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State/Territory Name: Indiana

State Plan Amendment (SPA) #: 22-0008

This file contains the following documents in the order listed:

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

Medicaid and CHIP Operations Group

October 7, 2022

Allison Taylor, Medicaid Director
Indiana Family and Social Services Administration
402 W. Washington Street
Indianapolis, IN 46207-7083

RE: IN 22-0008 §1915(i) Home and Community-Based Services (HCBS) State Plan Amendment (SPA)

Dear Ms. Taylor:

The Centers for Medicare & Medicaid Services (CMS) is approving the state's request to amend its 1915(i) state plan home and community-based services (HCBS) benefit, transmittal number IN 22-0008. The effective date for this amendment is October 7, 2022. With this amendment, the state expands 1915(i) eligibility by accepting the attestation of an individual's assessment of need, which the State Evaluation Team uses to determine an individual's eligibility for this benefit, from additional licensed providers.

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

- Attachment 3.1-i, pages 41-124S
- Attachment 4.19-B, pages 9-11

CMS reminds the state that the state must have an approved spending plan in order to use the money realized from section 9817 of the ARP. Approval of this action does not constitute approval of the state's spending plan.

It is important to note that CMS approval of this change to the state's 1915(i) HCBS state plan benefit solely addresses the state's compliance with the applicable Medicaid authorities. CMS approval does not address the state's independent and separate obligations under federal laws including, but not limited to, the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, or the Supreme Court's Olmstead decision. Guidance from the Department of Justice concerning compliance with the Americans with Disabilities Act and the Olmstead decision is available at http://www.ada.gov/olmstead/q&a_olmstead.htm.

If you have any questions concerning this information, please contact me at (410) 786-7561. You may also contact Kathleen Creggett at Kathleen.Creggett@cms.hhs.gov or (415) 744-3656.

Sincerely,

[redacted]

George P. Failla, Jr., Director
Division of HCBS Operations and Oversight

Enclosure

cc: Lynell Sanderson, CMCS, CMS
Cynthia Nanes, CMCS CMS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 22-0008

2. STATE: IN

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
~~July 1, 2022~~ October 7, 2022

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR 441.710

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2022 $ 0
b. FFY 2023 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 3.1-i, Pages 41 - ~~124~~ 124Q
Attachment 4.19-B, Pages 9-11

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 3.1-i, Pages 41 - ~~124~~ 124S
Attachment 4.19-B, Pages 9 - 11

9. SUBJECT OF AMENDMENT
This State Plan Amendment makes conforming changes to the Medicaid State Plan to bring Indiana Medicaid into compliance with Senate Enrolled Act 82, which expands providers.

10. GOVERNOR'S REVIEW *(Check One)*
( ) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
(●) OTHER, AS SPECIFIED:

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Allison Taylor

13. TITLE
Medicaid Director

14. DATE SUBMITTED
07/11/2022

15. RETURN TO
Allison Taylor
Medicaid Director
Indiana Office of Medicaid Policy and Planning
402 West Washington Street, Room W374
Indianapolis, IN 46204
Attn: Madison May-Gruthusen, Federal Relations Lead

FOR CMS USE ONLY

16. DATE RECEIVED July 11, 2022

17. DATE APPROVED October 7, 2022

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
October 7, 2022

19. SIGNATURE OF APPROVING [redacted]

20. TYPED NAME OF APPROVING OFFICIAL
George P. Failla, Jr.

21. TITLE OF APPROVING OFFICIAL
Director, Division HCBS Operation and Oversight

22. REMARKS
Pen and Ink changes made to box 4, 7 and 8.
Approved by state on 10/7/2022

Instructions on Back

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 the state's service title(s) for the HCBS defined under "Services" and listed in Attachment 4.19-B):*

Adult Mental Health Habilitation (AMHH)
Adult Day Services
Home and Community Based (HCB) Habilitation and Support – Individual Setting
HCB Habilitation and Support – Family/Couple with the Recipient Present (Individual Setting)
HCB Habilitation and Support – Family/Couple without the Recipient Present (Individual Setting)
HCB Habilitation and Support – Group Setting
HCB Habilitation and Support – Family/Couple with Recipient Present (Group Setting)
HCB Habilitation and Support – Family/Couple without Recipient Present (Group Setting)
Respite Care
Therapy and Behavioral Support Services – Individual Setting
Therapy and Behavioral Support Services – Family/Couple with Recipient Present (Individual Setting)
Therapy and Behavioral Support Services – Family/Couple without Recipient Present (Individual Setting)
Therapy and Behavioral Support Services – Group Setting
Therapy and Behavioral Support Services – Family/Couple with Recipient Present (Group Setting)
Therapy and Behavioral Support Services – Family/Couple without Recipient Present (Group Setting)
Addiction Counseling – Individual Setting
Addiction Counseling – Family/Couple with Recipient Present (Individual Setting)
Addiction Counseling – Family/Couple without Recipient Present (Individual Setting)
Addiction Counseling – Group Setting
Addiction Counseling – Family/Couple with Recipient Present (Group Setting)
Addiction Counseling – Family/Couple without Recipient Present (Group Setting)
Supported Community Engagement Services
Care Coordination
Medication Training and Support – Individual Setting
Medication Training and Support – Family/Couple with Recipient Present (Individual Setting)
Medication Training and Support – Family/Couple without Recipient Present (Individual Setting)
Medication Training and Support – Group Setting
Medication Training and Support – Family/Couple with Recipient Present (Group Setting)

Medication Training and Support – Family/Couple without Recipient Present (Group Setting)

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

***Select one*:**

○	**Not applicable**
○	**Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act.** The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of 1915(i) State plan HCBS. Participants may *voluntarily* elect to receive *waiver* and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. *Specify:*
(a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1);
(b) the geographic areas served by these plans;
(c) the specific 1915(i) State plan HCBS furnished by these plans;
(d) how payments are made to the health plans; and
(e) whether the 1915(a) contract has been submitted or previously approved.

☑ **Waiver(s) authorized under §1915(b) of the Act.**
Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

The updated 1915(b)(4) application was submitted December 30, 2019.

Specify the §1915(b) authorities under which this program operates (*check each that applies*):

☐	§1915(b)(1) (mandated enrollment to managed care)	☐	§1915(b)(3) (employ cost savings to furnish additional services)
☐	§1915(b)(2) (central broker)	☒	§1915(b)(4) (selective contracting/limit number of providers)

☐ **A program operated under §1932(a) of the Act.**
Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

☐ **A program authorized under §1115 of the Act.** *Specify the program*:

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 Division of Mental Health & Addiction (DMHA) is the operating agency under the umbrella of Indiana's SMA. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.
☐	The State plan HCBS benefit is operated by *(name of agency)*		

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

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

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

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
1 Individual State plan HCBS enrollment	☑	☑	☐	☐
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) or a State contracted entity. OMPP is responsible for quality and program oversight for Functions 1-10. OMPP meets quarterly for trending and analysis of performance measure data for all functions. OMPP works with DMHA and/or contracted entities to develop and evaluate quality improvement strategies.

Function #4 – Prior Authorization

On behalf of the Family and Social Services Administration (FSSA), the State Evaluation Team (SET) reviews all AMHH PA requests for Indiana Health Coverage Programs (IHCP) members on a case-by-case basis through the Data Assessment Registry Mental Health and Addiction (DARMHA) system.

Function #5 – Utilization Management

The contracted entity is the Medicaid Surveillance Utilization Review Contractors, for qualified provider enrollment, item 6 the contracted entity is DMHA and Medicaid Fiscal Agent, for the execution of Medicaid provider agreement, item 7 the contracted entity is the Medicaid Fiscal Agent, and for the establishment of a consistent rate methodology for each State plan HCBS, item 8 the contracted entity is an actuarial service. Function #5- Utilization Management (Medicaid Surveillance Utilization Review Contractors):

The benefit 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 benefit 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 benefit requirements.

Function #6 – Qualified Provider Enrollment

Providers interested in providing AMHH services must first apply for certification through DMHA. Next, the provider must enroll as a Medicaid provider with Indiana Health Coverage Programs (IHCP). OMPP contracts with a fiscal agent to process IHCP provider enrollments. The fiscal agent processes the applications, verifies licensure and certification requirements are met, maintains the provider master file, assigns provider ID numbers, and stores National Provider Identifier and taxonomy information. Upon successful completion of the provider enrollment process an enrollment confirmation letter is mailed to the new provider.

Function #7 – Execution of Medicaid Provider Agreement (Medicaid Fiscal Agent):

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 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 #8 – Establishment of a consistent rate methodology for each State Plan HCBS (Medicaid Actuarial Contractor):

OMPP has an actuarial service under contract to develop and assess rate methodology for HCBS. Rate methodology for AMHH services is assessed and reviewed at least every five years. The actuarial contractor completes the cost surveys and calculates rate adjustments. OMPP reviews and approves the fee schedule to ensure consistency, efficiency, economy, quality of care, and sufficient access to providers for AMHH services.

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

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

The Independent State Evaluation Team (SET) is responsible for determining the 1915(i) eligibility and approving the individualized services requested in the proposed care plan. The members of the SET are prohibited from having any financial relationships with the applicant/recipient requesting services, their families, or the entity selected to provide services. Assessments are completed and proposed plans of care (Individualized Integrated Care Plan – IICP) are submitted by a qualified provider entity to the SET for final eligibility determination and care plan approval. This benefit includes a concurrent managed care authority that allows for the limitation of provider choice to Community Mental Health Centers (CMHCs). Hence, CMHCs, certified by the Division of Mental Health & Addiction (DMHA), are the only willing and qualified entities to perform the individual assessments of need and develop the service plans.

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

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

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

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

The benefit includes a concurrent managed care authority that allows for the limitation of provider choice.

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 anexplanation that these services do not include special education and related services defined in the Individuals with Disabilities Education Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

Number Served

1. **Projected Number of Unduplicated Individuals To Be Served Annually.**
(Specify for year one. Years 2-5 optional):

Annual Period	From	To	Projected Number of Participants
Year 1	10/1/2018	9/30/2019	50
Year 2			
Year 3			
Year 4			
Year 5			

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

Financial Eligibility

1. ☑ **Medicaid Eligible.** *(By checking this box the state assures that):* Individuals receiving State plan HCBS are included in an eligibility group that is covered under the State's Medicaid Plan and have income that does not exceed 150% of the Federal Poverty Line (FPL). (This election does not include the optional categorically needy eligibility group specified at §1902(a)(10)(A)(ii)(XXII) of the Social Security Act. States that want to adopt the §1902(a)(10)(A)(ii)(XXII) eligibility category make the election in Attachment 2.2-A of the state Medicaid plan.)

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

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

☐ The State provides State plan HCBS to the medically needy. (*Select one*):

☐ The state elects to disregard the requirements section of 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy. When a state makes this election, individuals who qualify as medically needy on the basis of this election receive only 1915(i) services.

☐ The state does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act.

Evaluation/Reevaluation of Eligibility

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

☑	Directly by the Medicaid agency
○	By Other (*specify State agency or entity under contract with the State Medicaid agency*):

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

Individuals conducting the State evaluation for eligibility determination and approval of plans of care hold at least a bachelor's degree in social work, counseling, psychology, or similar field.

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

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

Each person referred for 1915(i) services must receive a face-to-face bio-psychosocial needs assessment by the referring provider projection including but not limited to the Adult Needs and Strengths Assessment (ANSA) tool and the 1915(i) referral form developed by OMPP/DMHA.

The ANSA tool consists of items that are rated as:
'0' no evidence or no need for action
'1' need for watchful waiting to see whether action is needed
'2' need for action
'3' need for either immediate or intensive action due to a serious disability need.

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

The user's manual for the ANSA is found on-line at:

Https://dmha.fssa.in.gov/DARMHA/Documents/ANSAManual_712011.pdf

The referral form and supporting documentation provide specific information about the person's health status, current living situation, family functioning, vocation/employment 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 referral also includes information about the person's participation in MRO services and the outcomes for those services.

The agency staff and the applicant jointly develop a proposed plan of care (Individualized Integrated Care Plan (IICP)) that includes desired goal and is person-centered in nature. The plan developed must contain at a minimum, the types of services to be furnished, the amount, the frequency and duration of each service, and the provider to furnish each service. Upon completion of the referral packet, the agency staff submit the documents to DMHA through a secure electronic file transfer process. The referral packet can include, but is not limited to the ANSA, referral form, and proposed plan of care.

Upon receipt of the referral packet, the state evaluation team reviews all submitted documentation and determines whether the applicant is eligible for 1915(i) AMHH program and services.

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

If determined eligible for 1915(i) services, an eligibility determination and care plan service approval letter is sent and includes an end date for MRO eligibility and a start date for 1915(i) eligibility (consecutive dates so there is no lapse in service). Once eligible, services may begin immediately.

If determined ineligible for 1915(i) services, a denial letter is sent to the applicant and the agency staff member informing them that their application for services has been denied. The denial letter is generated by DMHA. The denial letter includes the reason for denial, appeal rights, and process.

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

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

5. ☑ **Needs-based HCBS Eligibility 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):*

In the context of needs base criteria, "significant" is operationally defined in the algorithm for the 1915(i) as an assessed "need for immediate or intensive action due to a serious or disabling need."

All of the following needs-based criteria must be met for 1915(i) eligibility:

1. Without ongoing habilitation services as demonstrated by written attestation by a psychiatrist, ~~or~~ Health Services Provider in Psychology (HSPP), Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), Licensed Mental Health Counselor (LMHC), or Licensed Clinical Addiction Counselor (LCAC), the person is likely to deteriorate and be at risk of institutionalization (e.g., acute hospitalization, State hospital, nursing home, jail).
2. The recipient must demonstrate the need for significant assistance** in major life domains related to their mental illness (e.g., physical problems, social functioning, basic living skills, self-care, potential for harm to self or others).
3. The recipient must demonstrate significant needs related to his/her behavioral health.
4. The recipient must demonstrate significant impairment in self-management of his/her mental illness or demonstrate significant needs for assistance with mental illness management.
5. The recipient must demonstrate a lack of sufficient natural supports to assist with mental illness management.
6. The recipient is not a danger to self or others at the time of application for AMHH services program eligibility is submitted for State review and determination.

**Assistance includes any support from another person (mentoring, supervision, reminders, verbal cueing, or hands-on assistance) needed because of mental health condition or disorder

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

State plan HCBS needs-based eligibility criteria	NF (& NF LOC** waivers)	ICF/IID (& ICF/IID LOC waivers)	Applicable Hospital* (& Hospital LOC waivers)
Needs based eligibility criteria are specified in Item four above.	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,	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 the individual meets the following conditions:	Dangerous to self or others or gravely disabled. (IC-12-26-1)

	essentially seven days a week. 405 IAC 1-3-2 (a) Intermediate nursing level of 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 is functionally eligible for either NF or an NF level of care waiver if the need for medical or nursing supervision and attention is determined by any of the following findings from the functional screening: 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	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 onset prior to age 22. 4. Individual needs a combination or sequence of services. 5. Has 3 of 6 substantial functional limitations as defined in 42 CFR 435.1010 in areas of (1) self-care, (2) learning, (3) self-direction, (4) capacity for independent living, (5) language, and (6) mobility.	

*Long Term Care/Chronic Care Hospital

**LOC= level of care

7. ☑ **Target Group(s).** The state elects to target this 1915(i) State plan HCBS benefit to a specific population based on age, disability, diagnosis, and/or eligibility group. With this election, the state will operate this program for a period of 5 years. At least 90 days prior to the end of this 5-year period, the state may request CMS renewal of this benefit for additional 5-year terms in accordance with 1915(i)(7)(C) and 42 CFR 441.710(e)(2). (*Specify target group(s)*):

The AMHH Program Eligibility, 405 IAC 5-21.6-4:

- Age 19 or over
- Medicaid enrolled
- ANSA Level of Need 3 or higher
- Approved AMHH eligible primary diagnosis

  Code ICD-10 Description
  - F20.0 Paranoid schizophrenia
  - F20.1 Disorganized schizophrenia
  - F20.2 Catatonic schizophrenia
  - F20.3 Undifferentiated schizophrenia
  - F20.5 Residual schizophrenia
  - F20.81 Schizophreniform disorder
  - F20.89 Other schizophrenia
  - F20.9 Schizophrenia
  - F22 Delusional Disorder
  - F25.0 Schizoaffective disorder, bipolar type
  - F25.1 Schizoaffective disorder, depressive type
  - F25.8 Other schizoaffective disorders
  - F25.9 Schizoaffective disorder, unspecified
  - F29 Unspecified schizophrenia spectrum and other psychotic disorder
  - F30.10 Manic episode without psychotic symptoms, unspecified
  - F30.12 Manic episode without psychotic symptoms, moderate
  - F30.13 Manic episode, severe, without psychotic symptoms
  - F30.2 Manic episode, severe with psychotic symptoms
  - F30.3 Manic episode in partial remission
  - F30.9 Manic episode, unspecified
  - F31.0 Bipolar I disorder, current or most recent episode hypomanic
  - F31.10 Bipolar disorder, current episode manic without psychotic features, unspecified
  - F31.12 Bipolar I disorder, current or most recent episode manic, moderate
  - F31.13 Bipolar I disorder, current or most recent episode manic, severe
  - F31.2 Bipolar I disorder, current or most recent episode manic, with psychotic features
  - F31.30 Bipolar disorder, current episode depressed, mild or moderateseverity, unspecified
  - F31.32 Bipolar I disorder, current or most recent episode depressed, moderate
  - F31.4Bipolar I disorder, current or most recent episode depressed, severe
  - F31.5 Bipolar I disorder, current or most recent episode depressed, with psychotic features
  - F31.60 Bipolar disorder, current episode mixed, unspecified
  - F31.62 Bipolar disorder, Current episode mixed, moderate
  - F31.63 Bipolar disorder, current episode mixed, severe, without psychotic features
  - F31.64 Bipolar disorder, current episode mixed, severe, with psychotic features
  - F31.71 Bipolar disorder, in partial remission, most recent episode hypomanic
  - F31.73 Bipolar I disorder, current or most recent episode hypomanic, inpartial remission

- F31.75 Bipolar I disorder, Current or most recent episode depressed, inpartial remission
- F31.77 Bipolar disorder, in partial remission, most recent episode mixedF31.81 Bipolar II disorder
- F31.89 Other specified bipolar and related disorder
- F31.9 Bipolar I disorder, current or most recent episode depressed, hypomanic or manic, unspecified or Unspecified bipolar and related disorder
- F33.1 Major depressive disorder, recurrent episode, moderate
- F33.2 Major depressive disorder, recurrent episode, severe
- F33.3 Major depressive disorder, recurrent episode, with psychotic features
- F33.41 Major depressive disorder, recurrent episode, in partial remission
- F33.9 Major depressive disorder, recurrent episode, unspecified
- F42.3 Hoarding disorder

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

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

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

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

i.	**Minimum number of services**. The minimum number of 1915(i) State plan services (one or more) that an individual must require in order to be determined to need the 1915(i) State plan HCBS benefit is: 1
ii.	**Frequency of services**. The state requires (select one):

○	**The provision of 1915(i) services at least monthly**
☑	**Monthly monitoring of the individual when services are furnished on a less than monthly basis** If the state also requires a minimum frequency for the provision of 1915(i) services other than monthly (e.g., quarterly), specify the frequency: *Every 90 days/Quarterly by the Community Mental Health Center. Monitoring can be face to face or telehealth, in accordance with Indiana Administrative Code. Face to face or telehealth should be based on what is clinically appropriate and the preferences of the individual receiving care. There must be at least one monitoring service that is conducted face to face during the 360 day package period, however other monitoring services should also be based on what is clinically appropriate and the preferences of the individual receiving care.*

Home and Community-Based Settings

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

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

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

Applicants that are interested in applying for Adult Mental Health Habilitation (AMHH) must receive their mental health services from one of the DMHA-approved CMHCs. HCBS requires the applicant reside in an HCBS compliant setting in order to receive HCBS services.

The majority of individuals receiving HCBS services reside in their own private/independent home while receiving mental health services. At this time, CMS has made the assumption that private/independent homes are compliant with the HCBS Final Settings Rule. In regard to residential and non-residential settings, DMHA Adult 1915(i) requires CMHC's to identify and notify DMHA of settings that an HCBS provider owns, controls and/or operates (POCO). The following are types of residential settings where an HCBS member can reside while receiving services through their CMHC:

1. Alternative family homes for adults- AFA
2. Supervised group living- SGL
3. Semi-independent living facility- SILP
4. Transitional residential living facility- TRS

When a provider notifies the DMHA State Evaluation Team (SET) of a new or previously unidentified CMHC POCO residential and non-residential setting, a provider self-assessment and, if required, a member survey is completed and return to the DMHA SET for review. Both the provider self-assessment and the member surveys were developed from the exploratory questions provided by Centers for Medicaid and Medicare Services (CMS). For CMHC POCO settings, the DMHA SET will review the provider and member survey responses to assess compliance with the HCBS Final Settings Rule. When there are non-compliant findings, the provider is required to complete a Setting Action Plan (SAP) which describes their plan to address the non-compliant findings in order to bring the setting into full compliance with the HCBS Final Settings Rule. For non-CMHC POCO settings that are under the authority of Division of Aging (DA) and/or Division of Disability and Rehabilitative Services (DDRS), assessment and compliance determinations are made by DA and/or DDRS. For settings that are neither a CMHC POCO nor a non-CMHC POCO, these settings are defined as non-POCO settings. The local CMHC works with the Setting Operating Authority (SOA) to assess the setting for HCBS compliance and address any non-compliant findings in order for the setting to come into compliance with the HCBS Settings Final Rule.

Person-Centered Planning & Service Delivery

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

1. ☑There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment meets federal requirements at 42 CFR §441.720.

2. ☑Based on the independent assessment, there is a person-centered service plan for each individual determined to be eligible for the State plan HCBS benefit. The person-centered service plan is developed using a person-centered service planning process in accordance with 42 CFR §441.725(a), and the written person-centered service plan meets federal requirements at 42 CFR §441.725(b).

3. ☑ The person-centered service plan is reviewed and revised upon reassessment of functional need as required under 42 CFR §441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.

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

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

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

Licensed professional means any of the following persons:

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

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

- an individual who has had at least two (2) years of clinical experience treating persons with mental illness under the supervision of a licensed professional, as defined above, such experience occurring after the completion of a master's degree or doctoral degree, or both, in any of the following disciplines:
  - in psychiatric or mental health nursing from an accredited university, plus a license as a registered nurse in Indiana;
  - in pastoral counseling from an accredited university; or
  - in rehabilitation counseling from an accredited university.
- an individual who is under the supervision of a licensed professional, as defined above, is eligible for and working toward licensure, and has completed a master's or doctoral degree, or both, in any of the following disciplines:
  - in social work from a university accredited by the Council on Social Work Education;
  - in psychology from an accredited university;
  - in mental health counseling from an accredited university; or
  - in marital and family therapy from an accredited university.
- a licensed independent practice school psychologist under the supervision of a licensed professional, as defined above.
- an authorized health care professional (AHCP), defined as follows:
  - a physician assistant with the authority to prescribe, dispense and administer drugs and medical devices or services under an agreement with a supervising physician and subject to the requirements of IC 25-27.5-5.
  - a nurse practitioner or a clinical nurse specialist, with prescriptive authority and performing duties within the scope of that person's license and under the supervision of, or under a supervisory agreement with, a licensed physician pursuant to IC 25-23-1.

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

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

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

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

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

The IICP is developed through a collaboration process that includes the applicant/recipient, identified community supports (family/nonprofessional caregivers), and all individuals/agency staff involved in assessing and/or providing care for the applicant/recipient. The IICP is a treatment plan that integrates all components and aspects of care that are deemed medically necessary, needs based, are clinically indicated, and are provided in the most appropriate setting to achieve the recipient's goals. An IICP must be developed with each applicant/recipient (405 IAC 5-21.5-16). The IICP must include all indicated medical and support services needed by the applicant/recipient in order to reside in the community, to function at the highest level of independence possible, and to achieve his/her goals.

The IICP is developed after completing a holistic clinical and bio-psychosocial assessment. The holistic assessment includes documentation in the applicant/recipient's medical record of the following:

- Review, discussion, and documentation of the applicant/recipient's desires, needs, and goals. Goals are recovery/habilitative in nature with outcomes specific to the habilitative needs identified by the applicant/recipient.
- Review of psychiatric symptoms and how they affect the applicant/recipient's functioning, and ability to attain desires, needs and goals.
- Review of the applicant/recipient's skills and the support needed for the applicant/recipient to participate in a long-term recovery process, including stabilization in the community and ability to function in the least restrictive living, working, and learning environments.
- Review of the applicant/recipient's strengths and needs, including medical, behavioral, social, housing, and employment.

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

The IICP must reflect the applicant/recipient's desires and choices. The applicant/recipient's signature demonstrating their participation in the development of an ongoing IICP reviews is required to be submitted to the SET. Infrequently, an applicant/recipient may request services but refuse to sign the IICP for various reasons (i.e. thought disorder, paranoia, etc.). If a recipient refuses to sign the IICP, the agency staff member is required to document on the plan of care that

the recipient agreed to the plan but refused to sign the plan. The agency staff member must also document in the clinical record progress notes that a planning meeting with the recipient did occur and that the IICP reflects the recipient's choice of services and agreement to participate in the services identified in the IICP. The progress note must further explain any known reasons why the recipient refused to sign the plan and how those will be addressed in the future.

Each eligible AMHH provider agency is required to ensure a written statement of rights is provided to each recipient. The statement shall include:
(1) The toll-free consumer service line number and the telephone number for Indiana Disability Rights.
(2) Document that agency staff provides both a written and an oral explanation of these rights to each applicant/recipient.

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

(1) The Indiana Disability Rights Line" (800-622-4845);
(2) The "Consumer Service Line" (800-901-1133)
(3) In-person to a DMHA staff member; or
(4) Via written complaint or email that is submitted to DMHA.

The IICP must also include the following documentation:

- Outline of goals that promote stability and potential movement toward independence and integration into the community, treatment of mental illness symptoms, and habilitating areas of functional deficits related to the mental illness.
- Individuals or teams responsible for treatment, coordination of care, linkage, and referrals to internal or external resources and care providers to meet identified needs.
- The plan must be person-centered and contain at a minimum, the types of services to be furnished, the amount, the frequency and duration of each service, and the provider to furnish each service,

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

The State maintains a network of Community Mental Health Centers (CMHCs). As a DMHA-approved AMHH provider agency, each CMHC is an enrolled Medicaid provider that offers a full continuum of behavioral health care services, as is mandated by DMHA for all CMHCs, in addition to providing AMHH services as documented in the Indiana benefit and this waiver. The care coordinator explains the process for making an informed choice of provider(s) and answers questions. The applicant/recipient is also advised that choice of providers and provider agencies is ongoing for the duration of the program. Therefore, providers within an agency and provider agencies themselves can be changed as necessary. As a service is identified, a list is generated in randomized sequence of qualified agency providers of the 1915(i) and is presented to the applicant/recipient by the care coordinator. A listing of approved/enrolled 1915(i) provider agencies is also posted on the Indiana Medicaid website at www.indianamedicaid.com. Applicants/recipients and family members may interview potential service providers and make their own choice.

This 1915(i) State Plan benefit is to run concurrently with the 1915(b)(4) Fee-For-Service Selective Contracting waiver (IN-02).

When accessing indianamedicaid.com website, the individual has a choice of a "Member" tab and "Provider" tab. The Member tab notes: *If you are an Indiana Medicaid Member or are interested in applying to becoming a Member, please click the "Member" tab.*

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

8. **Process for Making Person-Centered Service Plan Subject to the Approval of the Medicaid Agency**. *(Describe the process by which the person-centered service plan is made subject to the approval of the Medicaid agency):*

The Indiana Office of Medicaid Policy and Planning (OMPP) retains responsibility for service plan approvals made by the Division of Mental Health and Addiction (DMHA). As part of its routine operations, DMHA reviews each service plan submitted to OMPP to ensure that the plan addresses all pertinent issues identified through the assessment, including physical health issues.

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

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

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

Services

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

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

Service Title:	Adult Day Services

Service Definition (Scope):

Community-based group programs designed to meet the needs of adults with significant behavioral health impairments as identified in the IICPs. These comprehensive, non-residential programs provide health, wellness, social, and therapeutic activities. These services are provided in a structured, supportive environment. The services provide supervision, support services, and personal care as required by the IICP.

Service Requirements include:

- Direct service providers must be supervised by a licensed professional;
- Clinical oversight must be provided by a licensed physician, who is on-site at least once a week and available to program staff when not physically present;
- Each date of service must be appropriately documented.
- At minimum a weekly review and update of progress toward habilitative goals occurs and is documented in the recipient's clinical record;

- Adult Day Services that are included are:
  - care planning,
  - treatment,
  - monitoring of weight, blood glucose level, and blood pressure,
  - medication administration,
  - nutritional assessment and planning,
  - individual or group exercise training,
  - training in activities of daily living,
  - skill reinforcement on established skills, and
  - other social activities.

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

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☑	Categorically needy *(specify limits):*

	The service is offered in half day units, A single half-day (1/2 day) day unit is defined as one unit of a minimum of three (3) hours to a maximum of five (5) hours/day. Two units are defined as more than five (5) hours to a maximum of 8 hours/day. A maximum of two half-day (1/2 day) units/day is allowed up to 5 days per week. Exclusions: • Recipient receiving MRO services • Recipient receiving inpatient or partial hospitalization through the Clinic Option on the same day Services shall not be reimbursed when provided in a residential setting as defined by DMHA.
☐	Medically needy *(specify limits): N/A*

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Agency	N/A	DMHA-certified Community Mental Health Center (CMHC)	DMHA-approved AMHH provider agencies must meet DMHA and OMPP-defined criteria and standards, including the following: (A) Provider agency has acquired a National Accreditation by an entity approved by DMHA. (B) Provider agency is an enrolled Medicaid provider that offers a full-continuum of care. (C) Provider agency must maintain documentation in accordance with the Medicaid requirements defined under 405 IAC 1-5-1 and 405 IAC 1-5-3. (D) Provider agency must meet all AMHH provider agency criteria, as defined in the benefit and AMHH operating policy. In addition to meeting criteria for a provider agency, the agency must certify that individual agency staff providing an AMHH service must meet the following standards for this service, as follows: (A) Licensed professional; (B) QBHP; or (C) OBHP. Medication administration provided within Adult Day Services must be provided within the scope of practice as defined by federal and State law. Providers must meet the following qualifications: (A) physician;

			(B) authorized health care professional (AHCP); (C) registered nurse (RN); (D) licensed practical nurse (LPN) or (E) a medical assistant who has graduated from a two year clinical program Nutritional assessment and planning services must be provided by a certified dietician as defined in IC 25-14.5-1-4 and within the scope of practice as defined in state and federal law.

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):*
Agency	DMHA	Initially, and at the time of DMHA certification renewal.

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

☐	Participant-directed	☑	Provider managed

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

Service Title: Home and Community Based Habilitation and Support – Individual Setting

Service Definition (Scope)*:*

Individualized face-to-face services directed at the health, safety and welfare of the recipient and assisting in the management, adaptation and/or retention of skills necessary to support recipients to live successfully in the most integrated setting appropriate to the recipient's needs. Assist recipient to gain an understanding of/and self-management of behavioral and medical health conditions. Services are provided in the recipient's home (living environment) or other community-based settings outside of a clinic/office environment. Skills training as used in this service description means: Assisting in the reinforcement, management, adaptation and/ or retention of skills necessary to live successfully in the community.

- Service requires face-to-face contact in an individual setting.
- Recipients are expected to benefit from services.
- Services must be goal-oriented and related to the IICP.
- Activities include implementation of the individualized support plan, assistance with personal care, coordination and facilitation of medical and non-medical services to meet healthcare needs.
- Services that are included:
  - Skills training in food planning and preparation, money management, maintenance of living environment.
  - Training in appropriate use of community services.

- Training in skills needed to locate and maintain a home, renter skills training including landlord/tenant negotiations, budgeting to meet housing and housing-related expenses, how tolocate and interview prospective roommates, and renter's rights and responsibilities training.

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

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☑ Categorically needy *(specify limits):*

Home and Community Based Habilitation and Support, including all subtypes (individual, group, family/couple, with and without recipient present) may be provided for up to a total of six (6) hours per day (twenty-four 15-minute units per day).

Exclusions:

- Recipient receiving MRO services
- Recipients in partial hospitalization or inpatient hospitalization on the same day

☐ Medically needy *(specify limits): N/A*

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Agency	N/A	DMHA-certified Community Mental Health Center (CMHC)	DMHA-approved AMHH provider agencies must meet DMHA and OMPP-defined criteria and standards, including the following: (A) Provider agency has acquired a National Accreditation by an entity approved by DMHA. (B) Provider agency is an enrolled Medicaid provider that offers a full continuum of care. (C) Provider agency must maintain documentation in accordance with the Medicaid requirements defined under 405 IAC 1-5-1 and 405 IAC 1-5-3. (D) Provider agency must meet all AMHH provider agency criteria, as defined in the benefit and AMHH operating policy. In addition to meeting criteria for a provider agency, the agency must certify that agency staff providing an AMHH

			service must meet the following standards for this service, as follows: (A) Licensed professional; (B) QBHP; or (C) OBHP.

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):*
Agency	DMHA	Initially and at time of DMHA certification renewal

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

☐	Participant-directed	☑	Provider managed

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

Service Title:	Home and Community Based Habilitation and Support – Family/Couple with the Recipient Present – Individual Setting

Service Definition (Scope)*: Definition*

Individualized face-to-face services directed at the health, safety and welfare of the recipient and assisting in the acquisition, improvement, and retention of skills necessary to support recipients to live successfully in the community. Training and education to instruct a parent, or other family member, or primary caregiver about the treatment regimens appropriate to the recipient; and to improve the ability of the parent, family member or primary caregiver to provide the care to or for the recipient. Skills training as used in this service description means: Assisting in the reinforcement, management, adaptation and/ or retention of skills necessary to live successfully in the community.

Service Requirements include:

- Service requires face-to-face contact in an individual setting.
- Recipients are expected to show benefit from services.
- Services must be goal-oriented and related to the IICP.
- Activities include implementation of the individualized support plan, assistance with personal care, coordination and facilitation of medical and non-medical services to meet healthcare needs.

- Services that are included:
    - Skills training in food planning and preparation, money management, maintenance of living environment.
    - Training in appropriate use of community services.
    - Medication-related education and training by non-medical staff
    - Training in skills needed to locate and maintain a home, renter skills training including landlord/tenant negotiations, budgeting to meet housing and housing-related expenses, how to locateand interview prospective roommates, and renter's rights and responsibilities training.

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

Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*	
☑	Categorically needy *(specify limits): Insert Program Standards*
	Home and Community Based Habilitation and Support, including all subtypes (individual, group, family/couple, with and without recipient present) may be provided for up to a total of six (6) hours per day (twenty-four 15-minute units per day). Exclusions: • Recipients receiving MRO services • Recipients in partial hospitalization or inpatient hospitalization on the same day
☐	Medically needy *(specify limits): N/A*

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Agency	N/A	DMHA - certified Community Mental Health Center (CMHC)	DMHA-approved AMHH provider agencies must meet DMHA and OMPP-defined criteria and standards, including the following: (A) Provider agency has acquired a National Accreditation by an entity approved by DMHA. (B) Provider agency is an enrolled Medicaid provider that offers a full continuum of care. (C) Provider agency must maintain documentation in accordance with the Medicaid requirements defined under 405 IAC 1-5-1 and 405 IAC 1-5-3. (D) Provider agency must meet all AMHH provider agency criteria, as defined in the benefit and AMHH operating policy. In addition to meeting criteria for a provider agency, the agency must certify that the agency staff providing an AMHH service must meet the following standards for this service, as follows: (A) Licensed professional; (B) QBHP; or (C) OBHP.

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):*

Agency	DMHA	Initially, and at the time of DMHA certification renewal.

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

☐	Participant-directed	☑	Provider managed

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

Service Title:	Home and Community Based Habilitation and Support – Family/Couple without the Recipient Present – Individual Setting

Service Definition (Scope):

Skills training and education instructs a parent, or other family member, or primary caregiver about the treatment regimens appropriate to the recipient; and how to improve the ability of the parent, family member or primary caregiver to more effectively assist the beneficiary in learning/implementing skills for activities of daily living. This service includes individualized face-to-face services directed at the health, safety and welfare of the recipient and assisting in the acquisition, improvement, and retention of skills necessary to support recipients to live successfully in the community. Skills training as used in this service description means: Assisting in the reinforcement, management, adaptation and/ or retention of skills necessary to live successfully in the community.

Service Requirements include:

- Service requires face-to-face contact with family members or non-professional caregivers in an individual setting.
- Recipients are expected to show benefit from services.
- Services must be goal-oriented and related to the IICP.
- Activities include implementation of the individualized support plan, assistance with personal care, coordination and facilitation of medical and non-medical services to meet healthcare needs.

Services that are included:

- Skills training in food planning and preparation, money management, maintenance of living environment.
- Training in appropriate use of community services
- Medication-related education and training by non-medical staff.
- Training in skills needed to locate and maintain a home, renter skills training including landlord/tenant negotiations, budgeting to meet housing and housing-related expenses, how to locateand interview prospective roommates, and renter's rights and responsibilities training.

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

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):	
☑	Categorically needy *(specify limits):*
	Home and Community Based Habilitation and Support, including all subtypes (individual, group, family/couple, with and without recipient present) may be provided for up to a total of six (6) hours per day (twenty-four 15-minute units per day). Exclusions: • Recipients receiving MRO services • Recipients in partial hospitalization or inpatient hospitalization on the same day
☐	Medically needy *(specify limits):N/A*

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Agency	N/A	DMHA-certified Community Mental Health Center (CMHC)	DMHA-approved AMHH provider agencies must meet DMHA and OMPP-defined criteria and standards, including the following: (A) Provider agency has acquired a National Accreditation by an entity approved by DMHA. (B) Provider agency is an enrolled Medicaid provider that offers a full continuum of care. (C) Provider agency must maintain documentation in accordance with the Medicaid requirements defined under 405 IAC 1-5-1 and 405 IAC 1-5-3. (D) Provider agency must meet all AMHH provider agency criteria, as defined in the benefit and AMHH operating policy. In addition to meeting criteria for a provider agency, the agency must certify that the agency staff providing an AMHH service must meet the following standards for this service, as follows: (A) Licensed professional; (B) QBHP; or (C) OBHP.

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):*

Agency	DMHA	Initially, and at the time of DMHA certification renewal.

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

☐	Participant-directed	☑	Provider managed

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

Service Title: Home and Community Based Habilitation and Support – Group Setting

Service Definition (Scope):

Face-to-face services provided in a group setting directed at the health, safety and welfare of the recipient and assisting in the management, adaptation and/or retention of skills necessary to support recipients to live successfully in the most integrated setting appropriate to the recipient's needs. Assisting recipients to gain an understanding of/and self-management of behavioral and medical health conditions. Services are provided in the recipient's home (living environment) or other community based settings outside of a clinic/office environment. Skills training as used in this service description means: Assisting in the reinforcement, management, adaptation and/ or retention of skills necessary to live successfully in the community.

Service Requirements include:

- Recipients are expected to show benefit from services.
- Services must be goal-oriented and related to the IICP.
- Activities include implementation of the individualized support plan, assistance with personal care, coordination and facilitation of medical and non-medical services to meet healthcare needs.

Services that are included:

- Skills training in food planning and preparation, money management, maintenance of living environment.
- Training in appropriate use of community services.
- Medication-related education and training by non-medical staff.
- Training in skills needed to locate and maintain a home, renter skills training include landlord/tenantnegotiations, budgeting to meet housing and housing-related expenses, how to locate and interview prospective roommates, and renter's rights and responsibilities training.

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

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☑	Categorically needy *(specify limits):*

	Home and Community Based Habilitation and Support, including all subtypes (individual, group, family/couple, with and without consumer present) may be provided for up to a total of six (6) hours per day (twenty-four 15- minute units per day). Exclusions: • Recipients receiving MRO services • Recipients in partial hospitalization or inpatient hospitalization on the same day
☐	Medically needy *(specify limits):N/A*

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Agency	N/A	DMHA-certified Community Mental Health Center (CMHC)	DMHA-approved AMHH provider agencies must meet DMHA and OMPP-defined criteria and standards, including the following: (A) Provider agency has acquired a National Accreditation by an entity approved by DMHA. (B) Provider agency is an enrolled Medicaid provider that offers a full continuum of care. (C) Provider agency must maintain documentation in accordance with the Medicaid requirements defined under 405 IAC 1-5-1 and 405 IAC 1-5-3. (D) Provider agency must meet all AMHH provider agency criteria, as defined in the benefit and AMHH operating policy. In addition to meeting criteria for a provider agency, the agency must certify that the agency staff providing an AMHH service must meet the following standards for this service, as follows: (A) Licensed professional; (B) QBHP; or (C) OBHP.

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):*

Agency	DMHA	Initially, and at the time of DMHA certification renewal.

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

☐	Participant-directed	☑	Provider managed

Service Title:	Home and Community Based Habilitation and Support – Family/Couple with Recipient Present (Group Setting)

Service Definition (Scope)*: Definition*

Face-to-face services provided in a group setting directed at the health, safety and welfare of the recipient and assist in the management, adaptation and/or retention of skills necessary to support recipients to live successfully in the most integrated setting appropriate to the recipient's needs. Training and education to instruct a parent, or other family member, or primary caregiver about the treatment regimens appropriate to the recipient; and to improve the ability of the parent, family member or primary caregiver to provide the care to or for the recipient. Skills training as used in this service description means: Assisting in the reinforcement, management, adaptation and/ or retention of skills necessary to live successfully in the community.

Service Requirements include:

- Service requires face-to-face contact in a group setting.
- Recipients are expected to show benefit from services.
- Services must be goal-oriented and related to the IICP.
- Activities include implementation of the individualized support plan, assistance with personal care, coordination and facilitation of medical and non-medical services to meet healthcare needs.
- Services that are included:
  - Skills training in food planning and preparation, money management, maintenance of living environment.
  - Training in appropriate use of community services.
  - Medication-related education and training by non-medical staff.
  - Training in skills needed to locate and maintain a home, renter skills training including landlord/tenant negotiations, budgeting to meet housing and housing-related expenses, how to locateand interview prospective roommates, and renter's rights and responsibilities training.

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

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

☑	Categorically needy *(specify limits):*
	Home and Community Based Habilitation and Support, including all subtypes (individual, group, family/couple, with and without recipient present) may be provided for up to a total of six (6) hours per day (twenty-four 15-minute units per day). Exclusions: • Recipients receiving MRO services • Recipients in partial hospitalization or inpatient hospitalization on the same day

☐	Medically needy *(specify limits):N/A*

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Agency	N/A	DMHA-certified Community Mental Health Center (CMHC)	DMHA-approved AMHH provider agencies must meet DMHA and OMPP-defined criteria and standards, including the following: (A) Provider agency has acquired a National Accreditation by an entity approved by DMHA. (B) Provider agency is an enrolled Medicaid provider that offers a full continuum of care. (C) Provider agency must maintain documentation in accordance with the Medicaid requirements defined under 405 IAC 1-5-1 and 405 IAC 1-5-3. (D) Provider agency must meet all AMHH provider agency criteria, as defined in the benefit and AMHH operating policy. In addition to meeting criteria for a provider agency, the agency must certify that the agency staff providing an AMHH service must meet the following standards for this service, as follows: (A) Licensed professional; (B) QBHP; or (C) OBHP.

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):*
Agency	DMHA	Initially, and at the time of DMHA certification renewal.

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

☐	Participant-directed	☑	Provider managed

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

Service Title:	Home and Community Based Habilitation and Support – Family/Couple without Recipient Present (Group Setting)

Service Definition (Scope)*: Definition*

Skills training and education in a group setting instructs a parent, or other family member, or primary caregiver about the treatment regimens appropriate to the recipient; and to improve the ability of the parent, family member or primary caregiver to effectively assist the beneficiary in learning/implementing skills for activities of daily living. This service includes individualized face-to-face services with the family or nonprofessional caregivers directed at the health, safety and welfare of the recipient and assisting in the acquisition, improvement, and retention of skills necessary to support recipients to live successfully in the community.

Home and Community Based Habilitation and Support – Family/Couple without the recipient present (group setting) involves face-to-face contact with the family or nonprofessional caregivers that result in the recipient's development and/or retention of skills (for example, self-care, daily life management, or problem-solving skills), in a group setting. The service is focused on the health, safety and welfare of the recipient and assisting in the acquisition, improvement, and retention of skills necessary to support recipients to live successfully in the community. This service is provided through structured interventions for attaining goals identified in the IICP and the monitoring of the recipient's progress in achieving those skills.

Skills training as used in this service description means: Assisting in the reinforcement, management, adaptation and/ or retention of skills necessary to live successfully in the community.

Service Requirements include:

- Service requires face-to-face contact in a group setting.
- Recipients are expected to show benefit from services.
- Services must be goal-oriented and related to the IICP.
- Activities include implementation of the individualized support plan, assistance with personal care, coordination and facilitation of medical and non-medical services to meet healthcare needs.
- Services that are included:
  - Skills training in food planning and preparation, money management, maintenance of living environment.
  - Training in appropriate use of community services
  - Medication-related education and training by non-medical staff.
  - Training in skills needed to locate and maintain a home, renter skills training include landlord/tenantnegotiations, budgeting to meet housing and housing-related expenses, how to locate and interview prospective roommates, and renter's rights and responsibilities training.

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

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

☑ Categorically needy *(specify limits): Insert Program Standards*

Home and Community Based Habilitation and Support, including all subtypes (individual, group, family/couple, with and without recipient present) may be provided for up to a total of six (6) hours per day (twenty-four 15-minute units per day).

Exclusions:

- Recipients receiving MRO services
- Recipients in partial hospitalization or inpatient hospitalization on the same day

☐	Medically needy *(specify limits): N/A*

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Agency	N/A	DMHA-certified Community Mental Health Center (CMHC)	DMHA-approved AMHH provider agencies must meet DMHA and OMPP-defined criteria and standards, including the following: (A) Provider agency has acquired a National Accreditation by an entity approved by DMHA. (B) Provider agency is an enrolled Medicaid provider that offers a full continuum of care. (C) Provider agency must maintain documentation in accordance with the Medicaid requirements defined under 405 IAC 1-5-1 and 405 IAC 1-5-3. (D) Provider agency must meet all AMHH provider agency criteria, as defined in the benefit and AMHH operating policy. In addition to meeting criteria for a provider agency, the agency must certify that the agency staff providing an AMHH service must meet the following standards for this service, as follows: (A) Licensed professional; (B) QBHP; or (C) OBHP.

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):*
Agency	DMHA	Initially, and at the time of DMHA certification renewal.

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

☐	Participant-directed	☑	Provider managed

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):

Services provided to recipients who are unable to care for themselves and are living with a non-professional (unpaid) caregiver. These services are furnished on a short-term basis because of the non-professional caregiver's absence or need for relief. These services can be provided in the recipient's home or place of residence, in the caregiver's home, or in a non-private residential setting (such as a group home or adult foster care).

Service Requirements include:

- Recipient must be living with a non-professional (unpaid) caregiver.
- Location of service and level of professional care is based on the needs of the recipient receiving the service including regular monitoring of medications or behavioral symptoms as identified in the IICP.
- Service must be provided in the least restrictive environment available and ensure the health and welfare of the recipient.

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

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☑ Categorically needy *(specify limits):*

This service is offered at a 15-minute unit rate for up to seven (7) hours (28 15-minute units) per day and a maximum of 75 hours per year (300 15-minute units). Eight (8) hours to 24 hours of Respite Care a day is offered at the daily rate. Respite care may be provided for up to 14 consecutive days for a maximum of 28 days during any year.

Exclusions:

- Shall not be used as care to allow the persons normally providing care to go to work or attend school.
- Services provided to a recipient living in a DMHA licensed residential facility.
- Services provided to a recipient living in supportive housing.
- Respite care must not duplicate any other service being provided under the recipient's IICP.

☐ Medically needy *(specify limits): N/A*

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Agency	N/A	DMHA-certified Community Mental Health Center (CMHC)	DMHA-approved AMHH provider agencies must meet DMHA and OMPP-defined criteria and standards, including the following: (A) Provider agency has acquired a National Accreditation by an entity approved by DMHA. (B) Provider agency is an enrolled

			Medicaid provider that offers a full continuum of care. (C) Provider agency must maintain documentation in accordance with the Medicaid requirements defined under 405 IAC 1-5-1 and 405 IAC 1-5-3. (D) Provider agency must meet all AMHH provider agency criteria, as defined in the benefit and AMHH operating policy. In addition to meeting criteria for a provider agency, the agency must certify that the agency staff providing an AMHH service must meet the following standards for this service, as follows: (A) Licensed professional; (B) QBHP; or (C) OBHP. Medication administration and medical support services provided within Respite Care must be provided within the scope of practice as defined by federal and state law. Providers must meet the following qualifications: (A) Physician; (B) Advanced Practice Nurse (APN); (C) Physician Assistant (PA); (D) Registered Nurse (RN); or (E) Licensed Practical Nurse (LPN).

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):*
Agency	DMHA	Initially, and at the time of DMHA certification renewal.

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

☐	Participant-directed	☑	Provider managed

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

Service Title:	Therapy and Behavioral Support Services – Individual Setting
Service Definition (Scope)*:*	

Therapy and behavioral support services is a series of time-limited, structured, face-to-face sessions that work toward the goals identified in the individualized integrated care plan. Therapy and behavioral support services must be provided at the recipient's home (living environment) or at other locations outside the clinic setting.

Service Requirements include:

- The Medicaid identified recipient is the focus of the treatment.
- Documentation must support how the service specifically benefits the identified recipient.
- Therapy / behavioral support services must demonstrate progress toward and/or achievement of individual treatment goals.
- Therapy / behavioral support services goals must be habilitative in nature.
- Observation of the recipient in personal environment for purpose of care plan development.
- Development of a person-centered behavioral support plan and subsequent revisions which maybe a part of the individualized integrated care plan.
- Implementation of the behavior support plan for staff, family members, roommates, and other appropriate individuals.
- Allowable training activities include:
  - Assertiveness,
  - stress reduction techniques, and
  - the acquisition of socially accepted behaviors.

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

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☑ Categorically needy *(specify limits):*

Individual setting Therapy and Behavioral Support service, including all three (3) subtypes (individual, family/couple, with and without recipient present) may be provided for a maximum of 75 hours (300 15-minute units) per year.

Exclusions:

- Recipients receiving MRO services.
- Recipients in partial hospitalization or inpatient hospitalization on the same day.
- Therapy services provided in a clinic setting are not billable under the 1915(i) but may qualify for reimbursement under the clinic option.

☐ Medically needy *(specify limits): N/A*

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*

Agency	N/A	DMHA-certified Community Mental Health Center (CMHC)	DMHA-approved AMHH provider agencies must meet DMHA and OMPP-defined criteria and standards, including the following: (A) Provider agency has acquired a National Accreditation by an entity approved by DMHA. (B) Provider agency is an enrolled Medicaid provider that offers a full continuum of care. (C) Provider agency must maintain documentation in accordance with the Medicaid requirements defined under 405 IAC 1-5-1 and 405 IAC 1-5-3. (D) Provider agency must meet all AMHH provider agency criteria, as defined in the benefit and AMHH operating policy. In addition to meeting criteria for a provider agency, the agency must certify that the agency staff providing an AMHH service must meet the following standards for this service, as follows: (A) Licensed professional, except for a licensed clinical addiction counselor, as defined under IC 25-23.6-10.5; or (B) QBHP.

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):*
Agency	DMHA	Initially, and at the time of DMHA certification renewal.

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

☐	Participant-directed	☑	Provider managed

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

Service Title:	Therapy and Behavioral Support Services – Family/Couple with the Recipient Present (Individual Setting)

Service Definition (Scope)*:*

Family/Couple Counseling and Therapy with the recipient present is a series of time-limited, structured, face-to-face sessions that work toward the goals identified in the individualized integrated care plan. The face-to-face interaction may be with the recipient and family members or non-professional caregivers in an individual setting. Family/Couple Counseling and Therapy must be provided at home (living environment) or other locations outside the clinic setting.

Service Requirements include:

- The Medicaid identified recipient is the focus of the treatment.
- Documentation must support how the service specifically benefits the identified recipient.
- Therapy/behavioral support services must demonstrate progress toward and/or achievement of individual treatment goals.
- Therapy/behavioral support services goals must be habilitative in nature.
- Observation of the recipient in their environment for purpose of care plan development.
- Development of a person-centered behavioral support plan and subsequent revisions which maybe a part of the individualized integrated care plan
- Implementation of the behavior support plan for staff, family members, roommates, and other appropriate individuals
- Allowable training activities include:
    - Assertiveness,
    - stress reduction techniques, and
    - the acquisition of socially accepted behaviors

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

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☑ Categorically needy *(specify limits):*

Individual setting, Therapy and Behavioral Support service, including all three (3) subtypes (individual, family/couple, with and without recipient present) may be provided for a maximum of 75 hours (300 15-minute units) per year.

Exclusions:

- Recipients receiving MRO services
- Recipients in partial hospitalization or inpatient hospitalization on the same day
- Therapy services provided in a clinic setting are not billable under the 1915(i) but may qualify for reimbursement under the clinic option

☐ Medically needy *(specify limits): N/A*

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*

Agency	N/A	DMHA-certified Community Mental Health Center (CMHC)	DMHA-approved AMHH provider agencies must meet DMHA and OMPP-defined criteria and standards, including the following: (A) Provider agency has acquired a National Accreditation by an entity approved by DMHA. (B) Provider agency is an enrolled Medicaid provider that offers a full continuum of care. (C) Provider agency must maintain documentation in accordance with the Medicaid requirements defined under 405 IAC 1-5-1 and 405 IAC 1-5-3. (D) Provider agency must meet all AMHH provider agency criteria, as defined in the benefit and AMHH operating policy. In addition to meeting criteria for a provider agency, the agency must certify that the agency staff providing an AMHH service must meet the following standards for this service, as follows: (A) Licensed professional, except for a licensed clinical addiction counselor, as defined under IC 25-23.6-10.5; or (B) QBHP.

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):*
Agency	DMHA	Initially, and at the time of DMHA certification renewal.

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

☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	Therapy and Behavioral Support Services – Family/Couple without the Recipient Present (Individual Setting)
Service Definition (Scope)*:*	

Family/Couple Counseling and Therapy without the recipient present is a series of time-limited, structured, face-to-face sessions that work toward the goals identified in the individualized integrated care plan. Skills training and education is for the family/couple to more effectively assist the beneficiary in learning/implementing these skills. The face-to-face interaction may be with family members or non-professional caregivers in an individual setting. Family/Couple Counseling and Therapy must be provided at home (living environment) or other locations outside the clinic setting.

Service Requirements include:

- The Medicaid identified recipient is the focus of the treatment.
- Documentation must support how the service specifically benefits the identified recipient.
- Therapy/behavioral support services must demonstrate progress toward and/or achievement of individual treatment goals.
- Therapy/behavioral support services goals must be habilitative in nature.
- Observation of the recipient in their environment for purpose of care plan development.
- Development of a person-centered behavioral support plan and subsequent revisions which may be a part of the individualized integrated care plan.
- Implementation of the behavior support plan for staff, family members, roommates, and other appropriate individuals.
- Allowable training activities include:
    - Assertiveness,
    - stress reduction techniques, and
    - the acquisition of socially accepted behaviors.

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

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☑ Categorically needy *(specify limits):*

Individual setting, Therapy and Behavioral Support service, including all three (3) subtypes (individual, family/couple, with and without recipient present) may be provided for a maximum of 75 hours (300 15-minute units) per year.

Exclusions:

- Recipients receiving MRO services.
- Recipients in partial hospitalization or inpatient hospitalization on the same day.
- Therapy services provided in a clinic setting are not billable under the 1915(i) but may qualify for reimbursement under the clinic option.

☐ Medically needy *(specify limits): N/A*

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*

Agency	N/A	DMHA-certified Community Mental Health Center (CMHC)	DMHA-approved AMHH provider agencies must meet DMHA and OMPP-defined criteria and standards, including the following: (A) Provider agency has acquired a National Accreditation by an entity approved by DMHA. (B) Provider agency is an enrolled Medicaid provider that offers a full continuum of care. (C) Provider agency must maintain documentation in accordance with the Medicaid requirements defined under 405 IAC 1-5-1 and 405 IAC 1-5-3. (D) Provider agency must meet all AMHH provider agency criteria, as defined in the benefit and AMHH operating policy. In addition to meeting criteria for a provider agency, the agency must certify that the agency staff providing an AMHH service must meet the following standards for this service, as follows: (A) Licensed professional, except for a licensed clinical addiction counselor, as defined under IC 25-23.6-10.5; or (B) QBHP.

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):*
Agency	DMHA	Initially, and at the time of DMHA certification renewal

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

☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):*	
Service Title:	Therapy and Behavioral Support Services – Group Setting
Service Definition (Scope)*:*	
Group Counseling and Therapy is a series of time-limited, structured, face-to-face sessions that work toward the goals identified in the individualized integrated care plan. Group Counseling and Therapy	

must be provided at the recipient's home (living environment) or at other locations outside the clinic setting.

Service Requirements include:

- The Medicaid identified recipient is the focus of the treatment.
- Documentation must support how the service specifically benefits the identified recipient.
- Therapy/behavioral support services must demonstrate progress toward and/or achievement of individual treatment goals.
- Therapy/behavioral support services goals must be habilitative in nature.
- Observation of the recipient in their environment for purpose of care plan development.
- Development of a person-centered behavioral support plan and subsequent revisions which may be a part of the individualized integrated care plan.
- Implementation of the behavior support plan for staff, family members, roommates, and other appropriate individuals.
- Allowable training activities include:
  - Assertiveness,
  - stress reduction techniques, and
  - the acquisition of socially accepted behaviors.

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

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

☑ Categorically needy *(specify limits):*

Group setting, Therapy and Behavioral Support service, including all three (3) subtypes (group with recipient, and group with family/couple, with and without recipient present) may be provided for a maximum of 75 hours (300 15-minute units) per year.

Exclusions:

- Recipients receiving MRO services.
- Recipients in partial hospitalization or inpatient hospitalization on the same day.
- Therapy services provided in a clinic setting are not billable under the 1915(i) but may qualify for reimbursement under the clinic option.

☐ Medically needy *(specify limits): N/A*

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Agency	N/A	DMHA-certified Community Mental Health Center (CMHC)	DMHA-approved AMHH provider agencies must meet DMHA and OMPP-defined criteria and standards, including the following: (A) Provider agency has acquired a National Accreditation by an entity approved by DMHA. (B) Provider agency is an enrolled Medicaid provider that offers a full continuum of care. (C) Provider agency must maintain documentation in accordance

			with the Medicaid requirements defined under 405 IAC 1-5-1 and 405 IAC 1-5-3. (D) Provider agency must meet all AMHH provider agency criteria, as defined in the benefit and AMHH operating policy. In addition to meeting criteria for a provider agency, the agency must certify that the agency staff providing an AMHH service must meet the following standards for this service, as follows: (A) Licensed professional, except for a licensed clinical addiction counselor, as defined under IC 25-23.6-10.5; or (B) QBHP.

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):*
Agency	DMHA	Initially, and at the time of DMHA certification renewal.

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

☐	Participant-directed	☑	Provider managed

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

Service Title:	Therapy and Behavioral Support Services – Family/Couple with Recipient Present (Group Setting)

Service Definition (Scope)*:*

Family/Couple Counseling and Therapy with the recipient present is a series of time-limited, structured, face-to-face sessions that work toward the goals identified in the individualized integrated care plan. The face-to-face interaction may be with the recipient and family members or non-professional caregivers in a group setting. Family/Couple Counseling and Therapy must be provided at home (living environment) or other locations outside the clinic setting.

Service Requirements include:

- The Medicaid identified recipient is the focus of the treatment.
- Documentation must support how the service specifically benefits the identified recipient.
- Therapy / behavioral support services must demonstrate progress toward and/or achievement of individual treatment goals.
- Therapy / behavioral support services goals must be habilitative in nature.
- Observation of the recipient in their environment for purpose of care plan development.

- Development of a person-centered behavioral support plan and subsequent revisions which may bea part of the individualized integrated care plan.
- Implementation of the behavior support plan for staff, family members, roommates, and other appropriate individuals
- Allowable training activities include:
  - Assertiveness;
  - stress reduction techniques;
  - the acquisition of socially accepted behaviors.

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

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

☑ Categorically needy *(specify limits):*

Group setting Therapy and Behavioral Support service, including all three (3) subtypes (group with recipient, and group with family/couple, with and without recipient present) may be provided for a maximum of 75 hours (300 15-minute units) per year.

Exclusions:

- Recipients receiving MRO services.
- Recipients in partial hospitalization or inpatient hospitalization on the same day.
- Therapy services provided in a clinic setting are not billable under the 1915(i) but may qualify for reimbursement under the clinic option.

☐ Medically needy *(specify limits): N/A*

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Agency	N/A	DMHA-certified Community Mental Health Center (CMHC)	DMHA-approved AMHH provider agencies must meet DMHA and OMPP-defined criteria and standards, including the following: (A) Provider agency has acquired a National Accreditation by an entity approved by DMHA. (B) Provider agency is an enrolled Medicaid provider that offers a full continuum of care. (C) Provider agency must maintain documentation in accordance with the Medicaid requirements defined under 405 IAC 1-5-1 and 405 IAC 1-5-3. (D) Provider agency must meet all AMHH provider agency criteria, as defined in the benefit and AMHH operating policy. In addition to meeting criteria for a provider agency, the agency must certify

			that the agency staff providing an AMHH service must meet the following standards for this service, as follows: (A) Licensed professional, except for a licensed clinical addiction counselor, as defined under IC 25-23.6-10.5; or (B) QBHP.

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):*
Agency	DMHA	Initially, and at the time of DMHA certification renewal.

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

☐	Participant-directed	☑	Provider managed

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

Service Title:	Therapy and Behavioral Support Services – Family/Couple without Recipient Present (Group Setting)

Service Definition (Scope)*:*

Family/Couple Counseling and Therapy without the recipient present is a series of time-limited, structured, face-to-face sessions that work toward the goals of the recipient identified in the individualized integrated care plan. Skills training and education is for the family/couple to more effectively assist the beneficiary in learning/implementing these skills. The face-to-face interaction may be with family members or non-professional caregivers in a group setting. Family/Couple Counseling and Therapy must be provided at home (living environment) or other locations outside the clinic setting.

Service Requirements include:

- The Medicaid identified recipient is the focus of the treatment.
- Documentation must support how the service specifically benefits the identified recipient.
- Therapy / behavioral support services must demonstrate progress toward and/or achievement of individual treatment goals.
- Therapy / behavioral support services goals must be habilitative in nature.
- Observation of the recipient in their environment for purpose of care plan development.
- Development of a person-centered behavioral support plan and subsequent revisions which may be a part of the individualized integrated care plan.
- Implementation of the behavior support plan for staff, family members, roommates, and other appropriate individuals.
- Allowable training activities include:
    - Assertiveness,
    - stress reduction techniques, and.

o the acquisition of socially accepted behaviors	
Additional needs-based criteria for receiving the service, if applicable *(specify): N/A*	
Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*	
☑	Categorically needy *(specify limits):*
	Group setting Therapy and Behavioral Support service, including all three (3) subtypes (group with recipient, and group with family/couple, with and without recipient present) may be provided for a maximum of 75 hours (300 15-minute units) per year. Exclusions: • Recipients receiving MRO services. • Recipient in partial hospitalization or inpatient hospitalization on the same day. • Therapy services provided in a clinic setting are not billable under the 1915(i) but may qualify for reimbursement under the clinic option.
☐	Medically needy *(specify limits): N/A*

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Agency	N/A	DMHA-certified Community Mental Health Center (CMHC)	DMHA-approved AMHH provider agencies must meet DMHA and OMPP-defined criteria and standards, including the following: (A) Provider agency has acquired a National Accreditation by an entity approved by DMHA. (B) Provider agency is an enrolled Medicaid provider that offers a full continuum of care. (C) Provider agency must maintain documentation in accordance with the Medicaid requirements defined under 405 IAC 1-5-1 and 405 IAC 1-5-3. (D) Provider agency must meet all AMHH provider agency criteria, as defined in the benefit and AMHH operating policy. In addition to meeting criteria for a provider agency, the agency must certify that the agency staff providing an AMHH service must meet the following standards for this service, as follows: (A) Licensed professional, except for a licensed clinical addiction counselor, as defined under IC 25-23.6-10.5; or

			(B) QBHP.

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):*
Agency	DMHA	Initially, and at the time of DMHA certification renewal.

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

☐	Participant-directed	☑	Provider managed

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

Service Title: Addiction Counseling – Individual Setting

Service Definition (Scope)*:*

Individual Addiction Counseling is a planned and organized face-to-face service with the recipient where addiction professionals and other clinicians provide counseling intervention that works toward the recipient's recovery goals identified in the IICP.

Service Requirements include:

- The recipient is the focus of Addiction Counseling.
- Documentation must support how Addiction Counseling benefits the recipient.
- Addiction Counseling requires face-to-face contact with the recipient.
- Addiction Counseling consists of regularly scheduled sessions.
- Counseling must demonstrate progress towards and/or achievement of goals identified in the IICP.
- Referral to available community recovery support programs is available.
- Addiction Counseling includes the following:
    - Education on addiction disorders.
    - Skills training in communication, anger management, stress management, relapse prevention.

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

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

☑ Categorically needy *(specify limits):*

The combined total of individual and group Addiction Counseling service may be provided for a maximum of 75 hours (1 hour = 1 unit) per year.

Exclusions:

- Recipients with withdrawal risk/symptoms whose needs cannot be managed at this level of care or who need detoxification services.
- Recipients at risk of harm to self or others.
- Addiction counseling sessions that consist of only education services are not reimbursed.

☐	Medically needy *(specify limits): N/A*

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Agency	N/A	DMHA-certified Community Mental Health Center (CMHC)	DMHA-approved AMHH provider agencies must meet DMHA and OMPP-defined criteria and standards, including the following: (A) Provider agency has acquired a National Accreditation by an entity approved by DMHA. (B) Provider agency is an enrolled Medicaid provider that offers a full continuum of care. (C) Provider agency must maintain documentation in accordance with the Medicaid requirements defined under 405 IAC 1-5-1 and 405 IAC 1-5-3. (D) Provider agency must meet all AMHH provider agency criteria, as defined in the benefit and AMHH operating policy. In addition to meeting criteria for a provider agency, the agency must certify that the agency staff providing an AMHH service must meet the following standards for this service, as follows: (A) Licensed professional; (B) QBHP.

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):*
Agency	DMHA	Initially, and at the time of DMHA certification renewal.

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

☐	Participant-directed	☑	Provider managed

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

Service Title:	Addiction Counseling – Family/Couple with Recipient Present (Individual Setting)
Service Definition (Scope):	

Family/Couple Addiction Counseling is a planned and organized face-to-face service with the recipient, where addiction professionals and other clinicians provide counseling intervention with family and/or significant others that work toward the recipient's recovery goals identified in the IICP.

Service Requirements include:

- The Medicaid identified recipient is the focus of the treatment.
- Documentation must support how the service specifically benefits the identified recipient.
- Counseling must demonstrate progress towards and/or achievement of individual treatment goals.
- Referral to available community recovery support programs is available.

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

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

☑ Categorically needy *(specify limits):*

The combined total of individual and group Addiction Counseling service may be provided for a maximum of 32 hours (128 15-minute units) per year.

Exclusions:

- Recipients with withdrawal risk/symptoms whose needs cannot be managed at this level of care or who need detoxification services.
- Recipients at risk of harm to self or others.
- Addiction counseling sessions that consist of only education services are not reimbursed.
- Addiction Counseling may not be provided for professional caregivers.

☐ Medically needy *(specify limits): N/A*

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Agency	N/A	DMHA-certified Community Mental Health Center (CMHC)	DMHA-approved AMHH provider agencies must meet DMHA and OMPP-defined criteria and standards, including the following: (A) Provider agency has acquired a National Accreditation by an entity approved by DMHA. (B) Provider agency is an enrolled Medicaid provider that offers a full continuum of care. (C) Provider agency must maintain documentation in accordance with the Medicaid requirements defined under 405 IAC 1-5-1 and 405 IAC 1-5-3. (D) Provider agency must meet all AMHH provider agency criteria, as defined in the benefit and AMHH operating policy. In addition to meeting criteria for a provider agency, the agency must certify

			that the agency staff providing an AMHH service must meet the following standards for this service, as follows: (A) Licensed professional; (B) QBHP.

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):*
Agency	DMHA	Initially, and at the time of DMHA certification renewal

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

☐	Participant-directed	☑	Provider managed

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

Service Title:	Addiction Counseling – Family/Couple without Recipient Present (Individual Setting)

Service Definition (Scope)*:*

Family/Couple Addiction Counseling without the recipient present is a series of time-limited, structured, face-to-face sessions that work toward the goals of the recipient identified in the individualized integrated care plan. Skills training and education is for the family/couple to more effectively assist the beneficiary in learning/implementing these skills. The face-to-face interaction may be with family members or non-professional caregivers in an individual setting. Family/Couple Counseling and Therapy must be provided at home (living environment) or other locations outside the clinic setting.

Service Requirements include:

- The Medicaid identified recipient is the focus of the treatment.
- Documentation must support how the service specifically benefits the identified recipient.
- Counseling must demonstrate progress towards and/or achievement of individual treatment goals.
- Referral to available community recovery support programs is available.

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

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

☑ Categorically needy *(specify limits):*

The combined total of individual and group Addiction Counseling service may be provided for a maximum of 32 hours (128 15-minute units) per year.

Exclusions:

- Recipients with withdrawal risk/symptoms whose needs cannot be managed at this level of care or who need detoxification services.
- Recipients at risk of harm to self or others.

	• Addiction counseling sessions that consist of only education services are not reimbursed. • Addiction Counseling may not be provided for professional caregivers.
☐	Medically needy *(specify limits): N/A*

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Agency	N/A	DMHA-certified Community Mental Health Center (CMHC)	DMHA-approved AMHH provider agencies must meet DMHA and OMPP-defined criteria and standards, including the following: (A) Provider agency has acquired a National Accreditation by an entity approved by DMHA. (B) Provider agency is an enrolled Medicaid provider that offers a full continuum of care. (C) Provider agency must maintain documentation in accordance with the Medicaid requirements defined under 405 IAC 1-5-1 and 405 IAC 1-5-3. (D) Provider agency must meet all AMHH provider agency criteria, as defined in the benefit and AMHH operating policy. In addition to meeting criteria for a provider agency, the agency must certify that the agency staff providing an AMHH service must meet the following standards for this service, as follows: (A) Licensed professional; (B) QBHP.

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):*
Agency	DMHA	Initially, and at the time of DMHA certification renewal

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

☐	Participant-directed	☑	Provider managed

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

Service Title:	Addiction Counseling – Group Setting

Service Definition (Scope):

Group Addiction Counseling is a planned and organized face-to-face service with the recipient where addiction professionals and other clinicians provide counseling intervention in a group setting that works toward the recipient's individualized recovery goals identified in the IICP.

Service Requirements include:

- The Medicaid identified recipient is the focus of the treatment.
- Documentation must support how the service specifically benefits the recipient.
- Treatment consists of regularly scheduled sessions.
- Counseling must demonstrate progress towards and/or achievement of recipient treatment goals.
- Referral to available community recovery support programs is available.
- Services may include the following:
  - Education on addiction disorders.
  - Skills training in communication, anger management, stress management, relapse prevention.

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

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

☑ Categorically needy *(specify limits)*:

The combined total of individual and group Addiction Counseling service may be provided for a maximum of 32 hours (128 15-minute units) per year.

Exclusions:

- Recipients with withdrawal risk/symptoms whose needs cannot be managed at this level of care or who need detoxification services.
- Recipients at imminent risk of harm to self or others.
- Addiction counseling sessions that consist of only education services are not reimbursed.
- Addiction Counseling may not be provided for professional caregivers.

☐ Medically needy *(specify limits)*: N/A

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

Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
Agency	N/A	DMHA-certified Community Mental Health Center (CMHC)	DMHA-approved AMHH provider agencies must meet DMHA and OMPP-defined criteria and standards, including the following: (A) Provider agency has acquired a National Accreditation by an entity approved by DMHA. (B) Provider agency is an enrolled Medicaid provider that offers a full continuum of care. (C) Provider agency must maintain documentation in accordance with the Medicaid requirements defined under 405 IAC 1-5-1 and

			405 IAC 1-5-3. (D) Provider agency must meet all AMHH provider agency criteria, as defined in the benefit and AMHH operating policy. In addition to meeting criteria for a provider agency, the agency must certify that the agency staff providing an AMHH service must meet the following standards for this service, as follows: (A) Licensed professional; (B) QBHP.

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):*
Agency	DMHA	Initially, and at the time of DMHA certification renewal

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

☐	Participant-directed	☑	Provider managed

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

Service Title:	Addiction Counseling – Family/Couple with Recipient Present (Group Setting)

Service Definition (Scope)*:*

Group Addiction Counseling with the recipient present is a planned and organized face-to-face service with the recipient and family members or non-professional caregivers where addiction professionals and other clinicians provide counseling intervention in a group setting that works toward the recipient's individualized recovery goals identified in the IICP. Addiction Counseling must be provided at home (living environment) or other locations outside the clinic setting.

Service Requirements include:

- The Medicaid identified recipient is the focus of the treatment.
- Documentation must support how the service specifically benefits the recipient.
- Treatment consists of regularly scheduled sessions.
- Counseling must demonstrate progress towards and/or achievement of recipient treatment goals.
- Referral to available community recovery support programs is available.
- Services that are included:
    - Education on addiction disorders.
    - Skills training in communication, anger management, stress management, relapse prevention.

Additional needs-based criteria for receiving the service, if applicable *(specify):*	
Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*	
☑	Categorically needy *(specify limits):*
	The combined total of individual and group Addiction Counseling service may be provided for a maximum of 32 hours (128 15-minute units) per year. Exclusions: • Recipients with withdrawal risk/symptoms whose needs cannot be managed at this level of care or who need detoxification services. • Recipients at imminent risk of harm to self or others. • Addiction counseling sessions that consist of only education services are not reimbursed. • Addiction Counseling may not be provided for professional caregivers.
☐	Medically needy *(specify limits): N/A*

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Agency	N/A	DMHA - certified Community Mental Health Center (CMHC)	DMHA-approved AMHH provider agencies must meet DMHA and OMPP-defined criteria and standards, including the following: (A) Provider agency has acquired a National Accreditation by an entity approved by DMHA. (B) Provider agency is an enrolled Medicaid provider that offers a full continuum of care. (C) Provider agency must maintain documentation in accordance with the Medicaid requirements defined under 405 IAC 1-5-1 and 405 IAC 1-5-3. (D) Provider agency must meet all AMHH provider agency criteria, as defined in the benefit and AMHH operating policy. In addition to meeting criteria for a provider agency, the agency must certify that the agency staff providing an AMHH service must meet the following standards for this service, as follows: (A) Licensed professional; (B) QBHP.

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):*

Agency	DMHA	Initially, and at the time of DMHA certification renewal

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

☐	Participant-directed	☑	Provider managed

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

Service Title: Addiction Counseling – Family/Couple without Recipient Present (Group Setting)

Service Definition (Scope):

Group Addiction Counseling without the recipient present is a planned and organized face-to-face service with family members or non-professional caregivers where addiction professionals and other clinicians provide counseling intervention in a group setting that works toward the recipient's individualized recovery goals identified in the IICP. Skills training and education is for the family/couple to more effectively assist the beneficiary in learning/implementing these skills. Addiction Counseling must be provided at home (living environment) or other locations outside the clinic setting.

Service Requirements include:

- The Medicaid identified recipient is the focus of the treatment.
- Documentation must support how the service specifically benefits the recipient.
- Treatment consists of regularly scheduled sessions.
- Counseling must demonstrate progress towards and/or achievement of recipient treatment goals.
- Referral to available community recovery support programs is available.
- Services that are included:
  - Education on addiction disorders.
  - Skills training in communication, anger management, stress management, relapse prevention.

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

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

☑ Categorically needy *(specify limits):*

The combined total of individual and group Addiction Counseling service may be provided for a maximum of 32 hours (128 15-minute units) per year.

Exclusions:

- Recipients with withdrawal risk/symptoms whose needs cannot be managed at this level of care or who need detoxification services.
- Recipients at imminent risk of harm to self or others.
- Addiction counseling sessions that consist of only education services are not reimbursed.
- Addiction Counseling may not be provided for professional caregivers.

☐ Medically needy *(specify limits): N/A*

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*

Agency	N/A	DMHA-certified Community Mental Health Center (CMHC)	DMHA-approved AMHH provider agencies must meet DMHA and OMPP-defined criteria and standards, including the following: (A) Provider agency has acquired a National Accreditation by an entity approved by DMHA. (B) Provider agency is an enrolled Medicaid provider that offers a full continuum of care. (C) Provider agency must maintain documentation in accordance with the Medicaid requirements defined under 405 IAC 1-5-1 and 405 IAC 1-5-3. (D) Provider agency must meet all AMHH provider agency criteria, as defined in the benefit and AMHH operating policy. In addition to meeting criteria for a provider agency, the agency must certify that the agency staff providing an AMHH service must meet the following standards for this service, as follows: (A) Licensed professional; (B) QBHP.

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):*
Agency	DMHA	Initially, and at the time of DMHA certification renewal

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

☐	Participant-directed	☑	Provider managed

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

Service Title: Supported Community Engagement Services

Service Definition (Scope):

Services that engage a recipient in meaningful community involvement in activities such as volunteerism or community service. These include teaching concepts to encourage attendance, task completion, problem solving and safety. Services are aimed at the general result of community engagement. Services are habilitative in nature and shall not include explicit employment objectives.

Service Requirements include:

- Collaboration with the organization to develop an individualized training plan that identifies specific supports required organizational expectations, training strategies, timeframes, and responsibilities.
- Services must be explicitly identified in the IICP and related to goals identified by the recipient.
- Services are provided to members who may benefit from community engagement and are unlikely to achieve this involvement without the provision of support.
- These services shall be provided in a community setting.
- Services include assisting the recipient in developing relationships with community organizations specific to the recipient's interests and needs.
- Allowable activities include teaching the following concepts:
    - Attendance.
    - Task completion; and
    - Problem solving and safety for the purpose of achieving a generalized skill or behavior that may prepare the recipient for an employment setting.

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

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

☑ Categorically needy *(specify limits):*

This service is offered for up to eighteen hours per month (72 15-minute units).

Exclusions:

	• If a provider chooses to compensate a recipient for such activities, the provider must use non-Medicaid funding and must be able to document the funding source. • Training in specific job tasks. • Recipients who are currently competitively employed. • Services are not available as vocational rehabilitation services funded under the Rehabilitation Act of 1973.
☐	Medically needy *(specify limits): N/A*

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Agency	N/A	DMHA-certified Community Mental Health Center (CMHC)	DMHA-approved AMHH provider agencies must meet DMHA and OMPP-defined criteria and standards, including the following: (A) Provider agency has acquired a National Accreditation by an entity approved by DMHA. (B) Provider agency is an enrolled Medicaid provider that offers a full continuum of care. (C) Provider agency must maintain documentation in accordance with the Medicaid requirements defined under 405 IAC 1-5-1 and 405 IAC 1-5-3. (D) Provider agency must meet all AMHH provider agency criteria, as defined in the benefit and AMHH operating policy. In addition to meeting criteria for a provider agency, the agency must certify that the agency staff providing an AMHH service must meet the following standards for this service, as follows: (A) Licensed professional; (B) QBHP; or (C) OBHP.

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):*
Agency	DMHA	Initially, and at the time of DMHA certification renewal

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

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

Service Definition (Scope):

Care coordination consists of services that help recipients gain access to needed medical, social, educational, and other services. This includes direct assistance in gaining access to services, coordination of care, oversight of the entire case, and linkage to appropriate services. Care coordination includes: (1) assessment of the eligible recipient to determine service needs; (2) development of an individualized integrated care plan (IICP); (3) referral and related activities to help the recipient obtain needed services; (4) monitoring and follow-up; and (5) evaluation. Care coordination does not include direct delivery of medical, clinical, or other direct services. Care coordination is on behalf of the recipient, not to the recipient.

Service Requirements include:

- Care coordination must provide direct assistance in gaining access to needed medical, social, educational, and other services.
- Care coordination includes the development of an individualized integrated care plan, limited referrals to services, and activities or contacts necessary to ensure that the individualized integrated care plan is effectively implemented and adequately addresses the mental health and/or addiction needs of the eligible recipient.
- Care coordination includes:
    - Needs Assessment: focusing on needs identification of the recipient to determine the need for any medical, educational, social, or other services. Specific assessment activities may include: taking recipient history, identifying the needs of the recipient, and completing the related documentation. It also includes the gathering of information from other sources, such as family members or medical providers, to form a complete assessment of the recipient.
    - Individualized Integrated Care Plan Development: the development of a written individualized integrated care plan based upon the information collected through the assessment phase. The individualized integrated care plan identifies the habilitative activities and assistance needed to accomplish the objectives.
    - Referral/Linkage: activities that help link the recipient with medical, social, educational providers, and/or other programs and services that are capable of providing needed habilitative services.
    - Monitoring/Follow-up: Contact must occur at least every 90 days. Contacts and related activities are necessary to ensure the individualized integrated care plan is effectively implemented and adequately addresses the needs of the recipient. The activities and contacts may be with the recipient, family members, non-professional caregivers, providers, and other entities. Monitoring and follow-up are necessary to help determine if services are being furnished in accordance with a service plan of the recipient, the adequacy of the services in the individualized integrated care plan, and

changes in the needs or status of the recipient. This function includes making necessary adjustments in the individualized integrated care plan and service arrangement with providers.

- Evaluation: the care coordinator must periodically reevaluate the recipient's progress toward achieving the individualized integrated care plan's objectives. Based upon the care coordinator's review, a determination would be made on if changes should be made. Time devoted to formal supervision of the case between care coordinator and licensed supervisor are included activities and should be documented accordingly. This must be documented appropriately and billed under one provider only.

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

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

☑ Categorically needy *(specify limits):*

Care Coordination service may be provided for a maximum of 400 hours (1600 15- minute units) per year.

Exclusions:

- Activities billed under Behavioral Health Reassessment (by a non-physician).
- The actual or direct provision of medical services or treatment. Examples include, but are not limited to:
  - Training in daily living skills.
  - Training in work skills and social skills.
  - Grooming and other personal services.
  - Training in housekeeping, laundry, cooking.
  - Transportation services.
  - Individual, group, or family therapy services.
  - Crisis intervention services.
  - Services that go beyond assisting the recipient in gaining access to needed services. Examples include:
    - Paying bills and/or balancing the recipient's checkbook.
    - Traveling to and from appointments with recipients.

☐ Medically needy *(specify limits): N/A*

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Agency	N/A	DMHA-certified Community Mental Health Center (CMHC)	DMHA-approved AMHH provider agencies must meet DMHA and OMPP-defined criteria and standards, including the following: (A) Provider agency has acquired a National Accreditation by an entity approved by DMHA. (B) Provider agency is an enrolled Medicaid provider that offers a full continuum of care. (C) Provider agency must maintain documentation in accordance

			with the Medicaid requirements defined under 405 IAC 1-5-1 and 405 IAC 1-5-3. (D) Provider agency must meet all AMHH provider agency criteria, as defined in the benefit and AMHH operating policy. In addition to meeting criteria for a provider agency, the agency must certify that the agency staff providing an AMHH service must meet the following standards for this service, as follows: (A) Licensed professional; (B) QBHP; or (C) OBHP.

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):*
Agency	DMHA	Initially, and at the time of DMHA certification renewal

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

☐	Participant-directed	☑	Provider managed

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

Service Title:	Medication Training and Support – Individual Setting

Service Definition (Scope)*:*

Individual Medication Training and Support involves face-to-face contact with the recipient, in an individual setting, for the purpose of monitoring medication compliance, providing education and training about medications, monitoring medication side effects, and providing other nursing or medical assessments. Medication Training and Support also includes certain related non face-to-face activities.

Service Requirements include:

- Face-to-face contact in an individual setting that includes monitoring self-administration of prescribed medications and monitoring side effects, including weight, blood glucose level, and blood pressure.
- When provided in a clinic setting, Medication Training and Support may compliment, but not duplicate, activities associated with medication management activities available under the Clinic Option.
- When provided in residential treatment settings, Medication Training and Support may include components of medication management services.

- The recipient is the focus of the service.
- Documentation must support how the service benefits the recipient.
- Medication Training and Support must demonstrate movement toward and/or achievement of recipient treatment goals identified in the individualized integrated care plan (IICP).
- Medication Training and Support goals are habilitative in nature
- Medication Training and Support may also include the following services that are not required to be provided face-to-face with the recipient:
  - Transcribing physician or AHCP medication orders.
  - Setting or filling medication boxes.
  - Consulting with the attending physician or AHCP regarding medication-related issues.
  - Ensuring linkage that lab and/or other prescribed clinical orders are sent.
  - Ensuring that the recipient follows through and receives lab work and services pursuant to other clinical orders.
  - Follow up reporting of lab and clinical test results to the recipient and physician.

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

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

☒ Categorically needy *(specify limits):*

Medication Training and Support service including all subtypes (individual, group, family/couple, with and without recipient present) may be provided for a maximum of 182 hours (728 15- minute units) per year.

Exclusions:

- If clinic option medication management, counseling, or psychotherapy is provided and medication management is a component, then Medication Training and Support may not be billed separately for the same visit by the same provider.
- Coaching and instruction regarding recipient self-administration of medications is not reimbursable under Medication Training and Support, but may be billed as Skills Training and Development.

☐ Medically needy *(specify limits): N/A*

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Agency	N/A	DMHA-certified Community Mental Health Center (CMHC)	DMHA-approved AMHH provider agencies must meet DMHA and OMPP-defined criteria and standards, including the following: (A) Provider agency has acquired a National Accreditation by an entity approved by DMHA. (B) Provider agency is an enrolled Medicaid provider that offers a full continuum of care. (C) Provider agency must maintain documentation in accordance with the Medicaid requirements

			defined under 405 IAC 1-5-1 and 405 IAC 1-5-3. (E) Provider agency must meet all AMHH provider agency criteria, as defined in the benefit and AMHH operating policy. In addition to meeting criteria for a provider agency, the agency must certify that the agency staff providing an AMHH service must meet the following standards for this service, as follows: (A) Medication Training and Support is provided within the scope of practice as defined by federal and state law. (B)Agencies certify that individual providing the service meets the following qualifications: • Licensed physician • Authorized health care professional (AHCP) • Licensed registered nurse (RN) • Licensed practical nurse (LPN) • Medical Assistant (MA) who has graduated from a two (2) year clinical program.

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):*
Agency	DMHA	Initially, and at the time of DMHA certification renewal

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

☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):*	
Service Title:	Medication Training and Support – Family/Couple with the Recipient Present (Individual Setting)
Service Definition (Scope)*:*	
Family/Couple Medication Training and Support with the recipient present involves face-to-face contact with the recipient and family members or other non-professional caregivers, in an individual setting, for the purpose of monitoring medication compliance, providing education and training about	

medications, monitoring medication side effects, and providing other nursing and medical assessments. Medication Training and Support also includes certain non-face-to-face activities.

Service Requirements include:

- Face-to-face contact in an individual setting with family members or non-professional caregivers in support of the recipient.
- May include training of family members or non-professional caregivers to monitor self-administration of prescribed medications and monitoring side effects, including weight, blood glucose level, and blood pressure.
- When provided in the clinic setting, Medication Training and Support may compliment, but not duplicate, activities associated with medication management activities available under the Clinic Option.
- When provided in residential treatment settings, Medication Training and Support may include components of medication management services.
- The recipient is the focus of Medication Training and Support.
- Documentation must support how the service benefits the recipient, including when Medication Training and Support is provided in a group setting.
- Medication Training and Support results in demonstrated movement toward, or achievement of, the recipient's treatment goals identified by the individualized integrated care plan.
- Medication Training and Support goals are habilitative in nature.

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

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

☑ Categorically needy *(specify limits):*

Medication Training and Support service including all subtypes (individual, group, family/couple, with and without recipient present) may be provided for a maximum of 182 hours (728 15-minute units) per year.

Exclusions:

- If Clinic Option medication management, counseling, or psychotherapy is provided and medication management is a component, then Medication Training and Support may not be billed separately for the same visit by the same provider.
- Coaching and instruction regarding recipient self-administration of medications is not reimbursable under Medication Training and Support, but may be billed as Skills Training and Development.

☐ Medically needy *(specify limits):N/A*

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Agency	N/A	DMHA-certified Community Mental Health Center (CMHC)	DMHA-approved AMHH provider agencies must meet DMHA and OMPP-defined criteria and standards, including the following: (A) Provider agency has acquired a National Accreditation by an

			entity approved by DMHA. (B) Provider agency is an enrolled Medicaid provider that offers a full continuum of care. (C) Provider agency must maintain documentation in accordance with the Medicaid requirements defined under 405 IAC 1-5-1 and 405 IAC 1-5-3. (D) Provider agency must meet all AMHH provider agency criteria, as defined in the benefit and AMHH operating policy. In addition to meeting criteria for a provider agency, the agency must certify that the agency staff providing an AMHH service must meet the following standards for this service, as follows: (A) Medication Training and Support is provided within the scope of practice as defined by federal and state law. (B) Agencies certify that individual providing the service meets the following qualifications: • Licensed physician • Authorized health care professional (AHCP) • Licensed registered nurse (RN) • Licensed practical nurse (LPN) • Medical Assistant (MA) who has graduated from a two (2) year clinical program

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):*
Agency	DMHA	Initially, and at the time of DMHA certification renewal

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

☐	Participant-directed	☑	Provider managed

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

Service Title:	Medication Training and Support – Family/Couple without the Recipient Present (Individual Setting)

Service Definition (Scope):

Family/Couple Medication Training and Support without the recipient present involves face-to-face contact with family members or other non-professional caregivers, in an individual setting, for the purpose of monitoring medication compliance, providing education and training about medications, monitoring medication side effects, and providing other nursing and medical assessments. Skills training and education is for the family/couple to more effectively assist the beneficiary in learning/implementing these skills. Medication Training and Support also includes certain non face-to-face activities.

Service Requirements include:

- Face-to-face contact in an individual setting with family members or non-professional caregivers on behalf of the recipient.
- May include training of family members or non-professional caregivers to monitor assist with administration of prescribed medications and monitoring side effects, including weight, blood glucose level, and blood pressure.
- When provided in the clinic setting, Medication Training and Support may compliment, but not duplicate, activities associated with medication management activities available under the Clinic Option.
- When provided in residential treatment settings, Medication Training and Support may include components of medication management services.
- The recipient is the focus of Medication Training and Support.
- Documentation must support how the service benefits the recipient, including when Medication Training and Support is provided in a group setting.
- Medication Training and Support results in demonstrated movement toward, or achievement of, the recipient's treatment goals identified by the individualized integrated care plan.
- Medication Training and Support goals are habilitative in nature.

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

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

☑ Categorically needy *(specify limits):*

Medication Training and Support service including all subtypes (individual, group, family/couple, with and without recipient present) may be provided for a maximum of 182 hours (728 15-minute units) per year.

Exclusions:

- If Clinic Option medication management, counseling, or psychotherapy is provided and medication management is a component, then Medication Training and Support may not be billed separately for the same visit by the same provider.
- Coaching and instruction regarding recipient self-administration of medications is not reimbursable under Medication Training and Support, but may be billed as Skills Training and Development.

☐ Medically needy *(specify limits):N/A*			
Provider Qualifications *(For each type of provider. Copy rows as needed)*:			
Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Agency	N/A	DMHA-certified Community Mental Health Center (CMHC)	DMHA-approved AMHH provider agencies must meet DMHA and OMPP-defined criteria and standards, including the following: (A) Provider agency has acquired a National Accreditation by an entity approved by DMHA. (B) Provider agency is an enrolled Medicaid provider that offers a full continuum of care. (C) Provider agency must maintain documentation in accordance with the Medicaid requirements defined under 405 IAC 1-5-1 and 405 IAC 1-5-3. (D) Provider agency must meet all AMHH provider agency criteria, as defined in the benefit and AMHH operating policy. In addition to meeting criteria for a provider agency, the agency must certify that the agency staff providing an AMHH service must meet the following standards for this service, as follows: (A) Medication Training and Support is provided within the scope of practice as defined by federal and state law. (B) Agencies certify that individual providing the service meets the following qualifications: • Licensed physician • Authorized health care professional (AHCP) • Licensed registered nurse (RN) • Licensed practical nurse (LPN) • Medical Assistant (MA) who has graduated from a two (2) year clinical program
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):*
Agency	DMHA	Initially, and at the time of DMHA certification renewal

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

☐	Participant-directed	☑	Provider managed

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

Service Title: Medication Training and Support – Group Setting

Service Definition (Scope):

Group Medication Training and Support involves face-to-face contact with the recipient, in a group setting, for the purpose of providing education and training about medications and medication side effects.

Service Requirements include:

- Face-to-face contact in a group setting that includes monitoring self-administration of prescribed medications and monitoring side effects, including weight, blood glucose level, and blood pressure.
- When provided in the clinic setting, Medication Training and Support may compliment, but not duplicate, activities associated with medication management activities available under the Clinic Option.
- When provided in residential treatment settings, Medication Training and Support may include components of medication management services.
- The recipient is the focus of Medication Training and Support.
- Documentation must support how the service benefits the recipient, including when services are provided in a group setting.
- Medication Training and Support results in demonstrated movement toward, or achievement of, the recipient's treatment goals identified in the individualized integrated care plan (IICP).
- Medication Training and Support goals are habilitative in nature.

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

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

☑ Categorically needy *(specify limits):*

Medication Training and Support service including all subtypes (individual, group, family/couple, with and without recipient present) may be provided for a maximum of 182 hours (728 15-minute units) per year.

Exclusions:

- If Clinic Option medication management, counseling, or psychotherapy is provided and medication management is a component, then Medication Training and Support may not be billed separately for the same visit by the same provider.
- Coaching and instruction regarding recipient self-administration of medications is not

	reimbursable under Medication Training and Support, but may be billed as Skills Training and Development.
☐	Medically needy *(specify limits): N/A*

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Agency	N/A	DMHA-certified Community Mental Health Center (CMHC)	DMHA-approved AMHH provider agencies must meet DMHA and OMPP-defined criteria and standards, including the following: (A) Provider agency has acquired a National Accreditation by an entity approved by DMHA. (B) Provider agency is an enrolled Medicaid provider that offers a full continuum of care. (C) Provider agency must maintain documentation in accordance with the Medicaid requirements defined under 405 IAC 1-5-1 and 405 IAC 1-5-3. (D) Provider agency must meet all AMHH provider agency criteria, as defined in the benefit and AMHH operating policy. In addition to meeting criteria for a provider agency, the agency must certify that the agency staff providing an AMHH service must meet the following standards for this service, as follows: (A) Medication Training and Support is provided within the scope of practice as defined by federal and state law. (B) Agencies certify that individual providing the service meets the following qualifications: • Licensed physician • Authorized health care professional (AHCP) • Licensed registered nurse (RN) • Licensed practical nurse (LPN) • Medical Assistant (MA) who has graduated from a two (2) year clinical program

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):*
Agency	DMHA	Initially, and at the time of DMHA certification renewal

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

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):*	
Service Title:	Medication Training and Support – Family/Couple with the Recipient Present (Group Setting)

Service Definition (Scope):

Family/Couple Medication Training and Support with the recipient present involves face-to-face contact, in a group setting with the recipient and family members or other non-professional caregivers, for the purpose of providing education and training about medications and medication side effects.

Service Requirements include:

- Face-to-face contact with family members or non-professional caregivers in support of a recipient that includes education and training on the administration of prescribed medications and side effects including weight, blood glucose level, and blood pressure, and/or conducting medication groups or classes.
- When provided in the clinic setting, Medication Training and Support may compliment, but not duplicate, activities associated with medication management activities available under the Clinic Option.
- When provided in residential treatment settings, Medication Training and Support may include components of medication management services.
- The recipient is the focus of Medication Training and Support.
- Documentation must support how the service benefits the recipient, including when services are provided in a group setting.
- Medication Training and Support results in demonstrated movement toward, or achievement of, the recipient's treatment goals identified in the individualized integrated care plan.
- Medication Training and Support goals are habilitative in nature.

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

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

☑	Categorically needy *(specify limits):*
	Medication Training and Support service including all subtypes (individual, group, family/couple, with and without recipient present) may be provided for a maximum of 182 hours (728 15-minute units) per year. Exclusions:

	• If Clinic Option medication management, counseling or psychotherapy is provided and medication management is a component, then Medication Training and Support may not be billed separately for the same visit by the same provider. • Coaching and instruction regarding recipient self-administration of medications is not reimbursable under Medication Training and Support, but may be billed as Skills Training and Development. • The following non face-to-face services are excluded: o Transcribing physician or AHCP medication orders. o Setting or filling medication boxes. o Consulting with the attending physician or AHCP regarding medication-related issues. o Ensuring linkage that lab and/or other prescribed clinical orders are sent. o Ensuring that the recipient follows through, and receives lab work and other clinical orders. o Follow up reporting of lab and clinical test results to the recipient and physician. • Medication Training and Support may not be provided to professional caregivers.
☐	Medically needy *(specify limits):N/A*

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Agency	N/A	DMHA-certified Community Mental Health Center (CMHC)	DMHA-approved AMHH provider agencies must meet DMHA and OMPP-defined criteria and standards, including the following: (A) Provider agency has acquired a National Accreditation by an entity approved by DMHA. (B) Provider agency is an enrolled Medicaid provider that offers a full continuum of care. (C) Provider agency must maintain documentation in accordance with the Medicaid requirements defined under 405 IAC 1-5-1 and 405 IAC 1-5-3. (D) Provider agency must meet all AMHH provider agency criteria, as defined in the benefit and AMHH operating policy. In addition to meeting criteria for a provider agency, the agency must certify that the agency staff providing an AMHH service must meet the following standards for this service, as follows:

			(A) Training and Support is provided within the scope of practice as defined by federal and state law. (B) Agencies certify that individual providing the service meets the following qualifications: • Licensed physician • Authorized health care professional (AHCP) • Licensed registered nurse (RN) • Licensed practical nurse (LPN) • Medical Assistant (MA) who has graduated from a two (2) year clinical program

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):*
Agency	DMHA	Initially, and at the time of DMHA certification renewal

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

☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):*	
Service Title:	Medication Training and Support – Family/Couple without the Recipient Present (Group Setting)

Service Definition (Scope)*:*

Family/Couple Medication Training and Support without the recipient present is conducted face-to-face, in a group setting with family members or other non-professional caregivers The purpose is to provide skills training and education for the family/couple to more effectively assist the beneficiary in learning/implementing skills about medications and medication side effects. .

Service Requirements include:

- Face-to-face contact with family members or non-professional caregivers on behalf of a recipient that includes education and training on the administration of prescribed medications and side effects including weight, blood glucose level, and blood pressure, and/or conducting medication groups or classes.
- When provided in the clinic setting, Medication Training and Support may compliment, but not duplicate, activities associated with medication management activities available under the Clinic Option.
- When provided in residential treatment settings, Medication Training and Support may include components of medication management services.
- The recipient is the focus of Medication Training and Support.

- Documentation must support how the service benefits the recipient, including when services are provided in a group setting and the recipient is not present.
- Medication Training and Support results in demonstrated movement toward, or achievement of, the recipient's treatment goals identified in the individualized integrated care plan.
- Medication Training and Support goals are habilitative in nature.

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

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

☑ Categorically needy *(specify limits):*

Medication Training and Support service including all subtypes (individual, group, family/couple, with and without recipient present) may be provided for a maximum of 182 hours (728 15-minute units) per year.

Exclusions:

- If Clinic Option medication management, counseling or psychotherapy is provided and medication management is a component, then Medication Training and Support may not be billed separately for the same visit by the same provider.
- Coaching and instruction regarding recipient self-administration of medications is not reimbursable under Medication Training and Support, but may be billed as Skills Training and Development.
- The following non face-to-face services are excluded:
  - Transcribing physician or AHCP medication orders.
  - Setting or filling medication boxes.
  - Consulting with the attending physician or AHCP regarding medication-related issues.
  - Ensuring linkage that lab and/or other prescribed clinical orders are sent.
  - Ensuring that the recipient follows through, and receives lab work and other clinical orders.
  - Follow up reporting of lab and clinical test results to the recipient and physician.
- Medication Training and Support may not be provided to professional caregivers.

☐ Medically needy *(specify limits):N/A*

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Agency	N/A	DMHA-certified Community Mental Health Center (CMHC)	DMHA-approved AMHH provider agencies must meet DMHA and OMPP-defined criteria and standards, including the following: (A) Provider agency has acquired a National Accreditation by an entity approved by DMHA. (B) Provider agency is an enrolled Medicaid provider that offers a full continuum of care. (C) Provider agency must maintain documentation in accordance

			with the Medicaid requirements defined under 405 IAC 1-5-1 and 405 IAC 1-5-3. (D) Provider agency must meet all AMHH provider agency criteria, as defined in the benefit and AMHH operating policy. In addition to meeting criteria for a provider agency, the agency must certify that the agency staff providing an AMHH service must meet the following standards for this service, as follows: (A) Medication Training and Support is provided within the scope of practice as defined by federal and state law. (B) Agencies certify that individual providing the service meets the following qualifications: • Licensed physician • Authorized health care professional (AHCP) • Licensed registered nurse (RN) • Licensed practical nurse (LPN) • Medical Assistant (MA) who has graduated from a two (2) year clinical program

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):*
Agency	DMHA	Initially, and at the time of DMHA certification renewal

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):

Participant-Direction of Services

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

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

☑	The state does not offer opportunity for participant-direction of State plan HCBS.
○	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):**

Indiana does not offer self-directed care.

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

○	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)*:

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
	☐	☐
	☐	☐

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 Person-Centered Service Plan.** *(By checking this box the state assures that):* Based on the independent assessment required under 42 CFR §441.720, the individualized person-centered service plan is developed jointly with the individual, meets federal requirements at 42 CFR §441.725, and:
   - Specifies the State plan HCBS that the individual will be responsible for directing;
   - Identifies the methods by which the individual will plan, direct or control services, including whether the individual will exercise authority over the employment of service providers and/or authority over expenditures from the individualized budget;
   - Includes appropriate risk management techniques that explicitly recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assures the appropriateness of this plan based upon the resources and support needs of the individual;
   - Describes the process for facilitating voluntary and involuntary transition from self-direction including any circumstances under which transition out of self-direction is involuntary. There must be state procedures to ensure the continuity of services during the transition from self-direction to other service delivery methods; and
   - Specifies the financial management supports to be provided.

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

8. **Opportunities for Participant-Direction**

   a. **Participant–Employer Authority** (individual can select, manage, and dismiss State plan HCBS providers). (*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 that does not result in payment for medical assistance to the individual). (*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 the method for calculating the dollar values in the budget based on reliable costs and service utilization, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the person-centered service plan.):*
	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

Quality Measures

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

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

   The State Evaluation Team (SET) annually reviews 100% of all individualized integrated care plans (IICPs) through both the Data Assessment Registry Mental Health and Addiction (DARMHA) database and the required annual AMHH provider Quality Assurance onsite reviews. During the reviews of the IICPs, the SET ensures they are updated timely and there is documentation that supports the applicant received a choice of services and providers. Analysis and aggregation are ongoing. If a corrective action plan is needed it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.

Requirement	1a. Service plans address assessed needs of 1915(i) participants, are updated annually, and document choice of services and providers.
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of IICPs that address recipient's needs *N: Total number IICPs reviewed that address recipient needs* *D: Total number of IICPs reviewed*
Discovery Activity *(Source of Data & sample size)*	100% of IICPs are reviewed and approved through the waiver database
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Division of Mental Health and Addiction
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Division of Mental Health and Addiction
Frequency *(of Analysis and Aggregation)*	Analysis and aggregation are ongoing. If a corrective action plan is needed it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.
Requirement	1b. Service plans address assessed needs of 1915(i) participants, are updated annually, and document choice of services and providers.
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of IICPs reviewed and revised as warranted on or before annual review date *N: Total number of IICPs reviewed and revised as warranted on or before the annual review date* *D: Total number of IICPs due*
Discovery Activity	100% of IICPs are reviewed and approved through the waiver database

(Source of Data & sample size)	
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Division of Mental Health and Addiction
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Division of Mental Health and Addiction
Frequency *(of Analysis and Aggregation)*	Analysis and aggregation are ongoing. If a corrective action plan is needed it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.

Requirement	1c. Service plans address assessed needs of 1915(i) participants, are updated annually, and document choice of services and providers.
Discovery	

	Discovery Evidence *(Performance Measure)*	Number and percent of recipients with documentation of choice of eligible services *N: Number and percent of recipients with documentation of choice of eligible services* *D: Total number of recipients reviewed*
	Discovery Activity *(Source of Data & sample size)*	Record Review – on site/off site with 95% confidence level with 5% margin of error
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Division of Mental Health and Addiction
	Frequency	Ongoing
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Division of Mental Health and Addiction
	Frequency *(of Analysis and Aggregation)*	Analysis and aggregation are ongoing. If a corrective action plan is needed it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.

Requirement	1d. Service plans address assessed needs of 1915(i) participants, are updated annually, and document choice of services and providers.
Discovery	

	Discovery Evidence *(Performance Measure)*	Number and percent of recipients with documentation of choice of providers *N: Total number of recipients reviewed who had documentation of choice of providers* *D: Total number of recipients reviewed*
	Discovery Activity *(Source of Data & sample size)*	Record Review – on site/off site with 95% confidence level with 5% margin of error
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Division of Mental Health and Addiction
	Frequency	Ongoing
Remediation		

	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Division of Mental Health and Addiction
	Frequency *(of Analysis and Aggregation)*	Analysis and aggregation are ongoing. If a corrective action plan is needed it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.

2. Eligibility Requirements: (a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future; (b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately; and (c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.

For each application for AMHH that is submitted to the SET, providers are required to complete a face-to-face AMHH evaluation and Adult Needs Strengths Assessment for each applicant. Information from the evaluation assessment is submitted along with an IICP with other supporting documentation to the SET for review for eligibility. The process is the same for the AMHH renewal as it is for an initial AMHH service request.

The SET conducts annual QA review to verify compliance of eligibility requirements.

Requirement	2a. An evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of new enrollees who had an evaluation for AMHH eligibility prior to enrollment *N=The number of new enrollees who had an evaluation for AMHH eligibility prior to enrollment* *D=The total number of new enrollees*
Discovery Activity *(Source of Data & sample size)*	Record Review – on site/off site with 95% confidence level with 5% margin of error
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Division of Mental Health and Addiction
Frequency	Ongoing

Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Division of Mental Health and Addiction
	Frequency *(of Analysis and Aggregation)*	Analysis and aggregation are ongoing. If a corrective action plan is needed it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.

Requirement		2b. The processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately
Discovery		
	Discovery Evidence *(Performance Measure)*	Number and percent of *Adult Needs and Strengths Assessment (ANSA)s* that were completed according to policy *N: Total number of applicants that had an up to date ANSA at time of submission of IICP according to policy* *D: Total number applicants that required an ANSA*
	Discovery Activity *(Source of Data & sample size)*	Record Review – on site/off site with 95% confidence level with 5% margin of error
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Division of Mental Health and Addiction
	Frequency	Ongoing
Remediation		

Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Division of Mental Health and Addiction
Frequency *(of Analysis and Aggregation)*	Analysis and aggregation are ongoing. If a corrective action plan is needed it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.
Requirement	2c. The 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of AMHH re-evaluations conducted *N: Number of AMHH evaluations documented as face-to-face in a progress note at least annually* *D: Number of AMHH evaluations required*
Discovery Activity *(Source of Data & sample size)*	Record Review – on site/off site with 95% confidence level with 5% margin of error
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Division of Mental Health and Addiction
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Division of Mental Health and Addiction
Frequency *(of Analysis and Aggregation)*	Analysis and aggregation are ongoing. If a corrective action plan is needed it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.

3. Providers meet required qualifications.

FSSA's Division of Mental Health and Addiction (DMHA) certified Community Mental Health Centers (CMHCs) are permitted by Indiana's State Medicaid agency (OMPP) to be approved to by DMHA provide AMHH services according the standards and expectations outlined in the 1915(i) State Plan Benefit. CMHCs approved by DMHA to provide AMHH services must meet all provider agency standards documented in the State Plan Benefit and ensure that all direct care agency staff members providing AMHH services to a recipient meet all standards required for the service being provided. Analysis and aggregation are ongoing. If a corrective action plan is needed it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.

Requirement	3a. Providers meet required qualifications.
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of provider agencies that meet qualifications at time of enrollment *N: Total number of providers enrolled that met qualifications at the time of enrollment* *D: Total number of providers enrolled*
Discovery Activity *(Source of Data & sample size)*	100% of provider agency applications are reviewed prior to approval
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Division of Mental Health and Addiction
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Division of Mental Health and Addiction
Frequency *(of Analysis and Aggregation)*	Analysis and aggregation are ongoing. If a corrective action plan is needed it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.

Requirement	3b. Providers meet required qualifications.
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of provider agencies recertified timely. *N: Total number of agencies recertified timely* *D: Total number of agencies recertified*
Discovery Activity *(Source of Data & sample size)*	100% of provider agency applications are reviewed prior to approval
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Division of Mental Health and Addiction
Frequency	Every three years or at time of reaccreditation
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Division of Mental Health and Addiction
Frequency *(of Analysis and Aggregation)*	Analysis and aggregation are ongoing. If a corrective action plan is needed it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.

4. Settings meet the home and community-based setting requirements as specified in this benefit and in accordance with 42 CFR 441.710(a)(1) and (2).

The State assures that the settings transition plan included with this SPA renewal will be subject to any provisions or requirements included in the State's approved Statewide Transition Plan. The State will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its SPA when it submits the next amendment or renewal.

HCBS surveys are to be completed by the provider and every member that resided in the setting and then returned to the SET for compliance determinations. Settings are determined to be either Fully Compliant, Needs Modifications and/or Potential Presumed Institutional. Once the provider is informed

of the assigned setting compliance designations, the provider determines if they wanted to pursue HCBS compliance or to opt out of providing HCBS services. The Setting Action Plan (SAP) requires the provider to identify action steps for the setting to come into compliance. Once the SAP is returned to the SET and the action steps meet the intent of the final rule, the settings listed under the provider are then determined to be fully compliant with the HCBS requirements. The provider has a total of 180 days, with a possible additional 180 day extension, to have their setting come into compliance. Once a determination is made by the SET, the provider is notified of this decision.

DMHA-approved CMHCs receive assistance provided by the State via webinars, onsite trainings and technical assistance calls to increase the understanding of HCBS requirements for providers to successfully implement the HCBS standards.

Requirement		4a. Settings meet the home and community-based setting requirements as specified in this benefit and in accordance with 42 CFR 441.710(a)(1) and (2).
Discovery		
	Discovery Evidence *(Performance Measure)*	Number and percent of settings in compliance with criteria that meets standards for community living *N: Total number of IICPs with compliant HCBS settings* *D: Total number of IICPs reviewed*
	Discovery Activity *(Source of Data & sample size)*	100% of IICPs will be reviewed to ensure members reside in HCBS compliant settings
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Division of Mental Health and Addiction
	Frequency	Ongoing
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Division of Mental Health and Addiction
	Frequency *(of Analysis and Aggregation)*	Analysis and aggregation are ongoing. IICPs that list a non-HCBS setting as a residence will be returned by the State for additional information within 5 business days with requirement that updated plan is resubmitted within 5 business days for a total of 10 business days.

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

Requirement	5a. The SMA retains authority and responsibility for program operations and oversight.
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of performance measure data reports from DMHA and contracted entities reviewed to ensure administrative oversight. *N=Number of data reports provided timely and in format.* *D=Number of data reports due.*
Discovery Activity *(Source of Data & sample size)*	100% review of DMHA Administrative Authority Quality Management Report
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	OMPP
Frequency	Quarterly
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMHA and OMPP
Frequency *(of Analysis and Aggregation)*	Quarterly

6. The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.

Requirement	6a. The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.
Discovery	

	Discovery Evidence *(Performance (Measure)*	Number and percent of 1915(i) claims paid during the review period according to the published rate. *N: Total number of claims paid according to the published rate* *D: Total number of claims submitted*
	Discovery Activity *(Source of Data & sample size)*	Medicaid Management Information System (MMIS) claims data reports 100% review
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	OMPP and Medicaid Fiscal Contractor
	Frequency	Monthly
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	OMPP & DMHA 45 days
	Frequency *(of Analysis and Aggregation)*	Monthly

Requirement	6b. The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.
Discovery	

	Discovery Evidence *(Performance Measure)*	Number and percent of 1915(i) claims paid during the review period for recipients enrolled in the 1915(i) program on the date the service was delivered. *N: Total number of claims paid during the review period for recipients enrolled in the AMHH on the date of service delivery* *D: Total number of claims paid during the review period*
	Discovery Activity *(Source of Data & (sample size)*	OMPP & Medicaid Management Information System (MMIS) claims data reports 100% review
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	OMPP and Medicaid Fiscal Contractor
	Frequency	Monthly
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	OMPP & DMHA 45 days
	Frequency *(of Analysis and Aggregation)*	Quarterly

7. The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation; medication errors; and the use of restraints.

The State will review 100% of all IICPs to ensure health and welfare needs are addressed as well as review 100% of all submitted incident reports to monitor if the incident report is submitted within the required timeframe. Analysis and aggregation are ongoing. Incomplete IICPs will be returned by the State for additional information within 5 business days with requirement that updated plan is resubmitted within 5 business days for a total of 10 business days.

Requirement	7a. The State identifies, addresses and seeks to prevent incidents of abuse, neglect, and exploitation; medication errors; and use of restraints.
Discovery	

	Discovery Evidence *(Performance Measure)*	Number and percent of IICPs that address health and welfare needs of the recipient. *N: Total number of IICPs reviewed that addressed the health and welfare needs of a recipient* *D: Total number of IICPs reviewed*
	Discovery Activity *(Source of Data & sample size)*	100% of IICPs reviewed to ensure health and welfare needs are addressed
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Division of Mental Health and Addiction
	Frequency	Ongoing
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Division of Mental Health and Addiction
	Frequency *(of Analysis and Aggregation)*	Analysis and aggregation are ongoing. Incomplete IICP will be returned by the State for additional information within 5 business days with requirement that updated plan is resubmitted within 5 business days for a total of 10 business days.

Requirement	7b. The State identifies, addresses and seeks to prevent incidents of abuse, neglect, and exploitation; medication errors; and use of restraints.
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of incidents reported within required timeframe. *N:Total number of incident reports submitted within the required timeframe* *D: Total number of incident reports submitted*
Discovery Activity *(Source of Data & sample size)*	100% review of incident reports submitted

	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Division of Mental Health and Addiction
	Frequency	Ongoing
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Division of Mental Health and Addiction
	Frequency *(of Analysis and Aggregation)*	Analysis and aggregation are ongoing. Report submitted to State within 72 hours. State will review plan and respond within 5 business days. If a corrective action plan is needed it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.

Requirement	7c. The State identifies, addresses and seeks to prevent incidents of abuse, neglect, and exploitation; medication errors; and use of restraints.
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of reports for medication errors resolved according to policy *N: Total number of medication errors that were resolved according to policy* *D: Total number of reports for medication errors*
Discovery Activity *(Source of Data & sample size)*	100% review of incident reports submitted
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Division of Mental Health and Addiction
Frequency	Ongoing
Remediation	

Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Division of Mental Health and Addiction

Requirement	7d. The State identifies, addresses and seeks to prevent incidents of abuse, neglect, and exploitation; medication errors; and use of restraints.
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of reports of seclusions and restraints resolved according to policy *N: Total number of reports for seclusion and restraint that were resolved according to policy* *D: Total number of reports for seclusion and restraint*
Discovery Activity *(Source of Data & sample size)*	100% review of incident reports submitted
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Division of Mental Health and Addiction
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Division of Mental Health and Addiction
Frequency *(of Analysis and Aggregation)*	Analysis and aggregation are ongoing. Report submitted to State within 72 hours. State will review plan and respond within 5 business days. If a corrective action plan is needed it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.

Requirement	7e. The State identifies, addresses and seeks to prevent incidents of abuse, neglect, and exploitation; medication errors; and use of restraints.
Discovery	

	Discovery Evidence *(Performance Measure)*	Number and percent of reports for abuse, neglect and exploitation resolved according to policy *N: Total number of reports submitted for abuse, neglect and exploitation that were resolved according to policy* *D: Total number of reports for abuse, neglect and exploitation*
	Discovery Activity *(Source of Data & sample size)*	100% review of reports submitted
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Division of Mental Health and Addiction
	Frequency	Ongoing
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Division of Mental Health and Addiction
	Frequency *(of Analysis and Aggregation)*	Analysis and aggregation are ongoing. Report submitted to State within 72 hours. State will review plan and respond within 5 business days. A corrective action plan is required to be submitted within 30 business days and the State will respond in 30 business days for a total of 60 business days.

Requirement	7f. The State identifies, addresses and seeks to prevent incidents of abuse, neglect, and exploitation; medication errors; and use of restraints.
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of incident for abuse, neglect and exploitation that required a corrective action plan *N: Total number of CAPs associated with complaints that were implemented within prescribed time period.* *D: Total number of CAPs associated with complaints with implementation timeframes due.*
Discovery Activity *(Source of Data & sample size)*	100% review of incident reports submitted

	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Division of Mental Health and Addiction
	Frequency	Ongoing
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Division of Mental Health and Addiction
	Frequency *(of Analysis and Aggregation)*	Analysis and aggregation are ongoing. If a corrective action plan is needed it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days

System Improvement

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

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

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

2. Roles and Responsibilities

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

3. Frequency

Monthly, Quarterly, and Annually

4. Method for Evaluating Effectiveness of System Changes

1. During the monthly meeting between DMHA and OMPP, the need for new system changes as well as the effectiveness of previous system changes will be discussed and evaluated. Additional changes will be made as necessary, including changes in provider agency training, bulletins, policy changes, and refinements.

Methods and Standards for Establishing Payment Rates

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

☑	HCBS Case Management – Care Coordination
	Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private agency providers of Adult Day Services. The agency's fee schedule rate effective on October 1, 2018, is for services provided on or after that date. All rates are published on the agency's website at www.indianamedicaid.com.
☐	HCBS Homemaker
☐	HCBS Home Health Aide
☐	HCBS Personal Care
☑	HCBS Adult Day Health
	Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private agency providers of Adult Day Services. The agency's fee schedule rate effective on October 1, 2018, is for services provided on or after that date. All rates are published on the agency's website at www.indianamedicaid.com.
☑	HCBS Habilitation
	Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private agency providers of Habilitation and Support. The agency's fee schedule rate effective on October 1, 2018, is for services provided on or after that date. All rates are published on the agency's website at www.indianamedicaid.com. Home and Community Based (HCB) Habilitation and Support – Individual Setting HCB Habilitation and Support – Family/Couple with the Recipient Present (Individual Setting) HCB Habilitation and Support – Family/Couple without the Recipient Present (Individual Setting) HCB Habilitation and Support – Group Setting HCB Habilitation and Support – Family/Couple with Recipient Present (Group Setting) HCB Habilitation and Support – Family/Couple without Recipient Present (Group Setting)
☑	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 Respite Care. The agency's fee schedule rate effective on October 1, 2018, is for services provided on or after that date. All rates are published on the agency's website at www.indianamedicaid.com.
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)
☑	Other Services (specify below)	
	Therapy and Behavioral Support Services Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private agency providers of Therapy and Behavioral Support Services. The agency's fee schedule rate effective on October 1, 2018, is for services provided on or after that date. All rates are published on the agency's website at www.indianamedicaid.com. Therapy and Behavioral Support Services – Individual Setting Therapy and Behavioral Support Services – Family/Couple with Recipient Present (Individual Setting) Therapy and Behavioral Support Services – Family/Couple without Recipient Present (Individual Setting) Therapy and Behavioral Support Services – Group Setting Therapy and Behavioral Support Services – Family/Couple with Recipient Present (Group Setting) Therapy and Behavioral Support Services – Family/Couple without Recipient Present (Group Setting)	
	Addiction Counseling Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private agency providers of Addiction Counseling. The agency's fee schedule effective on October 1, 2018, is for services provided on or after that date. All rates are published on the agency's website at www.indianamedicaid.com. Addiction Counseling – Individual Setting Addiction Counseling – Family/Couple with Recipient Present (Individual Setting) Addiction Counseling – Family/Couple without Recipient Present (Individual Setting) Addiction Counseling – Group Setting Addiction Counseling – Family/Couple with Recipient Present (Group Setting) Addiction Counseling – Family/Couple without Recipient Present (Group Setting)	

	Supported Community Engagement Services Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private agency providers of Supported Community Engagement Services. The agency's fee schedule rate effective on October 1, 2018, is for services provided on or after that date. All rates are published on the agency's website at www.indianamedicaid.com.

	Medication Training and Support Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private agency providers of Medication Training and Support. The agency's fee schedule effective on October 1, 2018, is for services provided on or after that date. All rates are published on the agency's website at www.indianamedicaid.com. Medication Training and Support – Individual Setting Medication Training and Support – Family/Couple with Recipient Present (Individual Setting) Medication Training and Support – Family/Couple without Recipient Present (Individual Setting) Medication Training and Support – Group Medication Training and Support – Family/Couple with Recipient Present (Group Setting) Medication Training and Support – Family/Couple without Recipient Present (Group Setting)