§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.

1. **Services.** *(Specify service title(s) for the HCBS listed in Attachment 4.19-B that the State plans to cover):*

Indiana provides the following State Plan §1915(i) home and community-based services, which are referred to in this document as Child Mental Health Wraparound (CMHW) services:

1) Wraparound Facilitation
2) Habilitation
3) Respite Care
4) Training and Support for Unpaid Caregivers

2. **Target Group(s).** *(If applicable, specify the target population(s) that the State plans to include):*

The State elects to target this 1915(i) State Plan HCBS benefit to the population defined below. 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).

Target Groups:
Indiana's CMHW services program is designed to serve youth meeting the following targeted eligibility criteria:

1) Age 6 through the age of 17;
2) Meets criteria for two (2) or more DSM IV-TR (or subsequent revision) diagnoses not excluded under 2b. below as exclusionary criteria; and
3) Youth does not meet exclusionary criteria for CMHW services.

Exclusionary Criteria:
The following exclusionary criteria are used to identify those youth the CMHW services program is not designed to serve. A youth with any of the criteria below is not eligible for CMHW services:

1) Primary Substance Use Disorder.
2) Primary or Secondary Pervasive Developmental Disorder (Autism Spectrum Disorder).
3) Primary Attention Deficit Hyperactivity Disorder.
4) Intellectual disability/disabilities.
5) Dual diagnosis of serious emotional disturbance and intellectual disabilities.

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

○	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 *(select one)*:	
	○ The Medical Assistance Unit *(name of unit)*:	
	○ Another division/unit within the SMA that is separate from the Medical Assistance Unit	
	(name of division/unit) *This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.*	
◉	The State plan HCBS benefit is operated by *(name of agency)*	

	The Indiana Family and Social Services Administration Division of Mental Health and Addiction (DMHA) is a separate agency of the State that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.

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	☑	☑	☐	☐
2 Eligibility evaluation	☑	☑	☐	☐
3 Review of participant service plans	☑	☑	☑	☐
4 Prior authorization of State plan HCBS	☑	☑	☐	☐
5 Utilization management	☑	☑	☑	☐
6 Qualified provider enrollment	☑	☑	☐	☐
7 Execution of Medicaid provider agreement	☑	☑	☑	☐
8 Establishment of a consistent rate methodology for each State plan HCBS	☑	☑	☐	☐
9 Rules, policies, procedures, and information development governing the State plan HCBS benefit	☑	☑	☐	☐
10 Quality assurance and quality improvement activities	☑	☑	☑	☐

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

Functions 1-10 are performed/administered by the Division of Mental Health and Addiction (DMHA), with assistance from contracted entities for Items 3 (Quality Assurance Contractors), 5 (Medicaid Surveillance Utilization Review Contractors), 7 (Medicaid Fiscal Agent) and 10 (Quality Assurance Contractors).

Function #3- Review of Participant Service Plans (Quality Assurance Contractors):
The Quality Assurance contractor is specially trained by DMHA and OMPP in the guidelines and expectations of the 1915(i) SPA; and is directly supervised by DMHA. The contractor is responsible to review all 1915(i) Participant Plans of Care to ensure all participants are receiving services based on 1915(i) Provider policies, procedures, Wraparound principles and System of Care philosophy. This includes but is not limited to review of eligibility and needs-based criteria, goals, outcomes, interventions, crisis plan, cost allocations and service providers in submitted plan. Contractor is additionally responsible to approve or deny the submitted Plan of Care based upon the plan's completeness and adherence to 1915(i) guidelines. The review determination is entered into the DMHA database that interfaces with the Medicaid system for review and payment of claims. DMHA and the OMPP may overturn any Quality Assurance determination.

Function #5- Utilization Management (Medicaid Surveillance Utilization Review Contractors):
The SPA auditing function is incorporated into the Surveillance Utilization Review (SUR) functions of the contract between the OMPP and SUR Contractor. OMPP has expanded its program integrity activities by using a multi-pronged approach to SUR activity that includes provider self-audit, contractor desk audit and full on-site audit functions. The SUR Contractor sifts and analyzes claims data and identifies providers/claims that indicate aberrant billing patterns and/or other risk factors.
The audit process utilizes data mining, research, identification of outliers, problematic billing patterns, aberrant providers and issues that are referred by DMHA and OMPP. The SUR Unit meets with DMHA and OMPP at least quarterly to discuss audits and outstanding issues. The SUR Contractor is a Subject Matter Expert (SME) responsible for directly coordinating with the DMHA and OMPP. This individual also analyzes data to identify potential areas of program risk and identify providers that appear to be outliers warranting review. The contractor may also perform desk or on-site audits and be directly involved in review of the SPA program and providers. Throughout the entire SUR process, oversight is maintained by OMPP. The SUR Unit offers education regarding key program initiatives and audit issues at provider meetings to promote ongoing compliance with Federal and State guidelines, including all Indiana Health Coverage Programs (IHCP) and SPA requirements.

Function #7- Execution of Medicaid Provider Agreement (Medicaid Fiscal Agent):
The OMPP has a fiscal agent under contract which is obligated to assist OMPP in processing approved Medicaid Provider Agreements to enroll approved eligible providers in the Medicaid MMIS for claims processing. This includes the enrollment of DMHA approved 1915(i) providers. The fiscal agent also conducts provider training and provides technical assistance concerning claims processing. The Medicaid Fiscal Agent contract defines the roles and responsibilities of the Medicaid fiscal contractor.
DMHA tracks all provider enrollment requests and receives information directly from the MMIS Fiscal Agent contractor regarding provider enrollment activities as they occur for monitoring of completion, timeliness, accuracy, and to identify issues. Issues are shared with the OMPP.
DMHA and/or OMPP attend the MMIS Fiscal Agent's scheduled Provider Training sessions required in OMPP's contract with the Fiscal Agent. DMHA may also participate in the Fiscal Agent's individualized provider training for providers having problems.

Function #10- Quality Assurance and Quality Improvement Activities (Quality Assurance Contractors):
The Quality Assurance Contractor is responsible for reviewing delivery of 1915(i) services provided in a manner that adheres to 1915(i) policy and guidelines, as well as being provided with High Wraparound Fidelity and according to Wraparound principles and System of Care philosophy. To ensure quality in 1915(i) service delivery the contractor is responsible to meet with Access Site Contact, Wraparound Facilitator or System of Care Coordinator for an Access Site Review or Case Review. Access Site Reviews and/or Case Reviews may include, but are not limited to the following tasks:

1) Observe a Child and Family Team meeting to ensure system of care philosophy and wraparound values are

being implemented.
2) Speak with family and participant to ensure that they have freedom of choice with providers on the Child and Family Team, as well as voice, choice and ownership of the plan of care.
3) Conduct review of at least one participant's plan of care, crisis plan and any other documentation regarding participant's care to ensure 1915(i) services are adequately documented and plan reflects family or participant's needs.
4) Submit written documentation within five (5) business days of review on above tasks that summarizes the review and includes any required follow up on behalf of DMHA, OMPP or reviewer.
   a) All concerns requiring a Corrective Action Plan will be documented and reported in writing to the agency/individual under review and DMHA.
   b) Contractor will provide corrective feedback, education and follow-up with agency/individual to ensure areas needing correction have been resolved.

(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 provider in a geographic area, and the State devises conflict of interest protections. *(If the State chooses this option, specify the conflict of interest protections the State will implement):*

To prevent conflict of interest, family choice of participation in the State's high-fidelity Wraparound CMHW services is a minimum expectation to meet the standard for quality care. Youth and Families are presented with all available treatment options at the point of assessment and plan of care development, including CMHW services, and must consent to participation in the CMHW services and choose the providers who will provide those services.

Additionally, the family develops and leads the Child and Family Team with assistance from the Wraparound Facilitator. The individuals on the team consist of service providers, community supports and any natural supports as determined by the family. The wraparound team is committed to building an effective array of supports and interventions to ensure that the family vision is achieved. At the time of the initial evaluation, assessment and POC development, the CMHW evaluator provides the Applicant and Family with written documentation from DMHA and OMPP that explains the Family's right to exercise *freedom of choice* regarding the CMHW services selected on the Plan of Care and who will provide each of the CMHW services specified on the DMHA-approved Plan of Care. The Family selects CMHW service provider(s) from a pick list of DMHA-authorized CMHW service providers. Additionally, the Wraparound Facilitator is responsible to inform the Participant/family of their right to change their CMHW provider, including the Wraparound Facilitator, at any time during the CMHW services program.

To further prevent conflict of interest between evaluators, service providers, and the Participant and family, the following State processes are in place:
1) The Wraparound Facilitator is DMHA-authorized to provide only Wraparound Facilitation and is not authorized to provide any other CMHW service.
2) DMHA, the independent State entity making the final eligibility determination and providing authorization for the Plan of Care, is not related by blood or marriage to the Applicant/Participant; to

any of the individual's paid caregivers; or to anyone financially responsible for the individual or empowered to make financial or health related decisions on the Applicant/Participant's behalf. Additionally, DMHA is not a provider of CMHW services.

3) The Quality Improvement Specialists provide oversight for CMHW providers and engage in quality management activities to promote adherence to Wraparound service delivery practices, including family choice and direction in the development of the Plan of Care, selection of service providers and preference for service delivery. Quality Improvement Specialists are responsible to provide training, education, site visits, record reviews and consultation to ensure provider compliance with CMHW requirements and standards.
4) Participants and families are educated regarding their rights and how to submit grievances, complaints or appeals regarding all aspects of CMHW service delivery, providers, inclusion in treatment planning, DMHA eligibility determinations or Plan of Care authorization.
5) The assessments, person-centered service plan and direct CMHW services are all based on a county level geographic region. All Access Sites and approved providers are required to designate the geographical area of service by county as a part of the enrollment process. The providers may request to add or decrement counties as needs change.

To ensure compliance with CMHW requirements the State utilizes a System of Care Governance Board comprised of family members, advocates, providers, community supports and state leadership (including representation from the OMPP) to provide oversight of the State's CMHW Quality Improvement plan and performance measures. The board quarterly reviews the following:

1) Grievances, complaints, appeals and resulting decisions.
2) Performance measures, including identified problems with service utilization, provider practice and Participant outcomes.
3) Outcomes for quality improvement initiatives implemented to increase compliance with CMHW service delivery requirements and standards.

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 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.

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

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

(ii) Resides in a home or apartment that is owned, leased or controlled by a provider of one or more health related treatment or support services, if such residence meets standards for community living as

defined by the State. *(If applicable, specify any residential settings, other than an individual's home or apartment, in which residents will be furnished State plan HCBS. Describe the standards for community living that optimize participant independence and community integration, promote initiative and choice in daily living, and facilitate full access to community services):*

1915(i) CMHW services are provided within the Participant's/Family's home and community, based upon the Participant's/Family's preferences. For purposes of this document "home" includes any community-based residence that Participant lives in with the guardian/caregiver, including a foster home. Excluded from our definition would be any type of residential or institutional residence (e.g., group home or residential home).

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	Jul. 1, 2013	June 30, 2014	750
Year 2			
Year 3			
Year 4			
Year 5			

DMHA primarily based its projections for the number of youth served in the first year on information collected from the State database. To begin the analysis process, the CANS assessment data for all youth in the State with a serious emotional disturbance (SED, as defined at 440 Indiana Administrative Code 8-2-4) and who are also receiving Medicaid Rehabilitation Option (MRO) services was pulled. This assessment data was used to identify the whole population of persons whose most recent assessment shows a need for intensive community services, based on a CANS behavioral recommendation of a 4, 5 or 6. The data set was then reduced by applying the basic target group eligibility criteria established for the CMHW services program (Refer to section #2, Target Groups, for criteria used).

Next, the State applied the CMHW needs-based criteria to the data. To determine a level of need for CMHW services, the State will apply an additional algorithm to specific item ratings on the CANS assessment for State-identified life domains/areas of need (Refer to the Needs-Based HCBS Eligibility Criteria in section #4 below for specific criteria and areas identified). The use of this algorithm enables the State to identify youth who meet the needs-based criteria for CMHW services.

The resulting number from the State's analysis of the data, in addition to historical data for the number of youth served yearly under the Community Alternative to Psychiatric Residential Treatment Facility (CA-PRTF) Demonstration Grant, is being used for planning purposes for the CMHW services program. However, the State is aware that the actual number of persons who are fully eligible for the CMHW services program may fluctuate

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. ☑ **Income Limits.** *(By checking this box the State assures that):* Individuals receiving State plan HCBS are in eligibility group covered under the State's Medicaid State plan, and who have income that does not exceed 150% of the Federal Poverty Level (FPL). Individuals with incomes up to 150% of the FPL who are only eligible for Medicaid because they are receiving 1915(c) waiver services may be eligible to receive services under 1915(i) provided they meet all other requirements of the 1915(i) State plan option. The State has a process in place that identifies individuals who have income that does not exceed 150% of the FPL.

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 at section 1902(a) (10) (C) (i) (III) of the Social Security Act relating to community income and resource rules for the medically needy.
○	The State does not elect to disregard the requirements at section 1902(a) (10) (C) (i) (III).

Needs-Based Evaluation/Reevaluation

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*):

○	Directly by the Medicaid agency
◉	By Other (*specify State agency or entity with contract with the State Medicaid agency*):
	The Indiana Family and Social Services Administration Division of Mental Health and Addiction (DMHA)

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

Since 2008, Indiana has supported the provision of evidenced-based services, in particular Wraparound services for intensive home and community-based treatment for severely emotionally disturbed (SED) youth. As such, the State wishes to maintain fidelity to the principles of Wraparound, while completing the evaluation, initial determinations, reevaluations and service plans both accurately and expeditiously. Therefore, the evaluation, service plan and reevaluation processes for CMHW services utilize both state and non-state entities to complete the process, as follows:

Evaluation:
DMHA-authorized Access Site Evaluators interview the applicant, gather data, and make recommendations for the initial assessment which is then sent to the State for completion, thereafter leading to a determination of eligibility by the State. The specific criteria required to meet eligibility (Child and Adolescent Needs and Strengths (CANS) assessment tool rating 4, 5 or 6) must be supported by clinical documentation supplied as part of the evaluation. If the applicant is found eligible, the State then completes an initial care plan including the service of Wraparound Facilitation, the specific provider having been previously selected by the applicant from a pick list during the evaluation process. Using this process, the person-centered care plan development, and therefore therapeutic services, can begin as soon as possible.
In order for a site to be authorized by DMHA as qualified to conduct evaluations for the purpose of 1915(i) CMHW eligibility, it must be committed to the Wraparound philosophy. The Wraparound philosophy is based

on principles shared by the person-centered process. According to the Wraparound philosophy, care planning incorporates participation and input from the Child and Family Team. All members on the team are selected by the participant and family. The Child and Family Team utilizes resources and talents from a variety of sources, resulting in a plan of care that incorporates the family vision and story, team mission, strengths, needs, resources, and strategies. These principles are inherent in the person-centered process.

Qualifications of Individuals Performing the State Determination of Eligibility:
The determination of level of need and eligibility for CMHW services in the evaluation/reevaluation process is determined by DMHA staff or contracted entity that possesses the following qualifications:

1) Bachelor's degree, with two (2) or more years of clinical experience; or
2) Master's degree in social work, psychology, counseling, nursing or other related field, with two (2) or more years of clinical experience; and
3) Completed DMHA- and OMPP-approved training for CMHW services, including CMHW eligibility and service utilization.

Re-Evaluation:
During the service delivery period, the Wraparound Facilitator and the Child and Family Team work closely with the participant and family to provide care that is participant-driven. They also ensure that care and services remain consistent with the participant's and family's needs, strengths and preferences. The service plan/Plan of Care is 365 days, however it is a requirement of the State that the CANS be re-administered no less often than every six months from the most recent assessment. (A recommendation of 4, 5, or 6 on the CANS is required to maintain eligibility for participation in the program.) At this time, the Wraparound facilitator, with feedback from the Child and Family Team, conducts the evaluation and gathers data for eligibility redetermination by the State. The Wraparound Facilitator, support team, family, and participant review the needs and progress of the participant via the Wraparound process. An updated care plan arises from this process which is submitted for approval by the State in conjunction with the eligibility evaluation. Indiana has chosen to conduct eligibility redeterminations in the manner described above in order to maintain fidelity with the wraparound philosophy and principles.
DMHA assesses evaluations and retains the final determination of eligibility and authorizations of service plans/Plans of Care. DMHA ensures that the participants and service plans meet all CMHW eligibility requirements as mandated by CMS, Indiana Administrative Code and defined within the SPA.

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:

All referrals for CMHW services must be received through one of the DMHA-authorized Access Sites within the State. An interested Family and Applicant will receive education about Wraparound practice, available CMHW services, and the face-to-face evaluation at the Access Site. This face-to-face evaluation includes administration of the Child and Adolescent Needs and Strengths (CANS) assessment and completion of the CMHW application form developed by the OMPP and the DMHA. The youth/family will determine whether to pursue application/assessment for 1915(i) services.

The assessment and supporting documentation identifies specific information about the Applicant's strengths, underlying needs, health status, current living situation, family functioning, exposure to trauma, vocational status, social functioning, living skills, self-care skills, capacity for decision making, living situation, potential for self-injury or harm to others, substance use/abuse, and medication adherence.

The Access Site must submit the complete application packet to DMHA within ten (10) business days of receiving the parent/guardians signature. DMHA notifies the Access Site regarding the eligibility determination on the Eligibility Determination Form within five (5) working days of receiving the application packet. The Eligibility Determination Form serves as the written notice documenting a DMHA determination

regarding an Applicant's eligibility for participation in the CMHW services program. Information included on the Eligibility Determination form includes:

1) Approval or Denial of Applicant's level of need/eligibility to participate in the CMHW services program;
2) The effective dates and reasons for the action(s) taken; and
3) The Applicant's Appeal and Fair Hearing rights and procedural information.

The Access Site communicates DMHA's determination information on the Eligibility Determination Form to the Applicant/family. Referrals to alternate services are made if Applicant is not eligible for CMHW services.

At least annually, the Participant will undergo a reevaluation to ensure eligibility criteria for CMHW services are still being met. The annual reevaluation process is the same as described for the initial evaluation/assessment process above, except the reevaluation is completed by the Wraparound Facilitator (rather than the Access Site) and includes input from the Child and Family Team. To maintain Wraparound Fidelity, the Wraparound Facilitator will complete the face-to-face reevaluation with the Participant and Family, including the administration of the CANS assessment tool, to ensure all eligibility criteria for CMHW Wraparound participation are met. And since the Wraparound process requires active investment by a wraparound team willing to be accountable for meeting the Participant's needs, the Child and Family Team also provides input regarding the Participant's progress in moving towards achieving the family vision.

The Wraparound Facilitator submits the results of the reevaluation to DMHA which determines the Participant's continued eligibility for the CMHW services program. DMHA forwards the Eligibility Determination Form to the Wraparound Facilitator, who communicates DMHA's eligibility determination to the Participant, family and to the Child and Family Team.

In the event the Participant is no longer eligible for CMHW services, the Wraparound Facilitator and Child and Family Team prepare the Participant and Family for transition from CMHW services to other more appropriate services (e.g., State plan services, community and natural supports).

Indiana has providers and access sites authorized to provide CMHW assessments and services across Indiana. However, in some of the state's more rural areas there are not sufficient providers authorized to provide CMHW services. In those cases, the person performing the Access Site responsibilities may be required to provide CMHW services in addition to the eligibility evaluation and assessment. DMHA is the entity which approves eligibility and plan of care for each Participant.

OMPP, through an MOU with DMHA, delegates the responsibility for accurate and timely evaluations and re-evaluations to DMHA. OMPP retains the authority and oversight of the 1915(i) program functions delegated to DMHA by meeting routinely to discuss issues, trends and member appeals related to program operations including member evaluations and re-evaluations. OMPP reviews and approves policies, procedures, forms and standards for evaluation and re-evaluation of eligibility. OMPP may review and overrule the approval or disapproval of any specific eligibility determination by DMHA serving in its capacity as the operating agency for the 1915(i) HCBS Benefit.

4. ☑ **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):*

The CANS assessment tool (developed for assessing youth ages 5 to 17) (Lyons, 1999) is used by the State to assist in assessing the youth and caregiver's strengths and needs (The assessment tool can be reviewed at: http://dmha.in.gov/DARMHA/mainDocuments.aspx). Patterns of CANS ratings derived from assessing six dimensions of the youth's life (e.g., life functioning, behavioral health symptoms, risk behaviors, youth

strengths, caregiver strengths and needs and acculturation) have been used to develop a Behavioral Health Decision Model (algorithm).

The recommendation is a result of an algorithm run on the CANS assessment ratings over multiple life domains. The CANS Behavioral Recommendation indicates the following levels of need for behavioral health services:

0- No treatment services indicated
1- Outpatient Services
2- Outpatient Services, with Limited Case Management
3- Supportive Community Services
4- Intensive Community Services: High-Fidelity Wraparound
5- Intensive Community-Based Services
6- High-Intensity Services: PRTF, State hospital, Intensive Community Based

Needs-Based Eligibility Criteria:
In addition to meeting the Target Group Eligibility criteria, applicants must also meet the following needs-based eligibility criteria:

1) Youth is experiencing significant* emotional and/or functional impairments that impact his/her level of functioning at home or in the community, as a result of a mental illness. A behavioral recommendation of a 4, 5, or 6 is required.
2) The Applicant, who meets a 4, 5, or 6 behavioral recommendation on the CANS, must also meet the following needs-based criteria:
   a) Dysfunctional patterns of behavior due to one or more of the following behavioral/emotional need(s), as identified on the CANS assessment tool:
      i. Adjustment to Trauma;
      ii. Psychosis;
      iii. Debilitating anxiety;
      iv. Conduct problems;
      v. Sexual aggression; and/or
      vi. Fire-setting.
   b) Demonstrates significant* needs in at least one of the following Family/caregiver area(s), as indicated on the CANS assessment tool, that results in a negative impact on the child's mental illness and may indicate a higher level of need:
      i. Mental Health;
      ii. Supervision issues;
      iii. Family Stress; and/or
      iv. Substance abuse.

*"Significant" is determined by an assessed need for *immediate or intensive action due to a serious or disabling need in a variety of life domains* on the CANS assessment tool used by the State to assess an Applicant's Level of Need (LON).

Exclusionary Criteria:
The following exclusionary criteria are used to identify those youth the CMHW services program is not designed to serve:

1) A youth who is at imminent risk of harm to self or others.
2) A youth who is identified as not able to feasibly receive intensive community-based services without compromising his/her safety, or the safety of others, will be referred to a facility capable of providing the level of intervention or care needed to keep the youth safe.

5. ☑ **Needs-based Institutional and Waiver Criteria.** *(By checking this box the State assures that):* There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the State has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chart below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):*

Needs-Based/Level of Care (LOC) Criteria

State plan HCBS needs-based eligibility criteria	NF (& NF LOC waivers)	ICF/MR (& ICF/MR LOC waivers)	Applicable Hospital* LOC (& Hospital LOC waivers)
In addition to meeting the Target Group Eligibility criteria, applicants must also meet the following needs-based eligibility criteria: 1) Youth is experiencing significant* emotional and/or functional impairments that impact his/her level of functioning at home or in the community, as a result of a mental illness. A behavioral recommendation of a 4, 5, or 6 is required, 2) The Applicant, who meets a 4, 5, or 6 behavioral recommendation on the CANS, must also meet the following needs-based criteria: a) Dysfunctional patterns of behavior due to one or more of the following behavioral/emotional need(s), as identified on the CANS assessment tool: i. Adjustment to Trauma; ii. Psychosis; iii. Debilitating anxiety; iv. Conduct problems; v. Sexual aggression; and/or vi. Fire-setting. b) Demonstrates significant* needs in at least one of the following Family/caregiver area(s), as indicated on the CANS assessment tool: i. Mental Health; ii. Supervision issues;	Indiana Law allows reimbursement to NFs for eligible persons who require skilled or intermediate nursing care as defined in 405 Indiana Administrative Code 1-3-1 and 1-3-2. 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) 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. A person in functionally eligible	Indiana Law allows reimbursement to ICF/MRs for eligible persons as defined in 405 IAC 1-1-11. A person may be functionally eligible for an ICF/MR LOC waiver when documentation shows he individually meets the following conditions: 1) Has a diagnosis of intellectual disability (mental retardation), cerebral palsy, epilepsy, autism, or condition similar to intellectual disability (mental retardation). 2) Condition identified in #1 is expected to continue. 3) Condition identified in #1 had an age of	Admission criteria for Psychiatric Residential Treatment Facilities (PRTFs), which include the following factors: 1) Individual's mental disorder is rated as severe or complex; 2) Multiple disruptive behaviors; 3) Serious family functioning impairments; 4) Prior failure of acute and/or emergency treatment to sufficiently ameliorate the condition; 5) Symptom complexes showing a need for extended treatment in a residential setting due to a threat to self or others; 6) Impaired safety

iii. Family Stress; and/or iv. Substance abuse. *"Significant" is determined by an assessed need for *immediate or intensive action due to a serious or disabling need in a variety of life domains* on the CANS assessment tool used by the State to assess an Applicant's Level of Need (LON). **Exclusionary Criteria:** The following exclusionary criteria are used to identify those youth the CMHW services program is not designed to serve: 1) A youth who is at imminent risk of harm to self or others. 2) A youth who is identified as not able to feasibly receive intensive community-based services without compromising his/her safety, or the safety of others, will be referred to a facility capable of providing the level of intervention or care needed to keep the youth safe.	for either 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: 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.	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: Self-care; learning; self-direction; capacity for independent living; language; and mobility.	issues; and 7) Need for long-term treatment modalities.

*Long Term Care/Chronic Care Hospital

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

6. ☑ **Reevaluation Schedule.** Needs-based eligibility reevaluations are conducted at least every twelve months.

7. ☑ **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 (1) (D) (ii).

Person-Centered Planning & Service Delivery

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

1. ☑ There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment is based on:
   - An objective face-to-face assessment with a person-centered process by an agent that is independent and qualified;
   - Consultation with the individual and if applicable, the individual's authorized representative, and includes the opportunity for the individual to identify other persons to be consulted, such as, but not limited to, the individual's spouse, family, guardian, and treating and consulting health and support professionals caring for the individual;

- An examination of the individual's relevant history, including findings from the independent evaluation of eligibility, medical records, an objective evaluation of functional ability, and any other records or information needed to develop the plan of care;
- An examination of the individual's physical and mental health care and support needs, strengths and preferences, available service and housing options, and when unpaid caregivers will be relied upon to implement the plan of care, a caregiver assessment;
- If the State offers individuals the option to self direct State plan HCBS, an evaluation of the ability of the individual (with and without supports), or the individual's representative, to exercise budget and/or employer authority; and
- A determination of need for (and, if applicable, determination that service-specific additional needs-based criteria are met for), at least one State plan home and community-based service before an individual is enrolled into the State plan HCBS benefit.

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

3. **Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities.** There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with physical and mental needs for HCBS. *(Specify qualifications):*

The individual administering the CANS assessment tool and collecting clinical information and data used to determine an Applicant's/Participant's level of need for CMHW services must meet the following qualifications and standards:

1) Affiliated with a DMHA-approved Access Site.
2) One of the following clinical qualifications:
   a) A psychiatrist;
   b) A physician;
   c) A licensed psychologist or a psychologist endorsed as a health service provider in psychology (HSPP);
   d) A licensed clinical social worker;
   e) A licensed mental health counselor;
   f) A licensed marriage and family therapist;
   g) An advanced practice nurse under IC 25-23-1-1(b)(3) who is credentialed in psychiatric or mental health nursing by the American Nurses Credentialing Center;
   h) A licensed independent practice school psychologist; or
   i) An unlicensed individual who does not have a license to practice independently but practices under the supervision of one of the above mentioned persons; and possesses one of the following:
      i. a Bachelor's degree, plus two years clinical experience; or
      ii. A Master's Doctoral degree in social work, psychology, counseling, nursing, or other mental health field, plus two years clinical experience.

3) Successful completion of DMHA/OMPP required training and certification (certification refers to the CANS assessment tool certification program).

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

The CMHW service provider developing the Plan of Care must meet the following criteria:
1) Meets required clinical standards:
   a) Qualifies as an Other Behavioral Health Professional (OBHP), as defined in 405 IAC 5-21.5-1(d); and
   b) Possesses a Bachelor's degree in human service field, with 2 or more years of clinical intervention skills; or
   c) Possesses a Master's degree; plus two or more years of clinical intervention skills.
2) Successful completion of DMHA/OMPP required training.

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

All CMHW services adhere to the Wraparound model of service delivery. Engagement and involvement of the family in the Plan of Care development is fundamental to the definition of Wraparound Facilitation, and to the Child and Family Wraparound Team paradigm. Wraparound Facilitation by definition is a variety of specific tasks and activities designed to engage the family in the planning process that follows a series of steps and is provided through a Child and Family Wraparound Team (a treatment/support team developed by the CMHW-enrolled Participant and family to assist them in developing and implementing the individualized Plan of Care).

During initial assessment at the Access Site, the family is offered a list of available Wraparound Facilitators and their agencies for the county in which the family lives. The family may choose any Wraparound Facilitator from this randomly generated list. The Access Site submits the family's Wraparound Facilitator selection along with eligibility documents to the State for review and approval. If State approves eligibility, the family information will be forwarded to the Wraparound Facilitator by the State. The Wraparound Facilitator will begin the person-centered planning process to develop the initial plan of care.

The family-selected Wraparound Facilitator will guide the family through the ongoing Wraparound process and development of the CMHW service plan. (The Wraparound Facilitator is responsible for coordination of care and ensuring Participant's care/service delivery adheres to the Wraparound model.) Once a Wraparound Facilitator is selected by the family, the Access Site sends the initial plan of care to the State for approval of plan, provider and service authorizations.

Prior to meeting with the Child and Family Team, the Wraparound Facilitator (responsible for coordination of care and ensuring Participant's care/service delivery adheres to the Wraparound model) prepares the Participant and family for the team meeting by discussing the team process; explaining the meaning of Wraparound services; and assisting the Participant/family in identifying who should be on their Child and Family team (including friends and other advocates that are not providing services). The participant and family determine the members on the Child and Family Team.

The Child and Family Team supports the Participant and family in the POC development and is responsible to assure that the Participant's needs, and the entities responsible for addressing them, are identified in a written Plan of Care.

In the Wraparound process, the following principles ensure the Plan of Care development occurs with Participant/family involvement:

1) Participant/family decides who will be part of their Child and Family Team.
2) Child and Family Team meetings are only convened when the Participant/family is available to be an active participant in the team meeting.
3) The Plan of Care is developed within the Child and Family Team process with active participation from the Participant and family.

Assurance that the family is being appropriately supported and has the authority to determine who will be involved in the development of the Plan of Care is evaluated through the use of the "Wraparound Fidelity Index" described below:

1) The Wraparound Fidelity Index 4.0 (WFI-4) is a set of interviews that measure the nature of the Wraparound process that an individual family receives.
2) The WFI-4 is completed through brief, confidential telephone or face-to-face interviews with four types of respondents: caregivers, Participant (11 years of age or older), Wraparound facilitators, and team members. It is important to gain the unique perspectives of all these informants to understand fully how Wraparound is being implemented. A demographic form is also part of the WFI-4 battery.
3) The WFI-4 interviews are organized by the four phases of the Wraparound process (Engagement and Team Preparation, Initial Planning, Implementation, and Transition).
4) In addition, the 40 items of the WFI interview are keyed to the 10 principles of the Wraparound process, with four items dedicated to each principle. In this way, the WFI-4 interviews are intended to assess both conformances to the Wraparound practice model, as well as adherence to the principles of Wraparound in service delivery.
5) The 10 Principles of Wraparound, intended to support the family in the treatment process, include:
    a) *Family Voice and Choice*: Wraparound Team specifically elicits and prioritizes the family and youth perspectives during all phases of the Wraparound Process. The Team strives to provide options and choices such that the Plan reflects family values and preferences.
    b) *Team Based*: The Team consists of individuals agreed upon by the family and committed to them through informal, formal and community support and service relationships.
    c) *Natural Supports*: The Team encourages the full participation of team members chosen from the family's networks of interpersonal and community relationships.
    d) *Collaboration*: Team members cooperate and share responsibility for developing, implementing, monitoring and evaluating a single wraparound plan. The plan reflects a blending of team members' perspectives, mandates and resources. The Plan guides and coordinates each team member's work towards meeting the Team's goals
    e) *Community-Based*: The Team implements services and supports that take place in the most inclusive, responsive, accessible and least restrictive settings possible that safely promote youth and family integration into home and community life.
    f) *Culturally Competent*: The Wraparound Process respects and builds on the values, preferences, beliefs, culture, and identity of the youth and family and their community. Non-family Team members refrain from imposing personal values on the Plan.
    g) *Individualized*: The Team develops and implements customized strategies, supports and services to achieve the goals laid out in the Plan.
    h) *Strengths Based*: Both the Wraparound Process and Plan identify, build on, and enhance the capabilities, knowledge, skills, and assets of the youth and family, their community and the other team members.
    i) *Persistence*: Regardless of challenges that may occur, the Team persists in working toward the goals included in the Plan until the Team agrees that a formal Wraparound

Process is no longer required.

j) *Outcome Based*: The goals and strategies of the Plan are tied directly to observable or measurable indicators of success. The Team monitors progress in terms of these indicators and revises the Plan accordingly.

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

The Youth/family determine who will provide treatment, based upon lists of DMHA-approved providers within their community. The Access site initially assists the family/youth in selecting the Wraparound Facilitator, by providing the youth/family with a listing of DMHA approved Wraparound Facilitators in the family's community. Once selected, the Wraparound Facilitator informs the Participant/family, verbally and in writing, about their right to choose CMHW service providers for each service identified on the Plan of Care.

As a service is identified, the Wraparound Facilitator generates a list of local CMHW service providers (called a Pick List), which is given to the Participant/family for review and provider selection. Participants and family members may interview potential service providers and make their own choice regarding who will provide each service on the approved Plan of Care. A copy of the signed Pick-List is maintained in the Participant's record, indicating Family choice in the provider(s) providing CMHW services.

A listing of approved/enrolled CMHW service providers is also posted on the Indiana Medicaid website at www.indianamedicaid.com*.

At the time of Plan of Care development, and during Child and Family team Meetings, the Wraparound Facilitator ensures the Participant/family is aware of their option to change CMHW service providers. This includes the option to change the Wraparound Facilitator. The Participant/family can request a Pick List at any time to select a different service provider.

*When accessing indianamedicaid.com website, the individual has a choice of a "Member" tab and "Provider" tab. The Member tab notes: *"If you are an Indiana Medicaid Member or are interested in applying to become 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 individuals to target their search by selecting types of providers by city, county or state. The resulting list includes the provider's name, address, telephone number and a link to the map for each provider location.

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

OMPP, through an MOU with DMHA, delegates the responsibility for service plan approval to DMHA. As part of its routine operations, DMHA's contracted entity, must review each service plan submitted to ensure the plan addresses all pertinent issues identified through the assessment, including physical health issues. The DMHA contractor enters the determination of his/her review in the DMHA database. The DMHA database interfaces with the Medicaid Management Information System for processing and tracking of eligible individuals, CMHW services and claims reimbursements. The DMHA contractor informs DMHA and OMPP of any issues related to the review and approval or denial of service plans.

OMPP retains the authority and oversight of the 1915(i) program delegated to DMHA through routine monthly meetings to discuss issues, trends and member appeals and provider issues related to program operations including service plan approvals. OMPP and DMHA plan to maintain this close working relationship with the addition of 1915(i) services.

In addition, the OMPP reviews and approves the policies, processes and standards for developing and

approving the care plan. Based on the terms and conditions of this State Plan Amendment, the Medicaid agency may review and overrule the approval or disapproval of any specific plan of care acted upon by the DMHA serving in its capacity as the operating agency for the 1915(i) HCBS benefit program.

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

☐	Medicaid agency	☑	Operating agency	☐	Case manager
☐	Other *(specify):*				

Services

1a. 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:	Wraparound Facilitation
Service Definition (Scope):	

Wraparound Facilitation is a comprehensive service comprised of a variety of specific tasks and activities designed to carry-out the Wraparound process. Wraparound Facilitation is a required component of the CMHW services program. Wraparound is a planning process that follows a series of steps and is provided through a Child and Family Wraparound Team. The Wraparound Team is responsible to assure that the Participant's needs, and the entities responsible for addressing them, are identified in a written Plan of Care (POC). The Wraparound Facilitator (WF) is the individual who facilitates and supervises this process, in addition to the following:

1) Completes a comprehensive assessment of the Participant, including administration of the CANS assessment tool.
2) Guides the family engagement process, by exploring and assessing strengths and needs.
3) Facilitates, coordinates, and attends Child and Family Team meetings.
4) Works in full partnership with Child and Family Team members to ensure the POC is developed, written and approved by DMHA;
5) Assists Participant/family in gaining access to a full-continuum of services (i.e., medical, social, educational, and/or other needed services).
6) Guides the Plan of Care planning process by informing the team of the family's vision and ensuring that the family's vision is central to all service planning and delivery.
7) Develops, implements and monitors the crisis plan; and intervenes during a crisis situation, if needed.
8) Assures that all work to be done to assist the youth and family in obtaining goals on the POC is identified and assigned to a Child and Family Team member.
9) Oversees implementation of the POC
10) Reassess, amends, and secures on-going approval of the POC.
11) Monitors all services authorized for a Participant's POC.
12) Assures care is delivered in a manner consistent with strength-based, family driven, and culturally competent values.
13) Offers consultation and education to all CMHW service providers regarding the values and principles of the Wraparound model.
14) Monitors Participant progress toward treatment goals.
15) Ensures that necessary data for evaluation is gathered and recorded.
16) Ensures that all CMHW assessment and service-related documentation is gathered and reported to DMHA, as mandated.
17) Completes the annual CMHW services Level of Need re-evaluation, with active involvement of the

Participant and the Child and Family Wraparound Team.

18) Communicates and coordinates with local Division of Family Resources (DFR) regarding continued Medicaid eligibility status.

19) Guides the transition of the Participant and family from CMHW services to State plan, or other community-based services, when indicated.

The Wraparound model involves 4 stages (Miles, Brunes, Osher & Walker, 2006). The Wraparound Facilitator is responsible to guide the Participant, family and the Wraparound team through the 4 Stages of Wraparound:

1) *Engagement*: The family meets the Wraparound Facilitator (WF). Together they explore the family's strengths, needs, and culture. They talk about what has worked in the past and what they expect from the Wraparound process. The WF engages other team members, identified by the Participant and family, and prepares for the first Child and Family Team meeting.
2) *Planning*: The WF informs the Child and Family Wraparound team members about the family's strengths, needs, and vision for the future. The Wraparound team does not meet unless the family is present. The team decides what to work on, how the work will be accomplished, and who is responsible for each task. POC development is facilitated by the WF, who is responsible to write the POC and obtain approval for the POC from DMHA. The WF also facilitates development of a crisis plan to manage crises that may occur.
3) *Implementation*: Child and Family and Team members meet monthly, or as needed. Meetings are facilitated by the WF, who ensures that the family guides the Child and Family Team meeting process. The team reviews accomplishments and progress toward goals and makes adjustments, as needed. Family and team members work together to implement the POC.
4) *Transition*: As the Participant nears reaching their POC goals, preparations are made for the youth to transition out of CMHW services to State plan services appropriate to meet the Participant's level of need for continued outpatient and/or home-based services, as needed. The family and team together decide how the Participant/family will continue to get support, when needed once the Participant has transitioned from CMHW services.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

None

Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*

☑ Categorically needy *(specify limits):*

No limits

☐ 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)*:
Accredited Agency	Individuals from Accredited Agencies must meet standards in the *Other Standard* section.	AAAHC, COA, URAC, CARF, ACAC, JCAHO, or NCQA Accreditation	Individuals providing this service must be affiliated with a DMHA- authorized CMHW accredited agency that adheres to the following standards: 1) Agency participates in a local System of Care, which includes both a governing coalition and service delivery system that endorses the values and principles of Wraparound; or in the event the area of the State does not have an organized System of Care, provider is a part of a

			DMHA-authorized/designated Access Site for services. 2) Agency must maintain documentation that the individual providing the service meets the following standards: a) Qualifies as an Other Behavioral Health Professional (OBHP), as defined in 405 IAC 5-21.5-1(d); and one of the following: i. A Bachelor's degree, with 2 or more year's clinical experience; or ii. A Master's degree in social work, psychology, counseling, nursing, or other related field, with 2 or more year's clinical experience. b) Individual has completed and submitted proof of the following screens: i. Finger-print based national and state criminal history background screen; ii. Local law enforcement screen; iii. State and local Department of Child Services abuse registry screen; and iv. Five-panel drug screen, or Agency meets same requirements specified under the Federal Drug Free Workplace Act 41 U.S.C. 10 Section 702(a)(1). 3) All approved providers must complete DMHA and OMPP approved training and certification for CMHW services. Wraparound Facilitators must complete the Wraparound Practitioner Certification Program. This certification allows the state to ensure fidelity to the Wraparound service delivery model.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Accredited Agency	DMHA	Verification documentation submitted to DMHA:

		Initially at point of DMHA authorization of the CMHW agency and at least every three years thereafter. Must resubmit documentation for verification again at time of re-accreditation for agency.

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

1b. State plan HCBS.

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):*

Service Title: Habilitation

Service Definition (Scope):

Habilitation services are provided with the goal of enhancing the Participant's level of functioning, quality of life and use of social skills; as well as building Participant and family's strengths, resilience and positive outcomes. This is accomplished through development of the following skills:

1) Identification of feelings;
2) Anger and emotional management;
3) How to give and receive feedback, criticism, or praise;
4) Problem-solving and decision making;
5) Learning to resist negative peer pressure and develop pro-social peer interactions;
6) Improve communication skills;
7) Build and promote positive coping skills; and,
8) Learn how to have positive interactions with peers and adults

Habilitation services are provided face-to-face in the Participant's home or other community-based setting based upon the preferences of the Participant/family.

Service exclusions include:

Services provided to anyone other than the Participant, when the activity occurs in a group setting.

1) Service provided to Participant's family members.
2) Service provided in order to give the family/caregiver respite.
3) Service provided that is strictly vocational/educational in nature, such as tutoring or any other activity available to the Participant through the local educational agency under the Individuals with Disabilities Education Improvement Act of 2004; or covered under the Rehabilitation Act of 1973.
4) Activities provided in the service provider's residence.
5) Leisure activities that provide a diversion, rather than a therapeutic objective.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

None

Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*

☑ Categorically needy *(specify limits):*

Habilitation services will be limited to up to three (3) hours daily and up to thirty (30) hours of services per Participant/per month.

☐ 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)*:
Accredited Agency	None	AAAHC, COA, URAC, CARF, ACAC, JCAHO, or NCQA Accreditation	DMHA- authorized CMHW-accredited agencies must receive approval from DMHA for an individual to provide this service, based on the qualifications of the individual. Agencies must maintain documentation that the individual providing the service meets the following requirements and standards: 1) Individual is at least 21 years of age and possesses a High school diploma, or equivalent. 2) Individual has three (3) years of qualifying experience working with or caring for children and youth with serious emotional disturbances (SED), as defined by DMHA. 3) Individual has completed and submitted proof of the following screens: a) Finger-print based national and state criminal history background screen; b) Local law enforcement screen c) State and local Department of Child Services abuse registry screen; and d) Five-panel drug screen, or Agency meets same requirements specified under the Federal Drug Free Workplace Act 41 U.S.C. 10 Section 702(a)(1). 4) Documentation of safe driving record and maintained vehicle, as well as: a) Current Driver's License; and b) Proof of auto insurance coverage. 5) Staff providing treatment must obtain supervision by a Health Service Provider in Psychology (HSPP) as defined by IC 25-33-1; Licensed Marriage and Family Therapist (LMFT); Licensed Clinical Social Worker (LCSW); or Licensed Mental Health Counselor (LMHC) under IC 25-23.6. 6) All approved providers must complete DMHA and OMPP approved training for CMHW services.

Non-Accredited Agency	None	None	DMHA- authorized CMHW non-accredited agencies must receive approval from DMHA for an individual to provide this service, based on the qualifications of the individual. Agencies must maintain documentation that the individual providing the service meets the following requirements and standards: 1) Individual is at least 21 years of age and possesses a High school diploma, or equivalent. 2) Individual has three (3) years of qualifying experience working with or caring for SED children/youth, as defined by DMHA. 3) Individual has completed and submitted proof of the following screens: a) Finger-print based national and state criminal history background screen; b) Local law enforcement screen c) State and local Department of Child Services abuse registry screen; and d) Five-panel drug screen, or Agency meets same requirements specified under the Federal Drug Free Workplace Act 41 U.S.C. 10 Section 702(a)(1). 4) Documentation of safe driving record and maintained vehicle, as well as: a) Current Driver's License; and b) Proof of auto insurance coverage. 5) Staff providing treatment must obtain supervision by a Health Service Provider in Psychology (HSPP) as defined by IC 25-33-1; Licensed Marriage and Family Therapist (LMFT); Licensed Clinical Social Worker (LCSW); or Licensed Mental Health Counselor (LMHC) under IC 25-23.6. 6) All approved providers must complete DMHA and OMPP approved training for CMHW services.
Individual	None	None	The DMHA- authorized CMHW individual provider delivering the service must meet the following requirements and standards: 1) Individual is at least 21 years of age and possesses a High school diploma, or equivalent.

			2) Individual has three (3) years of qualifying experience working with or caring for SED children/youth, as defined by DMHA. 3) Complete and submit proof of the following screens: a) Finger-print based national and state criminal history background screen; b) Local law enforcement screen c) State and local Department of Child Services abuse registry screen; and d) Five-panel drug screen. 4) Documentation of safe driving record and maintained vehicle, as well as: a) Current Driver's License; and b) Proof of auto insurance coverage. 5) Staff providing treatment must obtain supervision by a Health Service Provider in Psychology (HSPP) as defined by IC 25-33-1; Licensed Marriage and Family Therapist (LMFT); Licensed Clinical Social Worker (LCSW); or Licensed Mental Health Counselor (LMHC) under IC 25-23.6. 6) All approved providers must complete DMHA and OMPP approved training for CMHW services.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Accredited Agency	DMHA	Verification documentation submitted to DMHA: Initially at point of DMHA authorization of the CMHW agency and at least every three years thereafter. Must resubmit documentation for verification again at time of re-accreditation for agency.
Non-Accredited Agency	DMHA	Verification documentation submitted to DMHA: Initially at point of DMHA authorization of the CMHW agency and at least every two years thereafter.
Individual	DMHA	Verification documentation

		submitted to DMHA: Initially at point of DMHA authorization of the CMHW provider and at least every two years thereafter.

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

1c. State plan HCBS.

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):*

Service Title: Respite Care

Service Definition (Scope):

Respite care is defined as a service provided for a Participant unable to care for him/herself, and the service is furnished because of the absence or need for relief of those persons who normally provide care for the Participant. Respite care services are provided for Participants on an as needed, short-term basis to offer relief to the family from the stressors associated with caring for a seriously emotionally disturbed (SED) youth—thus increasing the ability of the family to maintain the Participant in the home and community for treatment. The service is authorized by the State based upon the Participant/Family's identified needs. The State monitors the utilization of CMHW services, including respite care, each time the Plan of care is revised or updated. Continued use of Respite services would be contingent upon the Participant meeting criteria for the service.

The Respite Care Service may be provided in the following manner for planned or routine time frames where the caregiver is aware of needing relief/assistance through the respite care service:

1) On an hourly basis, billed less than 7 hours in the same day.
2) On a daily basis, as follows:
   a) Billed for service provided 7 to 24 hours in the same day.
   b) Respite provided as a daily service cannot exceed fourteen (14) consecutive days at one time. There is no limitation regarding how many times a family may use the 14 consecutive days for Respite. However, all services utilized must be included on the Participant's plan of care, including type of service and frequency. The utilization of and response to CMHW services is continually monitored by the Child and Family Team. The State authorizes the utilization of CMHW services on the plan of care, based upon the Participant's identified needs.

Crisis Respite Care Service may be provided on an unplanned basis, as an emergency response to a crisis situation in the family, when a caregiver has an unexpected situation requiring assistance in caring for the Participant.

1) A crisis situation is one where the Participant's health and welfare would be seriously impacted in the absence of the Crisis Respite Care.
2) Crisis Respite is provided on a daily basis, billed 8 to 24 hours in the same day.
3) Crisis Respite cannot exceed fourteen (14) consecutive days at one time.

Respite Care may be provided in the Participant's home/private place of residence, or any facility licensed by the Indiana Family and Social Services Administration, Division of Family Resources, or the Indiana Department of Child Services. Approved CMHW service providers may also include:

1) DMHA-authorized CMHW Respite Care provider meeting standards and qualifications for an individual service provider. Any CMHW-approved accredited facility licensed by the Indiana Family and Social Services Administration, Division of Family Resources, or the Indiana Department of Child Services.

2) Any relative related by blood, marriage, or adoption, who is not the legal guardian; and who does not live in the home with the Participant and who meets the standards and qualifications of an individual CMHW service provider. DMHA will monitor any Respite Care services provided by a relative approved to provide the service, to ensure the service is being provided as specified by CMHW policy and procedure; which may include, but is not limited to, an unannounced visit in the home by a CMHW service provider during the period the Respite Care service is authorized. All CMHW service providers, including approved relatives, are required to be a part of the wraparound facilitation process. Relatives approved by the Child and Family Team and the State for a Participant must meet the provider qualifications and standards required of all DMHA- authorized CMHW providers, including provision of services according to the Wraparound principles.

Respite Care services must be provided in the least restrictive environment available and ensure the health and welfare of the Participant. A Participant who needs consistent 24-hour supervision, with regular monitoring of medications or behavioral symptoms, should be placed in a facility under the supervision of a psychologist, psychiatrist, physician or nurse who meets respective licensing or certification requirements of his/her profession in the state of Indiana. All of the licensed settings listed under Provider Qualifications are allowed to provide Respite Care. However, expectations are that Respite Care will be provided in the least restrictive setting possible.

Allowed Respite Care service activities include:

1) Assistance with daily living skills; including assistance with accessing/transporting to/from community activities.
2) Assistance with grooming and personal hygiene.
3) Meal preparation, serving and cleanup.
4) Administration of medications.
5) Supervision.

Service exclusions include:

1) Respite Care provided by:
   a) Parents of a Participant who is a minor child;
   b) Any relative who is the primary caregiver of the Participant; or
   c) Anyone living in the Participant's residence.
2) Respite services must not be provided as a substitute for regular childcare to allow the parent/caregiver to hold a job, engage in job-related or job search activities; or attend school.
3) Respite care must not be provided in an individual CMHW respite care service provider's residence.
4) Respite care shall not be used to provide service to the Participant while he/she is attending school.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

None

Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*

☑ Categorically needy *(specify limits):*

Respite provided at Daily Rate (7 to 24 hours in the same day) and Crisis Respite (8 to 24 hours in the same day) cannot exceed 14 consecutive days.

☐ 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)*:
Accredited Agency	1) Emergency shelters licensed	DMHA-approved accreditation as a mental health	Agency must maintain documentation that individual providing the service meets the following requirements and standards:

	under 465 IAC 2-10; 2) Foster Homes licensed under IC 31-27-4 including Special Needs and Therapeutic Foster Homes only when the Licensed Child Placing Agency (LCPA) is the 1915(i) approved agency provider. DMHA will have the authority to request a copy of the home study that was conducted on the foster parent providing 1915(i) Respite Care services; 1) Other child caring institutions licensed under IC-31-27-3; 2) Child Care Centers licensed under IC 12-17.2-4; 3) Child Care Homes licensed under IC 12-17.2-5-1;	service provider	1) Individual is at least 21 years of age and has a High school diploma, or equivalent. 2) Individual has three (3) years of qualifying experience working with or caring for SED children/youth, as defined by DMHA. 3) Individual has completed and submitted proof of the following screens: a) Finger-print based national and state criminal history background screen; b) Local law enforcement screen c) State and local Department of Child Services abuse registry screen; and d) Five-panel drug screen, or Agency meets same requirements specified under the Federal Drug Free Workplace Act 41 U.S.C. 10 Section 702(a) (1). 4) Documentation of safe driving record and maintained vehicle, as well as: a) Current Driver's License; and b) Proof of auto insurance coverage. 5) All approved providers must complete DMHA and OMPP approved training for CMHW services.

	4) School Age Child Care Project licensed under IC 12-17-12; or 5) Psychiatric Residential Treatment Facility (PRTF) licensed under 465 IAC 2-11-1 as a private secure residential facility for Medicaid certification under 405 IAC 5-20-3.1.		
Non-Accredited Agency	None	None	Agency must maintain documentation that individual providing the service meets the following requirements and standards: 1) Individual is at least 21 years of age and has a High school diploma, or equivalent. 2) Individual has three (3) years of qualifying experience working with or caring for SED children/youth, as defined by DMHA. 3) Individual has completed and submitted proof of the following screens: a) Finger-print based national and state criminal history background screen; b) Local law enforcement screen c) State and local Department of Child Services abuse registry screen; and d) Five-panel drug screen, or Agency meets same requirements specified under the Federal Drug Free Workplace Act 41 U.S.C. 10 Section 702(a) (1). 4) Documentation of safe driving record and maintained vehicle, as well as: a) Current Driver's License; and b) Proof of auto insurance coverage. 5) All approved providers must complete DMHA and OMPP approved training for CMHW services.

Individual	None	None	A DMHA-authorized CMHW individual provider delivering the service must meet the following standards and requirements: 1) Individual is at least 21 years of age and has a High school diploma, or equivalent. 2) Individual has three (3) years of qualifying experience working with or caring for SED children/youth, as defined by DMHA. 3) Complete and submit proof of the following screens: a) Finger-print based national and state criminal history background screen; b) Local law enforcement screen c) State and local Department of Child Services abuse registry screen; and d) Five-panel drug screen. 4) Documentation of safe driving record and maintained vehicle, as well as: a) Current Driver's License; and b) Proof of auto insurance coverage. 5) All approved providers must complete DMHA and OMPP approved training for CMHW services.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Accredited Agency	**DMHA**	Verification documentation submitted to DMHA: Initially at point of DMHA authorization of the CMHW agency and at least every three years thereafter. Must resubmit documentation for verification again at time of re-accreditation for agency.
Non-Accredited Agency	**DMHA**	Verification documentation submitted to DMHA: Initially at point of DMHA authorization of the CMHW agency and at least every two years thereafter.
Individual	**DMHA**	Verification documentation submitted to DMHA: Initially at point of DMHA authorization of the CMHW provider and at least every

		two years thereafter.
Service Delivery Method. *(Check each that applies)*:		
☐ Participant-directed	☑	Provider managed

1d. State plan HCBS.

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover)*:	
Service Title:	Training and Support for Unpaid Caregivers
Service Definition (Scope):	

Training and Support for Unpaid Caregivers is a service provided for an individual who is providing unpaid support, training, companionship or supervision for the Participant. The intent of the service is to provide education and supports to the caregiver that preserve the family unit.

Training and support activities, and the providers selected for these activities, are based on the family/caregiver's unique needs and are identified in the POC. Covered activities may include, but are not limited to, the following:

1) Practical living and decision-making skills.
2) Child development and parenting skills.
3) Home management skills.
4) Use of community resources and development of informal supports.
5) Conflict resolution.
6) Coping skills.
7) Gaining an understanding of the Participant's mental health needs.
8) Learning communication and crisis de-escalation skills geared for working with Participant's mental health and behavioral needs.

Training and Support for Unpaid Caregivers may be delivered by the following types of resources:

1) Non-profit, civic, faith-based, professional, commercial, or government agency or organization.
2) Community colleges, vocational schools or university.
3) Lecture series, workshop, conference or seminar.
4) On-line training program.
5) Community Mental Health Center.
6) Other qualified community service agency.

Provision of service is:

1) Available as a non-hourly service that reimburses for the costs of registration/conference training fees, books and supplies associated with the training and support needs, as documented on the participant's POC; and
2) Available on an hourly schedule for one-on-one training by an approved CMHW service provider, as documented on the participant's POC.

Additional needs-based criteria for receiving the service, if applicable *(specify)*:
None
Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies)*:
☑ Categorically needy *(specify limits)*:

	Hourly service (billed in quarter-hour units) is limited to a maximum of two hours per day ($120 per day). There is no annual limit for hourly Training and Support for Unpaid Caregivers. The maximum annual limitation for non-hourly Training and Support for Unpaid Caregivers is $500. Reimbursement is not available for the costs of travel, meals, or overnight lodging.
☐	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)*:
Accredited Agency	None	AAAHC, COA, URAC, CARF, ACAC, JCAHO, or NCQA Accreditation	Agency must maintain documentation that individual providing the service meets the following requirements and standards: 1) Individual is at least 21 years of age and has a High school diploma, or equivalent; and a resume documenting two (2) years paid, volunteer or personal experience working with children/youth with serious emotional disturbances (SED) or caregivers of children or youth with SED; and 2) Individual has completed and submitted proof of the following screens: a) Finger-print based national and state criminal history background screen; b) Local law enforcement screen c) State and local Department of Child Services abuse registry screen; and d) Five-panel drug screen, or Agency meets same requirements specified under the Federal Drug Free Workplace Act 41 U.S.C. 10 Section 702(a) (1). 3) All approved providers must complete OMHA and OMPP approved training for CMHW services.
Non-Accredited Agency	None	None	Agency must maintain documentation that individual providing the service meets the following requirements and standards: 1) Individual is at least 21 years of age; and has a High school diploma, or equivalent, and a resume documenting two (2) years paid, volunteer or personal experience working with children/youth with serious emotional disturbances (SED) or caregivers of children or youth with SED; and

			2) Individual has completed and submitted proof of the following screens: a) Finger-print based national and state criminal history background screen; b) Local law enforcement screen c) State and local Department of Child Services abuse registry screen; and d) Five-panel drug screen, or Agency meets same requirements specified under the Federal Drug Free Workplace Act 41 U.S.C. 10 Section 702(a) (1). 3) All approved providers must complete DMHA and OMPP approved training for CMHW services.
Individual	None	None	The DMHA- authorized CMHW individual provider delivering the service must reside within a one county area from the youth's place of residence and must meet the following standards: 1) Individual is at least 21 years of age and has a High school diploma, or equivalent; and a resume documenting two (2) years paid, volunteer or personal experience working with children/youth with serious emotional disturbances (SED) or caregivers of children or youth with SED; and 2) Individual has completed and submitted proof of the following screens: a) Finger-print based national and state criminal history background screen; b) Local law enforcement screen c) State and local Department of Child Services abuse registry screen; and d) Five-panel drug screen, or Agency meets same requirements specified under the Federal Drug Free Workplace Act 41 U.S.C. 10 Section 702(a) (1). 3) All approved providers must complete DMHA and OMPP approved training for CMHW services.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type	Entity Responsible for Verification	Frequency of Verification

(Specify):	*(Specify)*:	*(Specify)*:
Accredited Agency	DMHA	Verification documentation submitted to DMHA: Initially at point of DMHA authorization of the CMHW agency and at least every three years thereafter. Must resubmit documentation for verification again at time of re-accreditation for agency.
Non-Accredited Agency	DMHA	Verification documentation submitted to DMHA: Initially at point of DMHA authorization of the CMHW agency and at least every two years thereafter.
Individual	DMHA	Verification documentation submitted to DMHA: Initially at point of DMHA authorization of the CMHW provider and at least every two years thereafter.

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	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)*:

When other CMHW providers are not local to the Participant, or the Participant's Child and Family Team has identified that it is in the best interest of the youth, CMHW Respite Care services may be provided by any relative related by blood, marriage, or adoption who is not the legal guardian and who does not live in the home with the Participant. Respite Care providers who are relatives must meet the following criteria and standards:

1) Be approved by DMHA as an Individual CMHW Respite Care service provider;
2) Be selected by the family/youth to provide the service; and
3) Follow and maintain the policy and procedures required for the CMHW Respite Care service.

Respite Care may not be provided by parents for a Participant who is a minor child, or by any relative who is the primary caregiver for the Participant.

DMHA will monitor Respite Care services provided by a relative approved to provide the Respite Care service

to ensure the service is being provided as specified by CMHW policy and procedure; which may include, but is not limited to, an unannounced visit in the home by a CMHW service provider during the period the Respite Care service is authorized.

Participant-Direction of Services

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

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

◉	The State does not offer opportunity for participant-direction of State plan HCBS. (*Skip to next section)*
○	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.
○	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. *(Specify criteria):*

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):*

NA

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

○	Participant direction is available in all geographic areas in which State plan HCBS are available.
○	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. (*Specify the areas of the State affected by this option)*:
	NA

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
NA	☐	☐
	☐	☐

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

○	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
○	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.

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

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

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

NA

7. **Opportunities for Participant-Direction**

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

○	The State does not offer opportunity for participant-employer authority.
○	Participants may elect participant-employer Authority *(Check each that applies):*
☐	**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.
☐	**Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

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

○	The State does not offer opportunity for participants to direct a budget.
○	Participants may elect Participant–Budget Authority.
	Participant-Directed Budget. *(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including how the method makes use of reliable cost estimating information, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the plan of care):*
	Expenditure Safeguards. *(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):*

Quality Improvement Strategy

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

Discovery Activities					Remediation	
Requirement	**Discovery Evidence** *(Performance Measures)*	**Discovery Activity** ***(Source of Data & sample size)***	**Monitoring Responsibilities** *(agency or entity that conducts discovery activities)*	**Frequency**	**Remediation Responsibilities** *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	**Frequency** *of Analysis and Aggregation*
Service plans address assessed needs of 1915(i) participants, are updated annually, and document choice of services and providers.	1) Number and percent of approved plans of care (POCs) that address assessed needs. *N= Total number of POCs reviewed that address* assessed needs. *D= Total number of POCs reviewed.*	1) DMHA database 100% review	1) DMHA	1) Continuous & ongoing	1) DMHA 45 days	1) Annually
	2) Total number and percent of participants whose POCs were reviewed and revised, as warranted, on or before annual review date. *N= Total number of participants whose plans were updated annually.* *D= Total number of participants due for annual POC review.*	2) DMHA database 100% review	2) DMHA	2) Quarterly	2) DMHA 45 days	2) Annually
	3) Total number and percent of participant records with a signed *Choice of Service* Statement indicating they were afforded choice of eligible services.	3) Record reviews; off-site Representative sample	3) DMHA	3) Quarterly	3) DMHA 45 days	3) Annually

	N= Total number of participant records with a signed Choice of Service *Statement.* *D= Total number of participant records sampled.*	95% confidence level; 5% confidence interval				
	4) Total number and percent of participant records with a signed *Provider Pick List* indicating they were afforded choice of providers. *N= Total number of participant records with a signed* Provider Pick List. *D= Total number of participant records sampled.*	4) Record reviews; off-site Representative sample 95% confidence level; 5% confidence interval	4) DMHA	4) Quarterly	4) DMHA 45 days	4) Annually
Providers meet required qualifications.	1) Number and percent of service providers meeting standards prior to approval and enrollment as a CMHW service provider. *N= Total number of approved providers with documentation meeting eligibility requirements.* *D= Total number of providers approved.*	1) Record review, offsite 100% review	1) DMHA	1) Continuous & ongoing	1) DMHA 45 days	1) Annually

	2) Number and percent of CMHW service providers reauthorized timely. *N= Total number of providers with timely CMHW provider reauthorization.* *D= Total number and percent of providers due for CMHW provider reauthorization*	2) Record reviews, off-site 100% review	2) DMHA	2) CMHW provider reauthorization is based upon the Agency and Provider type. Refer to Verification of Provider Qualifications (Services section) for reauthorization timelines.	2) DMHA 45 days	2) Annually
The SMA retains authority and responsibility for program operations and oversight.	1) Number and percent of CMHW policies/procedures approved by OMPP prior to implementation. *N= Total number of policies and procedures developed and approved.* *D= Total number policies and procedures implemented.*	1) HCBS Policy and Procedure Review Logs 100% review	1) DMHA	1) Quarterly	1) DMHA 45 days	1) Annually
	2) Number and percent of data reports specified in the MOU that were provided by DMHA on time and in the correct format. *N= Number of data reports provided timely and in format.* *D= Number of data reports due.*	2) DMHA Administrative Authority Quality Management Report 100% review	2) DMHA	2) Quarterly	2) DMHA 45 days	2) Annually

The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.	1) Number and percent of claims paid during the review period according to the published service rate. *N= Number of claims paid during the review period according to the published service rate.* *D= Number of claims submitted during the review period.*	1) Medicaid Management Information System (MMIS) claims data reports 100% review	1) OMPP & Medicaid fiscal contractor	1) Monthly	1) OMPP & DMHA 45 days	1) Monthly
	2) Number and percent of claims paid during the review period for participants enrolled in the *CMHW services* on the date that the service was delivered. *N= Number of claims paid during the review period for participants enrolled in the CMHW services on the date that the service was delivered.* *D= Number of claims submitted during the review period.*	2) OMPP & Medicaid Management Information System (MMIS) claims data reports 100% review	2) Medicaid fiscal contractor	2) Monthly	2) OMPP & DMHA 45 days	2) Quarterly
	3) Number and percent of claims paid during the review period for services that are specified in the participant's approved service plan. *N= Number of claims paid during the review period due to services having been identified on the approved service plan.*	3) Medicaid Management Information System (MMIS) claims data reports 100% review	3) OMPP & Medicaid	3) Monthly	3) OMPP & DMHA 45 days	3) Monthly

	D= Number of claims submitted during the review period.					
The State identifies, addresses and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.	1) Number and percent of incidents reported within required timeframe by type of incident. *N= Total number of incidents reported according to policy.* *D= Total number of incidents reported.*	1) Incident reports 100% review	1) DMHA	1) Continuous & ongoing	DMHA 45 days	1) Annually
	2) Number and percent of incidents resolved according to policy. *N= Total number of incidents resolved according to policy.* *D= Total number of incidents reported.*	2) Incident reports 100% review	2) DMHA	2) Continuous & ongoing	2) DMHA 45 days	2) Annually
	3) Number and percent of Corrective Action Plans (CAPS) associated with complaints that were implemented within prescribed time period. *N= Total number of CAPs associated with complaints that were implemented within prescribed time period.* *D= Total number of CAPs associated with complaints.*	3) Incident Report forms 100% review	3) DMHA	3) Continuous & ongoing	3) DMHA 45 days	3) Annually

System Improvement: *(Describe process for systems improvement as a result of aggregated discovery and remediation activities.)*			
Methods for Analyzing Data and	Roles and	Frequency	Method for Evaluating Effectiveness of

Prioritizing Need for System Improvement	Responsibilities		System Changes
DMHA will collect and track complaints related to implementation, providers and services offered through the 1915(i). Complaints could be received from consumers, family members, concerned citizens, providers or advocates. Complaints will be categorized as individual issue or system challenge/barrier:			
1) *System Challenge/Barrier Issues*: These types of complaints/issues will be discussed during bimonthly strategy meetings between DMHA and OMPP. System issues identified in the complaints will be prioritized with solutions discussed for highest priority items.	1) DMHA	1) Annual	1) DMHA and OMPP will meet every two months to discuss and evaluate the need for new system changes, as well as the effectiveness of previous system changes. Additional changes will be made as necessary, including changes in provider training, bulletins, policy changes and refinements.
2) *Individual/Quality Issues*: DMHA will review and analyze individual issues related to performance measures to identify any system level trends. DMHA and OMPP will monitor trends to identify the need for system changes.	2) DMHA	2) Annual	2) DMHA and OMPP will meet every two months to discuss trends identified by DMHA and determine the best way to address the issues (i.e., policy change, training, etc.), 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 training, bulletins, policy changes and refinements.

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

Methods and Standards for Establishing Payment Rates

1. **Services Provided Under Section 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)*:

Governmental or Private Entity Service Providers

Providers of CMHW Services for Children and Youth are private entities. No state or local government providers receive payment for CMHW Services for Children and Youth.

Required Documentation to Support Provider's Claim for Reimbursement

Pursuant to 42 CFR 431.107, the provider must maintain the following documentation:

While the format for clinical documentation is up to the individual provider or agency, the State mandates that the DMHA-approved provider/agency be compliant with the following Medicaid documentation requirements for each CMHW participant served:

1) All documentation is subject to review by the Centers for Medicare and Medicaid Services (CMS) and the State, or its designees.
2) Eligibility for claims payment under the program is based on the provider maintaining the required documentation.
3) The provider is subject to denial of payment or recoupment for paid claims for services if the provider does not have adequate documentation to support the service billed.
4) The following content must be documented in each service note:
   a) Participant's name.
   b) Recipient Identification Number (RID, Medicaid Number).
   c) Service provided (Must match service authorized in Plan of Care).
   d) Total number of service units provided.
   e) Primary location where service was provided.
   f) Date and time of the service (these must match date on claim and units billed); includes start and end times.
   g) Provider rendering the service, including, the last name, first initial and credentials (if applicable) of the person providing the service/making the documentation.
   h) Legible signature of person completing the documentation.
   i) Need identified on the Plan of Care that is being met through provision of the service.
   j) Goal being addressed by service delivered, and progress towards meeting that goal.
   k) Participant response to service provided.
   l) Any other specific documentation required for the service provided, per CMS or State.

☐	HCBS Case Management
☐	HCBS Homemaker
☐	HCBS Home Health Aide
☐	HCBS Personal Care
☐	HCBS Adult Day Health
☑	HCBS Habilitation
	Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of the Habilitation service. The agency's fee schedule rate will be set as of July 1, 2013 and

	be effective for services provided on or after that date. Upon State Plan approval by CMS, all rates will be published on the agency's website at www.indianamedicaid.com. The unit of service for the basis of the fee schedule rate is 15-minutes.
☑	HCBS Respite Care
	Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of the Respite Care service. The agency's fee schedule rate will be set as of July 1, 2013 and be effective for services provided on or after that date. Upon State Plan approval by CMS, all rates will be published on the agency's website at www.indianamedicaid.com. Respite Care service has three (3) units of service for the basis of the fee schedule rate: 1) Rate for Respite Care provided for less than seven (7) hours per day is based on a 15-minute unit of service. 2) Rate for Respite Care provided as a daily service of 7 to 24 hours is based on a daily unit of service. 3) Rate for Crisis Respite Care provided 8 to 24 hours is based on a daily unit of service.
☑	Other HCBS (*Specify*): Wraparound Facilitation
	Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of the Wraparound Facilitation service. The agency's fee schedule rate will be set as of July 1, 2013 and be effective for services provided on or after that date. Upon State Plan approval by CMS, all rates will be published on the agency's website at www.indianamedicaid.com. The unit of service for the basis of the fee schedule rate is a monthly unit. Monthly, the Wraparound facilitator will bill for the service based upon the provider's participation in the Child and Family Team meeting, engaging the child/family and consultation with other team members. The monthly clinical note will be used to trigger the billing. Wraparound Facilitation providers will maintain data onsite regarding the cost to provide Wraparound Facilitation specifically related to the covered services provided to each participant per month. DMHA will collect data from a random sampling of Wraparound Facilitator agencies for review and analysis. This data will be reviewed in conjunction with data from the DMHA database to determine utilization of Wraparound Facilitation. Additionally, Wraparound Facilitators are required to follow Medicaid regulations regarding documentation of the Wraparound Facilitation service provided and will record the number of hours of Wraparound Facilitation provided each month in the clinical record. The State's Quality Improvement Specialist (QIS) contractors review service utilization during onsite visits and during Plan of Care reviews to ensure Participants receive the types, quantities and intensity of services required to meet their specific needs and to ensure service delivery is consistent with the service description of the service provided. To ensure that the monthly FFS rate continues to be economic and efficient, the State will review and rebase the rate and its utilization at regular intervals, not to exceed twelve (12) months.
☑	Other HCBS (*Specify*): Training and Support for Unpaid Caregivers
	Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of the Training and Support for Unpaid Caregivers service. The agency's fee schedule rate will be set as of July 1, 2013 and be effective for services provided on or after that date. Upon State Plan approval by CMS, all rates will be published on the agency's website at www.indianamedicaid.com. Training and Support for Unpaid Caregivers service has two units of service for the basis of the fee schedule rate: 1) Rate for one-on-one Caregiver Training service is based on a 15-minute unit of service. 2) Rate for non-hourly Caregiver Training for conference registration fees/books/supplies is based on the actual cost of the service authorized in the participant's plan of care.
☐	Other HCBS (*Specify*):
For Individuals with Chronic Mental Illness, the following services:	

	☐	HCBS Day Treatment or Other Partial Hospitalization Services
	☐	HCBS Psychosocial Rehabilitation
	☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)

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

Methods and Standards for Establishing Payment Rates

1. **Services Provided Under Section 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)*:

☐	HCBS Case Management
☐	HCBS Homemaker
☐	HCBS Home Health Aide
☐	HCBS Personal Care
☐	HCBS Adult Day Health
☑	HCBS Habilitation The agency's fee schedule for Habilitation service was set using the same methodology that applies to Habilitation service in the CMS approved 1915(c) Psychiatric Residential Treatment Facilities (PRTF) Transition Waiver, CMS Control Number IN.03.R02.00. Rates are published on the agency's website at www.indianamedicaid.com.
☑	HCBS Respite Care The agency's fee schedule for Respite Care service was set using the same methodology that applies to Respite Care service in the CMS approved 1915(c) Psychiatric Residential Treatment Facilities (PRTF) Transition Waiver, CMS Control Number IN.03.R02.00. Rates are published on the agency's website at www.indianamedicaid.com.
☑	Other HCBS (*Specify*): Wraparound Facilitation To calculate the monthly Wraparound Facilitation CMHW case rate, the State analyzed the recent monthly utilization for both Wraparound Facilitation and Wraparound Technician services provided in the Community Alternative to Psychiatric Residential Treatment Facilities (CA-PRTF) Demonstration Grant (CMS Control Number IN.03.R01.05). The average utilization was multiplied by the CA-PRTF unit cost for Wraparound Facilitation ($28.75 per 15 minute unit). The final monthly rate was reduced by 10% to reflect efficiencies associated with reduced documentation requirements due to completing monthly documentation versus daily/per contact documentation. Rates are published on the agency's website at www.indianamedicaid.com.
☑	Other HCBS (*Specify*): Training and Support for Unpaid Caregivers The agency's fee schedule for Training and Support for Unpaid Caregivers service was set using the same methodology that applies to Training and Support for Unpaid Caregivers service in the CMS approved 1915(c) Psychiatric Residential Treatment Facilities (PRTF) Transition Waiver, CMS Control Number IN.03.R02.00. Rates are published on the agency's website at www.indianamedicaid.com.
☐	Other HCBS (*Specify*):
For Individuals with Chronic Mental Illness, the following services:	
☐	HCBS Day Treatment or Other Partial Hospitalization Services

	☐	HCBS Psychosocial Rehabilitation
	☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)