with individuals who need only verbal prompting and guidance, and must relate to an individualized need or interest. When utilized, some element of the underlying service definition must be provided and documented.

Electronic monitoring (also known as remote supports) remains available on the CIH waiver and should be explored as an alternative option, as appropriate.

The PCISP and/or CCB does NOT need to be updated in order to deliver services via telemedicine. The key issue is to ensure documentation is consistent with OMPP and BDDS guidance.

To view the Office of Medicaid Policy and Procedure webinars on telemedicine and other topics, please visit <https://www.in.gov/medicaid/providers/1014.htm>.

Is consent required for QIDP visits in residential settings if they are done virtually?

Yes, any service (or element of a service) delivered via telemedicine requires the individual's consent.

What happens if you don't receive signed signature pages back after a telemedicine meeting?

Appropriate consent from the individual must be obtained by the provider prior to delivering services. Consent for receiving a service through telemedicine and the location of the individual should both be documented.

Consent may be received verbally or by electronic signature, and should be documented as such. Uploading the visit documents with the claim is not required. Providers are encouraged to refer to [IHCP Bulletin BT202022](#).

In utilization of telemedicine/remote service delivery options for case management, can phone meetings be recorded?

It is not necessary for the telemedicine delivery portion of case management be recorded phone calls. BDDS is not recommending recorded calls at this time.

What changes are being made to the delivery of case management contacts and billing as it relates to the approval of telemedicine for the delivery of this service? Do all contacts need to be made virtually for this service to now be billable each month?

The utilization of telemedicine for case management is specifically related to completion of the face-to-face requirements of this service. It is not expected that every billable case management activity include a virtual component. To view the Office of Medicaid Policy and Procedure webinars on telemedicine and other topics, please visit <https://www.in.gov/medicaid/providers/1014.htm>.

What if a provider like BMAN or MUTH has told family that only virtual is allowable per their company, if client is unable to wear mask or social distance?

All providers are responsible for sharing their COVID-related policies and procedures with the individual, family and team. In planning visits, consider alternating modes of delivery (i.e. one virtual, next in person) and using alternative service locations (i.e. the park or front porch). During the visit, practice social distancing when possible. When appropriate, stay in one area of home and be mindful of the surfaces and objects touched. Other services should only be delivered in day programs or large group settings when warranted to address health and safety concerns or when no other option is available (i.e. case manager should not conduct visits at a day program when a home visit is possible). Congregate residential settings should document all team members and visitors who come in and out of the home and the dates present in order to notify them of possible exposure, if an individual or staff in the home is identified as COVID positive or presumed positive.

Teams should continue to be person-centered in deciding how to deliver services and should utilize the team process when there are concerns regarding service delivery.

Some telehealth has been provided due to COVID precautions especially due to singing being labeled as a super-spreading activity and therefore something like Music Therapy groups haven't been provided due to safety issues. This has been able to be provided through telehealth, but your slide says that it should be at the request of the family. Where is the line between a responsible facilitation of services and choice?

All waiver providers should continue to be person-centered in deciding how to deliver services and should utilize the team process when there are concerns regarding service delivery. Wearing a face mask or face covering and maintaining 6 feet away are advised by the CDC and ISDH as appropriate precautions in the spread of COVID-19. In addition, the [American Music Therapy Association](#) offers information and considerations for music therapists that include instrument cleaning and delivery of music therapy in person. All providers are responsible for sharing their COVID related policies and procedures with the individual, family and team. In planning visits, consider alternating modes of delivery (i.e. one virtual, next in person) and using alternative service locations (i.e. the park or front porch). During the visit, practice social distancing when



possible. When appropriate, stay in one area of home and be mindful of the surfaces and objects touched. Services should only be delivered in day programs or large group settings when warranted to address health and safety concerns or when no other option is available.

I'm wondering what the regulations are for if a therapist can provide telehealth services while she is out of state and the client remains in Indiana?

Appendix K allows for the use of telemedicine for several services within the waivers. Providers of these services are essential workers therefore when necessary and when typical precautions can be observed, appropriate face to face meetings should occur. The delivery of these services via telemedicine should be at the direction and request of the individual and/or guardian. Providers should contact the Indiana Professional Licensing Agency with specific questions on the requirements and responsibilities related to their licensure.

Please advise us for situations in which providing in-person supports is contra-indicated based on health status of the person supported who is choosing in-person supports over tele-medicine even though they are for example, COVID-19 positive, in quarantine due to exposure, or the person is not able to wear a mask to protect their service provider.

[“CDC Guidance: What to Do If You Are Sick”](#) provides information to share with the individual indicating if a person is COVID-19 positive or may have COVID-19, they should:

- Stay home except to get medical care
- Separate themselves from other people
- Monitor symptoms
- Call ahead before visiting their doctor
- If sick, wear a mask over their nose and mouth
- Cover coughs and sneezes
- Clean hands often
- Avoid sharing personal household items
- Clean all “high-touch” surfaces everyday

[“CDC Guidance on When You Can be Around Others After You Had or Likely Had COVID-19”](#) offers guidance on when the individual can be around others.

If the individual is unable to wear a mask once they are out of quarantine, the team should explore providing services in an outdoor setting that allows for social distancing.

Our organization is navigating the guidance to ask for consent for telemedicine before each meeting. We would like to understand what we do if someone says they want in person supports but they have recently been in direct contact with someone who has tested positive for COVID-19? What if the person is displaying symptoms? What if the staff member is in a high-risk group? We want to make sure that choice is offered, but we do worry that we will run into several incidents where our employee's health and the person's choice may be at odds.



[“CDC Guidance: What to Do If You Are Sick”](#) provides information to share with the individual indicating if a person is COVID-19 positive or may have COVID-19, they should:

- Stay home except to get medical care
- Separate themselves from other people
- Monitor symptoms
- Call ahead before visiting their doctor
- If sick, wear a mask over their nose and mouth
- Cover coughs and sneezes
- Clean hands often
- Avoid sharing personal household items
- Clean all “high-touch” surfaces every day

All team members are encouraged to take the appropriate precautions to protect themselves and each other. This includes social distancing, wearing face coverings, and good hand hygiene.

If the staff person is in a high-risk group, the provider should discuss with the individual the option of utilizing another staff person that is able to provide in-person supports once the individual supported has been symptom free for 14 days or tested negative for COVID-19. If the provider does not have another staff to provide the in-person supports, this should be communicated to the individual and team and the case manager should offer the individual the choice to select another provider that can provide in-person supports.

Can you please re-emphasize that case managers must reflect in the case notes that a consumer/guardian has requested a virtual meeting... it should not be a CM’s decision to blanketly do virtual meetings for everyone on their caseload.

Case management, when appropriate during the public health emergency and at the request of the individual and/or legal guardian, could be explored and utilized as telemedicine option. Case managers are essential workers therefore when necessary and when typical precautions can be observed, appropriate face-to-face meetings should occur. The delivery of these services via telemedicine should be at the direction and request of the individual and/or guardian and case managers should document the individual/family desire for a virtual meeting in a case note.

I have heard from some providers, such as MUTH or BMAN that their company policy is only to offer virtual at this time. How should CMs address this?

The following Home and Community Based services, when appropriate during the public health emergency and at the request of the individual and/or legal guardian, could be explored and utilized as telemedicine options:

- Case management
- Behavior management
- Therapies, including PT, OT, speech, psychological, music and recreational
- Extended services



- Wellness coordination
- Family and caregiver training

Providers of these services are essential workers therefore when necessary and when typical precautions can be observed, appropriate face-to-face meetings should occur. The delivery of these services via telemedicine should be at the direction and request of the individual and/or guardian.

I want to understand the piece about people needing to request services via telehealth. It seemed like you clarified that this is only if all health and safety guidance can be followed? We are concerned about putting our employees into risky situations as well as those we support.

The following home- and community-based services, when appropriate during the public health emergency and at the request of the individual and/or legal guardian, could be explored and utilized as telemedicine options:

- Case management
- Behavior management
- Therapies, including PT, OT, speech, psychological, music and recreational
- Extended services
- Wellness coordination
- Family and caregiver training

Providers of these services are essential workers; therefore, when necessary and when typical precautions can be observed, appropriate face-to-face meetings should occur. The delivery of these services via telemedicine should be at the direction and request of the individual and/or guardian.

I am still left feeling a little confused about which services telemedicine will be approved for in the new Appendix K flexibilities. Is this all services? Does MUTH fall into this?

Under this guidance, the following home- and community-based services, when appropriate during the public health emergency and at the request of the individual and/or legal guardian, could be explored and utilized as telemedicine options:

- Case management
- Behavior management
- Therapies, including PT, OT, speech, psychological, music and recreational
- Extended services
- Wellness coordination
- Family and caregiver training

Providers of these services are essential workers therefore when necessary and when typical precautions can be observed, appropriate face-to-face meetings should occur. The delivery of these services via telemedicine should be at the direction and request of the individual and/or guardian.

The PCISP and/or CCB DOES NOT need to be updated in order to deliver services via telemedicine. The key issue is to ensure documentation is consistent with OMPP and BDDS guidance.



If a person has health diagnoses that put them at higher risk for serious illness for COVID-19, and the person wants in-person supports, should the team discuss whether there is IST agreement that in-person supports can occur and if the benefits of in-person services outweigh the risk to the person's health?

The team should ensure that the individual has all the information necessary to make an informed choice. It is up to the individual to determine what risks they are willing to take and how they would like their services to be delivered. Teams should ensure that the individual and any in person supports have the proper PPE available to them as well as practice social distancing and frequent hand washing. Telemedicine options are available if and when the individual requests them.

When we do have a staff member with medical conditions that place them at high medical risk as it relates to COVID, we are working with people and their ISTs to ensure telehealth is still a viable option. Or we will be offering other alternative staff if possible. Can you please clarify the documentation required for offering telehealth to a person? For instance, can a provider work with a person to identify a timeframe where telehealth will still be the way services are provided? Or does that actually need to be asked before every single appointment.

The Office of Medicaid Policy and Planning has issued guidance permitting broad use of telemedicine to support service delivery, highlights include:

- Appropriate consent from the member must be obtained by the provider prior to delivering services.
- Documentation must be maintained by the provider to substantiate the services provided and that consent was obtained.
- Documentation must indicate that the services were rendered via telemedicine, clearly identify the location of the provider and individual, and be available for post-payment review.
- The provider and/or individual may be located in their home(s) during the time of these services.
- Telemedicine services may be provided using any technology that allows for real-time, interactive consultation between the provider and the individual.
- This includes, but is not limited to, the use of computers, phones, or television monitors. This policy includes voice-only communication, but does not include the use of non-voice communication such as emails or text messages.
- At this time, CoreMMIS does NOT allow modifier GT to be billed with HCBS claims. That does not mean HCBS providers cannot provide services via telemedicine. Rather, providers will need to record the service was performed via telemedicine in the individual or providers' record.

Providers are encouraged to refer to IHCP Bulletin BT202022, issued on March 19, for additional details. In addition, providers should utilize updated guidance from the Office of Civil Rights regarding HIPAA compliant telemedicine options available here: <https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telemedicine/index.html>.

To view OMPP webinars on telemedicine and other topics, please visit <https://www.in.gov/medicaid/providers/1014.htm>.



Hoping to clarify: if say, a behavior consultant is pregnant and her doctor says she should avoid in-person services for the first trimester. If the team discusses this and the person is okay with telemedicine even though he would prefer in-person, he does not want to choose another BMAN provider and will do telemedicine with the current BC. Is this acceptable?

The case manager should clearly document that the service is being delivered via telemedicine at the request of the individual. Documentation should include the IST's discussion around ensuring the individual was informed of all options, including telemedicine, a new BC and a new BMAN provider.

To make it clear, wellness can be done via telemedicine if that is what the individual/guardian would choose?

Appendix K flexibilities allow for wellness coordination to be utilized as telemedicine option through Feb. 28, 2021.

Can clients in a day program who cannot tolerate a mask and social distancing have virtual day programming?

Day habilitation may be delivered via telemedicine but this should be a last resort option, only with individuals who need only verbal prompting and guidance, and must relate to an individualized need or interest. When utilized, some element of the underlying service definition must be provided and documented.

Lack of response from families regarding services. I have some clients who declined telemedicine services and have not responded to messages about in-home, even when they are provided with both options. Please advise what a provider should do if they do not get a response from families regarding receiving services via telemedicine.

Individuals and guardians may choose not to receive services during this time. However, it is recommended that the case manager be notified and make contact with the individual and family to ensure that they have all the necessary information to make an informed decision.

Are we still able to do telehealth for wellness coordination?

Per the current Appendix K, the following home- and community-based services, when appropriate, should be explored and utilized as telemedicine options:

- Case management
- Behavior management
- Therapies, including PT, OT, speech, psychological, music and recreational
- Extended services
- Wellness coordination
- Family and caregiver training

If a guardian requests a virtual meeting due to COVID concerns and the case manager refuses to meet virtually and mandates that the team meets in person, what can the guardian do?



The guardian's request should be honored, and the team should meet virtually. If any team member has a concern that an in-person meeting is more appropriate for any reason, the IST can discuss the concern at the virtual meeting and schedule an in-person meeting if determined appropriate and if the guardian is in agreement.

Can individual or guardian deny a face-to-face visit from CM—even if social distancing is being followed?

Yes, the decision to meet virtually or face-to-face is that of the individual and guardian. If the CM believes an in-person contact is needed, the IST can discuss at a team meeting.

Living Well

Is there training for parents/families/guardians on the Living Well system/process? Being person-centered and person-driven?

Living Well is a grant that Indiana has received to increase quality of life outcomes for individuals with I/DD. Part of the Living Well grant focuses on developing trainings and resources for self-advocates and families that empower them to make decisions to live their best life. As those trainings and resources become available BDDS/BQIS will share that information. In the meantime, families can visit [Charting the LifeCourse](#) to find videos, tools and resources that will help them organize their ideas, vision and goals as well problem solve, navigate and advocate for supports.

Trajectory toward living well—many of the people we work with do not really know what they want for their “good life,” making it difficult for them to be the primary driver. It is hard to make choices when you don’t know what your choices are. Any suggestions on how to address this? Thank you.

It is all about the conversation! BDDS recommends that teams utilize the [LifeCourse Framework](#) philosophy and related tools to assist individuals in defining and achieving their good life. On the website you will find several resources that can assist individuals to develop their vision of a good life. The vision planning tool allows for individuals to explore each life domain with prompting questions that can narrow down what they want for their daily life, job, social experiences, etc.

The Life Experiences series is broken down by life stage where the team can talk through what may be happening during this stage of life and help you explore ideas for experiences. Individuals sometimes need supports that address all areas of their lives. Support provided by the IST, as well as friends and family, can include discovery and navigation which could include providing opportunities for an individual to try new activities, go new places, etc., to help them know more about the different choices and options they have. Support may also be in the form of connecting and networking perhaps via peer support.

Not every individual will be able or willing to be the “primary driver” right away but that should always be the goal for the team. The team should walk alongside the individual in his journey toward becoming the ‘primary driver’ and the focus should consistently be on the individual and what is important to and for him on his journey toward his good life.

Sheltered Workshop

Can you please clarify the decision to stop reimbursing for sheltered workshops, effective 8/14/20? Does this mean that these workshops will be closing and PV10 will no longer be a service offered through the waiver?

DDRS eliminated the state funded programs of caregiver support and community- and facility-based sheltered work effective 8/14/20 due to budgetary constraints. DDRS has granted an extension until **Friday, Sept. 18, 2020**. DDRS is not closing sheltered workshops and no waiver services are affected by this change.

Do most of those 260 clients losing state line workshop funds have a waiver?

Yes, all but one person impacted by this change has a waiver.

Policy changes applying to CIH and FSW

Is there any possibility that Appendix K will be extended beyond 8/31/20?

The Appendix K flexibilities are updated and many original flexibilities are extended to Feb. 28, 2021 (including the flexibilities around telemedicine).

In one of the first provider webinars for COVID-19 info, it was stated that there would be a transition period of 60 days after Appendix K ended in which Appendix K flexibilities could still be utilized while transitioning back to the new “normal” of service provision. We have clients and therapists who most likely will not be able to return to in-person services in September due to high-risk for COVID-19. If telehealth approval is not extended, is August 31 currently the hard end date of Appendix K flexibilities (telehealth)? Or will there be a 60-day transition period following the August 31 end date which would allow for telehealth to continue through October 30?

BDDS recognizes the need for a transition period when the flexibilities adopted due to the pandemic come to an end. As this time approaches, additional guidance will be given on the length of the transition period.

Do providers need to wait for Appendix K’s approval, to begin to put the temporary amendments to services into place?

Providers may implement any of the temporary changes for which guidance has been provided to date which can be found at <https://www.in.gov/fssa/ddrs/5762.htm> .

With the Appendix K, does this stop the Waiver Renewal changes (AISP blended into ongoing CM rate) on hold? Can Case Managers continue to add AISP to CCBs and bill for it?

In order to minimize confusion between Appendix K amendments and the Waiver Renewals (set to be effective in April 2020), BDDS requested and received approval for an extension of the current FSW and CIH Waiver through July 16, 2020.

Case managers can continue to utilize AISP through the extension.



What, if anything, is being considered for individuals on the FSW that are needing services provided in the family home, keeping in mind that their budgets do not support 1:1 ratio services (their current budgets are only able to accommodate larger group FHG/PV ratios) and their plans are exhausted?

ISTs are encouraged to meet (by phone or virtually) to discuss the array of service options in addition to those supports that may be available through state plan Medicaid\Medicaid PA. IST's are also encouraged to discuss the temporary flexibilities allowed under Appendix K.

I have a mom and dad that were diagnosed with COVID, but my client has not been tested, nor shows any signs/symptoms. Should she be tested? She is 16 years of age?

It is recommended that the parents contact their child's primary care physician to discuss.

Guidance for case managers

Are CMs going to be able to do face-to-face meetings in July?

BDDS has not restricted any provider, including case managers, from providing face to face services. However, delivery of case management via telemedicine is an option to allow for virtual meetings, assuming the individual agrees. This option is available through Feb. 28, 2021. Providers and case management companies are encouraged to have no blanket restrictions, which include the delivery of face-to-face meeting. Teams should work together to develop a plan that supports individuals in living their best life.

How do case managers handle unannounced visit that are showing up on our portal?

BDDS is not currently monitoring strict timelines for various processes. Case managers are encouraged to refer to the document, "[Provision for Case Management During COVID-19](#)" with any questions.

Is there an idea when case managers will begin doing in person meetings?

Per [Executive Order 20-08](#), all HCBS providers—including case managers—are essential workers. As such, BDDS has not placed restrictions on case managers doing in person meetings. While flexibilities to use telehealth for meetings may be used, it is up the IST to discuss how to safely conduct in-person contacts for case managers and other service providers, as needed or desired by the individual.

If a family has reservations about CMs coming into the home how should those situations be handled?

ISTs should come together to develop a plan to safely resume in person contacts while acknowledging any anxieties the families may have about what might happen. IST's may continue to meet telephonically or virtually to discuss concerns and address measures to be taken prior to meeting in person. These can include agreeing to outside meetings, developing a visitor protocol, and identifying needed supplies to ensure the safety of all involved.

Who do parents contact if they want to go straight to the source?

All information on BDDS COVID-19 policy and practices can be accessed at <https://www.in.gov/fssa/ddrs/5762.htm>. Persons with questions or concerns about BDDS policies and practices can reach out to their district BDDS office or email BDDSinfo@fssa.in.gov.



A RHS provider has asked CM to update CCB/Service Plan. There are three clients in the home; CM serves two with more than 24 hours to cover the home with all three. One staff has been providing services. The provider has requested that I change the FHIO and CHIO to FHG. My clients currently have FHG hours with the same provider. Does any change need to be made?

The IST should convene (virtually or telephonically) to discuss the current needs and wishes of the individual. No changes in an individual's services should be made without the individual's consent. ISTs are encouraged to be person centered which is particularly important in times of crisis.

How are EICs to be completed for transitions during social isolating?

EICs may be completed virtually utilizing real time face to face means. If this is not possible, the case manager should discuss the items on the EIC with the residential provider and document the responses in case notes. The case manager should visit the site as soon as possible to verify the information provided by the residential provider.

At this time, how are case managers to proceed with transition process in regard to meetings and the EIC? Can team meetings be held virtually for transition meetings if requested by the individual/family/guardian? Can team meeting be virtual and CM meet with just the individual/family/guardian face to face to discuss transition? Can the EIC be conducted virtually using Facetime, Zoom or other platforms, or should they now be done in person?

The determination of whether these activities should be done in-person or virtually should be based on the needs of the individual. Case managers are considered essential workers and are able to complete these activities on an in-person basis.

EICs may be completed virtually utilizing real time face-to-face means. If this is not possible, the case manager should discuss the items on the EIC with the residential provider and document the responses in case notes. The case manager should visit the site as soon as possible to verify the information provided by the residential provider.

If we submit an emergency transition because an individual has moved homes due to staffing and is there longer than seven days, what do we do when a regular transition is started automatically after closing emergency transition?

When the individual is visiting a new residential setting due to a COVID-19 related issue (quarantine, staffing, COVID-19 positive housemate), the case manager is not required to submit an emergency transition immediately. The case manager is required to make a case note indicating where the individual is visiting. If the individual is at the new location for more than seven days, an emergency transition should be submitted. Once the emergency transition is approved by BDDS, case managers are to enter the actual transition date but should NOT close the transition until the individual returns home. At that time, the responses to the closing questions should indicate the individual returned home. If a regular transition is started prior to the individual returning home and the individual still plans to return home, the regular transition can be canceled.

What guidance does BDDS have for resuming in-person IST meetings and what PPE should be used when attending in-person meetings?

Many individuals supported by BDDS are considered high risk with regard to COVID-19. Providers must consider this when reviewing their policies around the mandates within the Executive Order. In recognition of the varying needs of individuals supported, ISTs are encouraged to convene if there are outstanding issues or

questions related to a particular individual's needs and how they are being addressed as they relate to COVID-19. ISTs are encouraged to meet (by phone or virtually) early and often to ensure plans are in place to address the needs of those supported. Teams should work together to build in strategies and supports that consider the needs of the individual and their families and ensure everyone's safety and well-being.

Should a case management provider return a case to BDDS if the participant transitioning out of an institution is unsure if they want to move due to COVID-19?

BDDS encourages case management providers to allow individuals some time to process and cope with the current public health crisis. Case managers should consider more frequent contact and communication with individuals transitioning out of an institution in order to provide them with information to assist them in making an informed decision. BDDS requests that cases not be returned at this time without further discussion with the individual and BDDS district office.

Will there be considerations for case managers that have caseloads in the higher hit areas (Marion)?

Case managers are considered essential employees and can make in-person visits as needed. Precautions should be taken including utilizing the appropriate PPE and social distancing. Case Managers should follow guidance issued by federal, state, and local authorities.

I am a case manager and have an individual I support who has an open sentinel event IR. The sentinel event reviewer requested I visit the individual at his home within 24 hours. How do I do that given the pandemic?

Case managers are considered essential employees and can make in-person visits as needed. Precautions should be taken including utilizing the appropriate PPE and social distancing. Case Managers should follow guidance issued by federal, state, and local authorities.

Wouldn't the case manager giving him masks be considered a gift/solicitation and not allowed?

No.

Transitions and EIC at this time: should this be done via video chat or in person approved by CMCO?

The determination of whether these activities should be done in-person or virtually should be based on the needs of the individual. Case managers are considered essential workers and are able to complete these activities on an in-person basis.

What do case managers do about required annual in-home visits during this time? Is it still mandatory?

Case Managers are considered essential employees and can make in-person visits as needed. Precautions should be taken including utilizing the appropriate PPE and social distancing. Case managers should follow guidance issued by federal, state and local authorities.

So if a case manager test positive, who does she contact so that all the consumers and staff who she has had contact with get notified?

We all have a responsibility to each other to keep the ALL healthy and safe. A case manager who has tested positive should contact all team members that she has had face to face contact with. If the case manager is not able to do so due to being ill, she should contact her employer who should ensure notification is made.



If unannounced visits need to be done and the provider or family does not want a CM to enter the home do we continue to not complete the unannounced visit and just case note the attempt?

Case managers may complete unannounced visits at the home but remain outside. If the individual or family is willing and it is a provider owned and controlled setting, the case manager may complete a virtual visit that allows for the case manager to see the inside of the provider owned and controlled setting in addition to a visit where the case manager remains outside of the home. Case managers should explain to individuals and families their company's COVID-related policies and procedures, including screening practices and precautions during visits, so that individuals and families can make informed decisions regarding in-person visits.

Can a CM refuse to come to a meeting if the family has asked for more of the team members to show?

To ensure continuity of service planning and team meetings, BDDS will temporarily authorize the use of phone (or virtual) meetings as an alternative to face-to-face meetings. Case managers are essential employees therefore when necessary and when typical precautions can be observed, appropriate face to face meetings should occur. *Phone (or virtual) meetings should be utilized at the request of the individual and/or family.*

In the past, you said you were not monitoring timelines for items such as unannounced visits are you saying you are now monitoring these timelines?

Unannounced visits are required for individuals residing in provider owned and controlled settings to ensure the health, safety and well-being of the individual supported and to monitor the provision of services. BDDS is not currently monitoring timelines for various processes, including unannounced visits, but they must be completed and documented within a reasonable timeframe. During the public health crisis, case managers are encouraged to call the home of the day of the intended visit to ensure a face-to-face visit is appropriate as it relates to the COVID-19 status of that particular home.

Please offer additional LifeCourse Framework trainings for case managers. This process is key to bringing the team together dynamically. Is there a way to open up this training to more case management professionals during this quarter? Or is there a plan to offer more LifeCourse Framework three-part trainings in January to March 2021?

Additional trainings are being scheduled and an announcement will be made soon.

If CMs are made aware of instances where providers are not adhering to mask mandate is there somewhere to report that or does an IR need to be submitted?

In cases where CMs are aware of staff not adhering to the mask mandate, notification to the provider is recommended. In addition, reporting to BQIS can be done at <https://www.in.gov/fssa/ddrs/quality-improvement/>.

Could we ask case managers to also report to the agency if they find a staff not wearing a mask, so management is aware?

When a concern arises, teams are encouraged to communicate and work together to resolve the issue at hand. In instances where staff are not wearing a mask the case manager, individual, family, visitors and/or other staff should take their concerns to the provider. They may also file a complaint with BQIS at <https://www.in.gov/fssa/ddrs/quality-improvement/>.



Will there be guidance for CMs who have individuals and family who make it clear they do NOT practice social distancing and do not feel the pandemic is “real?”

Case managers are encouraged to communicate with individuals and families the necessary steps, protocols and state mandates put in place that the case manager must follow to keep themselves, their families and the other families and individuals in services safe. Case managers should take the necessary precautions to protect themselves including wearing a mask, asking to meet outside, using hand sanitizer and limiting the amount of personal items with them during the meeting. Case Managers are encouraged to provide resources on the pandemic to individuals and families in a manner that is respectful and meaningful to the individual. Case Managers, as all Hoosiers, are encouraged to take the appropriate precautions such as social distancing, wearing face coverings, and frequent hand washing.

Budget Modification Timelines

Should case managers complete Jira tickets when asked by a provider to change from daily RHS to hourly? Can there be more than 1 individual served by a provider on one ticket-regarding request for daily to hourly rate effective March 1?

No. Changes have been made which will allow a case manager to enter an exemption and immediately change a person from daily RHS to hourly RHS. Tickets will not be required.

Can the state relax the policy of having to change an individual from daily rate to hourly only at the beginning of the month?

Yes, it is temporarily permissible for an individual to change from daily to hourly RHS on any date during the month.

For requests to go from daily rate to hourly just submitted and approved to start 4/1, are providers able to request another to ask that daily be switched to hourly back to 3/1?

This is allowable only if there were changes implemented in the month of March.

Will monthly service budgets be extended? For example, if you are allotted an amount of hours on the NOA for a certain month, will you be able to use them the following month?

This depends on the individual, situation and service. However, this is currently allowable depending on how the service is authorized.

As a provider, we have been advised to move all residential to hourly rate. Is this true?

Providers and ISTs are encouraged to be person centered and consider each individual’s situation.

Could you please explain if budgets would be increased if clients are now in the residential homes 24/7? Would it be best for them to be placed on hourly rate vs, daily rate? Would there be an increase in budgets to support this?

Providers and ISTs are encouraged to be person-centered and consider each individual’s situation. Individuals may need to temporarily have a modified residential service arrangement due to changes in their normal routine

at this time. Providers are responsible for communicating changes in living arrangement or temporary location changes for individuals to their case manager. In certain situations, a temporary change may have an impact on the living arrangement or an individual's budget, such as an individual who returns to the family home temporarily and, due to specific COVID-19 impacts, the family becomes the paid staff in their home.

Changes to Residential Service Location

As providers work through this pandemic and a need arises to move someone who has the CIH waiver when their housemate tests positive for COVID-19 but the individual tests negative, is it acceptable for the person to move to an SGL/ICF on a temporary basis? Is there a limit on how many people can reside in an SGL/ICF in this situation? Can the provider continue to bill the waiver?

Appendix K allows for temporary moves to other locations as well as services being performed in other locations. ISTs will ensure that even with temporary moves, activities must be person-centered. Providers can continue to bill for waiver services while an individual temporarily resides in a group home setting.

If an individual who currently receives RHS hourly and lives alone is moving into a supported living setting temporarily, should the individual's living arrangement be changed?

For individuals temporarily visiting their family home, but maintaining their supported living residence, an emergency transition is not required. The case manager should document the visit in case notes. However, should the visit be longer than 60 days, an emergency transition should be submitted.

For individuals temporarily visiting another supported living home due to staffing needs or similar provider limitations, an emergency transition is not needed as long as the visit is limited to seven days or less. Case managers are to document the temporary relocation in case notes. If the visit exceeds seven days, an emergency transition is required.

If a CIH Waiver participant must relocate to a new residential setting, should the case manager submit a transition to BDDS?

If the individual is visiting a new residential setting due to a COVID-19 related issue (quarantine, staffing, COVID-19 positive housemate), the case manager is not required to submit an emergency transition immediately. The case manager is required to make a case note indicating where the individual is visiting. If the individual is at the new location for more than seven days, an emergency transition should be submitted.

It sounds like under correct condition a waiver residential can be moved to a group home but a waiver residential cannot move to another waiver. Am I understanding that correctly?

If a participant's current personal assistance and care, structured family caregiving setting or residential habilitation and support setting is compromised due to COVID-19 related circumstances, the individual may be temporarily relocated to a day program setting or an intermediate care facility for individuals with intellectual disabilities. The day program or ICF/IID setting must be accessible to participants and ensure participant's health and safety to the fullest extent possible. A participant may also move to another CIH waiver setting on a temporary basis.



Prior to relocating the individual, the participant's support team must approve of the temporary/alternate residential setting. The case manager must obtain and document approval from each team member by either a telephone call or virtual meeting with the individual's team or an email with the individual's team. The case manager will submit an emergency transition that references COVID-19 with the support team's approval within seven days of relocating the individual to the alternate residential setting.

If a CIH Waiver participant temporarily goes to an ICF due to a COVID-19 related issue, how does the residential provider bill for services rendered?

The residential provider would continue to provide residential support through the CIH Waiver and bill accordingly. The residential provider would not include that individual in the ICF billing.

How should a team handle transitions where a new client looking for a new provider?

There has been no change to this process. Individuals can continue to change providers of various services if they choose to do so.

I have a family that wants to transition to another waiver site (same company) but did not want to do any overnights due to the COVID-19. Is this allowed?

The types of visits and the frequency of visits to potential new homes should be determined by the needs of the individuals involved. There is no mandatory frequency or types of visits to potential homes through HCBS waivers.

Changes to annual level-of-care determination requirements

Can case managers continue to submit LOCSIs since we use collateral documents?

Collateral documents are a part of LOC assessments and do not replace the need to meet with the individual. BDDS will temporarily allow LOC assessments to be conducted by phone. Case managers must conduct phone meetings according to guidance issued on use of phone (or virtual) meetings for service planning. BDDS will extend the annual LOC determinations that are due on or before June 30, 2020, to have a new due date of Dec. 31, 2020.

Allowing use of phone (or virtual) meeting for service planning

As far as virtual meetings, is there a specific platform CMs should use? Can this include Skype, Facetime, etc.?

To ensure continuity of service planning and team meetings, BDDS will temporarily authorize the use of phone (or virtual) meetings as an alternative to face-to-face meetings. HIPAA federal guidance has been waived during this public health emergency. Please see <https://www.hhs.gov/sites/default/files/telehealth-faqs-508.pdf> for additional information. Providers are encouraged to take steps to protect confidential information to the best of their abilities.

Any technology that allows for real-time interactive communication between the individual and provider is acceptable. This could be done either in a video format or voice-only communication. Services provided via email and text message formats are not reimbursable.

Guidance on telemedicine delivery of extended services

Do we have a date that the Appendix K will end for extended services? At this time, will we go back to onsite face-to-face services only?

Appendix K flexibilities will be available until Aug. 31, 2020. So long as the public health emergency is still in place, BDDS will consider the need to seek an Appendix K extension.

The Appendix K flexibilities are updated and many original flexibilities are extended to Feb. 28, 2021 (including the flexibilities around telemedicine).

For extended services telemedicine guidelines indicate that it cannot occur over text or email. Are exceptions allowed for hearing impaired individuals?

The IST should explore resources that will accommodate the individual. Resources include: <http://relayindiana.com/>. Additionally, platforms such as Zoom or Microsoft Teams may still be used with the chat box instead of video. This would allow for focused real-time conversation in a manner that is accessible to the individual.

How can extended services be provided for individuals who have been temporarily laid off or unable to go to their place of employment due to closure?

Extended Services, when appropriate, may be explored and utilized via telemedicine. The delivery of Extended Services through telemedicine must be meaningful and within the scope of the individual's PCISP. In the event an individual is placed on temporary leave from their employer due to a COVID-19 related circumstance, Extended Services may continue to be delivered via telemedicine to the extent they are meaningful and contribute to ongoing job-specific goals or readiness of the participant to resume work with their current employer once public health emergency restrictions are lifted. If meaningful service cannot be delivered, consider postponing services and revisiting at a later time. Providers delivering services through telemedicine must continue to abide by service standards and limitations, including the requirement that extended services be delivered only when the individual is employed in competitive, integrated employment. *Extended services do not include sheltered work or other similar types of vocational services furnished in specialized facilities or volunteer endeavors.*

Allowing alternative settings for COVID-19-related circumstances

What is the process to look like to provide day services in the residential homes?

Services should be similar in nature to what was provided in the facility. Day services provided within an alternative residential setting should still follow the documentation standards and reimbursable activities found in the service definitions.

An individual being supported through the CIH waiver has RHS and day services on his plan. Due to COVID-19, some of his day services are being provided virtually in his home. He also has RHS staff present at the time of the virtual day services. Can the provider bill for both RHS and day service when the timing of the two services overlap?



Individualized support teams, including providers on the IST, need to coordinate concurrent services so that it is distinctly clear and well documented, the roles and purpose of each care provider in these situations to demonstrate that services are not duplicative, or nominally duplicative. As long as the provider(s) aren't delivering services that perform similar functions, and the services are (at most) nominally duplicative, two services could be received at the same time. Provider staff should ensure these activities are very well documented in all circumstances. CMS allows for waiver participants to be concurrently receiving two services that are, at most, nominally duplicative or overlapping.

Are we allowed to provide PV services in the home if they are working on goals?

BDDS has temporarily expanded settings where Facility Habilitation, Prevocational Services and Adult Day Services may be provided. Facility Habilitation, Prevocational Services and Adult Day Services may be temporarily provided at a facility-based day program, the home of the participant, an Intermediate Care Facilities for Individuals with Intellectual Disabilities or, upon approval from the participant's team, the home of a direct support professional. The alternate service delivery setting must be accessible to the participant and ensure the participant's health and safety to the fullest extent possible.

Regarding the current time frame that is in place to allow providers to provide day programming services such as facility group habilitation in an individual's (supported living) home for individuals on the CIH waiver: A provider is considering no longer providing day programming in the home and exploring other options. It was my understanding that day programming could still be provided in the home as a temporary measure for an individual's safety (instead of for example a traditional day program facility) if the team agrees to it. Can you please clarify how long a provider may provide day programming services in an individual's home?

Per the "Guidance for BDDS Providers on Temporary Policy Changes Related to COVID-19" and Appendix K, as of April 3, 2020, the only limitations on alternate service delivery setting are when an RHS setting has been converted to a Structured Family Caregiving site (limited to 30 days) and when an individual temporarily receives residential support in the home of a direct service professional familiar to them (limited to 60 days).

Can you provide examples of CHIO activities to do at home?

Activities completed as part of CHIO delivered in an alternate site should be based on the individual preferences and needs and items that are available or made available in the individual's home.

Could we provide day services in the homes of the supportive living homes? Are there any additional guidelines for doing this?

BDDS will temporarily expand settings where facility habilitation, prevocational services and adult day services may be provided. Facility habilitation, prevocational services and adult day services may be temporarily provided at a facility-based day program, the home of the participant, in intermediate care facilities for individuals with intellectual disabilities or, upon approval from the participant's team, the home of a direct support professional. The alternate service delivery setting must be accessible to the participant and ensure the participant's health and safety to the fullest extent possible. The service definitions remain the same.

As far as changing of setting where facility hab is served, will this service need to be still provided by the current provider staff?

Regardless of which staff provide support, they will need to follow all qualifications and training requirements as outlined in administrative code, as modified by “BDDS Temporary Policy Changes Related to COVID-19 and Appendix K.”

Can providers implement the changes to CHIO?

Yes. BDDS will temporarily expand settings where community-based habilitation may be provided. CHG/CHIO services may be temporarily provided at a facility-based day program, the home of the participant, an intermediate care facilities for individuals with intellectual disabilities or, upon approval from the participant’s team, the home of a direct support professional. The alternate service delivery setting must be accessible to the participant and ensure the participant’s health and safety to the fullest extent possible.

Will day habilitation flexibility continue where services can be provided in the residential home as well as in the community and/or facility?

BDDS will temporarily expand settings where day habilitation may be provided.

- Day habilitation services may be temporarily provided at a facility-based day program, the home of the participant, an intermediate care facilities for individuals with intellectual disabilities or, upon approval from the participant’s team, the home of a direct support professional.
- The alternate service delivery setting must be accessible to the participant and ensure the participant’s health and safety to the fullest extent possible. The alternate service delivery in an ICF setting may not exceed thirty (30) days for each participant.

If a participant’s current RSH setting is compromised due to COVID-19 related circumstances the individual may be temporarily relocated to a day program setting or ICF. Can you please define “COVID-19 related circumstances”?

COVID-19 related circumstance is defined as the individual or a DSP working with the individual has tested positive or is presumed positive for COVID-19.

Example staffing across the agency could be affected because of COVID (staff getting tested/having positive testing or overall lack of staffing due to COVID) would that be considered a related circumstance?

If the individual or a DSP working with the individual has tested positive or is presumed positive for COVID-19, then this would meet the criteria.

Increased payment flexibilities for allowable family caregivers

Have we received CMS approval so parents can start hiring process to be staff for minors?

Appendix K has been submitted and is currently pending approval. However, BDDS has implemented changes requested in Appendix K associated with parents as caregivers, for which guidance has been provided for how teams can identify when parents of minors as paid staff can be utilized.



The Appendix K flexibilities are updated and many original flexibilities are extended to Feb. 28, 2021, including flexibilities associated with parents as caregivers for which guidance has been provided for how teams can identify when parents of minors as paid staff can be utilized.

I have a 12-year-old child on the FSW who has received PAC for three years. Her PAC staff has COVID-19. Can I become her paid staff? If so, can I be paid for supporting her while my other two children are home with me?

Please contact your case manager to discuss your child's needs and resources available to address those needs.

The case manager and team should consider the following questions in determining how best to address the needs of the individual:

1. Is the disruption in current services due to the individual receiving services and/or current direct support professional having a positive test for COVID-19 or confirmed exposure of COVID-19 which creates an immediate need for intervention and response to ensure their health, safety and well-being?
2. Is the service critical to the health, safety and well-being of the individual?
3. Use the Integrated Supports Star or other similar tool, to identify other appropriate alternatives that are available to support the individual including other HCBS services, natural supports, technology, etc.
4. Does the temporary, immediate need for intervention and response fall within the purpose and guidelines of home and community based waiver services?
5. Determine if other support options should be explored during COVID-19 public health emergency.

If the above criteria are met and the parent temporarily becomes a paid caregiver, it is reasonable to expect that during the stay at home directive that the individuals siblings will be also be in the home during the public health emergency.

Effective Sept. 1, 2020, if it is determined that these flexibilities are warranted, the following options may be used on *temporary basis up to a total of 30 consecutive days per occurrence when the individual receiving services and/or the current direct support professional has a positive test for COVID-19 or confirmed exposure of COVID-19.*

Parent(s), step-parent(s), and legal guardian(s) will temporarily be allowed to provide services to minors up to 40 hours per week but not exceeding the current plan approved units to (as direct support staff via an existing BDDS approved provider) who are currently using or have a documented intent to use only the following services:

- Participant assistance and care available on the FSW
- Day habilitation available on the FSW and CIH
- Residential habilitation and support available on the CIH

Any parent(s), step-parent(s), legal guardian(s), and spouse accessing these flexibilities for the first time will need to work with their provider to meet the provider, state and/or federal hiring and training requirements. All paid family caregivers must also meet background check requirements currently in place for direct service professionals as outlined above.

My husband has the CIH waiver and was receiving RHS. His provider can no longer staff him due to so many staff having COVID-19. I want to become his SFC provider. How do I do that?

Please contact your case manager to discuss your spouse's needs and resources available to address those needs.

The case manager and team should consider the following questions in determining how best to address the needs of the individual:

1. Is the disruption in current services due to the individual receiving services and/or current direct support professional having a positive test for COVID-19 or confirmed exposure of COVID-19 which creates an immediate need for intervention and response to ensure their health, safety and well-being?
2. Is the service critical to the health, safety and well-being of the individual?
3. Use the Integrated Supports Star, or other similar tool, to identify other appropriate alternatives that are available to support the individual including other HCBS services, natural supports, technology, etc.
4. Does the temporary, immediate need for intervention and response fall within the purpose and guidelines of home and community based waiver services?
5. Determine if other support options should be explored during COVID-19 public health emergency.

If the above criteria are met, the spouse may temporarily become the SFC provider for their spouse.

Effective Sept. 1, 2020, if it is determined that these flexibilities are warranted, the following options may be used on *temporary basis up to a total of 30 consecutive days per occurrence when the individual receiving services and/or the current direct support professional has a positive test for COVID-19 or confirmed exposure of COVID-19.*

An adult spouse will temporarily be allowed to provide services to an adult individual up to 40 hours per week but not exceeding the current plan approved units to in the following services:

- Structured family caregiving available on the CIH
- Participant assistance and care available on the FSW

The 40-hour-per-week per paid caregiver limitation will be temporarily waived for adult participants by one sole paid caregiver providing over 40 hours of service for:

- Participant assistance and care available on the FSW
- Residential habilitation and support available on the CIH

Any parent(s), step-parent(s), legal guardian(s) and spouse accessing these flexibilities for the first time will need to work with their provider to meet the provider, state and/or federal hiring and training requirements. All paid family caregivers must also meet background check requirements currently in place for direct service professionals as outlined above.



If combined family/parents are providing 40 hours of RH10 to their adult child, and the day program closes due to pandemic, can the family/parents provide more than 40 hours a week combined at this time?

The CIH waiver renewal, effective July 16, 2020, updated the limitations to include language that RHS furnished to an adult waiver participant by a paid relative and/or legal guardian may not exceed a total of 40 hours per week per relative and/or legal guardian caregiver. The decision to use a paid relative and/or legal guardian caregiver must be documented in the individual's PCISP and done in a manner consistent with Section 7.9 of the Indiana Health Coverage Programs Provider Reference Module for DDRS home- and community-based waivers.

An individual on the CIH Waiver lives with his sister/guardian. Sister is RHS DSP. Due to the day program closure due to COVID-19, can the sister temporarily provide over 40 hours of RHS per week? No other staff can be in the home due to the individual, sister, and sister's husband being over 65 years of age and vulnerable to COVID-19.

In order to utilize the flexibility under Appendix K described, the IST should consider the following questions in determining how best to address the needs of the individual:

1. Is the disruption in current services due to the individual receiving services and/or current direct support professional having a positive test for COVID-19 or confirmed exposure of COVID-19 which creates an immediate need for intervention and response to ensure their health, safety and well-being?
 - a. Has the waiver provider suspended services due to COVID-19? *Yes. The provider closed the day program.*
 - b. Is the current staff not providing services because they have been exposed to or are ill with COVID-19? *No.*
 - c. Has the primary caregiver or legal guardian been exposed to or is ill with COVID-19? *No.*
 - d. Has the individual receiving waiver services been exposed to or is ill with COVID-19? *No.*

Is the service critical to the health, safety and well-being of the individual? *RHS is a service that is critical to the individual's health, safety and well-being.*

Use the Integrated Supports Star, or other similar tool, to identify other appropriate alternatives that are available to support the individual including other HCBS services, natural supports, technology, etc. *The IST will need to address this question.*

Does the temporary, immediate need for intervention and response fall within the purpose and guidelines of home- and community-based waiver services? *The IST will need to address this question.*

2. Determining what support options should be explored during COVID-19 public health emergency. *The IST will need to address this question.*

Can you talk a bit about any COVID allowances for children who have started the waiver in the last year and were working on selecting providers as this started?

In situations for individuals who are beginning waiver services for the first time, the case manager should be applying the relevant Appendix K flexibility questions as outlined in the September guidance. For minor



children starting services for the first time, the family and case manager would first need to determine if their situation upon start of the waiver is a COVID-19 situation that requires an immediate temporary intervention to ensure the health and safety of the minor child to evaluate whether any Appendix K flexibilities are applicable and appropriate.

What guidance would be given if a consumer does not meet criteria for Appendix K (parents as paid caregiver) but provider is allowing?

It is recommended that the IST convene and utilize the Integrated Supports Star, or other similar tool, to identify other appropriate alternatives that are available to support the individual including other HCBS services, natural supports, technology, etc.

How does Support Planning Scenario #1 apply if one has PAC as opposed to Respite?

Below is the Support Planning Scenario #1 applied to PAC:

Chloe is 7 years old and receives support through the FSW. Her current CCB includes Music Therapy, PAC, and Case Management. Chloe's parents have decided that due to Chloe being high risk for pulmonary complications they do not want to have any staff or therapists come into the home. Chloe's mom calls her case manager to discuss this decision and inquire about what types of supports they can put in place during this time. Chloe's mom also expressed that she has heard that she might be able to be paid to be Chloe's caregiver at this time.

Fast facts:

Chloe's PAC provider has not suspended services.

Chloe's DSP is still working with other families and has not been exposed or is ill with COVID-19.

Chloe's parents have not been exposed or are ill with COVID-19.

Chloe has not been exposed or is ill with COVID-19.

The case manager works through the questions provided in the temporary guidance to determine if Chloe and her family meet the criteria for the Appendix K flexibility allowing parents to be paid caregivers.

1. *Is the disruption in current services due to the individual receiving services and/or current direct support professional having a positive test for COVID-19 or confirmed exposure of COVID-19 which creates an immediate need for intervention and response to ensure their health, safety and well-being?*

The case manager shares with Chloe's parents that their situation does not meet the criteria to utilize the temporary Appendix K allowance for parents of minor children to be a paid caregiver.

2. *Is the service critical to the health, safety and well-being of the individual?*

PAC has been determined to be critical to the health, safety and well-being of Chloe. Music therapy has been determined to not be critical to the health, safety and well-being of Chloe. The case manager explains to mom that if she changes her mind about allowing staff in the home that Chloe can continue to receive PAC through her current provider because PAC is an essential service and DSPs are essential staff.

3. *Use the Integrated Support Star, or other similar tool, to identify other appropriate alternatives that are available to support the individual including other HCBS services, natural supports, technology, etc.*

Through the conversations with mom, the case manager learns that the family is comfortable having the mom's sister, Chloe's aunt, to come into the home and provide PAC. Aunt meets the qualifications under the service definition and is hired on as a DSP.

The case manager shares with mom that music therapy can be provided via telemedicine and discusses what that can look like.

4. *Does the temporary, immediate need for intervention and response fall within the purpose and guidelines of home- and community-based waiver services?*

The discussions and solutions that the case manager and mom have discussed fall within the purpose of HCBS waivers.

5. *Determining what support options should be explored during COVID-19 public health emergency*

The case manager discusses with mom other support options that may be available, such as what services Chloe may be eligible for through her local school district who has cancelled school for the remainder of the school year.

Question about Appendix K. Is it up to the case managers to determine if a family meet temporary provisions under Appendix K? What if you receive everything from the family/case manager to start services and realize that they do not meet provision under Appendix K to have a parent hired as a staff for their child?

ISTs have a responsibility to assist individuals and families in understanding the flexibilities permitted under Appendix K. The IST should convene and work through the following process of decision making:

1. *Is the disruption in current services due to the individual receiving services and/or current direct support professional having a positive test for COVID-19 or confirmed exposure of COVID-19, which creates an immediate need for intervention and response to ensure their health, safety and well-being?*

If the answer to this question is no, the individual does not qualify to utilize the flexibilities under Appendix K. But that doesn't mean the discussion with the family stops. The case manager needs to work with the family to determine how they can be supported during this time, either with waiver services, natural supports or possibly technology.

2. *Is the service critical to the health, safety and well-being of the individual?*

Whether the service is critical, or just desired, the case manager should continue the discussion to determine what else is available to the family.

3. *Use the Integrated Supports Star or other similar tool to identify other appropriate alternatives that are available to support the individual including other HCBS services, natural supports, technology, etc.*

Has the case manager worked through the Integrated Support Star, or other similar tool with the family? If so, were other options for supports identified that are aligned with HCBS services? For example, is there an aunt, grandparent, etc. who can provide services through existing service

definitions? Are there electronic apps that can provide prompts for completion of ADLs? The case manager should be having this conversation with the family.

4. *Does the temporary, immediate need for intervention and response fall within the purpose and guidelines of home- and community-based waiver services?*

This was touched on in the answer to 3. Consider using services and supports allowed in the currently approved FSW, natural supports, or possibly technology.

5. *Determining what support options should be explored during COVID-19 public health emergency.*

Going back to the family's discussion on how best to keep their family safe and free from COVID-19, consider all support options they are comfortable with. A number of services can be provided via telemedicine if that is what the individual and family prefer. The fact sheets available at <https://www.in.gov/fssa/ddrs/5762.htm> can be used to help the case manager talk with the family about what services provided by telemedicine might look like.

I have a consumer that does not have Respite Care on their current waiver. However, I received notification today that the family has a friend that would like to become Respite staff and we will train them. Can I add Respite to their CCB in this instance? Thank you!

The case manager should convene an IST meeting (virtually or telephonically) to discuss the needs and how the individual's HCBS waiver may assist in addressing the need. If the individual\guardian wants Respite added to the array of services on the CCB, the case manager can add this service. The temporary flexibilities allowed by Appendix K do not restrict choice of providers and services that existed prior to the current public health crisis.

Would there be an exception to allowing RSPO during when a parent is working right now, since children are home from school for those parents still working?

Respite as a waiver service cannot be provided while the parent is at work. However, respite through Medicaid PA can be utilized while the parent works. Additionally, the IST can convene and discuss the option of utilizing PAC under the FSW or RHS under the CIH while the parent works.

In expanding the use of family caregivers, can we hire a parent with a drug felony to care for the consumer?

There have been no exceptions or waiving of 460 IAC 6-10-5(9).

Consumer has Respite provided by family and the provider stopped it due to the pandemic. If providers are allowed to start providing respite due to the pandemic, why can't respite that is already in place be utilized?

This should be discussed with the individual's case manager.

What services can family members provide under Appendix K?

Parent(s), step-parent(s) and legal guardian(s) will temporarily be allowed to provide services to minors up to 40 hours per week but not exceeding the current plan approved units (as direct support staff via an existing BDDS approved provider) who are currently using or have a documented intent to use only the following services:

1. Participant assistance and care available on the FSW;
2. Day habilitation available on the FSW and CIH; and

3. Residential habilitation and support available on the CIH.

An adult spouse will temporarily be allowed to provide services to the adult individual up to 40 hours per week but not exceeding the current plan approved units to in the following services:

1. Structured family caregiving available on the CIH; and
2. Participant assistance and care available on the FSW.

Can parents provide respite care for their minor children during this time? If so, is the fact that the kids are at home instead of school a sufficient reason?

Respite is defined as a service that provided to participants unable to care for themselves that are furnished on a short-term basis in order to provide temporary relief to those unpaid persons normally providing care. A parent providing respite would not meet this definition however, a parent of a minor child can temporarily provide other services such as PAC on the FSW and RHS on the CIH.

School closure does not meet the criteria for a parent to become a paid caregiver under this temporary flexibility. In determining whether HCBS services should be utilized to address a COVID-19 related need, please see the table below.

If a parent becomes a DSP for a minor child, will they still be required to finish all of the training requirements after the emergency is lifted if it is before the 60-day limit?

Any parent(s), step-parent(s), legal guardian(s) and spouse accessing these flexibilities for the first time will need to work with their provider to meet the provider, state and/or federal hiring and training requirements. All paid family caregivers must also meet background check requirements currently in place for direct service professionals.

In regard to the temporary changes where family can be staff, if the family has lost their jobs due to COVID and being home with their individual, is this considered a reason to use Appendix K to employ the parents as caregivers?

In determining whether the temporary flexibilities provided by Appendix K regarding certain family members being paid staff should be used, the individual and their team should consider the following questions:

1. Is there a disruption in current services due to the individual receiving services and/or current direct support professional having a positive test for COVID-19 or confirmed exposure of COVID-19 which creates an immediate need for intervention and response to ensure their health and safety? (this does not include stay at home order or school being closed); and
2. Using the [Integrated Support Star](#) or other similar tool, what other appropriate alternatives are available to support the individual including other HCBS services, natural supports, technology, etc.? Is the service critical to the health and safety of the individual?
3. Is the temporary, immediate need for intervention and response fall within the purpose and guidelines of home- and community-based waiver services?

When should HCBS services be used in a COVID-19 related situation?



Currently, BDDS is providing the following chart to support teams in decision-making about whether and to what extent HCBS flexibilities should be used:

| HCBS flexibilities may be considered when: | Other support options should be utilized when: |
|--|---|
| <p>The BDDS provider in the PCISP has suspended services due to COVID 19.</p> | <p>The individual receiving BDDS services is no longer attending school in person due to closures due to COVID 19.</p> <p><i>School services are covered by IDEA and you should work with your local school district in securing those services. For more information or guidance, you may contact INSOURCE at www.insource.org.</i></p> |
| <p>The staff for BDDS services in my PCISP aren't providing services because they have been exposed or are ill with COVID 19.</p> | <p>The individual receiving BDDS services is also receiving First Steps services and is no longer receiving in home First Steps services due to COVID-19.</p> <p><i>First Steps services are covered by IDEA. Telehealth might be an option. Contact your First Steps service coordinator for options.</i></p> |
| <p>I'm the primary caregiver or legal guardian for the individual with BDDS services and I have been exposed or am ill with COVID-19.</p> | <p>The individual receiving BDDS services can no longer attend ABA services because the center closed to due COVID-19.</p> <p><i>ABA is not a waiver service and is covered by your Medicaid State Health plan and/or private insurance. Contact your ABA provider for their alternate options of service delivery, if any.</i></p> |
| <p>I'm an individual receiving BDDS services and have been exposed or am ill with COVID-19.</p> | <p>The individual receiving BDDS services and/or the parents and legal guardians have lost their job due COVID-19 and need assistance meeting basic needs.</p> <p><i>Individuals and families who are facing a financial hardship due to COVID-19 and need assistance with basic needs such as food, rent, and utilities should contact 211, visit the food assistance availability map and/or a statewide family/advocacy organization to locate local resources.</i></p> |



Would having day services canceled be considered a COVID-19 need?

If the cancelation of day services is related to the COVID-19 pandemic, then yes.

If a family member becomes paid staff due to COVID-19 related issues, does that family member still have to work for a provider?

Yes. Any parent(s), step-parent(s), legal guardian(s) and spouse accessing these flexibilities for the first time will need to work with their provider to meet the provider, state and/or federal hiring and training requirements. All paid family caregivers must also meet background check requirements currently in place for direct service professionals.

Are parents allowed to work respite hours?

Respite is defined as a service that provided to participants unable to care for themselves that are furnished on a short-term basis in order to provide temporary relief to those unpaid persons normally providing care. Respite would not be an appropriate service for a parent to provide if the parent is the usual caregiver.

Can PAC be added for individual under 18 and the parent be staffing during this time? Consumer did not previously have PAC.

Any parent(s), step-parent(s), legal guardian(s) and spouse accessing these flexibilities can only do so for PAC and other specified services if those were existing services that have been authorized on the current Cost Comparison Budget as of March 1, 2020.

During this time, are family caregivers able to work more than 40 hours weekly?

The 40-hour-per-week paid caregiver limitation will be temporarily be waived for Participant assistance and care available on the FSW and residential habilitation and support available on the CIH.

Effective Sept. 1, 2020:

Parent(s), step-parent(s) and legal guardian(s) will temporarily be allowed to provide services to minors up to 40 hours per week but not exceeding the current plan approved units to (as direct support staff via an existing BDDS approved provider) who are currently using or have a documented intent to use only the following services:

- Participant assistance and care available on the FSW
- Day habilitation available on the FSW and CIH
- Residential habilitation and support available on the CIH

An adult spouse will temporarily be allowed to provide services to an adult individual up to 40 hours per week but not exceeding the current plan approved units to in the following services:

- Structured family caregiving available on the CIH
- Participant assistance and care available on the FSW

The 40-hour-per-week per paid caregiver limitation will be temporarily waived for adult participants by one sole paid caregiver providing over 40 hours of service for:

- Participant assistance and care available on the FSW
- Residential habilitation and support available on the CIH

As far as allowing family members to provide PAC/RSPO to a minor, is this allowable for new services not already existing? Especially for parents who are perhaps off work due to school closures etc.

Any parent(s), step-parent(s), legal guardian(s) and spouse accessing these flexibilities can only do so for PAC and other specified services if those were existing services that have been authorized on the current Cost Comparison Budget as of March 1, 2020. Respite is defined as a service that provided to participants unable to care for themselves that are furnished on a short-term basis in order to provide temporary relief to those unpaid persons normally providing care. Respite would not be an appropriate service for a parent to provide if the parent is the usual caregiver. School closure does not meet the criteria for a parent to become a paid caregiver under this temporary flexibility.

An adult who lives in a waiver-funded home with 24/7 support returns to the family home on a temporary basis due to staffing shortage at provider. Can the family members get paid to provide services?

If the staffing shortage is due to COVID-19, then the family member could potentially be paid staff for the service of RHS or CHIO. To utilize this option, the team must meet to discuss the proposed changes, the case manager should document the discussion in the case notes and then update the living arrangement accordingly to reflect the change in living arrangement to allow for the family to be the paid caregiver in their own home. Any parent(s), stepparent(s), legal guardian(s), and spouse accessing these flexibilities for the first time will need to work with their provider to meet the provider, state and/or federal hiring and training requirements. All paid family caregivers must also meet background check requirements currently in place for direct service professionals.

Is there an option to help waiver families when the waiver participant is school-aged but not able to attend in person school because of COVID-19, leaving the parent unable to work due to having to support the participant to engage in virtual school? Is the parent able to be staff to provide PAC services for the minor during this unique situation?

Effective Sept. 1, 2020, parent(s), step-parent(s) and legal guardian(s) are temporarily allowed to provide PAC services as the direct support staff via an existing BDDS-approved provider up to 40 hours per week but not exceeding the current plan approved units to minors when:

- The minor and/or current direct support professional have tested positive or have a confirmed exposure of COVID-19 and
- Are currently using or have a documented intent to use PAC.

This flexibility can be used only up to a total of 30 consecutive days per occurrence. In situations where services are being provided to a minor by parents, stepparents and legal guardians, these waiver supports must not be used to supplant or replace services that would otherwise be funded by and the responsibility of another funding source, such as a school district, to provide.

Paid family caregivers can only work over 40 hours a week if the individual tests positive, correct?

The flexibilities allowed under Appendix K for families as caregivers must be utilized in response to a COVID-19 related need that creates a temporary, immediate need for intervention and response to ensure an individual's health and safety. In addition, these flexibilities must be utilized within the individual's existing budget.



Families and individuals should work with their case manager and team to determine if their current situation falls within the necessary criteria of Appendix K to access any of these flexibilities. The following questions should be considered in making this decision:

1. Is the disruption in current services due to the individual receiving services and/or current direct support professional having a positive test for COVID-19 or confirmed exposure of COVID-19 which creates an immediate need for intervention and response to ensure their health, safety and well-being? (Note: The “stay at home order,” schools being closed or closures of non-waiver entities are not sole qualifying circumstances.)
2. Is the service critical to the health, safety and well-being of the individual?
3. Use the Integrated Support Star, or other similar tool, to identify other appropriate alternatives that are available to support the individual including other HCBS services, natural supports, technology, etc.
4. Is the temporary, immediate need for intervention and response fall within the purpose and guidelines of home and community based waiver services?
5. If it is determined that these flexibilities are warranted, the following options may be used on a *temporary basis up to a total of 30 consecutive days per occurrence when the individual receiving services and/or the current direct support professional has a positive test for COVID-19 or confirmed exposure of COVID-19*:
 - Parent(s), step-parent(s) and legal guardian(s) will temporarily be allowed to provide services to minors up to 40 hours per week but not exceeding the current plan approved units to (as direct support staff via an existing BDDS approved provider) who are currently using or have a documented intent to use only the following services:
 - Participant assistance and care available on the FSW
 - Day habilitation available on the FSW and CIH
 - Residential habilitation and support available on the CIH
 - An adult spouse will temporarily be allowed to provide services to an adult individual up to 40 hours per week but not exceeding the current plan approved units to in the following services:
 - Structured family caregiving available on the CIH
 - Participant assistance and care available on the FSW
 - The 40-hour-per-week per paid caregiver limitation will be temporarily waived for adult participants by one sole paid caregiver providing over 40 hours of service for:
 - Participant assistance and care available on the FSW
 - Residential habilitation and support available on the CIH

Any parent(s), step-parent(s), legal guardian(s) and spouse accessing these flexibilities for the first time will need to work with their provider to meet the provider, state and/or federal hiring and training requirements. All paid family caregivers must also meet background check requirements currently in place for direct service professionals as outlined above.



In situations where services are being provided to a minor by parents, step-parents and legal guardians, these waiver supports must not be used to supplant or replace services that would otherwise be funded by and the responsibility of another funding source, such as a school district, to provide.

When applicable, paid caregiver hours would be subject to overtime rules.

Existing services are those services that have been authorized in the current Cost Comparison Budget as of March 1, 2020.

I have a parent that wants to be PAC staff for their 18-year-old son. This is on their annual plan. However, their provider does think they can because of Appendix K. But the provider doesn't have staff to do the job. Can the parent do the PAC position?

A parent of an adult can be paid staff for that adult as long as:

- The individual receiving services is at least 18 years of age.
- The parent is employed by or a contractor of an agency that is approved by the DDRS.
- The parent meets the appropriate provider standards for the services being provided.
- The decision for the parent to provide services to the adult child is part of the PCISP planning process, which indicates that the parent is the best choice of persons to provide services from the DDRS-approved provider agency and this decision is recorded and explained in the PCISP.
- There is detailed justification as to why the relative is providing service.
- The decision for the parent to provide services is evaluated periodically to determine whether it continues to be in the best interest of the individual.
- Payment is made only to the DDRS-approved Medicaid enrolled waiver provider agency in return for specific services rendered.

Can you provide clarification on the Appendix K guidelines with regard to having primary caregivers provide PAC service to minors?

Effective Sept. 1, 2020, if it is determined that these flexibilities are warranted, the following options may be used on temporary basis up to a total of 30 consecutive days per occurrence when the individual receiving services and/or the current direct support professional has a positive test for COVID-19 or confirmed exposure of COVID-19.

As noted, Parent(s), step-parent(s) and legal guardian(s) will temporarily be allowed to provide services to minors up to 40 hours per week but not exceeding the current plan approved units.

Change in Structured Family Caregiving required visits

Has there been discussion regarding SFC required visits being completed virtually? It is specifically referred to in your guidance that the two visits can be done by any combination of the manager and nurse. Is it allowable these visits to be done via telemedicine?

Yes. It is allowable as long as completing these visits virtually is appropriate for the individual.



HCBS in hospital settings

Is additional guidance on the HCBS in hospital settings forthcoming?

The HCBS guidance can be found at https://www.in.gov/fssa/files/HCBS_Hospitals_Guidance.pdf. If there are additional questions you can submit a question to BQIS Help.

Can you define “acute care” settings?

A hospital that provides inpatient medical care and other related services for surgery, acute medical conditions or injuries (usually for a short term illness or condition).

If a client who receives a CIH waiver and is in a rehab facility for six weeks due to broken ankle, can a DSP provide services to client at rehab facility?

This guidance is only applicable for individuals receiving BDDS waiver services who are seeking or receiving treatment in an acute care hospital setting for inpatient medical care or other related services for surgery, acute medical conditions, or injuries. This guidance does not pertain to individuals who require care in a facility based setting including but not limited to nursing homes, rehabilitation centers and/or treatment facilities.

Does the revised hospital guidelines cover a rehab hospital? A guardian has requested staff to go to the hospital due to the client needing companionship.

This guidance is only applicable for individuals receiving BDDS waiver services who are seeking or receiving treatment in an acute care hospital setting for inpatient medical care or other related services for surgery, acute medical conditions, or injuries. This guidance does not pertain to individuals who require long term care in a facility-based setting including but not limited to nursing homes, rehabilitation centers and/or treatment facilities.

Policy changes applying to CIH

Allowing RHS reimbursement for sleep staff

How should sleep staff approval be documented? Is a case note sufficient or is PCPISP update needed?

For the CIH waiver, BDDS will temporarily waive current restrictions preventing providers to bill for RHS reimbursement for time when staff/paid caregiver is asleep. Teams must have a discussion and documented approach for planned staff sleep circumstances in short-term situations where no other support options are available or appropriate, and the individuals can be appropriately supported. Unplanned, sleep time that is not previously discussed and agreed to by the IST is not allowable under this exception.

The PCISP and CCB do not need to be updated. However, the discussion should be documented by the case manager.

Effective Sept. 1, 2020, the allowance for staff to stay overnight in the residence to be available in emergent situations where an individual has been quarantined to their home with staff due to COVID-19 exposure or positive testing and no other staff or means to support the individual have been established such as remote



supports, family or natural supports. May occur for a maximum of 30 days from the initial determination. During this time the team will be required to determine and plan for alternate supports as soon as feasible.

Policy changes applying to ICFs

Any new guidance given for SGLs?

Guidance for SGLs is included in our [“Updated Guidance for BDDS Providers on Temporary Policies Changes Related to COVID-19”](#) and Appendix K and in our [“Updated FAQ on COVID-19 Policy Changes.”](#)

Can providers bill therapeutic leave days past 60 since the temporary change is 120 leave days? Same question for billing hospital leave days.

The therapeutic leave days have been extended to 180 days. SGL providers can bill the leave rate when an individual is on therapeutic leave for up to 180 days. The automatic discharge after 15 days in the hospital has been waived. SGL providers can bill the leave rate when an individual is in the hospital. However, if an individual is admitted to a nursing facility, the provider must discharge the individual.

If an individual in an ICF is hospitalized for more than 15 days, does the ICF have to officially discharge them?

No. The requirement for an automatic discharge after an individual is hospitalized for 15 days has been waived temporarily due to the COVID-19 pandemic.

We are aware that the therapeutic leave days for SGL group homes has increased to 120 days from 60 days. Has the 15 hospital days limitation been extended beyond 15 days prior to discharge?

The requirement for an automatic discharge after an individual is hospitalized for 15 days has been waived temporarily due to the COVID-19 pandemic.

Also, if a consumer in an SGL group home is transferred from the hospital to a nursing facility rehab center, is the consumer still required to be discharged from the SGL group home?

Yes. When an individual enters a nursing facility, their level of care changes which necessitates a discharge from the SGL.

Are individuals in ICFs still allowed to go to doctor appointments? Can the guardian go with the individual?

Many physicians are completing medical appointments via telemedicine. BDDS recommends contacting the physician for assistance in determining the risk associated with attending a medical appointment in-person versus the use of telemedicine. The guardian is encouraged to talk with the ICF provider regarding accompanying the individual to the doctor’s appointment if indeed the appointment is held in-person.



COVID-19 testing kits for congregate settings

How can BDDS congregate residential settings obtain COVID testing kits?

The recording and materials from the informational webinar on BinaxNOWtm testing for BDDS congregate residential settings is [now available](#). Congregate settings include Medicaid home- and community-based waiver settings serving two or more individuals and community residential facilities for persons with developmental disabilities (ICF/IDDs and SGLs).

If your organization already has a CLIA number, you will need to update your CLIA waiver by submitting [Form 116](#) to include BinaxNOWtm on the list of tests that you will perform under your CLIA certification. If you are adding locations, you will need to update this information as well. Once you submit this update, please complete the [BDDS Congregate Residential BinaxNOWtm Request](#) form.

When your organization receives your CLIA number, please complete the [BDDS Congregate Residential BinaxNOWtm Request](#) form. We will then work with the Indiana Department of Health to send you a shipment of BinaxNOWtm cards, at no cost to your organization.

If your organization is interested in accessing testing materials, the first step is obtaining your CLIA Certificate of Waiver. Information on the CLIA application process is available through the “How to Apply for a CLIA Waiver Workbook” linked with the presentation.

Is a two- or three-person waiver site considered a congregate site?

Congregate residential settings include Medicaid home- and community-based waiver settings serving two or more individuals and community residential facilities for persons with developmental disabilities (ICF/IDDs and SGLs), as defined in 460 IAC 9-1-2.