Application for

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

June, 2012

v1.0

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

Facesheet

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

The **name of the waiver program is**: HCBS Case Management Selective Contracting Program. (List each program name if the waiver authorizes more than one program.).

Type of request. This is:

☐ an initial request for new waiver. All sections are filled.

☒ a request to amend an existing waiver, which modifies Section/Part __Section A Parts I, I-B-1, I-C, I-D, II-A, II-B, II-C, III-A, III-B, IV-A, IV-B and Section B. __

☐ a renewal request

Section A is:

☐ replaced in full

☐ carried over with no changes

☐ changes noted in **BOLD**.

Section B is:

☐ replaced in full

☐ changes noted in **BOLD**.

Effective Dates: This waiver/renewal/amendment is requested for a period of _five (5)_ years beginning 08/01/2026 and ending 07/15/2030.

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

Section A – Waiver Program Description

Part I: Program Overview

Tribal Consultation:
Describe the efforts the State has made to ensure that Federally-recognized tribes in the State are aware of and have had the opportunity to comment on this waiver proposal (if additional space is needed, please supplement your answer with a Word attachment).

Federally-recognized Tribal Governments in Indiana received written notice of the State's intent to renew this 1915(b)(4) waiver application at least 60 days before the anticipated submission date to CMS as provided by Presidential Executive Order 13175 of November 6, 2000. The applicable tribal consultation notice and draft of this 1915(b)(4) amendment application was provided to the Tribal Governments on January 28, 2026, to begin the 60-day tribal consultation period that will be conducted through March 29, 2026. Evidence of the applicable notice is available through the Medicaid Agency.

Program Description:
Provide a brief description of the proposed selective contracting program or, if this is a request to amend an existing selective contracting waiver, the history of and changes requested to the existing program. Please include the estimated number of enrollees served throughout the waiver (if additional space is needed, please supplement your answer with a Word attachment).

Indiana has two Medicaid Home and Community Based Services (HCBS) 1915(c) waivers serving individuals with intellectual and developmental disabilities (IDD) – the Family Supports Waiver (FSW) and the Community Integration and Habilitation Waiver (CIH). Both waivers provide services to individuals in a range of community settings as an alternative to care in an intermediate care facility. Today, the state operates a selective contracting program under 1915(b)(4) authority for case management services for FSW and CIH waiver participants. This authority waives the freedom-of-choice of case management providers, which has enabled Indiana to assure access to high quality case management services for all FSW and CIH waiver participants. Over the course of the current waiver periods an estimated 9,523 individuals will be served through the CIH waiver and approximately 29,179 individuals will be served on the FSW waiver.

Through the existing case management selective contracting waiver program, the state has leveraged its purchasing power to assure a sufficient number of case managers are available, to assure that high quality case management services are delivered and to assure a more consistent participant experience. For example, the state has found that competitive procurement motivates CMOs to agree to requirements that would be very challenging or impossible to enforce in a noncompetitive environment and, in some cases, inspires the CMOs to propose creative approaches that they would not have cause to consider in a noncompetitive environment. Furthermore, we have found that, relative to traditional state agency-provider

relationships, the ensuing contractual relationships provide the state the opportunity to actively and rigorously monitor CMOs' provision of case management services.

The Family Social Services Administration (FSSA) is the single state Medicaid agency authorized to administer five of Indiana's 1915(c) waivers. The Indiana Division of Disability Aging and Rehabilitative Services (DDARS) and the Office of Medicaid Policy and Planning (OMPP), divisions under FSSA, have the authority to administer the FSW and CIH waivers as well as the Health and Wellness (H&W), Traumatic Brain Injury (TBI), and the PathWays for Aging waiver (which is operated with a separate 1915(b)(4) for purposes of authorizing managed care organizations to perform the daily operations for most of those served). The Bureau of Disabilities Services (BDS), a bureau under DDARS, performs the daily operational tasks for the FSW, CIH, H&W, and TBI waivers. OMPP provides oversight of the managed care organizations operating the PathWays for Aging waiver and directly administers this waiver for those individuals who remain in the fee-for-service portion of that program.

With this 1915(b)(4) waiver amendment, the State seeks to expand the operation of this selective contracting program to the two additional 1915(c) waiver programs operated by BDS (H&W and TBI) as well as to the fee-for-service portion of the Pathways for Aging waiver operated by OMPP. This amendment would waive the freedom-of-choice of providers for case management services offered under the FSW, CIH, H&W, TBI, and PathWays for Aging (fee-for-service population only) waivers to a new network of case management organizations (CMOs) identified through the completion of a new selective contracting process (Indiana Request for Services 26-84994) covering all five waivers. This arrangement will limit the number of entities providing this service across all five waivers, thereby allowing DDARS to further expand the more robust oversight and monitoring activities of this pivotal service, relative to what we could achieve in a traditional 1915(c) waiver.

Using the tools afforded through this 1915(b)(4) waiver authority will continue to enable the state to leverage existing infrastructure, ensure sustained and exceptional knowledge of local resources, allow proximity to enrollees and providers to arrange and monitor services, and provide the state with the tools necessary to ensure consistently high caliber case management through its selected CMO vendor(s). The state estimates that with this amendment 15,951 additional individuals will be served under this 1915(b)(4) (15,739 on the H&W, 193 on the TBI, and 19 on Pathways for Aging).

Waiver Services:

Please list all existing State Plan services the State will provide through this selective contracting waiver (if additional space is needed, please supplement your answer with a Word attachment).

The State will be offering case management services covered in the State's following 1915(c) HCBS waivers:

- Community Integration and Habilitation (CIH) Waiver
- Family Supports (FS) Waiver
- Health and Wellness (H&W) Waiver
- Traumatic Brain Injury (TBI) Waiver

- PathWays for Aging (PathWays) Waiver (fee-for-service population only)

A. Statutory Authority

1. **Waiver Authority**. The State is seeking authority under the following subsection of 1915(b):
   ☒ **1915(b) (4) - FFS Selective Contracting program**

2. **Sections Waived**. The State requests a waiver of these sections of 1902 of the Social Security Act:
   a. ☐ **Section 1902(a) (1) - Statewideness**
   b. ☐ **Section 1902(a) (10) (B) - Comparability of Services**
   c. ☒ **Section 1902(a) (23) - Freedom of Choice**
   d. ☐ **Other Sections of 1902** – (please specify)

B. Delivery Systems

1. **Reimbursement**. Payment for the selective contracting program is:
   ☐ the same as stipulated in the State Plan
   ☒ is different than stipulated in the State Plan (please describe)

Payment for case management services under this selective contracting program is made using a per member per month structure that aligns with the approved State Plan except as described below.

BDS will withhold up to two (2) percent of each CMO's case management fee and combine these funds into a shared pool. The pooled funds will be distributed on a quarterly basis to CMOs that meet the performance threshold for the Service Level Agreements (SLA) specified in the CMO contracts.

Each quarter, BDS will use reports submitted by the CMOs and data from the state's electronic case management system to determine each CMO's compliance with the SLAs. The pooled funds for that quarter will be distributed equally among the CMOs that meet the required SLA performance threshold. Any CMO that does not meet the required SLA performance threshold will not receive a distribution from the pooled funds for that quarter.

Service level agreements will include at minimum:

- Timely and accurate completion of PCISP initials, annuals and updates. To be considered "timely," initial PCISPs must be completed a minimum of six

weeks prior to the initial start date of services; annual PCISPs must be completed six weeks prior to the expiration of the current service plan; and updates to PCISPs must be completed within 7 calendar days.

- Timely and accurate completion of LOC screenings, when required. To be considered "timely," annual LOC screenings must be completed every three hundred sixty-five (365) calendar days at a minimum.
- Timely and accurate completion of incident reporting and required follow up. To be considered "timely," an initial report must be submitted within 24 hours of the occurrence of the incident; or the reporter becoming aware of or receiving information about an incident. A follow-up report concerning the incident must be submitted within seven days of the date of the initial report; and every seven days thereafter until the incident is resolved.
- Timely and accurate completion of mortality review activities. . To be considered "timely," completion of mortality review activities must be completed in the timeframes specified by BDS respective to each mortality review. *Timely and accurate completion of mortality review activities. To be considered "timely," completion of mortality review activities must be completed in the timeframes specified by BDS respective to each mortality review which is that no later than 30 calendar days after the individual's death the entity shall complete the internal review into the death and send all requested documents. Any additional information requested must be received within 10 calendar days. The CMO is the responsible entity when there is not a residential-based services provider.*
-
- Compliance with case manager case load sizes. Th C*ase manager's average caseload size must not exceed forty-seven (47) cases across full-time Case Managers who actively provide case management services to individuals receiving waiver services. A full-time Case Manager is defined as a Case Manager with a caseload of at least 22 cases.*
-
- Training of Case Managers. CMOs must ensure that each case manager has completed the case management training curriculum and certification exam and 10 additional hours of training annually.

BDS will use reports submitted by the CMOs and data from the state's electronic case management system to determine each CMO's compliance with the SLAs.

Additionally, CMOs will be eligible to receive non-financial incentives linked to performance measures and/or targets that differ from those used in the service level agreements.

"Non-financial incentives may include, but may not be limited to:

- Special designations (e.g., blue ribbon or 4-star designation) for meeting trauma informed care, employment, charting the life course, and community mapping expectations.
- Preferential status for auto-assignment of participants when necessary, due to extenuating circumstances where the individual is unable or unwilling to choose a case management organization.
- Reduced reporting or other administrative requirements, to recognize, for example, consistent and sustained high performance levels."

The overall payment approach supports access, quality, and efficient and economic provision of services by providing both financial and non-financial incentives to encourage CMOs to meet and/or exceed service level agreements.

2. **Procurement**. The State will select the contractor in the following manner:
   ☒ **Competitive** procurement
   ☐ **Open** cooperative procurement
   ☐ **Sole source** procurement
   ☐ **Other** (please describe)

C. Restriction of Freedom-of-Choice

1. **Provider Limitations**.
   ☐ Beneficiaries will be limited to a single provider in their service area.
   ☒ Beneficiaries will be given a choice of providers in their service area.
   (NOTE: Please indicate the area(s) of the State where the waiver program will be implemented)

The CIH, FS, H&W, and TBI waiver programs are each implemented statewide, and this waiver will apply to all case management services provided under those programs. Additionally, this waiver will apply to case management services provided to the fee-for-service population under the PathWays for Aging waiver.

CMOs will complete a competitive procurement process which will result in at least five (5) CMOs receiving contracts to provide case management services on a statewide basis. CMOs will be selected based on criteria that demonstrates effectiveness and efficiency in providing case management services including:

- Business criteria such as structure, current registration to do business in Indiana, financial stability, and experience serving governments; and
- Technical criteria such as experience providing case management and assessment services, coverage area, approaches to ensuring contract compliance, approaches to recruitment, training and management of case managers,

approaches to quality assurance and approaches to assessing the communication needs of the participants.

All CMOs will be required to provide case management services on a statewide basis upon the implementation date of this waiver amendment. Every individual will be given the choice of the contracted CMOs 3 months prior to the implementation date of this waiver amendment. Each individual will receive case management services from the CMO they select. If a participant is unable or unwilling to choose a CMO, the state will assign the participant to a CMO. To ensure continuity of care, the current CMO is required to participate in transition activities as outlined by the state and provide services until new assigned CMO is in place. The newly assigned CMO will respond to referral within one business day, assign a case manager within one business day of their response, and ensure that the assigned case manager contacts the individual within two business days of their assignment. Additionally, the state will provide the newly assigned CMO and case manager access to the individual's existing case management records in the state's electronic case management system.

Individuals may receive this service from only one provider at a given time; however, individuals have the right to change CMOs at any time and to request a change of case manager within a given CMO, should they wish to do so.

2. **State Standards**.
Detail any difference between the state standards that will be applied under this waiver and those detailed in the State Plan coverage or reimbursement documents (if additional space is needed, please supplement your answer with a Word attachment).

Under this waiver and per the corresponding contracts with each selected CMO, there will be additional reporting requirements beyond those outlined in the State Plan, as well as the opportunity for additional non-financial rewards for CMOs who meet a series of metrics as detailed in their contracts with the state. This includes:

- Timely and accurate completion of PCISP initials, annuals and updates
- Timely and accurate completion of LOC screenings, when required
- Timely and accurate completion of incident reporting, required follow up and CAPs
- Timely and accurate completion of mortality review activities
- Compliance with case manager case load sizes
- Training of Case Managers
- As part of non-financial incentives, CMO's receive approval for reduced reporting or other administrative requirements, to recognize consistent and sustained high performance levels.

D. Populations Affected by Waiver
(May be modified as needed to fit the State's specific circumstances)

1. **Included Populations**. The following populations are included in the waiver:
   - ☐ Section 1931 Children and Related Populations
   - ☐ Section 1931 Adults and Related Populations
   - ☒ Blind/Disabled Adults and Related Populations
   - ☒ Blind/Disabled Children and Related Populations
   - ☒ Aged and Related Populations
   - ☐ Foster Care Children
   - ☐ Title XXI CHIP Children

2. **Excluded Populations**. Indicate if any of the following populations are excluded from participating in the waiver:
   - ☐ Dual Eligibles
   - ☐ Poverty Level Pregnant Women
   - ☐ Individuals with other insurance
   - ☐ Individuals residing in a nursing facility or ICF/MR
   - ☐ Individuals enrolled in a managed care program
   - ☐ Individuals participating in a HCBS Waiver program
   - ☐ American Indians/Alaskan Natives
   - ☐ Special Needs Children (State Defined). Please provide this definition.
   - ☐ Individuals receiving retroactive eligibility
   - ☒ Other (Please define):

     This waiver is only applicable to individuals served through CIH, FS, H&W, TBI or PathWays for Aging (fee-for service population) waivers.

Part II: Access, Provider Capacity and Utilization Standards

A. Timely Access Standards

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

1. How does the State measure (or propose to measure) the timeliness of Medicaid beneficiary access to the services covered under the selective contracting program (if additional space is needed, please supplement your answer with a Word attachment)?

The state of Indiana ensures timely intake of eligible individuals and aids the individual in the selection of a CMO. Specifically, the CMO must review daily referral of files for acceptance or denial. The CMO must respond to referrals for acceptance or denial within one business day of receipt. The CMO must assign accepted referrals to a case manager within one business day of accepting the referral. Following assignment, the case manager shall initiate outreach to the individual within two business days.

The case manager must complete the initial PCISP a minimum of six weeks prior to the initial start date of services and must complete the annual PCISP six weeks prior to the expiration of the current service plan. The state further monitors timely access related to timely completion of the annual level of care (LOC) assessment, timely completion of the annual budget in support of the PCISP (as applicable), meeting requirements, semi-annual Individualized Support Team meetings, and face-to-face meetings with the individual at least every 90 days, and monthly case notes which demonstrate meaningful activity with or on behalf of the individual to address issues, monitor the plan, and make adjustments to the PCISP as needed. DDARS utilizes its IT systems to monitor if initial and annual PCISPs, annual budgets (as applicable), and annual LOC assessments are done in a timely manner.

DDARS also utilizes National Core Indicator (NCI) data and National Core Indicator Aging and Disabilities (NCI-AD) data to monitor timely access through questions about waiver participants' experiences. DDARS reviews these select NCI and NCI-AD data to monitor timely access for the system holistically, as NCI and NCI-AD data are not linked to specific individuals.

To be awarded and retain a contract, each CMO must show evidence of written policies and procedures which ensure timely access to appropriate disability services, supports, and assessments. Each CMO under the expanded program must also maintain a 24/7 emergency response line to address the urgent needs of program participants. These policies are provider-specific, however, each provider is responsible for ensuring that policies and procedures meet or exceed DDARS timely access standards and other DDARS requirements. Through regular file and rubrics reviews, review of quarterly reporting submitted by CMOs, and QTIPs (detailed below) state staff evaluate the agency's compliance with their documented policies and procedures. The specific expectations for this reporting are delineated in provider contracts and related state guidance.

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

- Readiness Review - During the transition phase associated with this amendment the state will conduct a readiness review to assure the selected CMOs are ready to assume responsibility for services once the contract is fully in effect. FSSA will distribute readiness review instructions, tool(s), timelines, and any related documentation at or before the time of contract award. This review will include

the FSSA review and approval of each CMOs detailed implementation plan outlining how the CMO will ensure services begin as intended and meet all contract requirements and standards.

- File and Rubrics Reviews - On a quarterly basis Bureau of Disabilities Services (BDS) staff review a statistically valid sample of case files and corresponding rubrics for individuals to determine case manager compliance with Indiana Code and Indiana Administrative Code. BDS saw a 50% increase in rubric scores in 3 years demonstrating compliance and quality outcomes. For any item reviewed that is not in compliance, BDS staff provide technical assistance to the CMO to correct non-compliance and take other necessary action as outlined in the remedies section below.
- Quarterly Performance Evaluation Reports- Specific requirements for quarterly performance evaluation will be outlined in CMO contracts under this selective contracting program. DDARS/BDS will issue a quarterly performance evaluation report to each CMO, not more than 75 calendar days following the close of the relevant quarter and prior to the quarterly meeting with each CMO. Information includes both that which is provided by the CMO and information pulled from DDARS data systems. These reports provide CMO specific measures for the previous quarter and cumulative for the year to allow for discussion of progress over time. CMOs are also given a snapshot of all case management organization measures as a whole, providing insight into how their performance fits within the broader system.
- Quality Tracking Improvement Process (QTIPs)- The QTIP is a quarterly meeting with each CMO using the information gathered in the performance evaluation reports to evaluate the quality of the services being provided. Each CMO must meet quarterly with DDARS/BDS to discuss the findings of the report, opportunities for quality improvement, successes, and ideas for improvement. BDS provides technical assistance during the QTIPs to each CMO as needed. Identified trends found during QTIPs feed directly into the content of the subsequent Semi-Annual Collaborative Touchpoints.
- Semi-Annual Collaborative Quality Touchpoints- All CMOs must participate in semi-annual meetings with DDARS to build shared understanding and support provision of quality case management services. During this meeting, DDARS/BDS will address system-wide issues identified through QTIPS. BDS will provide guidance and updates to ensure all CMOs receive the same message at the same time. BDS will collaborate with CMOs during these meetings to hear about suggestions for improvement, barriers to success, and positive promising practices.
- Individual and Family Satisfaction Survey – BDS offers the opportunity to complete an annual satisfaction survey to all program participants and their families regarding their case management services. Survey results are compiled, de-identified, and analyzed by an independent contractor and report for all CMOs will be issued no later than June 30th of the following year. Each CMO receives a detailed report of their findings as well as a statewide report demonstrating individual and family satisfaction as a whole with case

management. In 2025, for all but one question, over 50% of respondents rated their case manager as “excellent”.

2. Describe the remedies the State has or will put in place in the event that Medicaid beneficiaries are unable to access the contracted service in a timely fashion (if additional space is needed, please supplement your answer with a Word attachment).

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

If reassignment to an alternative CMO is required, the individual will be given the choice of selecting a new CMO. If an individual is unable or unwilling to choose a CMO, the state will assign the individual to a CMO. To ensure continuity of care, CMOs must provide service until new CMO is in place. Individuals have the right to change CMOs at any time.

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

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

B. Provider Capacity Standards

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

1. Provide a detailed capacity analysis of the number of providers (e.g., by type, or number of beds for facility-based programs), or vehicles (by type, per contractor for non-emergency transportation programs), needed per location or region to assure sufficient capacity under the selective contracting program (if additional space is needed, please supplement your answer with a Word attachment).

In order to plan and receive other services available through the applicable waivers, all individuals served by DDARS must utilize case management. As of December 2025, BDS served approximately 33,220 individuals in the CIH and FS waivers with a workforce of 805 case managers. Of these 805 case managers, the average number of individuals served per case manager was approximately 42. As of December 2025, BDS served approximately 13,200 individuals in the H&W, TBI and PathWays for Aging fee-for-service program with a workforce of 930 case managers.

Through its competitive procurement process, the state has selected five (5) case management organizations (CMOs) to provide case management services across all five waivers on a statewide basis.

DDARS's expansion of case management under a selective contracting program is not anticipated to impact the necessary supply of providers for the case management service as this expansion will not impact enrollment in the larger waiver programs. Annual growth in the relevant waiver programs will be monitored to ensure the available case management workforce can accommodate new enrollees while still adhering to the caseload limit of 47 as outlined in the applicable RFS. BDS does, and will continue to, monitor the average caseload sizes on an ongoing basis. The number of individuals served on each of the applicable waivers is directly tied to the funding approved by the state legislature and the number of slots outlined in each 1915(c) application. Therefore, FSSA will be well equipped to anticipate any forthcoming needs for additional capacity. Should the growth in any of these waivers exceed expected rates, DDARS will have the ability to notify each of the contracted CMOs of such, thereby allowing them to increase their workforce of case managers as warranted.

To ensure case managers have the necessary capacity to provide high caliber case management services to individuals, caseload size limits of an average of 47 across full time case managers will be imposed as part of CMO contracts. This limit will ensure case managers have adequate capacity to absorb increased utilization amongst the people they are serving, if necessary. Because case management is paid at a monthly per diem, changes in utilization associated with this caseload limit would not have an immediate corresponding cost to account for. CMOs are also allowed to develop their

own independent means of further managing caseload sizes within the average caseload limit. For example, a CMO may elect to have a case manager maintain a smaller caseload of individuals who are particularly complex or who have more extensive needs and another case manager maintain a higher caseload of individuals who have historically needed less intensive case management services.

CMOs have been notified of this caseload limit and will be contractually required to ensure a sufficient amount of case managers are employed to provide coverage in their designated geographic regions while maintaining the average caseload size.

The state's data reporting system allows for reports to be pulled which identify the total number of individuals at both the district and county level, thereby indicating the varying case management capacities necessary down to the county level. While DDARS does not require that case managers be located in the same county as those they serve, and in fact, most case managers currently serve more than one county, physical proximity between the case manager and service recipient is preferable to facilitate timely access and availability of the service. To ensure local understanding and knowledge as well as access, case managers must be physically present and work in the local communities they will serve. Case managers' physical work base (office or home, as determined by the CMO) must be located within the county or within 60 miles or 60 minutes of driving time to the residences of individuals on their caseload. Exceptions to this access distance standard may be granted if requested by the individual and agreed upon by the CMO, or when the CMO can demonstrate other reasons. Any exception to the access distance standard must be approved by FSSA. As service recipients move or new individuals are targeted for waiver services, their location information is updated or captured, allowing DDARS to analyze trends indicating changes in case management capacity requirements.

While DDARS intends to limit the total number of CMOs through the competitive procurement process, the state anticipates requiring more or less the same total workforce of individual case managers. Award of this contract will be contingent upon the CMO offering services in their designated geographic regions within 3 months of being notified of their selective contract award to facilitate choice of providers in even rural or sparsely populated areas of the state.

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

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

throughout the regions affected by the program (if additional space is needed, please supplement your answer with a Word attachment).

Award of this contract will be contingent upon the CMO offering services in their designated geographic regions within 3 months of being awarded the contract, thereby ensuring coverage by multiple entities in all areas of the state. Providers are required to submit as part of their contract, the process they have put into place to ensure caseload sizes per case manager appropriately address the geographical and complex needs of individuals. Information submitted by CMOs as part of their quarterly performance reports is used alongside information entered and maintained within the BDS online portal to evaluate appropriate distribution of providers and identify areas where adjustments may be needed. Issues around timely access and distribution of providers will be broadly discussed during the Semi-Annual Collaborative Quality Touchpoints and addressed with individual CMOs during their QTIPs as needed.

C. Utilization Standards

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

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

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

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

   DDARS specifically monitors utilization of the case management service through the submission of PCISPs, documentation of quarterly face-to-face visits with the individual within their home and service setting, and review of case notes which detail additional interaction with and support of the individual. These monitoring activities allow DDARS to identify how well the provider is supporting the full implementation of the individual's PCISP, ascertaining satisfaction with the waiver services and

addressing issues or concerns that have arisen—all key elements of the case management service.

More generally, DDARS utilizes a series of tools and processes to complete all monitoring specific to the CMO selective contracting program. These methods of monitoring are aimed at ascertaining appropriate utilization, as well as timely access, compliance with Indiana's quality standards, and compliance with contractual requirements:

- Compliance Reviews – During these reviews, the state will rely on a variety of information and data sources (e.g., CMOs' self-reported data and information, state data files) to assess each CMO's compliance with minimum service standards such as timely development/updates to the PCISP, timely quarterly visits, etc.
- File and Rubrics Reviews - On a quarterly basis Bureau of Disabilities Services (BDS) staff review a statistically valid sample of case files and corresponding rubrics for individuals to determine case manager compliance with Indiana Code and Indiana Administrative Code. BDS saw a 50% increase in rubric scores in 3 years demonstrating compliance and quality outcomes. For any item reviewed that is not in compliance, BDS staff provide technical assistance to the CMO to correct non-compliance and take other necessary action as outlined in the remedies section below.
- Quarterly Performance Evaluation Reports- Specific requirements for quarterly performance evaluation reports will be outlined in CMO contracts under this selective contracting program. DDARS/BDS will issue a quarterly performance evaluation report to each CMO, not more than 75 calendar days following the close of the relevant quarter and prior to the quarterly meeting with each CMO. Information includes both that which is provided by the CMO and information pulled from DDARS data systems. These reports provide CMO specific measures for the previous quarter and cumulative for the year to allow for discussion of progress over time. CMOs are also given a snapshot of all case management organization measures as a whole, providing insight into how their performance fits within the broader system.
- Quality Tracking Improvement Process (QTIPs)- The QTIP is a quarterly meeting with each CMO using the information gathered in the performance evaluation reports to evaluate the quality of the services being provided. Each CMO must meet quarterly with DDARS/BDS to discuss the findings of the report, opportunities for quality improvement, successes, and ideas for improvement. BDS provides technical assistance during the QTIPs to each CMO as needed. Identified trends found during QTIPs feed directly into the content of the subsequent Semi-Annual Collaborative Touchpoints.
- Semi-Annual Collaborative Quality Touchpoints- All CMOs must participate in semi-annual meetings with DDARS to build shared understanding and support provision of quality case management services. During this meeting, DDARS/BDS will address system-wide issues identified through QTIPS. BDS will provide guidance and updates to ensure all CMOs receive the same message at the same time. BDS will collaborate with CMOs during these meetings to hear

about suggestions for improvement, barriers to success, and positive promising practices.

- Individual and Family Satisfaction Survey – BDS offers the opportunity to complete a satisfaction survey to all program participants and their families regarding their case management services. Survey results are compiled, de-identified, and analyzed by an independent contractor and report for all CMOs will be issued no later than June 30th of the following year. Each CMO receives a detailed report of their findings as well as a statewide report demonstrating individual and family satisfaction as a whole with case management. In 2025, for all but one question, over 50% of respondents rated their case manager as "excellent".

2. Describe the remedies the State has or will put in place in the event that Medicaid beneficiary utilization falls below the utilization standards described above (if additional space is needed, please supplement your answer with a Word attachment).

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

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

In the event a provider does not comply with the requirements as outlined in Indiana Code, Indiana Administrative Code, DDARS/BDS policy and guidance, as well as any requirement laid out within the contract itself, and does not complete a timely corrective action plan to the reasonable satisfaction of DDARS/BDS or it's designee, DDARS/BDS will identify additional remedial actions permitted under the contract and/or within Indiana Code and Indiana Administrative Code. This may include withholding authorization for providing services to new individuals until which time the CAP has been satisfied, civil monetary penalties, or sanctions. DDARS/BDS also has

the ability to revoke the contract award as detailed within the provider contract and will do so in circumstances where the failure to comply with contract requirements are particularly egregious and persistent.

Part III: Quality

A. Quality Standards and Contract Monitoring

1. Describe the State's quality measurement standards specific to the selective contracting program (if additional space is needed, please supplement your answer with a Word attachment).

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

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

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

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

DDARS monitors compliance with the State's quality standards for case management through review of documentation that identifies all elements outlined above have been met. While much of this information is tracked and documented within the DDARS IT systems, within the confines of this

selective contracting program, providers are also expected to affirmatively supplement that documentation through the submission of quarterly reports detailing their own measurement of compliance with all policies, procedures, and service expectations. The state also uses post-payment audits and reviews to ensure that proper documentation of service delivery is present.

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

- File and Rubrics Reviews- On a quarterly basis Bureau of Disabilities Services (BDS) staff review a statistically valid sample of case files and corresponding rubrics for individuals to determine case manager compliance with Indiana Code and Indiana Administrative Code. BDS saw a 50% increase in rubric scores in 3 years demonstrating compliance and quality outcomes. For any item reviewed that is not in compliance, BDS staff provide technical assistance to the CMO to correct non-compliance and take other necessary action as outlined in the remedies section below.
- Quarterly Performance Evaluation Reports- Specific requirements for quarterly performance evaluation reports will be outlined in CMO contracts under this selective contracting program. DDARS/BDS will issue a quarterly performance evaluation report to each CMO, not more than 75 calendar days following the close of the relevant quarter and prior to the quarterly meeting with each CMO. Information includes both that which is provided by the CMO and information pulled from DDARS data systems. These reports provide CMO specific measures for the previous quarter and cumulative for the year to allow for discussion of progress over time. CMOs are also given a snapshot of all case management organization measures as a whole, providing insight into how their performance fits within the broader system.
- Quality Tracking Improvement Process (QTIPs)- The QTIP is a quarterly meeting with each CMO using the information gathered in the performance evaluation reports to evaluate the quality of the services being provided. Each CMO must meet quarterly with DDARS/BDS to discuss the findings of the report, opportunities for quality improvement, successes, and ideas for improvement. BDS provides technical assistance during the QTIPs to each CMO as needed. Identified trends found during QTIPs feed directly into the content of the subsequent Semi-Annual Collaborative Touchpoints.
- Semi-Annual Collaborative Quality Touchpoints- All CMOs must participate in semi-annual meetings with DDARS to build shared understanding and support provision of quality case management services. During this meeting, DDARS/BDS will address system-wide

issues identified through QTIPS. BDS will provide guidance and updates to ensure all CMOs receive the same message at the same time. BDS will collaborate with CMOs during these meetings to hear about suggestions for improvement, barriers to success, and positive promising practices.

- Individual and Family Satisfaction Survey – BDS offers the opportunity to complete a satisfaction survey to all program participants and their families regarding their case management services. Survey results are compiled, de-identified, and analyzed by an independent contractor and report for all CMOs will be issued no later than June 30th of the following year. Each CMO receives a detailed report of their findings as well as a statewide report demonstrating individual and family satisfaction as a whole with case management. In 2025, for all but one question, over 50% of respondents rated their case manager as "excellent".

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

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

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

2. Describe the State's contract monitoring process specific to the selective contracting program (if additional space is needed, please supplement your answer with a Word attachment).

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

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

The multi-step monitoring approach outlined in the response to Part 1 of this question was specifically designed to expand beyond compliance with Indiana Code and Indiana Administrative Code to incorporate review of those expectations defined under the specific contracts developed following this competitive procurement process. With the expansion of the selective contracting for case management program DDARS/BDS is reviewing the previous quarterly reporting requirements to determine what has been shown to be most effective and will develop new provider contracts that incorporate both standard measures that have been shown to be effective and measures detailed by providers in their responses to the request for services. The specific reporting requirements as well as the subsequent QTIPs and Quality Touchpoints are specifically aimed at ensuring compliance with the contractual requirements, including those that go beyond the case management service requirements outlined elsewhere.

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

If the vendor fails to comply with any of the requirements of the contract, the State may impose civil monetary penalties for poor performance. Ultimately, if the violations are considered egregious and persistent, the contract may be terminated and a new contractor sought for service delivery.

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

In the event a provider does not comply with the requirements as outlined in Indiana Administrative Code, as well as any requirement laid out within the contract itself, and does not complete a timely corrective action plan to the reasonable satisfaction of DDARS/BDS or its designee, DDARS/BDS will identify additional remedial actions permitted under the contract and/or within

Indiana Administrative Code. This may include withholding authorization for providing services to new individuals until which time the CAP has been satisfied, civil monetary penalties, or sanctions. DDARS/BDS also has the ability to revoke the contract award as detailed within the provider contract and will do so in circumstances where the failure to comply with contract requirements are particularly egregious and persistent. Contracts associated with this program come with the potential for extensions, at the discretion of DDARS/BDS, which will also take into account any failure to meet the contractual requirements and/or Indiana Administrative Code.

B. Coordination and Continuity-of-Care Standards

Describe how the State assures that coordination and continuity of care is not negatively impacted by the selective contracting program (if additional space is needed, please supplement your answer with a Word attachment).

The selective contracting program will ensure the highest quality and continuity of care is delivered by all selected CMOs. All contracted CMOs will have demonstrated their ability to serve individuals in their designated geographic regions within 3 months of the contract award. In addition to demonstrating the ability to absorb additional case managers and associated caseloads, CMOs will need to develop protocols for situations where an individual may be required to change case manager or CMO with an aim of ensuring minimal interruption to care continuity. DDARS/BDS developed and successfully implemented a series of processes to ensure coordination and continuity of care when the move to contracted case management was launched for the CIH and FS waiver and will maximize that learning to support smooth transitions associated with this program expansion and new RFS.

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

Part IV: Program Operations

A. Beneficiary Information

Describe how beneficiaries will get information about the selective contracting program (if additional space is needed, please supplement your answer with a Word attachment).

DDARS will continue to regularly make comprehensive information available to individuals regarding the CMO providers available to them upon their approval for 1915 (c) HCBS

waivers. The providers identified through the competitive solicitation will also be responsible for providing information to enrollees as outlined in their contracts.

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

The state is reprocuring CMO contracts with effective dates in mid-2026 to align with this amendment application. After the state makes CMO contract awards and completes readiness reviews, it will execute a robust communication plan to notify individuals and families about any changes in the CMOs available to them. Individuals who are currently being served by a CMO that does not receive a contract award will be notified that they are required to change CMOs. All communications will be conveyed via multiple modes including but not limited to mail, social media, newspapers, and telephone. These communications will be led by the state with support from outgoing, continuing, and incoming CMOs.

B. Individuals with Special Needs

☒ The State has special processes in place for persons with special needs

(Please provide detail).

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

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

Section B – Waiver Cost-Effectiveness and Efficiency

Efficient and economic provision of covered care and services:

1. Provide a description of the State's efficient and economic provision of covered care and services (if additional space is needed, please supplement your answer with a Word attachment).

Indiana ensures the efficient and economic provision of covered care and services under its 1915(b)(4) waiver by employing a targeted selective-contracting model that aligns with State Plan reimbursement rates and federal guidance. The waiver leverages the same fee-for-service methodologies in the State Plan—without new administrative markups—preserving fiscal efficiencies while enabling strategic provider sourcing. Case Management providers are competitively procured through transparent, outcome-driven processes intended to ensure quality, cost-effectiveness, and broad geographic coverage across both urban and rural areas. Streamlining the number of CMO's reinforces continuity and better integration of services. Contracted providers are held to rigorous network adequacy, access, utilization, and quality benchmarks, with continuous monitoring of timeliness, service utilization, and client experience. This structure strengthens care coordination, minimizes duplication of services tailored to diverse Medicaid populations, and supports federally required cost comparisons. Indiana projects waiver expenditures will be equal to or less than a similarly trended willing-provider environment, demonstrating that the program maintains fiscal discipline while delivering high-value, statewide coverage of covered services. Consistent with federal requirements, the State's cost projections demonstrate that waiver expenditures are expected to be equal to or lower than trended fee-for-service costs in an any-willing-provider environment. This approach affirms that the waiver advances efficiency, economy, and quality outcomes for the individuals in our services through the provision of case management.

2. Project the waiver expenditures for the upcoming waiver period.

Year 1 from: 07/16/2025 to 07/15/2026

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

Projected pre-waiver cost	$ 105,914,129.95
Projected Waiver cost	$ 105,914,129.95
Difference:	$ 0.00

Year 2 from: 07/16/2026 to 07/15/2027

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

Projected pre-waiver cost $ 107,587,326.73

Projected Waiver cost $ 107,587,326.73
Difference: $ 0.00

Year 3 (if applicable) from: 07/16/2027 to 07/15/2028
(For renewals, use trend rate from previous year and claims data from the CMS-64)

Projected pre-waiver cost $ 109,183,418.66
Projected Waiver cost $ 109,183,418.66
Difference: $ 0.00

Year 4 (if applicable) from: 07/16/2028 to 07/15/2029
(For renewals, use trend rate from previous year and claims data from the CMS-64)

Projected pre-waiver cost $ 110,706,689.30
Projected Waiver cost $ 110,706,689.30
Difference: $ 0.00

Year 5 (if applicable) from: 07/16/2029 to 07/15/2030
(For renewals, use trend rate from previous year and claims data from the CMS-64)

Projected pre-waiver cost $ 110,706,689.30
Projected Waiver cost $ 110,706,689.30
Difference: $ 0.00