

1915(i) State plan Home and Community-Based Services Administration and Operation

The State implements the optional 1915(i) State plan Home and Community-Based Services (HCBS) benefit for elderly and disabled individuals as set forth below.

Concurrent Operation with Other Programs:
 This §1915(i) State Plan Amendment operates concurrently with an approved fee-for-service selective contracting waiver authorized under §1915(b)(4) of the Act, effective April 1, 2014.

1. **Services.** (Specify the State’s service title(s) for the HCBS defined under “Services” and listed in Attachment 4.19-B):

Behavioral and Primary Healthcare Coordination (BPHC)

2. **State Medicaid Agency (SMA) Line of Authority for Operating the State plan HCBS Benefit.** (Select one):

<input type="radio"/>	The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program (<i>select one</i>):
<input type="radio"/>	The Medical Assistance Unit (<i>name of unit</i>):
<input type="radio"/>	Another division/unit within the SMA that is separate from the Medical Assistance Unit (<i>name of division/unit</i>) <i>This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.</i>
<input checked="" type="checkbox"/>	The State plan HCBS benefit is operated by (<i>name of agency</i>) Division of Mental Health and Addiction of the Indiana Family and Social Services Administration
	A separate agency of the State that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit.

3. Distribution of State plan HCBS Operational and Administrative Functions.

(By checking this box the State assures that): When the Medicaid agency does not directly conduct an administrative function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed (check each that applies):

(Check all agencies and/or entities that perform each function):

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
1 Individual State plan HCBS enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2 State plan HCBS enrollment managed against approved limits, if any	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 Eligibility evaluation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4 Review of participant service plans	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5 Prior authorization of State plan HCBS	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6 Utilization management	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7 Qualified provider enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8 Execution of Medicaid provider agreement	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
9 Establishment of a consistent rate methodology for each State plan HCBS	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10 Rules, policies, procedures, and information development governing the State plan HCBS benefit	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(Specify, as numbered above, the agencies/entities (other than the SMA) that perform each function):

Numbers 1, 4, 5, 7, 9-11 are performed by the Division of Mental Health and Addiction (DMHA).
 Number 6 is performed by DMHA and the Medicaid Surveillance Utilization Review (SUR) Contractor.
 Number 8 is performed by the Medicaid Fiscal Agent.
 Number 3 is performed by the Division of Family Resources (DFR), DMHA and the Medical Review Team (MRT) of the Family and Social Services Administration (FSSA). DMHA houses the Independent State Evaluation Team and is responsible for program eligibility determination based on needs-based and targeting criteria and service plan approvals and denials. DFR conducts all other elements of review for Medicaid eligibility, including but not limited to, income eligibility, age, citizenship and state residency. MRT is responsible for disability reviews if one of the exceptions under

42 CFR §435.541(c) applies.

(By checking the following boxes the State assures that):

4. **Conflict of Interest Standards.** The State assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:
- related by blood or marriage to the individual, or any paid caregiver of the individual
 - financially responsible for the individual
 - empowered to make financial or health-related decisions on behalf of the individual
 - providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the State, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified provider in a geographic area, and the State devises conflict of interest protections. *(If the State chooses this option, specify the conflict of interest protections the State will implement):*

The Independent State Evaluation Team is responsible for determining the 1915(i) eligibility and approving the individualized services requested in the proposed care plan. The members of this state team are prohibited from having any financial relationships with the applicant/recipient requesting services, their families or the entity selected to provide services. Assessments are completed and proposed plans of care (Individualized Integrated Care Plan – IICP) are submitted by a qualified provider entity to the Independent State Evaluation Team for needs-based clinical eligibility determination and care plan approval. The Independent State Evaluation Team reviews the documentation to determine if the needs-based criteria is met.

Responsibility for 1915(i) program eligibility determination and approval of the IICP proposed services in all cases is retained by the Independent State Evaluation Team in order to ensure no conflict of interest in the final determinations. The DMHA approved BPHC provider agency submits the results from the face-to-face assessment, required supporting documentation, and a proposed care plan to the state evaluation team for independent review. The state evaluation team determines needs-based clinical eligibility for 1915(i) services based upon their review of the clinical documentation of applicant's identified needs and alignment of needs, goals and recommended services.

The state also requires documentation, signed by the applicant/recipient that attests to the following:

- 1) The recipient is an active participant in the planning and development of the 1915(i) IICP.
- 2) The recipient is the person requesting 1915(i) services on the IICP.
- 3) The recipient received a randomized list of eligible 1915(i) service provider agencies in his/her community; and has selected the provider(s) of his or her choice to deliver the 1915(i) service on the IICP.

In addition, BPHC provider agencies are required to have written policies and procedures available for review by the state which clearly define and describe how conflict of interest requirements are implemented and monitored. The state ensures compliance through policies designed to be consistent with CMS conflict of interest assurances and through quality assurance activities.

5. **Fair Hearings and Appeals.** The State assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.
6. **No FFP for Room and Board.** The State has methodology to prevent claims for Federal financial participation for room and board in State plan HCBS.

7. **Non-duplication of services.** State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, State, local, and private entities. For habilitation services, the State includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

Number Served

1. **Projected Number of Unduplicated Individuals To Be Served Annually.**

(Specify for year one. Years 2-5 optional):

Annual Period	From	To	Projected Number of Participants
Year 1	4/1/2014	3/31/2015	4,562
Year 2			
Year 3			
Year 4			
Year 5			

2. **Annual Reporting.** *(By checking this box the State agrees to):* annually report the actual number of unduplicated individuals served and the estimated number of individuals for the following year.

Financial Eligibility

1. **Medicaid Eligible.** *(By checking this box the state assures that):* Individuals receiving State plan HCBS are included in an eligibility group that is covered under the State’s Medicaid Plan and have income that does not exceed 150% of the Federal Poverty Line (FPL). (This election does not include the optional categorically needy eligibility group specified at §1902(a)(10)(A)(ii)(XXII) of the Social Security Act.)
2. In addition to providing State plan HCBS to individuals described in item 1 above, the state is **also** covering the optional categorically needy eligibility group of individuals under 1902(a)(10)(A)(ii)(XXII) who are eligible for HCBS under the needs-based criteria established under 1915(i)(1)(A) and have income that does not exceed 150% of the federal poverty level, or who are eligible for HCBS under a waiver approved for the state under section 1915(c), (d) or (e) or section 1115 to provide such services to individuals whose income does not exceed 300% of the supplemental security income benefit rate (as described in Attachment 2.2A, Pages 23g-h of the state plan).
3. **Medically Needy** (Select one):

<input checked="" type="checkbox"/> The State does not provide State plan HCBS to the medically needy.
<input type="checkbox"/> The State provides State plan HCBS to the medically needy. (Select one):

- The state elects to disregard the requirements section of 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy. When a state makes this election, medically needy individuals only receive 1915(i) services
- The state does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act.

Evaluation/Reevaluation of Eligibility

1. Responsibility for Performing Evaluations / Reevaluations. Eligibility for the State plan HCBS benefit must be determined through an independent evaluation of each individual). Independent evaluations/reevaluations to determine whether applicants are eligible for the State plan HCBS benefit are performed (*Select one*):

<input type="radio"/>	Directly by the Medicaid agency
<input checked="" type="checkbox"/>	By Other (<i>specify State agency or entity under contract with the State Medicaid agency</i>): DMHA

2. Qualifications of Individuals Performing Evaluation/Reevaluation. The independent evaluation is performed by an agent that is independent and qualified. There are qualifications (that are reasonably related to performing evaluations) for the individual responsible for evaluation/reevaluation of needs-based eligibility for State plan HCBS. (*Specify qualifications*):

Persons conducting the state evaluation for eligibility determination and approval of plans of care hold a least a bachelor’s degree in social work, counseling, psychology, or similar field and have a minimum of 3 years post degree experience working with individuals with serious mental illness (SMI) and/or substance use disorders. Supervision of the evaluation team is provided by clinically licensed staff from the fields of social work, psychology, or psychiatry.

3. Process for Performing Evaluation/Reevaluation. Describe the process for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

Information about 1915(i) services is posted on the DMHA and Office of Medicaid Policy and Planning (OMPP) public websites. These websites summarize the eligibility criteria and note the available service, service provider agencies, locations where potential enrollees may go to apply, and how to access assessments and services. Any provider may identify potential enrollees who meet the 1915(i) eligibility criteria or individuals may notify their provider of an interest in the 1915(i) service. Any individual may contact the state for information about BPHC eligibility and the process to apply. The individual is given a list of BPHC eligible provider agencies that may be chosen to assist in the application process. After agency staff reviews the program information with the applicant, the two individuals discuss the options under this program; and together determine whether to complete an application for 1915(i) services. In deciding whether or not a referral for 1915(i) services is appropriate, the agency staff and applicant review the target group, needs-based and financial criteria and discuss whether a referral is merited.

Each person referred for 1915(i) services will receive a face to face bio-psychosocial needs assessment by the referring provider including but not limited to the Adult Needs and Strengths Assessment

(ANSA) tool and completion of the 1915(i) referral form developed by OMPP/DMHA.

The ANSA tool consists of items that are rated as:

- '0' no evidence or no need for action
- '1' need for watchful waiting to see whether action is needed
- '2' need for action
- '3' need for either immediate or intensive action due to a serious or disabling need

The items are grouped into categories or domains. Once the assessment has been completed, the agency staff receives a level of need recommendation based on the individual item ratings. The level of need recommendation from the ANSA is not intended to be a mandate for the level of services that an individual receives. There are many factors, including individual preferences and choice, that influence the actual intensity of treatment services.

The user's manual for the ANSA may be found on-line at:
<https://dmha.fssa.in.gov/DARMHA/mainDocuments.aspx>

The referral form and supporting documentation provide specific information about the person's health status, current living situation, family functioning, vocational/employment status, social functioning, living skills, self-care skills, capacity for decision making, potential for self-injury or harm to others, substance use/abuse, need for assistance managing a medical condition, and medication adherence.

The agency staff and the applicant jointly develop a proposed plan of care (Individualized Integrated Care Plan (IICP)) that includes desired goals and services requested and deemed necessary to address the goals. Please see the section "Supporting the Participant in Plan of Care Development" for further details regarding person-centered care planning. Upon completion of the referral packet (including but not limited to the ANSA, referral form, and proposed plan of care), the agency staff submit the documents to DMHA through a secure electronic file transfer process.

Upon receipt of the referral packet, the state evaluation team reviews all submitted documentation and determines whether or not the applicant meets the needs-based criteria for 1915(i).

Time spend for the initial evaluation, referral form, and IICP cannot be billed or reimbursed under the 1915(i) benefit before eligibility for this benefit has been determined. The eligibility determination process completed by the Independent State Evaluation Team is billed as administrative activities.

If determined eligible for the 1915(i) service, an eligibility determination and care plan service approval letter is sent. Once eligible, the approved service may begin immediately.

If determined ineligible for the 1915(i) service due to not meeting the needs-based criteria, a denial letter is sent to the applicant and the agency staff member informing them that their application for this program and service has been denied. The denial letter is generated by DMHA. The letters will include the reason for denial, appeal rights and process.

Re-evaluations for continued 1915(i) services follow this same process.

4. **Reevaluation Schedule.** *(By checking this box the State assures that):* Needs-based eligibility reevaluations are conducted at least every twelve months.

5. **Needs-based HCBS Eligibility service.** *(By checking this box the State assures that):* Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS.

The criteria take into account the individual’s support needs, and may include other risk factors: *(Specify the needs-based criteria):*

<p>All of the following needs-based criteria must be met for 1915(i) eligibility:</p> <ol style="list-style-type: none"> 1. The recipient must demonstrate needs related to management of his/her behavioral and physical health. 2. The recipient must demonstrate impairment in self-management of physical and behavioral health services. 3. The recipient has received a recommendation for intensive community based care on the uniform assessment tool defined by the State (the Adult Needs and Strengths Assessment-ANSA with a Level of 3 or higher). 4. The recipient demonstrates a health need which requires assistance and support in coordinating behavioral and physical health treatment.
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6. **Needs-based Institutional and Waiver Criteria.** *(By checking this box the State assures that):* There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the State has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chart below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):*

Needs-Based/Level of Care (LOC) Criteria

State plan HCBS needs-based eligibility criteria	NF (& NF LOC waivers)	ICF/MR (& ICF/MR LOC waivers)	Applicable Hospital* LOC (& Hospital LOC waivers)
Needs-based eligibility criteria are specified in Item 5 above.	<p>Indiana Law allows reimbursement to NFs for eligible persons who require skilled or intermediate nursing care as defined in 405 Indiana Administrative Code 1-3-1 and 1-3-2.</p> <p>405 IAC 1-3-1(a) Skilled nursing services, as ordered by a physician, must be required and provided on a daily basis, essentially 7 days a week.</p>	<p>Indiana Law allows reimbursement to ICF/MRs for eligible persons as defined in 405 IAC 1-1-11.</p> <p>A person may be functionally eligible for an ICF/MR LOC waiver when documentation shows the individual meets the following conditions:</p> <ol style="list-style-type: none"> 1. Has a diagnosis of intellectual disability (mental retardation), cerebral palsy, epilepsy, 	Dangerous to self or others or gravely disabled. (IC-12-26-1)

	<p>405 IAC 1-3-2 (a) Intermediate nursing care includes care for patients with long term illnesses or disabilities which are relatively stable, or care for patients nearing recovery and discharge who continue to require some professional medical or nursing supervision and attention.</p> <p>A person is functionally eligible for either NF or an NF level of care waiver if the need for medical or nursing supervision and attention is determined by any of the following findings from the functional screening:</p> <ol style="list-style-type: none"> 1. Need for direct assistance at least 5 days per week due to unstable, complex medical conditions. 2. Need for direct assistance for 3 or more substantial medical conditions including activities of daily living. 	<p>autism, or condition similar to intellectual disability (mental retardation).</p> <ol style="list-style-type: none"> 2. Condition identified in #1 is expected to continue. 3. Condition identified in #1 had an age of onset prior to age 22. 4. Individual needs a combination or sequence of services. 5. Has 3 of 6 substantial functional limitations as defined in 42 CFR 435.1010 in areas of (1) self-care, (2) learning, (3) self-direction, (4) capacity for independent living, (5) language, and (6) mobility. 	
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*Long Term Care/Chronic Care Hospital

7. **Target Group(s).** The State elects to target this 1915(i) State plan HCBS benefit to a specific population. With this election, the State will operate this program for a period of 5 years. At least 90 days prior to the end of this 5 year period, the State may request CMS renewal of this benefit for additional 5-year terms in accordance with 1915(i)(7)(C). (*Specify target group(s)*):

The target group includes individuals who:

- Are age 19 and over
- Have an eligible primary mental health diagnosis. The list of eligible diagnoses codes are published on the agency's website at www.indianamedicaid.com.

(By checking the following boxes the State assures that):

8. **Adjustment Authority.** The State will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).

9. **Residence in home or community.** The State plan HCBS benefit will be furnished to individuals who reside in their home or in the community, not in an institution. The State attests that each individual receiving State plan HCBS:

(i) Resides in a home or apartment not owned, leased or controlled by a provider of any health-related treatment or support services; or

(ii) Resides in a home or apartment that is owned, leased or controlled by a provider of one or more health-related treatment or support services, if such residence meets standards for community living as defined by the State and approved by CMS. (If applicable, specify any residential settings, other than an individual's home or apartment, in which 1915(i) participants will reside. Describe the standards for community living that optimize participant independence and community integration, promote initiative and choice in daily living, and facilitate full access to community services):

BPHC services are provided in home and community based settings. In this context, home refers to an environment of the consumer's choosing, which is a part of the community at large. This may include individual/single occupancy dwellings, or residences which support multiple individuals. The DMHA certified residential settings in which some individuals may choose to live are intended to promote opportunities to assist and support each individual to grow and develop skills needed to continue to live in the community. While in a DMHA certified residential facility, the provider's responsibility is to ensure the resident's involvement in decisions that affect his/her care, daily schedules and lifestyles. The overall atmosphere of the setting is conducive to the achievement of optimal independence, safety and development by the resident with his/her input. The location of the facility is made to provide residents reasonable access to the community at large including but not limited to agency, medical, recreational, and shopping areas, by public or agency-arranged transportation. Please note, the certified residential settings are intended to be homes where the individual lives. The majority of services and behavioral healthcare is provided in other locations outside of the residence, such as in the community at large or in a clinic setting. By design, BPHC services may not be provided in a residential setting.

Many persons eligible for the BPHC services live in their own home or with families or friends in the same manner as any adult who does not have a mental illness. Due to the eligibility criteria for the BPHC services, there are some persons seeking these services who do not have family or friends with whom they can live or are not functioning at a level where their health and safety can be supported in a totally independent setting. Depending upon the person's level of need and functioning, he/she may choose to live in full time supervised settings, settings that provide less than full time supervision or settings that provide no on-site supervision. The responses below relate only to living environments that are not fully independent.

State monitoring: The state maintains the authority to monitor and enforce the adherence to standards by conducting on-site visits to ensure compliance with standards and respond to any complaint or incident reported. In addition to consumer feedback and site visits, data is collected and analyzed per the Quality Improvement Strategy section of this SPA. There are also facility requirements for compliance with fire and safety codes which must be kept up to date. The state will conduct site visits to ensure standards are met. Individuals residing in any DMHA certified residential setting have the freedom to choose how they live and residents' rights are respected and honored.

DMHA standards for residential facilities include the following:

- The location of the residence shall provide opportunities for the resident to participate in community activities and have independent access to community services.
- The residence location in the community shall provide residents with reasonable access to the agency as well as to medical, recreational, and shopping areas by public or agency-arranged transportation.
- The residence shall be located in a suitable residential setting, and the location, design, construction, and furnishings of each residence shall be consistent with a family/personal home (home-like).
- Residents are afforded the opportunity to engage in community based programs that assist the individual in achieving goals including employment.

Prior to an individual's selection of a placement, alternatives are discussed with the individual, family, and guardian. The decision for the choice of placement is based on the individual's identified needs, goals and resources. Once the resident's placement is selected by him/her, an Individualized Integrated Care Plan (IICP) is developed and/or updated with the resident. The IICP reflects his/her aspirations and goals towards an independent lifestyle and how the residential setting contributes to empowering the individual to continue to live successfully in the community.

Each setting is required to have and enforce written policies regarding the resident's rights and responsibilities. DMHA standards for residential facilities, specific to the residents' personal rights and freedoms, include the following:

- The environment is safe;
- Each resident is free from abuse and neglect;
- Each resident is treated with consideration, respect, and full recognition of the resident's dignity and individuality;
- Each resident is free to communicate, associate, and meet privately with persons of the resident's choice as long as the exercise of these rights does not infringe on the rights of another resident and any restriction of this right is a part of the resident's individual treatment plan;
- Each resident has the right to confidentiality concerning personal information including health information;
- Each resident is free to voice grievances and to recommend changes in the policies and services offered by the agency;
- Each resident has the right to manage personal financial affairs or to seek assistance in managing them unless the resident has a representative payee or a court appointed guardian for financial matters;
- Each resident shall be informed about available legal and advocacy services, and may contact or consult legal counsel at the resident's own expense;
- Each resident shall be informed of DMHA's toll free consumer service number; and
- Each resident shall be free from coercion and restraints, restrictive interventions, and seclusion.

The referring provider is responsible for providing a list of BPHC provider agencies in the geographic area from which the individual may choose a preferred provider. Provider agencies are expected to have and share with individuals their policies and procedures to select and/or change service delivery providers within the agency, and/or request transfer to a different agency. The IICP and interventions are developed in collaboration with the individual, the treatment team, and when appropriate, the individual's family or guardian.

The State defines “homelike,” to the extent feasible, as an atmosphere with patterns and conditions of everyday life that are as close as possible to those of individuals without a diagnosis of mental illness. This includes an environment designed with the purpose and focus to increase the resident’s involvement in decisions that affect his/her care, daily schedules and lifestyles to be more similar to his/her peers who live on their own. The overall atmosphere of the setting is conducive to the achievement of optimal development of independence by the residents. The location of the facility is made to provide residents reasonable access to the community at large including but not limited to the agency, medical, recreational, and shopping areas by public or agency-arranged transportation.

DMHA supports a permanent supportive housing model which refers to a housing unit that is linked with community based services. The tenant holds the lease with a landlord and receives services based on need through a community mental health center or community service agency. The tenant’s housing is not contingent on the person participating in any mental health or addiction services. The individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the state’s landlord tenant law of the state, county, city or other designated entity. Each individual’s essential personal rights of privacy, dignity and respect, and freedom from coercion and restraint are protected.

The community residential settings certified by DMHA and identified in the SPA application are designed to provide an array of living options that span the continuum from minimal oversight to highly supervised settings. DMHA through certification and licensure standards requires the individual’s participation in planning their care and supports the recovery philosophy that promotes the least restrictive, most appropriate care to safely meet the individual’s identified needs and desires.

DMHA certified residential care settings are designed to be a component of an outpatient community based continuum of care. These settings are not a nursing facility, Intermediate Care Facility for Individuals with Intellectual Disability or an Institute for Mental Diseases. The residential care settings do not have any qualities of an institution, nor would they be permitted to be located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or disability-specific housing complex.

DMHA and OMPP have a strong partnership with state housing agencies: Indiana Housing and Community Development and Corporation for Supportive Housing. Together, these agencies have facilitated the development of supportive housing integrated into the community to meet the needs of individuals with mental health and addiction disorders.

Description of DMHA Certified Residential Facilities:

"Residential living facility" includes:

- (1) a supervised group living facility;
- (2) a transitional residential services facility;
- (3) a semi-independent living facility defined under IC 12-22-2-3; and
- (4) alternative family homes operated solely by resident householders.

BPHC recipients living in a DMHA-certified residential setting have the following rights:

- The right to privacy in his or her sleeping or living unit;
- Lockable entrance doors, with appropriate staff having keys to the doors;
- Freedom to share living units at the recipient’s choice;
- When sharing living units, recipients have a choice of roommates;
- Freedom to furnish and decorate his or her personal sleeping or living unit;
- Recipients are able to have visitors of their choosing at any time in the living unit;

- The setting is physically accessible to the recipient; and
- Freedom from restraints, restrictive interventions, and seclusion.
- Any modification of the resident's rights must be supported by a specific assessed need and documented in the person-centered IICP.

1) "Supervised group living facility" or "SGL" means a residential facility that provides a therapeutic environment in a homelike setting to persons with a psychiatric disorder or addiction who need the benefits of a group living arrangement as post psychiatric hospitalization intervention or as an alternative to hospitalization. "Therapeutic living environment" means a living environment:

- (A) in which the staff and other residents contribute; and
- (B) that presents no physical or social impediments to the habilitation and rehabilitation of the resident.

This setting is designed to assist individuals in their recovery process by offering a safe supportive home like environment. Individuals may come and go as needed to attend work/school, treatment appointments, recreation, etc. On site supervision is required 24/7 in this setting. While individuals would have access to food 24/7, there are typically planned meal times where individuals may eat together. Menus are developed by dietitians to provide healthy meals that are consistent with each individual's dietary needs/restrictions (e.g. diabetic, low sodium). Alternative food is available if an individual chooses not to eat the planned meal. Consumers are given input in the meal planning process.

A certified supervised group living facility serves up to ten (10) consumers in a single family dwelling and up to fifteen (15) consumers in an apartment building (which includes 3 or more dwelling units) or in a congregate residence.

2) "Transitional residential facility" or "TRS" means a twenty-four (24) hour per day service that provides food, shelter, and other support services to individuals with a psychiatric disorder or addiction who are in need of a short term supportive residential environment.

Individuals in this type of setting are provided with less than 24 hour supervision. They have input into household activities and may come and go as needed to attend work/school, treatment appointments, recreation, etc. While individuals would have access to food 24/7, there are typically planned meal times where individuals may eat together. Consumers are given input in the meal planning process. Menus are designed by dietitians to provide healthy meals that are consistent with each individual's dietary needs/restrictions (e.g. diabetic, low sodium). Alternative food is available if an individual chooses not to eat the planned meal. Individuals in this setting are likely preparing for or already participating in work or school activities.

A certified transitional residential facility serves fifteen (15) or fewer persons.

- 3) Semi-independent living facility" or "SILP" means a facility:
- (A) that is not licensed by another state agency and serves six (6) or fewer individuals with a psychiatric disorder or an addiction, or both, per residence who require only limited supervision; and
 - (B) in which the agency or its subcontractor:
 - (i) provides a resident living allowance to the resident; or
 - (ii) owns, leases, or manages the residence.

Individuals in this type of setting are provided with a minimum of oversight one hour per week. These settings are typically home like. Individuals have input into household activities and may come

and go as needed to attend work/school, treatment appointments, recreation, etc. While individuals would have access to food 24/7, there are typically planned meal times where individuals may eat together. Individuals are given input in the meal planning process. Menus are designed by dietitians to provide healthy meals that are consistent with each individual's dietary needs/restrictions (e.g. diabetic, low sodium). Alternative food is available if an individual chooses not to eat the planned meal. This setting is intended to prepare individuals for independent living settings.

4) "Alternative family for adults (AFA) program" means a program that serves six (6) or fewer individuals who:

- (A) have a psychiatric disorder or addiction, or both; and
- (B) reside with an unrelated householder.

Individuals in this type of setting are provided with a minimum of oversight two hours per month. These settings are home like. Individuals have input into house hold activities and may come and go as needed to attend work/school, treatment appointments, recreation, etc. While individuals would have access to food 24/7, there are typically planned meal times where individuals may eat together. Individuals are given input in the meal planning process. Menus are designed by dietitians to provide healthy meals that are consistent with each individual's dietary needs/restrictions (e.g. diabetic, low sodium). Alternative food is available if an individual chooses not to eat the planned meal. This setting is intended to prepare individuals for independent living settings or may become permanent housing if this best meets the individual's needs and a less restrictive setting is not wanted or deemed appropriate by the individual or treatment team.

Person-Centered Planning & Service Delivery

(By checking the following boxes the State assures that):

1. There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment is based on:
 - An objective face-to-face assessment with a person-centered process by an agent that is independent and qualified;
 - Consultation with the individual and if applicable, the individual's authorized representative, and includes the opportunity for the individual to identify other persons to be consulted, such as, but not limited to, the individual's spouse, family, guardian, and treating and consulting health and support professionals caring for the individual;
 - An examination of the individual's relevant history, including findings from the independent evaluation of eligibility, medical records, an objective evaluation of functional ability, and any other records or information needed to develop the plan of care;
 - An examination of the individual's physical and mental health care and support needs, strengths and preferences, available service and housing options, and when unpaid caregivers will be relied upon to implement the plan of care, a caregiver assessment;
 - If the State offers individuals the option to self-direct State plan HCBS, an evaluation of the ability of the individual (with and without supports), or the individual's representative, to exercise budget and/or employer authority; and
 - A determination of need for (and, if applicable, determination that service-specific additional needs-based criteria are met for), at least one State plan home and community-based service before an individual is enrolled into the State plan HCBS benefit.
2. Based on the independent assessment, the individualized plan of care:

- Is developed with a person-centered process in consultation with the individual, and others at the option of the individual such as the individual's spouse, family, guardian, and treating and consulting health care and support professionals. The person-centered planning process must identify the individual's physical and mental health support needs, strengths and preferences, and desired outcomes;
- Takes into account the extent of, and need for, any family or other supports for the individual, and neither duplicates, nor compels, natural supports;
- Prevents the provision of unnecessary or inappropriate care;
- Identifies the State plan HCBS that the individual is assessed to need;
- Includes any State plan HCBS in which the individual has the option to self-direct the purchase or control ;
- Is guided by best practices and research on effective strategies for improved health and quality of life outcomes; and
- Is reviewed at least every 12 months and as needed when there is significant change in the individual's circumstances.

3. Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities.

There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with physical and mental needs for HCBS. (*Specify qualifications*):

The agency staff member conducting the face-to-face assessment must be a certified user of the state required standardized assessment tool, with supervision by a certified super user of the tool. Minimum qualification for the person conducting the independent evaluation (1): Bachelor's in social sciences or related field with 2 or more years of clinical experience; (2) Have completed DMHA and OMPP approved training and orientation for 1915(i) eligibility and determination; (3) Have agency staff that have completed assessment tool Certification training.

4. Responsibility for Plan of Care Development. There are qualifications (that are reasonably related to developing plans of care) for persons responsible for the development of the individualized, person-centered plan of care. (*Specify qualifications*):

Licensed professional means any of the following persons:

- a licensed psychiatrist;
- a licensed physician;
- a licensed psychologist or a psychologist endorsed as a health service provider in psychology (HSPP);
- a licensed clinical social worker (LCSW);
- a licensed mental health counselor (LMHC);
- a licensed marriage and family therapist (LMFT); or
- a licensed clinical addiction counselor, as defined under IC 25-23.6-10.5.

Qualified behavioral health professional (QBHP) means any of the following persons:

- an individual who has had at least two (2) years of clinical experience treating persons with mental illness under the supervision of a licensed professional, as defined above, such experience occurring after the completion of a master's degree or doctoral degree, or both, in any of the following disciplines:
 - in psychiatric or mental health nursing from an accredited university, plus a license as a registered nurse in Indiana;
 - in pastoral counseling from an accredited university; or
 - in rehabilitation counseling from an accredited university.
- an individual who is under the supervision of a licensed professional, as defined above, is

eligible for and working toward licensure, and has completed a master's or doctoral degree, or both, in any of the following disciplines:

- in social work from a university accredited by the Council on Social Work Education;
- in psychology from an accredited university;
- in mental health counseling from an accredited university; or
- in marital and family therapy from an accredited university.
- a licensed independent practice school psychologist under the supervision of a licensed professional, as defined above.
- an authorized health care professional (AHCP), defined as follows:
 - a physician assistant with the authority to prescribe, dispense and administer drugs and medical devices or services under an agreement with a supervising physician and subject to the requirements of IC 25-27.5-5.
 - a nurse practitioner or a clinical nurse specialist, with prescriptive authority and performing duties within the scope of that person's license and under the supervision of, or under a supervisory agreement with, a licensed physician pursuant to IC 25-23-1.

Other behavioral health professional (OBHP) means any of the following persons:

- an individual with an associate or bachelor degree, and/or equivalent behavioral health experience, meeting minimum competency standards set forth by the behavioral health service provider and supervised by a licensed professional, as defined above, or QBHP, as defined above; or
- a licensed addiction counselor, as defined under IC 25-23.6-10.5 supervised by a licensed professional, as defined above, or QBHP, as defined under above.

- 5. Supporting the Participant in Plan of Care Development.** Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the plan of care development process. (*Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process:*)

Person centered planning is an existing requirement for DMHA approved provider agencies in Indiana. This requirement is covered via certification rules, requirement for national accreditation, and contracts connected to DMHA funding. All IICPs are to be developed with the recipient driving the care. The recipient has authority to determine who is included in the process. IICPs require staff and recipient signatures as well as clinical documentation of recipient participation.

The Independent State Evaluation Team reviews and approves or denies all proposed BPHC services submitted for consideration to ensure the applicant/recipient participated in the IICP development and to prevent a conflict of interest. The following process and expectations are adhered to by provider agencies assisting recipients in developing the IICP:

The IICP is developed through a collaboration that includes the applicant/recipient, identified community supports (family/nonprofessional caregivers), and all individuals/agency staff involved in assessing and/or providing care for the applicant/recipient. The IICP is a treatment plan that integrates all components and aspects of care that are deemed medically necessary, needs based, are clinically indicated, and are provided in the most appropriate setting to achieve the recipient's goals. An IICP must be developed with each applicant/recipient. The IICP must include all indicated medical and support service coordination needed by the applicant/recipient in order to reside in the community, to function at the highest level of independence possible, and to achieve his/her goals.

The IICP is developed after completing a holistic clinical and bio-psychosocial assessment. The

holistic assessment includes documentation in the applicant/recipient's medical record of the following:

- Review, discussion and documentation of the applicant/recipient's desires, needs, and goals. Goals are recovery, habilitative or rehabilitative in nature with outcomes specific to the needs identified by the applicant/recipient.
- Review of psychiatric symptoms and how they affect the applicant/recipient's functioning, and ability to attain desires, needs and goals and to self-manage health services.
- Review of the applicant/recipient's skills and the support needed for the applicant/recipient to manage his or her health condition and services.
- Review of the applicant/recipient's strengths and needs, including medical and behavioral.

A member of the treatment team involved in assessing the applicant/recipient's needs and desires fulfills the role of care coordinator and is responsible for documenting the IICP with the applicant/recipient's participation. In addition to driving the IICP development, the applicant/recipient of BPHC services is given a list of eligible provider agencies and services offered in his/her geographic area. The applicant/recipient is asked to select the provider agency of choice. The referring provider agency is responsible for linking the recipient to his/her selected provider. The provider agencies are required to have mechanisms in place to support the applicant/recipient's choice.

The IICP must reflect the applicant/recipient's desires and choices. The applicant/recipient's signature demonstrating his/her participation in the development of an ongoing IICP reviews is required to be submitted to the State Evaluation Team. Infrequently, an applicant/recipient may request services but refuse to sign the IICP for various reasons (i.e. thought disorder, paranoia, etc.). If a recipient refuses to sign the IICP, the agency staff member is required to document on the plan of care that the recipient agreed to the plan but refused to sign the plan. The agency staff member must also document in the clinical record progress notes that a planning meeting with the recipient did occur and that the IICP reflects the recipient's choice of services and agreement to participate in the services identified in the IICP. The progress note must further explain any known reasons why the recipient refused to sign the plan and how those will be addressed in the future.

Each eligible BPHC provider agency is required to ensure a written statement of rights is provided to each recipient. The statement shall include:

- (1) The toll-free consumer service line number and the telephone number for Indiana protection and advocacy.
- (2) Document that agency staff provides both a written and an oral explanation of these rights to each applicant/recipient.

In addition, all Approval/Denial Notification letters include an explanation of the action to be taken and the appeal rights. Applicants/recipients/authorized representatives may file a complaint or grievance with the State. All complaints/grievances regarding BPHC provider agencies are accepted by the following means:

- (1) The "Family/Consumer" section on the DMHA website;
- (2) The "Consumer Service Line" (800-901-1133)
- (3) In-person to a DMHA staff member; or
- (4) Via written complaint or email that is submitted to DMHA.

6. Informed Choice of Providers. *(Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the plan of care):*

The State maintains a network of Community Mental Health Centers (CMHCs). As a DMHA-

approved BPHC provider agency, each CMHC is an enrolled Medicaid provider that offers a full continuum of behavioral healthcare services, as is mandated by DMHA for all CMHCs, in addition to providing BPHC services as documented in this SPA. The care coordinator explains the process for making an informed choice of provider(s) and answers questions. The applicant/recipient is also advised that choice of providers and provider agencies is ongoing for the duration of the program. Therefore, providers within an agency and provider agencies themselves can be changed upon request from the enrollee.

A list of qualified BPHC agency providers in randomized sequence is presented to the applicant/recipient by the care coordinator. A listing of approved/enrolled BPHC provider agencies is also posted on the Indiana Medicaid website at www.indianamedicaid.com. When accessing indianamedicaid.com website, the individual has a choice of a “Member” tab and “Provider” tab. The Member tab notes: *If you are an Indiana Medicaid Member or are interested in applying to becoming a Member, please click the “Member” tab.*

Selection of the Member tab provides an array of information to individuals applying for or eligible for Medicaid services, including a “Find a Provider” link. This link allows the individual to target their search by selecting types of providers by city, county or state. The resulting lists include the provider’s name, address, telephone number and a link to the map for each provider location.

Applicants/recipients and family members may interview potential service providers and make their own choice.

This 1915(i) State Plan amendment is to run concurrently with the 1915(b)(4) fee-for-service selective contracting waiver (IN.02).

7. Process for Making Plan of Care Subject to the Approval of the Medicaid Agency. *(Describe the process by which the plan of care is made subject to the approval of the Medicaid agency):*

The Indiana Office of Medicaid Policy and Planning (OMPP) retains responsibility for service plan approvals made by the Division of Mental Health and Addiction (DMHA). The OMPP reviews and approves the policies, processes and standards for developing and approving BPHC plans of care. Based on the terms and conditions of the SPA, the OMPP may review and overrule the approval or disapproval of any specific plan of care acted upon by the DMHA serving in its capacity as the operating agency.

The OMPP reviews and approves the policies, processes and standards for developing and approving 1915(i) Plans of Care. In the instance of a complaint from a 1915(i) provider or applicant/recipient, the IICP submitted to DMHA may be reviewed by OMPP. Based on the terms and conditions of the 1915(i), the Medicaid agency may overrule the approval or disapproval of any specific IICP acted upon by the DMHA serving in its capacity as the administrating agency for the 1915(i).

8. Maintenance of Plan of Care Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each that applies)*:

<input type="checkbox"/>	Medicaid agency	<input checked="" type="checkbox"/>	Operating agency	<input type="checkbox"/>	Case manager
<input type="checkbox"/>	Other <i>(specify)</i> :				

Services

1. State plan HCBS. (Complete the following table for each service. Copy table as needed):

Service Specifications (Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):	
Service Title:	Behavioral & Primary Healthcare Coordination (BPHC)
Service Definition (Scope):	
<p>Behavioral & Primary Healthcare Coordination (BPHC) consists of coordination of healthcare services to manage the healthcare needs of the individual. BPHC includes logistical support, advocacy and education to assist individuals in navigating the healthcare system. BPHC consists of activities that help recipients gain access to needed health (physical and behavioral health) services, manage their health conditions such as adhering to health regimens, scheduling and keeping medical appointments, obtaining and maintaining a primary medical provider and facilitating communication across providers. This includes direct assistance in gaining access to services, coordination of care within and across systems, oversight of the entire case, and linkage to appropriate services. BPHC includes: (1) assessment of the eligible recipient to determine service needs; (2) development of an individualized integrated care plan (IICP); (3) referral and related activities to help the recipient obtain needed services; (4) monitoring and follow-up; and (5) evaluation. BPHC does not include direct delivery of medical, clinical, or other direct services. BPHC is on behalf of the recipient, not to the recipient.</p>	
Additional needs-based criteria for receiving the service, if applicable (specify):	
N/A	
Specify limits (if any) on the amount, duration, or scope of this service for (chose each that applies):	
<input checked="" type="checkbox"/>	Categorically needy (specify limits): <ul style="list-style-type: none"> • BPHC must provide direct assistance in gaining access to needed health (physical and behavioral health) services. • BPHC includes the development of an individualized integrated care plan which includes the development of consumer-driven goals for healthcare or lifestyle changes. Care Plans may include activities and goals such as referrals to medical services, education on health conditions, activities to ensure compliance with health regimens and healthcare provider recommendations, and activities or contacts necessary to ensure that the individualized integrated care plan is effectively implemented and adequately addresses the health (physical and behavioral health) needs of the individual. • BPHC may include: <ul style="list-style-type: none"> ○ Needs Assessment: focusing on needs identification of the recipient to determine the need for coordination of health services. Specific assessment activities may include: taking recipient history, identifying the needs of the recipient, and completing the related documentation. It also includes the gathering of information from other sources, such as family members or medical providers, to form a complete assessment of the recipient. ○ Individualized Integrated Care Plan Development: the development of a written individualized integrated care plan based upon the information collected through the needs assessment phase. The individualized integrated care plan identifies the health (physical and behavioral health) activities and assistance needed to accomplish the objectives. ○ Referral/Linkage: activities that help link the recipient with medical providers,

	<p>and/or other programs and services that are capable of providing needed health services.</p> <ul style="list-style-type: none"> ○ Coordination of health services across systems, including but not limited to: <ul style="list-style-type: none"> ▪ Physician consults ▪ Serving as a communication conduit between the consumer, specialty medical and behavioral health providers ▪ Notification, with the consumer’s permission, of changes in medication regimens and health status ▪ Coaching to consumers to help them interact more effectively with providers ○ Monitoring/Follow-up: Face to face contact must occur at least every 90 days. Contacts and related activities are necessary to ensure the individualized integrated care plan is effectively implemented and adequately addresses the needs of the recipient. The activities and contacts may be with the recipient, family members, non-professional caregivers, providers, and other entities. Monitoring and follow-up are necessary to help determine if services are being furnished in accordance with a service plan of the recipient, the adequacy of the services in the individualized integrated care plan, and changes in the needs or status of the recipient. This function includes making necessary adjustments in the individualized integrated care plan and service arrangement with providers. ○ Evaluation: the BPHC provider must periodically reevaluate the recipient’s progress toward achieving the individualized integrated care plan’s objectives. Based upon the review, a determination would be made on if changes should be made. Time devoted to formal supervision of the case between BPHC provider and licensed supervisor are included activities, and should be documented accordingly. This must be documented appropriately and billed under one provider only. <p>BPHC services may be provided for a maximum of 12 hours (48 units) per 6 months.</p> <p>Exclusions:</p> <ul style="list-style-type: none"> • Activities billed under MRO Case Management or AMHH Care Coordination • The actual or direct provision of medical services or treatment. Examples include, but are not limited to: <ul style="list-style-type: none"> ○ Medical screenings such as blood pressure screenings or weight checks ○ Medication training and support ○ Individual, group, or family therapy services ○ Crisis intervention services 		
<input type="checkbox"/>	Medically needy (<i>specify limits</i>):		
Provider Qualifications (<i>For each type of provider. Copy rows as needed</i>):			
Provider Type (<i>Specify</i>):	License (<i>Specify</i>):	Certification (<i>Specify</i>):	Other Standard (<i>Specify</i>):
Agency	N/A	DMHA-certified Community Mental Health Center (CMHC)	DMHA-approved BPHC provider agencies must meet DMHA and OMPP-defined criteria and standards, including the following: <ul style="list-style-type: none"> A) Provider agency has acquired a National Accreditation by an entity approved by DMHA. B) Provider agency is an enrolled

			<p>Medicaid provider that offers a full-continuum of care.</p> <p>C) Provider agency must maintain documentation in accordance with the Medicaid requirements defined under 405 IAC 1-5-1 and 405 IAC 1-5-3.</p> <p>D) Provider agency must meet all BPHC provider agency criteria, as defined in the SPA and BPHC operating policy.</p> <p>In addition to meeting criteria for a provider agency, the agency must certify that the agency staff providing a BPHC needs assessment, individualized integrated care plan development and adjustments, referral and linkage activities and physician consults must meet the following standards:</p> <p>A) Licensed professional; B) QBHP; or C) OBHP.</p> <p>The agency must certify that the agency staff providing all other BPHC services including coordination across health systems, monitoring and follow-up activities and reevaluation of the recipients progress toward achieving care plan objectives meet the following standards:</p> <p>A) Licensed professional; B) QBHP; C) OBHP; D) Certified Recovery Specialist; or E) Certified Community Health Worker.</p>
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Verification of Provider Qualifications (For each provider type listed above. Copy rows as needed):

Provider Type	Entity Responsible for Verification	Frequency of Verification
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<i>(Specify):</i>	<i>(Specify):</i>	<i>(Specify):</i>
Agency	DMHA	Initially and at time of DMHA certification renewal
Service Delivery Method. <i>(Check each that applies):</i>		
<input type="checkbox"/>	Participant-directed	<input checked="" type="checkbox"/> Provider managed

3. **Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians.** *(By checking this box the State assures that):* There are policies pertaining to payment the State makes to qualified persons furnishing State plan HCBS, who are relatives of the individual. There are additional policies and controls if the State makes payment to qualified legally responsible individuals or legal guardians who provide State Plan HCBS. *(Specify (a) who may be paid to provide State plan HCBS; (b) the specific State plan HCBS that can be provided; (c) how the State ensures that the provision of services by such persons is in the best interest of the individual; (d) the State’s strategies for ongoing monitoring of services provided by such persons; (e) the controls to ensure that payments are made only for services rendered; and (f) if legally responsible individuals may provide personal care or similar services, the policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual):*

Participant-Direction of Services

Definition: Participant-direction means self-direction of services per §1915(i)(1)(G)(iii).

1. **Election of Participant-Direction.** *(Select one):*

<input checked="" type="checkbox"/>	The State does not offer opportunity for participant-direction of State plan HCBS.
<input type="checkbox"/>	Every participant in State plan HCBS (or the participant’s representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
<input type="checkbox"/>	Participants in State plan HCBS (or the participant’s representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the State. <i>(Specify criteria):</i>

2. **Description of Participant-Direction.** *(Provide an overview of the opportunities for participant-direction under the State plan HCBS, including: (a) the nature of the opportunities afforded; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the approach to participant-direction):*

Indiana does not offer self-directed care.

3. **Limited Implementation of Participant-Direction.** *(Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to statewideness requirements. Select one):*

<input type="checkbox"/>	Participant direction is available in all geographic areas in which State plan HCBS are available.
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<input type="radio"/>	Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the State. Individuals who reside in these areas may elect self-directed service delivery options offered by the State, or may choose instead to receive comparable services through the benefit's standard service delivery methods that are in effect in all geographic areas in which State plan HCBS are available. <i>(Specify the areas of the State affected by this option):</i>

4. Participant-Directed Services. *(Indicate the State plan HCBS that may be participant-directed and the authority offered for each. Add lines as required):*

Participant-Directed Service	Employer Authority	Budget Authority
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

5. Financial Management. *(Select one):*

<input type="radio"/>	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
<input type="radio"/>	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.

6. Participant-Directed Plan of Care. *(By checking this box the State assures that):* Based on the independent assessment, a person-centered process produces an individualized plan of care for participant-directed services that:

- Be developed through a person-centered process that is directed by the individual participant, builds upon the individual's ability (with and without support) to engage in activities that promote community life, respects individual preferences, choices, strengths, and involves families, friends, and professionals as desired or required by the individual;
- Specifies the services to be participant-directed, and the role of family members or others whose participation is sought by the individual participant;
- For employer authority, specifies the methods to be used to select, manage, and dismiss providers;
- For budget authority, specifies the method for determining and adjusting the budget amount, and a procedure to evaluate expenditures; and
- Includes appropriate risk management techniques, including contingency plans, that recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assure the appropriateness of this plan based upon the resources and support needs of the individual.

6. Voluntary and Involuntary Termination of Participant-Direction. *(Describe how the State facilitates an individual's transition from participant-direction, and specify any circumstances when transition is involuntary):*

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7. Opportunities for Participant-Direction

a. Participant–Employer Authority (individual can hire and supervise staff). *(Select one):*

<input type="radio"/>	The State does not offer opportunity for participant-employer authority.
<input type="radio"/>	Participants may elect participant-employer Authority <i>(Check each that applies):</i>
<input type="checkbox"/>	Participant/Co-Employer. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.
<input type="checkbox"/>	Participant/Common Law Employer. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

b. Participant–Budget Authority (individual directs a budget). *(Select one):*

<input type="radio"/>	The State does not offer opportunity for participants to direct a budget.
<input type="radio"/>	Participants may elect Participant–Budget Authority.
	Participant-Directed Budget. <i>(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including how the method makes use of reliable cost estimating information, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the plan of care):</i>
	Expenditure Safeguards. <i>(Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards):</i>

Quality Improvement Strategy

(Describe the State's quality improvement strategy in the tables below):

Requirement	Discovery Activities				Remediation	
	Discovery Evidence <i>(Performance Measures)</i>	Discovery Activity <i>(Source of Data & sample size)</i>	Monitoring Responsibilities <i>(agency or entity that conducts discovery activities)</i>	Frequency	Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	Frequency of Analysis and Aggregation
Service plans address assessed needs of 1915(i) participants, are updated every six months, and document choice of services and providers.	1) Number and percent of IICP's that address recipient needs	1) 100% of IICP's are reviewed and approved through the State's database	1) DMHA	1) Ongoing	1) DMHA	1) Analysis and aggregation are ongoing. If a corrective action plan is needed it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.
	2) Number and percent of IICP's reviewed every six months	2) 100% of IICP's are reviewed and approved through the State's database	2) DMHA	2) Ongoing	2) DMHA	2) Analysis and aggregation are ongoing. If a corrective action plan is needed it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.
	3) Number and					

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	percent of recipients with documentation of choice of eligible services	3) Record Review – on site/off site with 95% confidence level with 5% margin of error	3) DMHA	3) Ongoing	3) DMHA	3) Analysis and aggregation are ongoing. If a corrective action plan is needed it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.
	4) Number and percent of recipients with documentation of choice of providers	4) Record Review – on site/off site with 95% confidence level with 5% margin of error	4) DMHA	4) Ongoing	4) DMHA	4) Analysis and aggregation are ongoing. If a corrective action plan is needed it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.
Providers meet required qualifications.	1) Number and percent of provider agencies that meet qualifications at time of enrollment	1) 100% of provider agency applications are reviewed prior to approval	1) DMHA	1) Ongoing	1) DMHA	1) Analysis and aggregation are ongoing. If a corrective action plan is needed it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.
	2) Number and percent of provider agencies recertified timely.	2) 100% of provider agency renewal applications are reviewed prior to renewal	2) DMHA	2) Every three years or at time of reaccreditation	2) DMHA	2) Analysis and aggregation are quarterly. If a corrective action plan is needed it must be provided within

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						30 business days and the State will respond in 30 business days for a total of 60 business days.
The SMA retains authority and responsibility for program operations and oversight.	1) Number and percent of data reports that were provided by DMHA on time and in the correct format. 2) Number and percent of corrective action plans appropriately and timely remediated by DMHA.	1) 100% review of DMHA data reports 2) 100% review of DMHA log sheet	1) DMHA and OMPP 2) DMHA and OMPP	1) Quarterly 2) Quarterly	1) DMHA and OMPP 2) DMHA and OMPP	1) Analysis and aggregation are completed annually. If a corrective action plan is needed from DMHA it must be provided within 30 business days and OMPP will respond in 30 business days for a total of 60 business days. 2) Analysis and aggregation will be annual. If a corrective action plan is needed from DMHA it must be provided within 30 business days and OMPP will respond in 30 business days for a total of 60 business days.
The SMA maintains financial accountability	1) Number and percent of 1915(i) claims paid during the review period	1) MMIS 100% review	1) OMPP and Medicaid Fiscal Contractor	1) Monthly	1) OMPP	1) Analysis and aggregation are completed annually. Corrective Action will

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<p>through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.</p>	<p>according to the published rate.</p> <p>2) Number and percent of 1915(i) claims paid during the review period for recipients enrolled in the 1915(i) program on the date the service was delivered.</p> <p>3) Number and percent of 1915(i) claims paid during the review period for services that are specified in the recipient's approved IICP.</p>	<p>2) MMIS 100% review</p> <p>3) MMIS 100% review</p>	<p>2) OMPP and Medicaid Fiscal Contractor</p> <p>3) OMPP and Medicaid Fiscal Contractor</p>	<p>2) Monthly</p> <p>3) Monthly</p>	<p>2) OMPP</p> <p>3) OMPP</p>	<p>follow the process identified in the contract between OMPP and MMIS vendor.</p> <p>2) Analysis and aggregation are completed annually. Corrective Action will follow the process identified in the contract between OMPP and MMIS vendor.</p> <p>3) Analysis and aggregation are completed annually. Corrective Action will follow the process identified in the contract between OMPP and MMIS vendor.</p>
<p>The State identifies, addresses and seeks to prevent incidents of</p>	<p>1) Number and percent of BPHC provider agencies who have policies and procedures to prevent incidents of</p>	<p>1) 100% of BPHC agencies policies and procedures will be reviewed to ensure health</p>	<p>1) DMHA</p>	<p>1) Annual</p>	<p>1) DMHA</p>	<p>1) Review of policies and procedures occurs annually. If policies and procedures are not in compliance, revised policies must be</p>

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abuse, neglect, and exploitation, including the use of restraints.	abuse, neglect, exploitation and the use of restraints.	and welfare needs are addressed				provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.
	2) Number and percent of incidents reported within required timeframe.	2) 100% review of incident reports submitted.	2) DMHA	2) Ongoing	2) DMHA	2) Analysis and aggregation are ongoing. Report submitted to State within 72 hours. State will review plan and respond within 5 business days. If a corrective action plan is needed it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.
	3) Number and percent of incident reports including medication errors, seclusions and restraints resolved according to policy.	3) 100% review of incident reports submitted	3) DMHA	3) Ongoing	3) DMHA	3) Analysis and aggregation are ongoing. Report submitted to State within 72 hours. State will review plan and respond within 5 business days. If a corrective action plan is needed it must be

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	4) Number and percent of residential settings in compliance with criteria that meets standards for community living	4) DMHA conducts annual compliance reviews, using both on-site and desk reviews, for a 5% confidence interval for residential settings in which 1915(i) recipients reside.	4) DMHA	4) Ongoing	4) DMHA	provided within 30 business days and the State will respond in 30 business days for a total of 60 business days. 4) Analysis and aggregation are ongoing. If a corrective action plan is needed it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.
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System Improvement: <i>(Describe process for systems improvement as a result of aggregated discovery and remediation activities.)</i>			
Methods for Analyzing Data and Prioritizing Need for System Improvement	Roles and Responsibilities	Frequency	Method for Evaluating Effectiveness of System Changes
1. DMHA collects and tracks complaints related to implementation, providers and services offered through the 1915(i). Complaints could be received from recipients, family members, concerned citizens, providers or	1) DMHA	1) Annual	1) During the bimonthly meeting between DMHA and OMPP, the need for new system changes as well as the effectiveness of previous system changes will be discussed and evaluated. Additional changes will be made as necessary, including changes in provider agency training, bulletins, policy changes and refinements.

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<p>advocates. Complaints are categorized as individual issue or system challenge/barrier. The system challenge/barrier complaints are discussed during bimonthly strategy meetings between DMHA and OMPP. System issues identified in the complaints are prioritized with solutions discussed for highest priority items.</p> <p>2) DMHA reviews and analyzes individual issues related to performance measures to identify any system level trends. DMHA and OMPP monitor trends to identify the need for system changes.</p>	<p>2) DMHA</p>	<p>2) Annual</p>	<p>2) During the bimonthly meeting between DMHA and OMPP, DMHA will share trends identified with OMPP to determine the best way to address the issues (policy change, training) as well as the effectiveness of previous system changes will be discussed and evaluated. Additional changes will be made as necessary, including changes in provider agency training, bulletins, policy changes and refinements.</p>
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Methods and Standards for Establishing Payment Rates

1. Services Provided Under Section 1915(i) of the Social Security Act. For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates):*

<input type="checkbox"/>	HCBS Case Management	
<input type="checkbox"/>	HCBS Homemaker	
<input type="checkbox"/>	HCBS Home Health Aide	
<input type="checkbox"/>	HCBS Personal Care	
<input type="checkbox"/>	HCBS Adult Day Health	
<input type="checkbox"/>	HCBS Habilitation	
<input type="checkbox"/>	HCBS Respite Care	
For Individuals with Chronic Mental Illness, the following services:		
<input type="checkbox"/>	HCBS Day Treatment or Other Partial Hospitalization Services	
<input type="checkbox"/>	HCBS Psychosocial Rehabilitation	
<input type="checkbox"/>	HCBS Clinic Services (whether or not furnished in a facility for CMI)	
<input checked="" type="checkbox"/>	Other Services (specify below)	
	Behavioral & Primary Healthcare Coordination (BPHC): Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private agency providers of BPHC. The agency's fee schedule rate set on April 1, 2014 is effective for services provided on or after that date. All rates are published on the agency's website at www.indianamedicaid.com .	

Groups Covered
Optional Groups other than the Medically needy

In addition to providing HCBS State plan services to individuals described in 1915(i)(1), the State is **also** covering the optional categorically needy eligibility group of individuals under 1902(a)(10)(A)(ii)(XXII) who are eligible for home and community-based services under the needs based criteria established 1915(i)(1)(A) and have income that does not exceed 150% of the FPL, or who are eligible for home and community-based services under a waiver approved for the State under section 1915(c), (d) or (e) or section 1115 to provide such services to individuals whose income does not exceed 300% of the supplemental security income benefit rate (Select at least one).

The State covers all of the individuals described in item (a) and (b) described below (Complete (a) and (b)).

or

The State covers only the following group individuals described below (Complete (a) or (b)):

(a) Individuals not otherwise eligible for Medicaid who meet the needs based criteria of the 1915(i) benefit, have income that does not exceed 150% of the federal poverty level, and will receive 1915(i) services.

Income Standard 150% FPL

Methodology used (Select one) SSI
 OTHER (describe):

For states that have elected the SSI methodology, the state uses the following less restrictive 1902(r)(2) income disregards for this group. (Describe the 1902(r)(2) income disregard(s) below):

After SSI countable income, the State disregards income in the amount of the difference between 150% of the Federal Poverty Level (FPL) and 300% of the FPL.

There is no resource test for this group.

(b)(i) Individuals who are eligible for home and community-based services under a waiver approved for the State under section 1915(c), (d) or (e) to provide such services to individuals whose income does not exceed 300% of the supplemental security income benefit rate.
(Select)

Income standard: For individuals eligible for 1915(c), (d) or (e) waiver services, this amount must be the same amount as the income standard specified under your State plan for the special income level group (Select one):

- 300% of the SSI/FBR
- (Specify) _____% Less than 300% of the SSI/FBR

The state uses the same eligibility criteria that it uses for the special income level group.

Specify the applicable name and or number of the applicable 1915(c) Waiver or Waivers that these individuals would be eligible. _____.

(b)(ii) Individuals eligible for 1915(c) like services under an approved 1115, Demonstration. The income and resource standards and methodologies are the same as the applicable approved 1115 Demonstration.

Specify the applicable name and or number 1115 waiver Demonstration or Demonstrations that these individuals would be eligible: _____.