

Table of Contents

State/Territory Name: Indiana

State Plan Amendment (SPA) #: 20-0005

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form/Summary Form (with 179-like data)
- 3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106



Medicaid and CHIP Operations Group

September 25, 2020

Allison Taylor, Medicaid Director
Family and Social Services Administration
402 West Washington, Room W374
Indianapolis, IN 46204

RE: IN-20-005 – Behavior and Primary Healthcare Coordination (BPHC) §1915(i) home and community-based services (HCBS) state plan amendment (SPA)

Dear Ms. Taylor:

The Centers for Medicare and Medicaid Services (CMS) is approving the state's request to amend its §1915(i) state plan home and community-based services (HCBS) benefit, transmittal number 20-005. The amendment is approved on September 23, 2020, with an effective date of October 1, 2020. With this amendment, the state is adding additional service units using the prior authorization (PA) process per the Mental Health Parity and Addiction Equity Act (MHPAEA).

Enclosed are the following approved SPA pages that should be incorporated into the approved state plan:

- Attachment 3.1-i Page 125-170
- Attachment 4.19-B Page 15

Since the state has elected to target the population who can receive §1915(i) State Plan HCBS, the 1915(i) benefit was approved for a five-year period expiring May 31, 2024, in accordance with §1915(i)(7) of the Social Security Act. To renew the §1915(i) State Plan HCBS benefit for an additional five-year period, the state must submit a renewal application to CMS at least 180 days prior to the end of the approval period, December 3, 2023. CMS' approval of a renewal request is contingent upon state adherence to federal requirements and the state meeting its objectives with respect to quality improvement and beneficiary outcomes.

It is important to note that CMS' approval of this change to the state's §1915(i) HCBS state plan benefit solely addresses the state's compliance with the applicable Medicaid authorities. CMS' approval does not address the state's independent and separate obligations under federal laws including, but not limited to, the Americans with Disabilities Act, §504 of the Rehabilitation Act, or the Supreme Court's Olmstead decision. Guidance from the Department of Justice concerning

compliance with the Americans with Disabilities Act and the Olmstead decision is available at http://www.ada.gov/olmstead/q&a_olmstead.htm.

If you have any questions concerning this information, please contact me at (206) 615-2356, or your staff may contact Michelle Taylor at Michelle.Taylor@cms.hhs.gov or (312) 353-8720.

Sincerely,

Digitally signed by David

David L. Meacham [Redacted] 9:31
07/00

David L. Meacham, Director
Division of HCBS Operations and Oversight

Enclosure

cc:

Sara Albertson, FSSA

Deanna Clark, CMS

Katherine Berland, CMS

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES	1. TRANSMITTAL NUMBER 20-005	2. STATE Indiana
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	

TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE October 1, 2020
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5. TYPE OF PLAN MATERIAL (*Check One*)

NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS NEW PLAN AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (*Separate transmittal for each amendment*)

6. FEDERAL STATUTE/REGULATION CITATION Section 1915 (i) of the Social Security Act	7. FEDERAL BUDGET IMPACT (<i>in thousands</i>): a. FFY 2021 \$ 0 b. FFY 2022 \$ 0
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8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT Attachment 3.1-i Page 125- 170; Attachment 4.19-B Page 15	9. PAGENUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>) Attachment 3.1-i Page 125- 175; Attachment 4.19-B Page 15
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SUBJECT OF AMENDMENT: The changes to the BPHC State Plan benefit include adding the ability to request additional service units, changing the Community Health Worker (CHW) provider type to the Integrated Health Technician (IHT), adding clarification with regard to three instances of the BPHC services must be provided to each eligible member every 180 days and documented in progress notes, and changing the BPHC staff qualifications for individuals who complete State evaluations for the program from three years of post-degree experience to two years of post-degree experience of working with individuals with serious mental illness (SMI) and/or substance use disorders (SUD)

10. GOVERNOR'S REVIEW (*Check One*)

GOVERNOR'S OFFICE REPORTED NO COMMENT OTHER, AS SPECIFIED
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

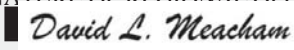
Indiana's Medicaid State Plan does not require the Governor's review. See Section 7.4 of the State Plan.

12. SIGNATURE OF STATE AGENCY OFFICIAL 	16. RETURN TO: Allison Taylor Medicaid Director Indiana Office of Medicaid Policy and Planning 402 West Washington Street, Room W461 Indianapolis, IN 46204 ATTN: Gabrielle Koenig, Government Affairs Director
13. TYPED NAME: Allison Taylor	
14. TITLE: Medicaid Director	
15. DATE SUBMITTED 07/07/2020	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED 07/07/2020	18. DATE APPROVED 09/23/2020
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PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL 10/01/2020	20. SIGNATURE OF REGIONAL OFFICIAL Digitally signed by David L. Meacham  Date: 2020.09.23 07:30:20 -07'00'
21. TYPED NAME David L. Meacham	22. TITLE Director, Division of HCBS Operations and Oversight

23. REMARKS

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.

- 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

- Concurrent Operation with Other Programs.** (Indicate whether this benefit will operate concurrently with another Medicaid authority):

Select one:

<input type="radio"/>	Not applicable		
<input checked="" type="checkbox"/>	Applicable		
Check the applicable authority or authorities:			
<input type="checkbox"/>	Services furnished under the provisions of §1915(a)(1)(a) of the Act. The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of 1915(i) State plan HCBS. Participants may <i>voluntarily</i> elect to receive <i>waiver</i> and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. <i>Specify:</i> (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the specific 1915(i) State plan HCBS furnished by these plans; (d) how payments are made to the health plans; and (e) whether the 1915(a) contract has been submitted or previously approved.		
<input checked="" type="checkbox"/>	Waiver(s) authorized under §1915(b) of the Act. Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved: This § 1915(i) State Plan benefit operates concurrently with an approved fee-for-service selective contracting waiver authorized under §1915(b)(4) of the Act, and was effective on 10/01/2018.		
Specify the §1915(b) authorities under which this program operates (<i>check each that applies</i>):			
<input type="checkbox"/>	§1915(b)(1) (mandated enrollment to managed care)	<input type="checkbox"/>	§1915(b)(3) (employ cost savings to furnish additional services)
<input type="checkbox"/>	§1915(b)(2) (central broker)	<input checked="" type="checkbox"/>	§1915(b)(4) (selective contracting/limit number of providers)

<input type="checkbox"/>	<p>A program operated under §1932(a) of the Act. <i>Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:</i></p>
<input type="checkbox"/>	<p>A program authorized under §1115 of the Act. <i>Specify the program:</i></p>

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

<input checked="" type="checkbox"/>	<p>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>:</p>	
<input type="checkbox"/>	<p>The Medical Assistance Unit <i>(name of unit)</i>:</p>	
<input checked="" type="checkbox"/>	<p>Another division/unit within the SMA that is separate from the Medical Assistance Unit</p>	
	<p><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></p>	<p>The Division of Mental Health & Addiction (DMHA) is the operating agency under the umbrella of Indiana’s SMA. 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.</p>
	<p>The State plan HCBS benefit is operated by <i>(name of agency)</i></p>	

4. 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 type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2 Eligibility evaluation	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3 Review of participant service plans	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4 Prior authorization of State Plan HCBS	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5 Utilization management	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6 Qualified provider enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7 Execution of Medicaid provider agreement	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
8 Establishment of a consistent rate methodology for each State plan HCBS	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
9 Rules, policies, procedures, and information development governing the State Plan HCBS benefit	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10 Quality assurance and quality improvement activities	<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):

Functions 5-8 are performed/administered by the Division of Mental Health and Addiction (DMHA) or a State contracted entity of the Family and Social Services Administration (FSSA), the State Medicaid Agency (SMA). DMHA is under the umbrella of Indiana’s SMA, but not part of the Medical Assistance Unit. The Office of Medicaid Policy and Planning (OMPP), the Medical Assistance Unit of the SMA is responsible for quality and program oversight for Functions 5-8. OMPP meets quarterly for trending and analysis of performance measure data for all functions. OMPP works with DMHA and/or contracted entities to develop and evaluate quality improvement strategies.

For utilization management, item 5, the contracted entity is the Medicaid Surveillance Utilization Review Contractors. For qualified provider enrollment, item 6, the agency is DMHA and the contracted entity is the Medicaid Fiscal Agent. For the execution of Medicaid provider agreement, item 7, the contracted entity is the Medicaid Fiscal Agent. For the establishment of a consistent rate methodology for each State plan HCBS, item 8, the contracted entity is an actuarial service.

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

5. **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 entity 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):*

6. **Fair Hearings and Appeals.** The state assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.
7. **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.
8. **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 Education 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	6/1/2019	5/31/2020	3000
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. States that want to adopt the §1902(a)(10)(A)(ii)(XXII) eligibility category make the election in Attachment 2.2-A of the state Medicaid plan.)

2. **Medically Needy** *(Select one):*

The State does not provide State plan HCBS to the medically needy.

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, individuals who qualify as medically needy on the basis of this election receive only 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.

3. 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.

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

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*):

Individuals 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 two (2) 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 services, service provider agencies, locations where potential enrollees may go to apply, and how to access assessments and services. Any provider may identify a potential enrollee who meets 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. The agency staff reviews the program information with the applicant, together discuss the options under the program, and determines whether to complete an application.

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 (LON) recommendation based on the individual item ratings.

The LON 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 preference and choice, which 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 dynamic, 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. Upon completion of the referral packet (including but not limited to the ANSA, referral form, and proposed plan of care (IICP)), the agency staff submits the documents to DMHA through a secure electronic file transfer process.

The State Evaluation Team (SET) is a special team of state employees who are part of DMHA. Upon receipt of the referral packet, the SET reviews all submitted documentation and determines whether or not the applicant meets the needs-based criteria for 1915(i).

Time spent 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 SET is billed as administrative activities.

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

If determined ineligible for the 1915(i) benefit, a denial letter, generated from DMHA, is sent to the applicant and the agency staff member informing them that the application for the program and service has been denied. The letters will include the reason for denial, appeal rights and process.

Re-evaluations for continued 1915(i) services follow the 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 Criteria.** *(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):*

All of the following needs-based criteria must be met for BPHC eligibility:

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 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.

*The evaluation for BPHC eligibility will include an assessment to manage a prescription medication regimen and the impact on health symptoms and functioning. Additionally, an individual will be assessed for awareness of co-occurring behavioral and physical healthcare needs and the ability to manage both.

**Impairment in self-management of physical and behavioral health is operationally defined as limited or impaired ability to carry out routine healthcare regimens, including but not limited to, taking medicine as prescribed, keeping medical appointments, maintaining linkage with a primary medical provider, diet, exercise and management of symptoms.

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):*

State plan HCBS needs-based eligibility criteria	NF (& NF LOC** waivers)	ICF/IID (& ICF/IID LOC waivers)	Applicable Hospital* (& Hospital LOC waivers)
Needs-based eligibility criteria are specified in Item 5 above.	Indiana Law allows reimbursement to NFs for eligible persons who require skilled or intermediate nursing care as defined in 405 IAC 1-3-1 and 1-3-2. 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. 405 IAC 1-3-2 (a)	Indiana Law allows reimbursement to ICF/IIDs for eligible persons as defined in 405 IAC 1-1-11. A person may be functionally eligible for an ICF/IID LOC waiver when documentation shows the individual meets the following conditions: 1. Has a diagnosis of intellectual disability, cerebral palsy, epilepsy, autism, or	Dangerous to self or others or gravely disabled. (IC-12-26-1)

	<p>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>condition similar to intellectual disability.</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 <ol style="list-style-type: none"> (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

**LOC= level of care

7. **Target Group(s).** The State elects to target this 1915(i) State Plan HCBS benefit to a specific population based on age, disability, diagnosis, and/or eligibility group. 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) and 42 CFR 441.710(e)(2). (*Specify target group(s)*):

<p>The BPHC Program Eligibility, 405 IAC 5-21.8:</p> <ul style="list-style-type: none"> • Age 19 or over • Approved BPHC eligible primary diagnosis 	
<p>ICD-10 Code</p>	<p>ICD-10 Description</p>

F10.10	Alcohol abuse, uncomplicated
F10.120	Alcohol abuse with intoxication, uncomplicated
F10.150	Alcohol abuse with alcohol-induced psychotic disorder with delusions
F10.151	Alcohol abuse with alcohol-induced psychotic disorder with hallucinations
F10.188	Alcohol abuse with other alcohol-induced disorder
F10.19	Alcohol abuse with unspecified alcohol-induced disorder
F10.20	Alcohol dependence, uncomplicated
F10.21	Alcohol dependence, in remission
F10.220	Alcohol dependence with intoxication, uncomplicated
F10.230	Alcohol dependence with withdrawal, uncomplicated
F10.250	Alcohol dependence with alcohol-induced psychotic disorder with delusions
F10.251	Alcohol dependence with alcohol-induced psychotic disorder with hallucinations
F10.29	Alcohol dependence with unspecified alcohol-induced disorder
F11.10	Opioid abuse, uncomplicated
F11.120	Opioid abuse with intoxication, uncomplicated
F11.150	Opioid abuse with opioid-induced psychotic disorder with delusions
F11.151	Opioid abuse with opioid-induced psychotic disorder with hallucinations
F11.159	Opioid abuse with opioid-induced psychotic disorder, unspecified
F11.19	Opioid abuse with unspecified opioid-induced disorder
F11.20	Opioid dependence, uncomplicated
F11.21	Opioid dependence in remission
F11.220	Opioid dependence with intoxication, uncomplicated
F11.250	Opioid dependence with opioid-induced psychotic disorder with delusions
F11.251	Opioid dependence with opioid-induced psychotic disorder with hallucinations
F11.259	Opioid dependence with opioid-induced psychotic disorder, unspecified
F11.29	Opioid dependence with unspecified opioid-induced disorder
F12.10	Cannabis abuse, uncomplicated
F12.120	Cannabis abuse with intoxication, uncomplicated
F12.150	Cannabis abuse with psychotic disorder with delusions
F12.151	Cannabis abuse with psychotic disorder with hallucinations
F12.19	Cannabis abuse with unspecified cannabis-induced disorder
F12.20	Cannabis dependence, uncomplicated
F12.21	Cannabis dependence, in remission
F12.220	Cannabis dependence with intoxication, uncomplicated
F12.250	Cannabis dependence with psychotic disorder with delusions
F12.251	Cannabis dependence with psychotic disorder with hallucinations
F12.29	Cannabis dependence with unspecified cannabis-induced disorder
F13.10	Sedative, hypnotic or anxiolytic abuse, uncomplicated
F13.120	Sedative, hypnotic or anxiolytic abuse with intoxication, uncomplicated
F13.150	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced psychotic disorder with delusions

F13.151	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced psychotic disorder with hallucinations
F13.188	Sedative, hypnotic or anxiolytic abuse with other sedative, hypnotic or anxiolytic-induced disorder
F13.19	Sedative, hypnotic or anxiolytic abuse with unspecified sedative, hypnotic or anxiolytic-induced disorder
F13.20	Sedative, hypnotic or anxiolytic dependence, uncomplicated
F13.21	Sedative, hypnotic or anxiolytic dependence, in remission
F13.220	Sedative, hypnotic or anxiolytic dependence with intoxication, uncomplicated
F13.230	Sedative, hypnotic or anxiolytic dependence with withdrawal, uncomplicated
F13.250	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder with delusions
F13.251	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder with hallucinations
F13.26	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced persisting amnesic disorder
F13.29	Sedative, hypnotic or anxiolytic dependence with unspecified sedative, hypnotic or anxiolytic-induced disorder
F14.10	Cocaine abuse, uncomplicated
F14.120	Cocaine abuse with intoxication, uncomplicated
F14.150	Cocaine abuse with cocaine-induced psychotic disorder with delusions
F14.151	Cocaine abuse with cocaine-induced psychotic disorder with hallucinations
F14.19	Cocaine abuse with unspecified cocaine-induced disorder
F14.20	Cocaine dependence, uncomplicated
F14.21	Cocaine dependence, in remission
F14.220	Cocaine dependence with intoxication, uncomplicated
F14.250	Cocaine dependence with cocaine-induced psychotic disorder with delusions
F14.251	Cocaine dependence with cocaine-induced psychotic disorder with hallucinations
F14.29	Cocaine dependence with unspecified cocaine-induced disorder
F15.10	Other stimulant abuse, uncomplicated
F15.120	Other stimulant abuse with intoxication, uncomplicated
F15.19	Other stimulant abuse with unspecified stimulant-induced disorder
F15.20	Other stimulant dependence, uncomplicated
F15.21	Other stimulant dependence, in remission
F15.220	Other stimulant dependence with intoxication, uncomplicated
F15.29	Other stimulant dependence with unspecified stimulant-induced disorder
F16.10	Hallucinogen abuse, uncomplicated
F16.120	Hallucinogen abuse with intoxication, uncomplicated
F16.183	Hallucinogen abuse with hallucinogen persisting perception disorder (flashbacks)
F16.188	Hallucinogen abuse with other hallucinogen-induced disorder
F16.19	Hallucinogen abuse with unspecified hallucinogen-induced disorder
F16.20	Hallucinogen dependence, uncomplicated

F16.21	Hallucinogen dependence, in remission
F16.220	Hallucinogen dependence with intoxication, uncomplicated
F16.250	Hallucinogen dependence with hallucinogen-induced psychotic disorder with delusions
F16.251	Hallucinogen dependence with hallucinogen-induced psychotic disorder with hallucinations
F16.283	Hallucinogen dependence with hallucinogen persisting perception disorder (flashbacks)
F16.288	Hallucinogen dependence with other hallucinogen-induced disorder
F16.29	Hallucinogen dependence with unspecified hallucinogen-induced disorder
F18.10	Inhalant abuse, uncomplicated
F18.120	Inhalant abuse with intoxication, uncomplicated
F18.150	Inhalant abuse with inhalant-induced psychotic disorder with delusions
F18.151	Inhalant abuse with inhalant-induced psychotic disorder with hallucinations
F18.19	Inhalant abuse with unspecified inhalant-induced disorder
F18.20	Inhalant dependence, uncomplicated
F18.21	Inhalant dependence, in remission
F18.220	Inhalant dependence with intoxication, uncomplicated
F18.250	Inhalant dependence with inhalant-induced psychotic disorder with delusions
F18.251	Inhalant dependence with inhalant-induced psychotic disorder with hallucinations
F18.29	Inhalant dependence with unspecified inhalant-induced disorder
F19.10	Other psychoactive substance abuse, uncomplicated
F19.120	Other psychoactive substance abuse with intoxication, uncomplicated
F19.122	Other psychoactive substance abuse with intoxication with perceptual disturbances
F19.150	Other psychoactive substance abuse with psychoactive substance-induced psychotic disorder with delusions
F19.151	Other psychoactive substance abuse with psychoactive substance-induced psychotic disorder with hallucinations
F19.16	Other psychoactive substance abuse with psychoactive substance-induced persisting amnesic disorder
F19.19	Other psychoactive substance abuse with unspecified psychoactive substance-induced disorder
F19.20	Other psychoactive substance dependence, uncomplicated
F19.21	Other psychoactive substance dependence, in remission
F19.220	Other psychoactive substance dependence with intoxication, uncomplicated
F19.222	Other psychoactive substance dependence with intoxication with perceptual disturbance
F19.230	Other psychoactive substance dependence with withdrawal, uncomplicated
F19.232	Other psychoactive substance dependence with withdrawal with perceptual disturbance
F19.250	Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder with delusions

F19.251	Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder with hallucinations
F19.26	Other psychoactive substance dependence with psychoactive substance-induced persisting amnesic disorder
F19.29	Other psychoactive substance dependence with unspecified psychoactive substance-induced disorder
F20.0	Paranoid schizophrenia
F20.1	Disorganized schizophrenia
F20.2	Catatonic schizophrenia
F20.3	Undifferentiated schizophrenia
F20.5	Residual schizophrenia
F20.81	Schizophreniform disorder
F20.89	Other schizophrenia
F20.9	Schizophrenia, unspecified
F22	Delusional disorders
F24	Shared psychotic disorder
F25.0	Schizoaffective disorder, bipolar type
F25.1	Schizoaffective disorder, depressive type
F25.8	Other schizoaffective disorders
F25.9	Schizoaffective disorder, unspecified
F28	Other psychotic disorder not due to a substance or known physiological condition
F29	Unspecified psychosis not due to a substance or known physiological condition
F30.10	Manic episode without psychotic symptoms, unspecified
F30.12	Manic episode without psychotic symptoms, moderate
F30.13	Manic episode, severe, without psychotic symptoms
F30.2	Manic episode, severe with psychotic symptoms
F30.3	Manic episode in partial remission
F30.9	Manic episode, unspecified
F31.0	Bipolar disorder, current episode hypomanic
F31.10	Bipolar disorder, current episode manic without psychotic features, unspecified
F31.12	Bipolar disorder, current episode manic without psychotic features, moderate
F31.13	Bipolar disorder, current episode manic without psychotic features, severe
F31.2	Bipolar disorder, current episode manic severe with psychotic features
F31.30	Bipolar disorder, current episode depressed, mild or moderate severity, unspecified
F31.32	Bipolar disorder, current episode depressed, moderate
F31.4	Bipolar disorder, current episode depressed, severe, without psychotic features
F31.5	Bipolar disorder, current episode depressed, severe, with psychotic features
F31.60	Bipolar disorder, current episode mixed, unspecified
F31.62	Bipolar disorder, current episode mixed, moderate
F31.63	Bipolar disorder, current episode mixed, severe, without psychotic features
F31.64	Bipolar disorder, current episode mixed, severe, with psychotic features

F31.71	Bipolar disorder, in partial remission, most recent episode hypomanic
F31.73	Bipolar disorder, in partial remission, most recent episode manic
F31.75	Bipolar disorder, in partial remission, most recent episode depressed
F31.77	Bipolar disorder, in partial remission, most recent episode mixed
F31.81	Bipolar II disorder
F31.89	Other bipolar disorder
F31.9	Bipolar disorder, unspecified
F32.1	Major depressive disorder, single episode, moderate
F32.2	Major depressive disorder, single episode, severe without psychotic features
F32.3	Major depressive disorder, single episode, severe with psychotic features
F32.4	Major depressive disorder, single episode, in partial remission
F33.1	Major depressive disorder, recurrent, moderate
F33.2	Major depressive disorder, recurrent severe without psychotic features
F33.3	Major depressive disorder, recurrent, severe with psychotic symptoms
F33.41	Major depressive disorder, recurrent, in partial remission
F33.9	Major depressive disorder, recurrent, unspecified
F34.0	Cyclothymic disorder
F34.1	Dysthymic disorder
F40.00	Agoraphobia, unspecified
F40.01	Agoraphobia with panic disorder
F40.02	Agoraphobia without panic disorder
F40.10	Social phobia, unspecified
F41.0	Panic disorder [episodic paroxysmal anxiety]
F41.1	Generalized anxiety disorder
F42.2	Mixed obsessional thoughts and acts
F42.3	Hoarding disorder
F43.10	Post-traumatic stress disorder, unspecified
F43.11	Post-traumatic stress disorder, acute
F43.12	Post-traumatic stress disorder, chronic
F44.81	Dissociative identity disorder
F45.41	Pain disorder exclusively related to psychological factors
F50.00	Anorexia nervosa, unspecified
F50.01	Anorexia nervosa, restricting type
F50.02	Anorexia nervosa, binge eating/purging type
F50.2	Bulimia nervosa
F50.81	Binge eating disorder
F50.82	Avoidant/restrictive food intake disorder
F50.89	Other specified eating disorder
F50.9	Eating disorder, unspecified
F51.4	Sleep terrors [night terrors]
F60.0	Paranoid personality disorder

F60.3	Borderline personality disorder
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Option for Phase-in of Services and Eligibility. If the State elects to target this 1915(i) State Plan HCBS benefit, it may limit the enrollment of individuals or the provision of services to enrolled individuals in accordance with 1915(i)(7)(B)(ii) and 42 CFR 441.745(a)(2)(ii) based upon criteria described in a phase-in plan, subject to CMS approval. At a minimum, the phase-in plan must describe: (1) the criteria used to limit enrollment or service delivery; (2) the rationale for phasing-in services and/or eligibility; and (3) timelines and benchmarks to ensure that the benefit is available statewide to all eligible individuals within the initial 5-year approval. (Specify the phase-in plan):

(By checking the following box 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. **Reasonable Indication of Need for Services.** In order for an individual to be determined to need the 1915(i) State plan HCBS benefit, an individual must require: (a) the provision of at least one 1915(i) service, as documented in the person-centered service plan, and (b) the provision of 1915(i) services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the person-centered service plan. Specify the state’s policies concerning the reasonable indication of the need for 1915(i) State plan HCBS:

i.	Minimum number of services.	The minimum number of 1915(i) State plan services (one or more) that an individual must require in order to be determined to need the 1915(i) State plan HCBS benefit is:
	1	
ii.	Frequency of services.	The State requires (select one):
	<input type="radio"/>	The provision of 1915(i) services at least monthly
	<input checked="" type="checkbox"/>	Monthly monitoring of the individual when services are furnished on a less than monthly basis
		If the State also requires a minimum frequency for the provision of 1915(i) services other than monthly (e.g., quarterly), specify the frequency: Three (3) instances of the BPHC service must be provided to each eligible member every 180 days and documented in progress notes.

Home and Community-Based Settings

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

1. **Home and Community-Based Settings.** The State plan HCBS benefit will be furnished to individuals who reside and receive HCBS in their home or in the community, not in an institution. (*Explain how residential and non-residential settings in this SPA comply with Federal home and community-based settings requirements at 42 CFR 441.710(a)(1)-(2) and associated CMS guidance. Include a description of the settings where individuals will reside and where individuals will receive HCBS, and how these settings meet the Federal home and community-based settings requirements, at the time of submission and in the future*):

(Note: In the Quality Improvement Strategy (QIS) portion of this SPA, the state will be prompted to include how the state Medicaid agency will monitor to ensure that all settings meet federal home and community-based settings requirements, at the time of this submission and ongoing.)

The state assures that this 1915(i) state plan HCBS benefit will be subject to any provisions or requirements included in the state's most recent and/or approved home and community-based settings Statewide Transition Plan. The state will implement any CMS required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan.

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 meets federal requirements at 42 CFR §441.720.
2. Based on the independent assessment, there is a person-centered service plan for each individual determined to be eligible for the State Plan HCBS benefit. The person-centered service plan is developed using a person-centered service planning process in accordance with 42 CFR §441.725(a), and the written person-centered service plan meets federal requirements at 42 CFR §441.725(b).
3. The person-centered service plan is reviewed, and revised upon reassessment of functional need as required under 42 CFR §441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.
4. **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 need 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 are: (1) bachelor's degree in social sciences or related field with two or more years of clinical experience; (2) completion of DMHA and OMPP approved training and orientation for 1915(i) eligibility and determination; and (3) completion of assessment tool Certification training.

5. **Responsibility for Development of Person-Centered Service Plan.** There are qualifications (that are reasonably related to developing service plans) for persons responsible for the development of the individualized, person-centered service plan. (*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.

- 6. Supporting the Participant in Development of Person-Centered Service Plan.** 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 person-centered service plan 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 leading 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. A copy of the IICP is offered to the client and/or legal guardian.

The Independent State Evaluation Team (SET) 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 person-centered service 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 in order 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 and recovery, habilitative or rehabilitative based in nature with outcomes specific to the applicant/recipient’s needs.
- Goals are identified by the applicant/recipient.
- Review of psychiatric symptoms and how they affect the applicant/recipient’s functioning, ability to attain desires and goals, as well as the applicant’s ability to self-manage mental and physical healthcare services.
- Applicant/recipient’s 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 attain desires, needs and goals toward self-managing mental and physical healthcare in order to remain in the community.
- Applicant/recipient’s ability to manage his or her health condition and services.

A member of the treatment team involved in assessing the applicant/recipients 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 which demonstrates his/her participation in the development of an ongoing IICP review is required in the clinical record and subject to State audit. The applicant must attest to participation in the development of the IICP on the BPHC application. 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 (POC) 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 "Office of Family and Consumer Affairs" on the DMHA website;
- (2) The "Consumer Service Line" (800-901-1133)
- (3) Indiana Disability Rights (800-622-4845)
- (4) In-person to a DMHA staff member; or
- (5) Via written complaint or email that is submitted to DMHA.

7. 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 person-centered service plan):*

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 State Plan benefit. The care coordinator explains the process for making an informed choice of provider(s) and answers questions. The applicant/recipient is also advised that the 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 by the care coordinator. A listing of approved BPHC provider agencies is also posted on the Indiana Medicaid website at www.indianamedicaid.com. When accessing [indianamedicaid.com](http://www.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 the 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 a choice.

This 1915(i) State Plan benefit runs concurrently with the 1915(b)(4) fee-for-service selective contracting waiver (IN.02.R01).

8. Process for Making Person-Centered Service Plan Subject to the Approval of the Medicaid Agency. *(Describe the process by which the person-centered service plan 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). OMPP reviews and approves the policies, processes and standards for developing and approving BPHC plans of care (POC). Based on the terms and conditions of the 1915(i) benefit, OMPP may review and overrule the approval or disapproval of any specific plan of care acted upon by DMHA serving in its capacity as the operating agency. In the instance of a complaint from a 1915(i) provider or applicant/recipient, the IICP submitted to DMHA may be reviewed by OMPP.

9. Maintenance of Person-Centered Service Plan 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):	
Behavioral & Primary Healthcare Coordination (BPHC) consists of coordination of healthcare services to manage the healthcare needs of the individual. The BPHC service includes the following. <ul style="list-style-type: none"> • Logistical support, advocacy and education to assist individuals in navigating the healthcare system <ul style="list-style-type: none"> ○ Activities that help recipients gain access to needed health (physical and behavioral health) services ○ Manage health conditions such as adhering to health regimens ○ Scheduling and keeping medical appointments ○ Obtaining and maintaining a primary medical provider ○ Coordination of care within and across systems • Assessment of the eligible recipient to determine service needs • Development of an individualized integrated care plan (IICP) • Referral and related activities to help the recipient obtain needed services • Monitoring and follow-up • Evaluation 	
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. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. (Choose each that applies):	
<input checked="" type="checkbox"/>	Categorically needy (specify limits):
	The BPHC service is initially offered in 15-minute units up to 48 units/12 hours per 180 days. Additional units are available upon request.

	Exclusions: <ul style="list-style-type: none"> ○ Time spent on the initial assessment, referral form and IICP Activities which are billed under MRO Case Management or AMHH Care Coordination ○ Direct delivery of medical, clinical, or other direct services
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<input type="checkbox"/>	Medically needy (specify limits):

Provider Qualifications (For each type of provider. Copy rows as needed):			
Provider Type (Specify):	License (Specify):	Certification (Specify):	Other Standard (Specify):
Agency	N/A	DMHA-certified Community Mental Health Center (CMHC)	<p>DMHA-approved BPHC provider agencies must meet DMHA and OMPP-defined criteria and standards, including the following:</p> <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 Medicaid provider that offers a full-continuum of care. 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. D) Provider agency must meet all BPHC provider agency criteria, as defined in the 1915(i) benefit and BPHC operating policy. <p>In addition to meeting criteria for a provider agency, the agency must certify the staff providing a BPHC needs assessment, development and adjustments to the IICP, referral and linkage activities, and physician consults must meet the following standards:</p> <ul style="list-style-type: none"> A) Licensed professional; B) QBHP; or C) OBHP. <p>The agency must certify the staff providing all other BPHC services including coordination across health systems, monitoring and follow-up activities, and re-evaluation of the recipients progress meet the following standards:</p> <ul style="list-style-type: none"> A) Licensed professional B) QBHP C) OBHP D) Certified Recovery Specialist; or E) Certified Integrated Health Technician (IHT). <p>A Certified Recovery Specialist (CRS) refers to an individual who meets all of the following criteria:</p>

			<ol style="list-style-type: none">1. Is maintaining healthy recovery from mental illness;2. Has completed the CRS Indiana Division of Mental Health and Addiction (DMHA) state-approved training program;3. Receives a passing score on the certification exam; and4. Is supervised by a licensed professional or QBHP. <p>A Certified IHT refers to an individual who meets all of the following criteria:</p> <ol style="list-style-type: none">1. Has completed the IHT job specific training from the community mental health center employing the IHT;2. Receives a passing score on the certification exam; and3. Is supervised by a licensed professional or Qualified Behavioral Health Professional.
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Verification of Provider Qualifications <i>(For each provider type listed above. Copy rows as needed):</i>		
Provider Type <i>(Specify):</i>	Entity Responsible for Verification <i>(Specify):</i>	Frequency of Verification <i>(Specify):</i>
Agency	DMHA	Initially, and at the time of DMHA certification and renewal.
Service Delivery Method. <i>(Check each that applies):</i>		
<input type="checkbox"/>	Participant-directed	<input checked="" type="checkbox"/> Provider managed

2. **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.
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3. Limited Implementation of Participant-Direction. *(Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to statewide requirements. Select one):*

<input type="checkbox"/>	Participant direction is available in all geographic areas in which State plan HCBS are available.
<input type="checkbox"/>	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="checkbox"/>	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
<input type="checkbox"/>	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.

6. Participant-Directed Person-Centered Service Plan. *(By checking this box the state assures that):* Based on the independent assessment required under 42 CFR §441.720, the individualized person-centered service plan is developed jointly with the individual, meets federal requirements at 42 CFR §441.725, and:

- Specifies the State plan HCBS that the individual will be responsible for directing;
- Identifies the methods by which the individual will plan, direct or control services, including whether the individual will exercise authority over the employment of service providers and/or authority over expenditures from the individualized budget;
- Includes appropriate risk management techniques that explicitly recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assures the appropriateness of this plan based upon the resources and support needs of the individual;
- Describes the process for facilitating voluntary and involuntary transition from self-direction including any circumstances under which transition out of self-direction is involuntary. There must be state procedures to ensure the continuity of services during the transition from self-direction to other service delivery methods; and
- Specifies the financial management supports to be provided.

7. 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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8. Opportunities for Participant-Direction

a. Participant–Employer Authority (individual can select, manage, and dismiss State plan HCBS providers). *(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 that does not result in payment for medical assistance to the individual). *(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 the method for calculating the dollar values in the budget based on reliable costs and service utilization, 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 person-centered service plan.):</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

Quality Measures

(Describe the state’s quality improvement strategy. For each requirement, and lettered sub-requirement, complete the table below):

(Table repeats for each measure for each requirement and lettered sub-requirement above.)

1. Service plans a) address assessed needs of 1915(i) participants; b) are updated annually; and c) document choice of services and providers.

The Division of Mental Health and Addiction (DMHA) reviews 100% of all Individualized Integrated Care Plans (IICPs) submitted through the Data Assessment Registry Mental Health and Addiction (DARMHA) database. During the review of the IICPs, DMHA ensures the needs of the participants are addressed, the IICP is updated timely, and documentation supports the applicant received a choice of services and providers.

Requirement	1a) Service plans address assessed needs of 1915(i) participants
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	Number and percent of IICPs that address recipient needs <i>N: Total number of IICPs reviewed that address recipient needs</i> <i>D: Total number of IICPs reviewed</i>
Discovery Activity <i>(Source of Data & sample size)</i>	100% of IICPs are reviewed and approved through the State’s database
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	DMHA
Frequency	Ongoing
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	DMHA

<p>Frequency <i>(of Analysis and Aggregation)</i></p>	<p>Analysis and aggregation are ongoing. If a corrective action plan (CAP) 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.</p>
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<p>Requirement</p>	<p>1b) Service plans are updated, at least, every 180 days</p>
<p>Discovery</p>	
<p>Discovery Evidence <i>(Performance Measure)</i></p>	<p>Number and percent of IICPs reviewed and revised on or before IICP review date <i>N: Total number of IICPs reviewed and revised on or before IICP review date</i> <i>D: Total number of IICPs reviewed</i></p>
<p>Discovery Activity <i>(Source of Data & sample size)</i></p>	<p>100% of IICPs are reviewed and approved through the State’s database</p>
<p>Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i></p>	<p>DMHA</p>
<p>Frequency</p>	<p>Ongoing</p>
<p>Remediation</p>	
<p>Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i></p>	<p>DMHA</p>
<p>Frequency <i>(of Analysis and Aggregation)</i></p>	<p>Analysis and aggregation are ongoing. If a CAP 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.</p>

<p>Requirement</p>	<p>1c) Service plans document choice of services</p>
<p>Discovery</p>	
<p>Discovery Evidence <i>(Performance Measure)</i></p>	<p>Number and percent of recipients with documentation of choice of eligible services <i>N: Total number of IICPs reviewed with recipient’s documented choice of eligible services</i> <i>D: Total number of IICPs reviewed</i></p>

Discovery Activity <i>(Source of Data & sample size)</i>	Record Review – onsite/off site Sample with 95% confidence level with 5% margin of error
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	DMHA
Frequency	Ongoing
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	DMHA
Frequency <i>(of Analysis and Aggregation)</i>	Analysis and aggregation are ongoing. If a CAP 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.

Requirement	1d) Service plans address choice of providers
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	Number and percent of recipients with documentation of choice of providers <i>N: Total number of IICPs reviewed with recipient’s documented choice of providers</i> <i>D: Total number of IICPs reviewed</i>
Discovery Activity <i>(Source of Data & sample size)</i>	Record Review - onsite/off site Sample with 95% confidence level with 5% margin of error
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	DMHA
Frequency	Ongoing
Remediation	

<p>Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i></p>	DMHA
<p>Frequency <i>(of Analysis and Aggregation)</i></p>	Analysis and aggregation are ongoing. If a CAP 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.

<p>Requirement</p>	1e. Client and/or legal guardian offered a copy of the IICP
<p>Discovery</p>	
<p>Discovery Evidence <i>(Performance Measure)</i></p>	<p>Number and percent of clients or legal guardians that were offered a copy of the completed IICP <i>N: Total number of attestations reviewed with documentation of offered IICP</i> <i>D: Total number of attestations reviewed</i></p>
<p>Discovery Activity <i>(Source of Data & sample size)</i></p>	<p>Record Review – onsite/off site Sample with 95% confidence level with 5% margin of error</p>
<p>Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i></p>	DMHA
<p>Frequency</p>	Ongoing
<p>Remediation</p>	
<p>Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i></p>	DMHA
<p>Frequency <i>(of Analysis and Aggregation)</i></p>	Analysis and aggregation are ongoing. If a CAP 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. **Eligibility Requirements:** (a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future; (b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately; and (c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.

For each BPHC application submitted, providers are required to complete a face-to-face BPHC evaluation and Adult Needs Strengths Assessment (ANSA). Information from the evaluation and assessment is submitted along with an IICP with other supporting documentation to DMHA for review for eligibility. The process is the same for the BPHC renewal application, as it is for the initial application.

DMHA conducts an annual quality assurance review for each BPHC provider to ensure compliance with all eligibility requirements.

Requirement	2a) An evaluation for eligibility is provided to all applicants
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	Number and percent of new applicants who had a face-to-face evaluation for BPHC eligibility prior to enrollment <i>N: Number of new applicants who had a face-to-face evaluation for BPHC eligibility prior to enrollment</i> <i>D: Total number of new applicants who had a BPHC evaluation prior to enrollment</i>
Discovery Activity <i>(Source of Data & sample size)</i>	Record Review - onsite/off site Sample with 95% confidence level with 5% margin of error
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	DMHA
Frequency	Ongoing
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	DMHA
Frequency	Analysis and aggregation are ongoing. If a CAP 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.

	<i>(of Analysis and Aggregation)</i>	
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Requirement	2b) The processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately	
Discovery		
Discovery Evidence <i>(Performance Measure)</i>	Number and percent of Adult Needs and Strengths Assessments (ANSA) completed according to policy <i>N: Number of applicants who had a face-to-face ANSA completed (within 60 days of application submission) for BPHC eligibility prior to enrollment</i> <i>D: Total number of new applicants who had an ANSA completed prior to enrollment</i>	
Discovery Activity <i>(Source of Data & sample size)</i>	Record Review - onsite/off site Sample with 95% confidence level with 5% margin of error	
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	DMHA	
Frequency	Ongoing	
Remediation		
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	DMHA	
Frequency <i>(of Analysis and Aggregation)</i>	Analysis and aggregation are ongoing. If a CAP 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.	

Requirement	2c) The 1915(i) benefit eligibility of enrolled individuals is re-evaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS	
Discovery		

<p>Discovery Evidence <i>(Performance Measure)</i></p>	<p>Number and percent of enrolled individuals re-evaluated at least bi-annually or more frequently, as specified in the approved 1915(i) benefit <i>N: Number of BPHC re-evaluations completed for enrolled individuals during the review period</i> <i>D: Total number of enrolled individuals due for re-evaluation during the review period</i></p>
<p>Discovery Activity <i>(Source of Data & sample size)</i></p>	<p>Record Review - onsite/off site Sample with 95% confidence level with 5% margin of error</p>
<p>Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i></p>	<p>DMHA</p>
<p>Frequency</p>	<p>Ongoing</p>
<p>Remediation</p>	
<p>Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i></p>	<p>DMHA</p>
<p>Frequency <i>(of Analysis and Aggregation)</i></p>	<p>Analysis and aggregation are ongoing. If a CAP 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.</p>

3. Providers meet required qualifications.

DMHA approves all providers for the BPHC program. The State’s 24 DMHA-certified Community Mental Health Centers (CMHCs) are the exclusive providers for the BPHC program. CMHC’s must meet all provider agency standards documented in the State Plan benefit and ensure that all direct care agency staff members providing services meet all required qualifications. The services are provided according to the standards and expectations outlined in the State Plan benefit.

All providers must be re-certified by DMHA to provide services. The re-certification is required every three (3) years or at the time of re-accreditation.

<p>Requirement</p>	<p>3a) Providers meet required qualifications</p>
<p>Discovery</p>	

Discovery Evidence <i>(Performance Measure)</i>	Number and percent of provider agencies who meet qualifications <i>N: Number of BPHC provider agencies who meet qualifications at re-certification</i> <i>D: Total number of BPHC provider agencies due for recertification</i>
Discovery Activity <i>(Source of Data & sample size)</i>	100% of provider agency applications are reviewed prior to approval
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	DMHA
Frequency	Ongoing
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	DMHA
Frequency <i>(of Analysis and Aggregation)</i>	Analysis and aggregation are ongoing. If a CAP 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.

Requirement	3b) Providers meet required qualifications
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	Number and percent of provider agencies re-certified timely <i>N: Number of BPHC provider agencies recertified timely</i> <i>D: Total number of BPHC provider agencies recertified</i>
Discovery Activity <i>(Source of Data & sample size)</i>	100% of provider agency re-certification applications are reviewed prior to approval
Monitoring Responsibilities	DMHA

	<i>(Agency or entity that conducts discovery activities)</i>	
	Frequency	Every 3 years or at a time of reaccreditation
Remediation		
	Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	DMHA
	Frequency <i>(of Analysis and Aggregation)</i>	Analysis and aggregation are quarterly. If a CAP 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. Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).

CMHC’s receive assistance provided through DMHA webinars, onsite trainings, and technical assistance calls to increase the understanding of HCBS requirements for providers to successfully implement standards.

Requirement	4) Provider owned, controlled, and operated residential settings meet the home and community-based setting requirements as specified in the benefit and in accordance with 42 CFR 441.710(a)(1)-(2)
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	Number and percent of provider owned, controlled, and operated residential settings in compliance with criteria that meets standards for community living <i>N: Number of provider-owned, controlled, and operated residential settings in compliance with HCBS Settings final rule</i> <i>D: Total number of provider-owned, controlled, and operated residential settings</i>
Discovery Activity <i>(Source of Data & sample size)</i>	100% of provider owned, controlled, and operated residential settings are reviewed to ensure applicants reside in HCBS compliant settings
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	DMHA

Frequency	Ongoing
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	DMHA
Frequency <i>(of Analysis and Aggregation)</i>	Analysis and aggregation are ongoing. If a CAP is needed, it must be provided to the State within 30 business days. The State will respond in 30 business days for a total of 60 business days.

5. The SMA retains authority and responsibility for program operations and oversight.

Requirement	5a) The SMA retains authority and responsibility for program operations and oversight
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	Number and percent of performance measure data reports from DMHA and contracted entities reviewed to ensure administrative oversight. <i>N: Number of data reports provided timely</i> <i>D: Total number of data reports due</i>
Discovery Activity <i>(Source of Data & sample size)</i>	100% review of DMHA Quality Management Reports
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	OMPP
Frequency	Quarterly
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates)</i>	DMHA and OMPP

<i>remediation activities; required timeframes for remediation)</i>	
Frequency <i>(of Analysis and Aggregation)</i>	Analysis and aggregation are completed annually. If a CAP 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.

Requirement	5b) The SMA retains authority and responsibility for program operations and oversight
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	Number and percent of performance measure data reports from DMHA and contracted entities reviewed to ensure administrative oversight. <i>N: Number of data reports provided in correct format</i> <i>D: Total number of data reports due</i>
Discovery Activity <i>(Source of Data & sample size)</i>	100% review of DMHA Quality Management Reports
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	OMPP
Frequency	Quarterly
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	DMHA and OMPP
Frequency <i>(of Analysis and Aggregation)</i>	Analysis and aggregation are completed annually. If a CAP 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 through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.**

Requirement	6a) The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	Number and percent of claims paid according to the published rate during the review period <i>N: Number of claims paid according to the published rate during the review period</i> <i>D: Total number of claims submitted during the review period</i>
Discovery Activity <i>(Source of Data & sample size)</i>	Medicaid Management Information System (MMIS) 100% review
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	OMPP and Medicaid Fiscal Contractor
Frequency	Monthly
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	OMPP
Frequency <i>(of Analysis and Aggregation)</i>	Analysis and aggregation are completed annually. Corrective Action will follow the process identified in the contract between OMPP and MMIS vendor.

Requirement	6b) The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	Number and percent of paid during the review period for recipients enrolled in the program on the date the service was delivered <i>N: Number of claims paid during the review period for recipients enrolled in the program on the date the service was delivered</i> <i>D: Total number of claims submitted for recipients enrolled in the) program on the date the service was delivered</i>
Discovery Activity	Medicaid Management Information System (MMIS) 100% review

	<i>(Source of Data & sample size)</i>	
	Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	OMPP and Medicaid Fiscal Contractor
	Frequency	Monthly
Remediation		
	Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	OMPP
	Frequency <i>(of Analysis and Aggregation)</i>	Analysis and aggregation are completed annually. Corrective Action will follow the process identified in the contract between OMPP and MMIS vendor.

The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.

DMHA reviews policies and procedures for all approved providers for the program to ensure health and welfare needs are addressed. Additionally, DMHA reviews 100% of all incident reports required to be and ensures the incident report is submitted within the required timeframe.

	Requirement	7a) The State identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints and medication errors.
Discovery		
	Discovery Evidence <i>(Performance Measure)</i>	Number and percent of provider agencies who have policies and procedures to prevent incidents of abuse, neglect, exploitation <i>N: Number of provider agencies with policies and procedures to prevent incidents of abuse, neglect, exploitation</i> <i>D: Total number of provider agencies with policies and procedures reviewed</i>
	Discovery Activity <i>(Source of Data & sample size)</i>	100% of provider agencies policies and procedures reviewed to ensure health and welfare needs are addressed.
	Monitoring Responsibilities	DMHA

	<i>(Agency or entity that conducts discovery activities)</i>	
	Frequency	Annually
Remediation		
	Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	DMHA
	Frequency <i>(of Analysis and Aggregation)</i>	Review of policies and procedures occurs annually. If policies and procedures are not in compliance, revised policies must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.

	Requirement	7b) The State identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints and medication errors.
Discovery		
	Discovery Evidence <i>(Performance Measure)</i>	Number and percent of incidents reported within required timeframe <i>N: Number of incident reports submitted within required timeframe D: Total number of incident reports submitted</i>
	Discovery Activity <i>(Source of Data & sample size)</i>	100% review of submitted incident reports
	Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	DMHA
	Frequency	Ongoing
Remediation		
	Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation)</i>	DMHA

<i>activities; required timeframes for remediation)</i>	
Frequency <i>(of Analysis and Aggregation)</i>	Analysis and aggregation are ongoing. Report submitted to State within 72 hours. State will review plan and respond within 5 business days. If CAP 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.

Requirement	7c) The State identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints, and medication errors.
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Discovery

Discovery Evidence <i>(Performance Measure)</i>	Number and percent of incident reports involving medication errors resolved according to policy <i>N: Number of incident reports including medication errors resolved according to policy</i> <i>D: Total number of incident reports including medication errors submitted</i>
Discovery Activity <i>(Source of Data & sample size)</i>	100% review of submitted incident reports
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	DMHA
Frequency	Ongoing

Remediation

Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	DMHA
Frequency <i>(of Analysis and Aggregation)</i>	Analysis and aggregation are ongoing. Report submitted to State within 72 hours. State will review plan and respond within 5 business days. If a CAP 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.

Requirement	7d) The State identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.
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Discovery		
Discovery Evidence <i>(Performance Measure)</i>	Number and percent of incident reports involving seclusions and restraints resolved according to policy <i>N: Number of incident reports including seclusion and restraints resolved according to policy</i> <i>D: Total number of incident reports including seclusion and restraints submitted</i>	
Discovery Activity <i>(Source of Data & sample size)</i>	100% review of submitted incident reports	
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	DMHA	
Frequency	Ongoing	
Remediation		
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	DMHA	
Frequency <i>(of Analysis and Aggregation)</i>	Analysis and aggregation are ongoing. Report submitted to State within 72 hours State will review plan and respond within 5 business days. If a CAP 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.	

Requirement	7e) The State identifies and addresses incident reports involving death
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	Number and percent of incident reports involving death resolved according to policy <i>N: Number of incident reports involving death where the participant’s health, safety, and welfare were met by the provider</i> <i>D: Total number of incident reports involving death</i>
Discovery Activity <i>(Source of Data & sample size)</i>	100% review of provider agencies’ critical incident reports involving death
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	DMHA
Frequency	Ongoing
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	DMHA
Frequency <i>(of Analysis and Aggregation)</i>	Analysis and aggregation are ongoing. Incident report submitted to State within 24 hours for residential settings and within 72 hours for participants in a private/independent home setting. State will review submitted report and respond within 5 business days. If a CAP is needed, it must be submitted to the State within 30 business days. The State will respond in 30 business days for a total of 60 business days.

System Improvement

(Describe the process for systems improvement as a result of aggregated discovery and remediation activities.)

1. Methods for Analyzing Data and Prioritizing Need for System Improvement

1) DMHA collects and tracks complaints related to the BPHC service offered through the 1915(i). Complaints could be received from recipients, family members, concerned citizens, providers, or advocates. Complaints are categorized as individual issue or system challenges. All complaints are discussed during monthly strategy meetings between DMHA and OMPP. System challenge/barrier issues identified in the complaints are prioritized with solutions discussed for highest priority items.

2. Roles and Responsibilities

DMHA reviews and analyzes individual issues related to performance measures to identify any system trends. DMHA and OMPP monitor trends to identify the need for system changes.

3. Frequency

Monthly, Quarterly, and Annually

4. Method for Evaluating Effectiveness of System Changes

During the monthly 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.

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)	
	<p>Behavioral & Primary Healthcare Coordination (BPHC) – Tier 1 Providers (Licensed professionals, qualified behavioral health professionals & other behavioral health Professionals as defined in Attachment 3.1i Person-Centered Planning & Service Delivery.) 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 effective on June 1, 2019 is for services provided on or after that date. All rates are published on the agency’s website at www.indianamedicaid.com.</p>	
	<p>Behavioral & Primary Healthcare Coordination (BPHC) – Tier 2 Providers (Certified Recovery Specialists & Integrated Health Technicians as defined Attachment 3.1i Services- Behavioral and Primary Healthcare Coordination.) 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 effective on June 1, 2019, is for services provided on or after that date. All rates are published on the agency’s website at www.indianamedicaid.com.</p>	