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):*

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

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

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:*

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 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 DMHA or a State contracted entity. Office of Medicaid Policy and Planning (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. Remediation can range from 24-48 hours for compliance issues that impact the imminent health, safety, or wellbeing of individual members and within thirty (30) business days for compliance issues that include missing a quarterly report deadline, missing a provider module update deadline, or quarterly data that appears to be trending near or below 86% compliance.

For utilization management, item 5 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 (Fraud & Abuse Detection System Contractor):

Surveillance & Utilization Review (SUR) is housed under Family and Social Services Administration's (FSSA) Program Integrity (PI) and is comprised of four (4) groups, one of which is SUR, which handles auditing functions. 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 sifts and analyzes claims data and identifies providers/claims that indicate aberrant billing patterns and/or other risk factors. PI contracts with Fraud & Abuse Detection System (FADS) contractors to help facilitate SUR activities. The FADS contractors assist PI through data analysis, audit services, and work to improve the integrity of the IHCP. The FADS contractor reviews claims data through the use of algorithms. All of the work conducted by the FADS contractors is approved and overseen by the PI team to ensure work is performed in compliance with State and Federal guidelines.

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 unit is the Subject Matter Expert (SME) responsible for directly coordinating with the DMHA and OMPP. The unit analyzes data to identify potential areas of program risk and identify providers that appear to be outliers warranting review. Throughout the entire SUR process, oversight is maintained by OMPP through the PI team. The PI team offers education regarding key program initiatives and audit issues at provider meetings to promote ongoing compliance with Federal and State guidelines, including all Indiana Health Coverage Programs (IHCP) and SPA requirements.

Function #6 – Qualified Provider Enrollment

Providers interested in providing CMHW services must first apply for authorization through DMHA. Next, the provider must enroll as a Medicaid provider with Indiana Health Coverage Programs (IHCP). The OMPP contracts with a fiscal agent to process IHCP provider enrollments. The fiscal agent processes the applications, verifies licensure and authorization 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 Management Information System (MMIS) for claims processing. This includes the enrollment of DMHA approved 1915(i) providers. The expected processing time for new provider applications is 15 days for electronic applications and 20 days for paper applications. 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 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 as needed. 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 CMHW 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):*

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

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

To further prevent conflict of interest between evaluators, service providers, the member, and family, the following State processes are in place:

1) The Wraparound Facilitation Agency adheres to conflict-free standards including but not limited to not providing any other CMHW service except for facility- based respite care.
2) The Wraparound Facilitator is DMHA-authorized to provide only Wraparound Facilitation and is not authorized to provide any other CMHW service to the member for whom they are the Wraparound Facilitator.
3) DMHA, the independent state entity making the final eligibility determination and providing authorization for the plan of care, is not related by blood or marriage to the individual/participant; to any of the individual's paid caregivers; or to anyone financially responsible for the individual or empowered to make financial or health related decisions on the Individual/Participant's behalf. Additionally, DMHA is not a provider of CMHW services.
4) The quality improvement specialists provide oversight for CMHW providers and engage in quality management activities to promote adherence to Wraparound service delivery practices, including family choice and direction in the development of the plan of care, selection of service providers and preference for service delivery. Quality improvement specialists are responsible to provide training, education, site visits, record reviews and consultation to ensure provider compliance with CMHW requirements and standards.
5) Participants and families are educated regarding their rights and how to submit complaints or appeals regarding all aspects of CMHW service delivery, providers, inclusion in treatment planning, DMHA eligibility determinations or Plan of Care authorization.
6) The assessments, person-centered service plan and direct CMHW services are all based on a county level geographic region. Authorized providers are required to designate the geographical area of service by county as a part of the enrollment process. The providers may request to add or decrement counties as needs change.

6. ☑ **Fair Hearings and Appeals.** The state assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.

7. ☑ **No FFP for Room and Board.** The state has methodology to prevent claims for Federal financial participation for room and board in State plan HCBS.

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

Number Served

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

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

Annual Period	From	To	Projected Number of Participants
Year 1	7/1/2023	6/30/2024	1,100
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):*

All determinations of eligibility, whether initial or renewal, are made by the State based upon the review of applications submitted by the access site (initials) or Wraparound Facilitators (renewals).

State employees making eligibility review decisions must meet the following qualifications:

1) Bachelor's degree in social services or related field
2) Experience working with children/youth identified as severely emotionally disturbed
3) Experience with the Child Adolescent Needs and Strengths (CANS) assessment tool and set algorithms established by the DMHA in partnership with the Praed Foundation and Indiana University.
4) Individuals performing evaluation/reevaluation must be employed with the State as a National Wraparound Implementation Center Local Coach candidate.

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

5) Affiliated with a DMHA-authorized access site (Initial) or DMHA-authorized Wraparound facilitation agency (renewal).
6) One of the following clinical qualifications:
    a) A psychiatrist;
    b) A physician;
    c) A licensed psychologist or a psychologist endorsed as a health service provider in psychology (HSPP);
    d) A licensed clinical social worker;
    e) A licensed mental health counselor;
    f) A licensed marriage and family therapist;
    g) An advanced practice registered nurse under IC 25-23-1-1(b)(3) who is credentialed in psychiatric or mental health nursing by the American Nurses Credentialing Center;
    h) A licensed independent practice school psychologist; or
    i) The provider must have a bachelor's degree or a master's degree with two (2) or more years of one or a combination of the following experience:
        i. Clinical
        ii. Case management
        iii. Skills building
        iv. Child welfare
        v. Juvenile justice
        vi. Education in a K-12 school setting

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

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:

The eligibility review process is the same for initial and annual reviews, with the exception that the initial is conducted by the access site, and the annual is conducted by the assigned Wraparound Facilitator.

All referrals for CMHW services must be received through the DMHA-authorized state-wide access site. An interested individual will receive education about Wraparound practice, available CMHW services, and the face-to-face evaluation. This face-to-face evaluation includes administration of the Child and Adolescent Needs and Strengths (CANS) assessment and completion of the CMHW application developed by OMPP and DMHA. The individual will determine whether to pursue application and assessment for 1915(i) services.

The assessment and supporting documentation identifies specific information about the individual's current strengths, needs, health status, living situation, family functioning, exposure to trauma, vocational status, social functioning, living skills, self-care skills, capacity for decision making, living situation, potential for self-injury or harm to others, substance use/abuse, and medication adherence. The access site also verifies the individual resides in a HCBS compliant setting, as defined by federal regulations.

The access site must submit the complete application packet to DMHA within ten (10) business days of receiving the parent/guardian's signature. DMHA notifies the access site regarding the eligibility determination on the eligibility determination form within five (5) working days of receiving the application packet. The eligibility determination form serves as the written notice documenting a DMHA determination regarding an individual's eligibility for participation in CMHW services. Information included on the Eligibility Determination form includes:

1) Approval or Denial of Individual's level of need/eligibility to participate in the CMHW services program;
2) The effective dates and reasons for the action(s) taken; and
3) The individual's appeal and fair hearing rights and procedural information.

The access site communicates DMHA's determination information on the eligibility determination form to the individual. Referrals to alternate services are made if the individual is not eligible for CMHW services.

At least annually, the Wraparound Facilitator conducts a review to ensure the participant continues to meet eligibility criteria. The Wraparound Facilitator will complete the face-to-face reevaluation with the participant, including the administration of the CANS assessment tool, to ensure all eligibility criteria for CMHW Wraparound participation are met. The high fidelity Wraparound process requires active investment by a wraparound team to meet the participant's needs. The Child and Family Team provides input regarding the participant's progress in moving towards achieving the vision.

The Wraparound Facilitator submits the results of the reevaluation to DMHA, which determines the participant's continued eligibility for the CMHW services. DMHA forwards the eligibility determination form to the Wraparound Facilitator, who communicates DMHA's eligibility

determination to the participant, family and to the Child and Family Team.

When it is anticipated that the participant may no longer be eligible for CMHW services, the Wraparound Facilitator and Child and Family Team will begin preparing the participant and family to transition to other more appropriate services (e.g., State plan services, community, and natural supports).

OMPP delegates the responsibility for accurate and timely eligibility reviews to DMHA. OMPP retains the authority and oversight of the 1915(i) benefit functions through regular monthly meetings to review quality assurance measures and to discuss issues, trends, and member appeals. OMPP reviews and approves policies, procedures, forms and standards for evaluation and re-evaluation of eligibility. OMPP may review and overrule the approval or disapproval of any specific eligibility determination by DMHA serving in its capacity as the operating agency for the 1915(i) HCBS State Plan Benefit.

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):*

The CANS assessment tool (developed for assessing youth ages 5 to 17) (Lyons, 1999) is used by the State to assist in assessing the youth and caregiver's strengths and needs (The assessment tool can be reviewed at: https://dmha.fssa.in.gov/DARMHA/mainDocuments). Patterns of CANS ratings derived from assessing six dimensions of the youth's life (e.g., life functioning, behavioral health symptoms, risk behaviors, youth strengths, caregiver strengths and needs and acculturation) have been used to develop a Behavioral Health Decision Model (algorithm). The recommendation is a result of an algorithm run on the CANS assessment ratings over multiple life domains. The CANS behavioral recommendation indicates the following levels of need for behavioral health services:

0-No treatment services indicated
1-Outpatient Services
2-Outpatient Services, with Limited Case Management
3- Supportive Community Services
4- Intensive Community Services: high-fidelity Wraparound
5- Intensive Community-Based Services
6- High-Intensity Services: Psychiatric Residential Treatment Facility (PRTF), State hospital, Intensive Community Based

Needs-Based Eligibility Criteria:

In addition to meeting the Target Group Eligibility criteria, individuals must also meet the following needs- based eligibility criteria:

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

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

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

1. An individual who is at imminent risk of harm to self or others. An individual who is identified as not able to feasibly receive intensive community-based services without compromising his/her safety, or the safety of others, will be referred to a facility capable of providing the level of intervention or care needed to keep the youth safe. Individuals residing in an institutional or otherwise HCBS non-compliant setting.

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)
In addition to meeting the Target Group Eligibility criteria, individuals must also meet the following needs-based eligibility criteria: 1) Youth is experiencing significant* emotional and/or functional impairments that impact his/her level of functioning at home or in the community, as a result of a mental illness. A minimum behavioral recommendation of a 4 is required, 2) The individual, who meets a minimum of 4 behavioral recommendation on the CANS, must also meet the following needs-based criteria: a) Dysfunctional patterns of behavior due to one or more of the following behavioral/emotional need(s), as identified on the CANS assessment tool: i. Adjustment to Trauma	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	Indiana Law allows reimbursement to ICF/IIDs for eligible persons as defined in 405 IAC 1-1-11. A person may be functionally eligible for an ICF/IID LOC waiver when documentation shows he individually meets the following conditions: 1) Has a diagnosis of intellectual disability, cerebral palsy,	Admission criteria for Psychiatric Residential Treatment Facilities (PRTFs), which include the following factors: 1) Individual's mental disorder is rated as severe or complex; 2) Multiple disruptive behaviors; 3) Serious family functioning impairments; 4) Prior failure of acute and/or emergency treatment to sufficiently ameliorate the condition;

ii. Psychosis; iii. Debilitating anxiety; iv. Conduct problems; v. Sexual aggression; and/or vi. Fire-setting. b) Demonstrates significant* needs in at least one of the following Family/caregiver area(s), as indicated on the CANS assessment tool: i. Mental Health; ii. Supervision issues; iii. Family Stress; and/or iv. Substance abuse. *"Significant" is determined by an assessed need for *immediate or intensive action due to a serious or disabling need in a variety of life domains* on the CANS assessment tool used by the State to assess an Individual's Level of Need (LON). **Exclusionary Criteria:** The following exclusionary criteria are used to identify those youth the CMHW services program is not designed to serve: 1) An individual who is at imminent risk of harm to self or others. 2) An individual who is identified as not able to feasibly receive intensive community-based services without compromising his/her safety, or the safety of others, will be referred to a facility capable of providing the level of intervention or care needed to keep the youth safe. 3) An individual residing in an institutional or otherwise HCBS non-compliant setting.	daily basis, essentially 7 days a week. 405 IAC 1-3-2 (a) Intermediate nursing care includes care for patients with long-term illnesses or disabilities which are relatively stable, or care for patients nearing recovery and discharge who continue to require some professional medical or nursing supervision and attention. A person is functionally eligible for either NF level of care or 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	2) epilepsy, autism, or condition similar to intellectual disability 3) Condition identified in #1 is expected to continue. 4) 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: Self-care; learning; self-direction; capacity for independent living; language; and mobility.	5) Symptom complexes showing a need for extended treatment in a residential setting due to a threat to self or others; 6) Impaired safety issues; and 7) Need for long-term treatment modalities. *The minimum eligibility rating for a child to qualify for institutional placement in a PRTF or state-operated facility (SOF) level of care is five (5) or higher, as determined by a behavioral recommendation from administration of the Child and Adolescent Needs and Strengths (CANS) Assessment Tool. While the algorithm that determines the CANS score is proprietary, the State has determined that a score of four (4) or higher meets the level of need criteria established for CMHW

	assistance at least 5 days per week due to unstable, complex medical conditions. Need for direct assistance for 3 or more substantial medical conditions including activities of daily living.		

*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 State elects to target this 1915(i) State Plan HCBS benefit to the population defined below. With this election, the State will operate this program for a period of five years. At least 90 days prior to the end of this five-year period, the State may request that CMS renew this benefit for an additional five year term in accordance with 1915(i)(7)(C).

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

1) The individual is age six through the age of 17 at the time of eligibility review;
2) The individual meets the criteria for two (2) or more DSM V diagnoses; and
3) The individual does not meet exclusionary criteria for CMHW services.

A participant who meets CMHW eligibility and began receiving CMHW 1915(i) services at or before the age of seventeen (17) shall remain eligible for up to one year of services beyond that participant's eighteenth birthday during the participant's benefit period as long as the remaining eligibility and needs-based criteria continue to be met.

Diagnostic Criteria:
The following diagnostic criteria are used to identify those youth the CMHW services program is designed to serve. A youth with any of the diagnoses below as primary is eligible for CMHW services:

Paranoid schizophrenia

Disorganized schizophrenia

Catatonic schizophrenia
Undifferentiated schizophrenia
Residual schizophrenia
Schizophreniform disorder
Other schizophrenia
Schizophrenia
Delusional Disorder
Shared psychotic disorder
Schizoaffective disorder, bipolar type
Schizoaffective disorder, depressive type
Other schizoaffective disorders
Schizoaffective disorder, unspecified
Other specified schizophrenia spectrum and other psychotic disorder
Unspecified schizophrenia spectrum and other psychotic disorder
Manic episode without psychotic symptoms, unspecified
Manic episode without psychotic symptoms, moderate
Manic episode, severe, without psychotic symptoms
Manic episode, severe with psychotic symptoms
Manic episode in partial remission
Manic episode, unspecified
Bipolar I disorder, current or most recent episode hypomanic
Bipolar disorder, current episode manic without psychotic features, unspecified
Bipolar I disorder, current or most recent episode manic, moderate
Bipolar I disorder, current or most recent episode manic, severe
Bipolar I disorder, current or most recent episode manic, with psychotic features
Bipolar disorder, current episode depressed, mild or moderate severity, unspecified
Bipolar I disorder, current or most recent episode depressed, moderate
Bipolar I disorder, current or most recent episode depressed, severe
Bipolar I disorder, current or most recent episode depressed, with psychotic features
Bipolar disorder, current episode mixed, unspecified
Bipolar disorder, Current episode mixed, moderate
Bipolar disorder, current episode mixed, severe, without psychotic features
Bipolar disorder, current episode mixed, severe, with psychotic features
Bipolar disorder, in partial remission, most recent episode hypomanic
Bipolar I disorder, current or most recent episode hypomanic, in partial remission
Bipolar I disorder, Current or most recent episode depressed, in partial remission
Bipolar disorder, in partial remission, most recent episode mixed
Bipolar II disorder
Other specified bipolar and related disorder
Bipolar I disorder, current or most recent episode depressed, hypomanic or manic, unspecified or Unspecified bipolar and related disorder
Major depressive disorder, single episode, moderate
Major depressive disorder, single episode, severe

Major depressive disorder, single episode, with psychotic features
Major depressive disorder, single episode, in partial remission
Major depressive disorder, recurrent episode, moderate
Major depressive disorder, recurrent episode, severe
Major depressive disorder, recurrent episode, with psychotic features
Major depressive disorder, recurrent episode, in partial remission
Major depressive disorder, recurrent episode, unspecified
Cyclothymic disorder
Persistent depressive disorder (dysthymia)
Disruptive mood dysregulation disorder
Agoraphobia
Agoraphobia with panic disorder
Agoraphobia without panic disorder
Social anxiety disorder (social phobia)
Panic disorder
Generalized anxiety disorder
Mixed obsessional thoughts and acts
Hoarding disorder
Posttraumatic stress disorder
Post-traumatic stress disorder, acute
Post-traumatic stress disorder, chronic
Dissociative identity disorder
Pain disorder exclusively related to psychological factors
Anorexia nervosa, unspecified
Anorexia nervosa, restricting type
Anorexia nervosa, binge eating/purging type
Bulimia nervosa
Binge eating disorder
Avoidant/restrictive food intake disorder
Pica in adults, avoidant/restrictive food intake disorder, other specified feeding or eating disorder
Unspecified feeding or eating disorder
Non-rapid eye movement sleep arousal disorders, Sleep terror type
Paranoid personality disorder
Borderline personality disorder
Conduct disorder confined to family context
Conduct disorder, Childhood-onset type
Conduct disorder, Adolescent-onset type
Other specified disruptive, impulse-control, and conduct disorder
Conduct disorder, Unspecified onset or Unspecified disruptive, impulse-control, and conduct disorder
Separation anxiety disorder
Reactive attachment disorder
Stereotypic movement disorder

Oppositional defiant disorder

The following diagnostic criteria are used to identify those youth the CMHW services program is designed to serve. A youth with any of the diagnoses below as secondary, but not primary, is eligible for CMHW services:

Alcohol use disorder, mild
Alcohol abuse with intoxication, uncomplicated
Alcohol abuse with alcohol-induced psychotic disorder with delusions
Alcohol abuse with alcohol-induced psychotic disorder with hallucinations
Alcohol abuse with other alcohol-induced disorder
Alcohol abuse with unspecified alcohol-induced disorder
Alcohol use disorder, moderate or severe
Alcohol dependence, in remission
Alcohol dependence with intoxication, uncomplicated
Alcohol dependence with withdrawal, uncomplicated
Alcohol dependence with alcohol-induced psychotic disorder with delusions
Alcohol dependence with alcohol-induced psychotic disorder with hallucinations
Alcohol dependence with unspecified alcohol-induced disorder
Opioid use disorder, mild
Opioid abuse with intoxication, uncomplicated
Opioid abuse with opioid-induced psychotic disorder with delusions
Opioid abuse with opioid-induced psychotic disorder with hallucinations
Opioid abuse with opioid-induced psychotic disorder, unspecified
Opioid abuse with unspecified opioid-induced disorder
Opioid use disorder, moderate or severe
Opioid dependence in remission
Opioid dependence with intoxication, uncomplicated
Opioid dependence with opioid-induced psychotic disorder with delusions
Opioid dependence with opioid-induced psychotic disorder with hallucinations
Opioid dependence with opioid-induced psychotic disorder, unspecified
Opioid dependence with unspecified opioid-induced disorder
Cannabis use disorder, mild
Cannabis abuse with intoxication, uncomplicated
Cannabis abuse with psychotic disorder with delusions
Cannabis abuse with psychotic disorder with hallucinations
Cannabis abuse with unspecified cannabis-induced disorder
Cannabis use disorder, moderate or severe
Cannabis dependence, in remission
Cannabis dependence with intoxication, uncomplicated
Cannabis dependence with psychotic disorder with delusions
Cannabis dependence with psychotic disorder with hallucinations
Cannabis dependence with unspecified cannabis-induced disorder
Sedative-, hypnotic-, or anxiolytic use disorder, mild

Sedative, hypnotic or anxiolytic abuse with intoxication, uncomplicated
Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced psychotic disorder with delusions
Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced psychotic disorder with hallucinations
Sedative, hypnotic or anxiolytic abuse with other sedative, hypnotic or anxiolytic-induced disorder
Sedative, hypnotic or anxiolytic abuse with unspecified sedative, hypnotic or anxiolytic-induced disorder
Sedative-, hypnotic-, or anxiolytic use disorder, moderate or severe
Sedative, hypnotic or anxiolytic dependence, in remission
Sedative, hypnotic or anxiolytic dependence with intoxication, uncomplicated
Sedative, hypnotic or anxiolytic dependence with withdrawal, uncomplicated
Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder with delusions
Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder with hallucinations
Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced persisting amnestic disorder
Sedative, hypnotic or anxiolytic dependence with unspecified sedative, hypnotic or anxiolytic-induced disorder
Cocaine use disorder, mild
Cocaine abuse with intoxication, uncomplicated
Cocaine abuse with cocaine-induced psychotic disorder with delusions
Cocaine abuse with cocaine-induced psychotic disorder with hallucinations
Cocaine abuse with unspecified cocaine-induced disorder
Cocaine use disorder, moderate or severe
Cocaine dependence, in remission
Cocaine dependence with intoxication, uncomplicated
Cocaine dependence with cocaine-induced psychotic disorder with delusions
Cocaine dependence with cocaine-induced psychotic disorder with hallucinations
Cocaine dependence with unspecified cocaine-induced disorder
Amphetamine-type substance use disorder or Other or unspecified stimulant use disorder, mild
Other stimulant abuse with intoxication, uncomplicated
Other stimulant abuse with unspecified stimulant-induced disorder
Amphetamine-type substance use disorder or Other or unspecified stimulant use disorder, moderate or severe
Other stimulant dependence, in remission
Other stimulant dependence with intoxication, uncomplicated
Other stimulant dependence with unspecified stimulant-induced disorder
Other Hallucinogen or Phencyclidine use disorder, mild
Hallucinogen abuse with intoxication, uncomplicated
Hallucinogen abuse with hallucinogen persisting perception disorder (flashbacks)
Hallucinogen abuse with other hallucinogen-induced disorder
Hallucinogen abuse with unspecified hallucinogen-induced disorder
Other Hallucinogen or Phencyclidine use disorder, moderate or severe

Hallucinogen dependence, in remission
Hallucinogen dependence with intoxication, uncomplicated
Hallucinogen dependence with hallucinogen-induced psychotic disorder with delusions
Hallucinogen dependence with hallucinogen-induced psychotic disorder with hallucinations
Hallucinogen dependence with hallucinogen persisting perception disorder (flashbacks)
Hallucinogen dependence with other hallucinogen-induced disorder
Hallucinogen dependence with unspecified Hallucinogen-induced disorder
Inhalant use disorder, mild
Inhalant abuse with intoxication, uncomplicated
Inhalant abuse with inhalant-induced psychotic disorder with delusions
Inhalant abuse with inhalant-induced psychotic disorder with hallucinations
Inhalant abuse with unspecified inhalant-induced disorder
Inhalant use disorder, moderate or severe
Inhalant dependence, in remission
Inhalant dependence with intoxication, uncomplicated
Inhalant dependence with inhalant-induced psychotic disorder with delusions
Inhalant dependence with inhalant-induced psychotic disorder with hallucinations
Inhalant dependence with unspecified inhalant-induced disorder
Other (or unknown) substance use disorder, with mild use disorder
Other psychoactive substance abuse with intoxication, uncomplicated
Other psychoactive substance abuse with intoxication with perceptual disturbances
Other psychoactive substance abuse with psychoactive substance-induced psychotic disorder with delusions
Other psychoactive substance abuse with psychoactive substance-induced psychotic disorder with hallucinations
Other psychoactive substance abuse with psychoactive substance-induced persisting amnestic disorder
Other psychoactive substance abuse with unspecified psychoactive substance-induced disorder
Other (or unknown) substance use disorder, with moderate or severe use disorder
Other psychoactive substance dependence, in remission
Other psychoactive substance dependence with intoxication, uncomplicated
Other psychoactive substance dependence with intoxication with perceptual disturbance
Other psychoactive substance dependence with withdrawal, uncomplicated
Other psychoactive substance dependence with withdrawal with perceptual disturbance
Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder with delusions
Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder with hallucinations
Other psychoactive substance dependence with psychoactive substance-induced persisting amnestic disorder
Other psychoactive substance dependence with unspecified psychoactive substance-induced disorder
Attention-deficit/hyperactivity disorder, Predominantly inattentive presentation
Attention-deficit/hyperactivity disorder, Predominantly hyperactive/impulsive presentation

Attention-deficit/hyperactivity disorder, Combined presentation

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

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

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

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

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

Home and Community-Based Settings

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

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

HCBS, and how these settings meet the Federal home and community-based settings requirements, at the time of submission and in the future):

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

The state assures that this SPA renewal will be subject to any provisions or requirements included in the State's most recent and/or approved home and community-based settings Statewide Transition Plan.

1915(i) CMHW services are provided in the member's home and community, based upon the member's preferences. Settings for service delivery are chosen by participant during the service planning process, identified in the participant's plan of care, reviewed, and approved by the State. During quality assurance reviews, service settings are reviewed for compliance as well. Settings found to be out of compliance are subject to remediation, including but not limited to corrective action and reclamation of funds.

Any type of institutional or institution-like residence (except approved respite facilities) as defined by federal regulations would be considered a non-complaint HCBS setting, and would be disallowed. For purposes of this document "home" includes any community-based residence that the participant lives in with the guardian/caregiver, including a foster home.

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Participants who reside with family members in homes or apartments in typical community neighborhoods where people who do not receive home and community-based services reside are presumed to be in compliance. If it is found that a participant living with family members who do not reside in typical community neighborhoods, but have relocated to an institution or institution-like setting will be considered as not fully complying with federal and state requirements. DMHA would require the participant and family to move to a compliant setting, and would work with the family on a month-by- month basis with demonstrated progress (such as the exploration of alternate residences) as is reasonable to accommodate any lease or other legal obligations, not to exceed one year from the date of formal notice. Progress toward this transition would have been monitored no less often than monthly as part of the required monthly Child and Family Team meetings, and would include assistance from the local System of Care and DMHA where appropriate.

Ongoing Compliance and Monitoring of Settings

In order to ensure ongoing compliance and monitoring of settings, DMHA will continue to train all providers on the setting requirements, including an assessment of the residential setting by access personnel as part of the initial application for eligibility process; requiring an annual confirmation of the compliance of the residential setting (attestation form); requiring Wraparound Facilitators to assess any changes in the residential setting during the program year, and reporting the assessment to the State; and the Child and Family Team, guided by the Wraparound Facilitator and other providers, determining the settings in which services will be delivered as part of plan development, to be reviewed and approved by the State.

All providers must participate in orientation and service specific training. This training includes information regarding the HCBS Settings Final Rule requirements. A description of the setting in which services are delivered is required in all service notes, as discussed in training. Demonstrated competency measures are included in DMHA trainings, and questions on this requirement have been included. Potential providers are required to pass the competency measure in order to be approvable as a provider. Ongoing support is available to providers who may have questions regarding allowable settings. All providers are given state contacts for technical assistance in any areas of need.

As part of the initial application for eligibility and again at the time of annual eligibility renewal, questions related to settings compliance will be addressed and included in the DMHA Youth and Family Rights Attestation form, which includes all of the rights offered to all participants. A field has been added to the Youth and Family Rights Attestation form that the family signs to validate the compliance of the participant's residential setting. Access personnel (who complete initial assessments for application for eligibility on behalf of the State) receive training on the setting requirements, understanding that it is a fundamental part of the initial assessment. A description of the participant's living situation has always been a requirement of the initial and annual application, which is then reviewed by the State as part of the eligibility process. The Wraparound Facilitators are in the participants' home at least once per month.+As part of the State's plan to ensure ongoing compliance, Wraparound Facilitators review any relocation of the participant to a new setting to ensure that the setting is compliant with the federal requirements, and communicate that to DMHA when updating the participant's demographic information.
If, during the eligibility period the participant is found to be in an institutional, institution-like, or otherwise non-compliant setting, the Wraparound Facilitator notifies DMHA to begin the remediation process.

Wraparound Facilitators guide the Child and Family Team meeting for plan of care development including determining services, strategies, responsible parties, and the setting in which services will take place. The plan of care is then reviewed and approved by DMHA quality assurance staff for compliance. DMHA quality assurance staff review 100% of service plans submitted before approval. There is currently an established process for the Wraparound Facilitator to notify DMHA if the participant will be out the identified setting for more than 24 hours. This includes but is not limited to camp, overnight with relatives or placement in an acute setting. This allows for DMHA to monitor changes in the living arrangement.

Upon enrollment in the program, youth and families are also given information regarding contacting DMHA for assistance with any concerns they may have. Anyone, provider, family member, or other, may submit a complaint to DMHA about any concern they may have including services provided in non-compliant or questionable settings. Access to the web-based complaint portal is provided on several DMHA webpages.

All issues involving HCBS settings compliance will be processed as complaints and accordingly will be tracked, monitored, and reported as a subsection of overall quality improvement activities. Review of settings issues will also be specifically included in overall trend analysis to determine any patterns requiring remediation.

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

1) Affiliated with a DMHA-approved access site (initial) or DMHA-authorized Wraparound Facilitation agency (renewal).
2) One of the following clinical qualifications:
    a) A psychiatrist;
    b) A physician;
    c) A licensed psychologist or a psychologist endorsed as a health service provider in psychology (HSPP);
    d) A licensed clinical social worker;
    e) A licensed mental health counselor;
    f) A licensed marriage and family therapist;
    g) An advanced practice nurse under IC 25-23-1-1(b)(3) who is credentialed in psychiatric or mental health nursing by the American Nurses Credentialing Center;
    h) A licensed independent practice school psychologist; or
    i) An unlicensed individual who does not have a license to practice independently but practices under the supervision of one of the above mentioned persons; The provider must have a bachelor's degree or a master's degree with two (2) or more years of one or a combination of the following experience:
        a. Clinical
        b. Case management
        c. Skills building
        d. Child welfare
        e. Juvenile justice
        f. Education in a K-12 school setting

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

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):*

The CMHW service provider developing the plan of care must meet the following criteria:

1. The provider must be employed by a DMHA-authorized accredited agency to be a provider of the service of Wraparound Facilitation.
2. The provider must have a bachelor's degree or a master's degree with two (2) or more years of one or a combination of the following experience:
    a. Clinical
    b. Case management
    c. Skills building
    d. Child welfare
    e. Juvenile justice
    f. Education in a K-12 school setting
3. The provider must complete the following office-required service provider training and certifications:
    a. CMHW services orientation
    b. Child and adolescent needs and strengths assessment tool SuperUser certification
    c. Wraparound practitioner training
    d. Cardiopulmonary resuscitation (CPR) certification

1. **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):*

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

During initial assessment at the access site, the family is offered a list of available Wraparound Facilitators and the agencies for the county in which the family lives. The family may choose any Wraparound Facilitation agency from this randomly generated list. The access site submits the family's choice of Wraparound Facilitator (via picklist) along with eligibility documents to the State for review and approval. If eligibility is approved, the State creates an initial plan of care authorizing two-to-three months of Wraparound Facilitation services. This is assigned to the chosen Wraparound Facilitator who begins the person-centered planning process to develop the comprehensive plan of care.

The Wraparound Facilitator will guide the family through the ongoing Wraparound process and development of the CMHW service plan. The Wraparound Facilitator is responsible for coordination of care and ensuring Participant's care/service delivery adheres to the high

fidelity Wraparound model.

The Wraparound Facilitator prepares the participant and family for the Child and Family Team meeting by discussing the individual's and family's rights; the high-fidelity Wraparound and team process; and assists the Participant/family to identify potential members of their Child and Family team (including friends and other advocates that are not providing services). The participant and family determine the members of the Child and Family Team.

All Plan of Care development takes place within the framework of the Child and Family Team meeting process. This process requires that the Child and Family Team meetings be only convened when the Participant/family is available, with their active participation at a location convenient to them.

The chosen providers and families sign the approved Person-Centered Plan. DMHA includes each person-centered-plan as part of the plan of care, which is then incorporated into the Care Plan that providers are required to sign.

The 10 Principles of Wraparound, intended to support the family in the treatment process, include:

- *Family Voice and Choice*: Wraparound Team specifically elicits and prioritizes the family and youth perspectives during all phases of the Wraparound Process. The Team strives to provide options and choices such that the Plan reflects family values and preferences.
- *Team Based*: The Team consists of individuals agreed upon by the family and committed to them through informal, formal and community support and service relationships.
- *Natural Supports*: The Team encourages the full participation of team members chosen from the family's networks of interpersonal and community relationships.
- *Collaboration*: Team members cooperate and share responsibility for developing, implementing, monitoring, and evaluating a single wraparound plan. The plan reflects a blending of team members' perspectives, mandates, and resources. The Plan guides and coordinates each team member's work towards meeting the Team's goals
- *Community-Based*: The Team implements services and supports that take place in the most inclusive, responsive, accessible, and least restrictive settings possible that safely promote youth and family integration into home and community life.
- *Culturally Competent*: The Wraparound Process respects and builds on the values, preferences, beliefs, culture, and identity of the youth and family and their community. Non-family Team members refrain from imposing personal values on the Plan.
- *Individualized*: The Team develops and implements customized strategies, supports and services to achieve the goals laid out in the Plan.
- *Strengths Based*: Both the Wraparound Process and Plan identify, build on, and enhance the capabilities, knowledge, skills, and assets of the youth and family, their community, and the other team members.
- *Persistence*: Regardless of challenges that may occur, the Team persists in working toward the goals included in the Plan until the Team agrees that a formal Wraparound Process is no longer required.
- *Outcome Based*: The goals and strategies of the Plan are tied directly to observable

or measurable indicators of success. The Team monitors progress in terms of these indicators and revises the Plan accordingly.

2. **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 participant and family determine who will provide services at all times while in the CMHW program. During the application process, the access site presents the participant and family with a pick list of DMHA-authorized providers of Wraparound Facilitation in their county for assignment if the application is approved. Once approved, the State creates the initial plan of care and assigns the participant and family to their selected Wraparound Facilitator. As part of the person-centered- planning process, the Wraparound Facilitator informs the participant and family, verbally and in writing, about their right to choose from among any DMHA-authorized provider of the chosen service in their county.

As a service is identified, the Wraparound Facilitator generates what is referred to as a pick list. Pick lists contain the names and contact information of all DMHA-authorized providers of a CMHW service in the county in which the participant resides. The providers are presented in random order each time the list is generated. Participants and family members may interview potential service providers and select the provider of each service on the Plan of Care. An image of the signed pick list is maintained in the State database, and the original maintained in the Participant's record managed by the Wraparound Facilitation providers.

The Wraparound Facilitator ensures the participant is aware of their option to change CMHW service providers at any time. This includes the option to change the Wraparound Facilitator. The participant can request a pick list at any time to select a different service provider.

At the time of authorization, the providers select the counties in which they will provide services. Families are provided a picklist which includes all providers who have elected to serve the member's county of residence.

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

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

3. **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):*

OMPP delegates the responsibility for service plan approval to DMHA. OMPP retains the authority and oversight of the 1915(i) program delegated to DMHA through routine monthly meetings to discuss issues, trends, member appeals and provider issues related to program operations including service plan approvals.

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

4. **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):*

1a. State plan HCBS.

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

Wraparound Facilitation is a comprehensive service comprised of a variety of specific tasks and activities designed to facilitate high fidelity Wraparound and is a required component of the CMHW services. The Wraparound Facilitator ensures that care is delivered in a manner consistent with strength-based, family-driven, and culturally competent values. The Wraparound Facilitator manages the entire wraparound process and ensures that the participant and family's voice, preferences, and needs are central in the plan of care development, throughout service delivery and into the child and family transition into a less intensive level of service delivery, when appropriate.

The Child and Family Team is responsible for assuring that the participant's needs, and the entities responsible for addressing them, are identified in a written plan of care (POC). The Wraparound Facilitator is the individual who facilitates and supervises this process, including:

1) Completing a comprehensive assessment of the participant, including administration of the CANS assessment tool.
2) Guiding the family engagement process by exploring and assessing strengths and needs through documentation of the family timeline and story.
3) Facilitating, coordinating, and attending Child and Family Team meetings.
4) Developing the plan of care in full partnership with Child and Family Team member, while ensuring compliance with high fidelity Wraparound and Medicaid standards.
5) Assists participant in gaining access to a full continuum of services (i.e., medical, social, educational, and/or other needed services).
6) Guides the POC planning process by informing the team of the participant and family's vision and ensuring that the participant and family's vision is central to all service planning and delivery.
7) Ensuring that the services are delivered in a HCBS compliant setting of the participant's

choice.

8) Ensuring that participants are informed of their right to choose from among enrolled, office-authorized providers, and to change providers at any time in the process.
9) Develops, implements, and monitors the crisis plan; and intervenes during a crisis, if needed.
10) Assures that all work to be done to assist the participant in obtaining goals on the POC is identified and assigned to a Child and Family Team member.
11) Oversees implementation of the POC.
12) Reassess, amends, and secures on-going approval of the POC.
13) Monitors all services authorized for a participant's POC.
14) Assures care is delivered in a manner consistent with strength-based, family driven, and culturally competent values.
15) Offers consultation and education to all CMHW service providers regarding the values and principles of the wraparound model.
16) Monitors participant progress toward treatment goals.
17) Ensures that necessary data for evaluation is gathered and recorded.
18) Ensures that all CMHW assessment and service-related documentation is gathered and reported to DMHA, as mandated.
19) Completes the annual CMHW services level of need re-evaluation, with active involvement of the Participant and the Child and Family Wraparound Team.
18) Communicates and coordinates with local Division of Family Resources (DFR) regarding continued Medicaid eligibility status.
19) Guides the transition of the Participant and family from CMHW services to State plan, or other community-based services, when indicated.

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

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

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

None	
Specify limits (if any) on the amount, duration, or scope of this service. 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):*
	No limits
☐	Medically needy *(specify limits):*

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Accredited Agency	Individuals from Accredited Agencies must meet standards in the *Other Standard* section.	Accreditation Association for Ambulatory Health Care (AAHC), Council on Accreditation (COA), Utilization Review Accreditation Commission (URAC), Commission on Accreditation of Rehab Facilities (CARF), American	Individuals providing this service must be affiliated with a DMHA- authorized CMHW accredited agency that adheres to the following standards: 1) Agency participates in a local system of care, where available, that endorses the values and principles of Wraparound. 2) Agency adheres to conflict-free standards including but not limited to not providing any other CMHW service except for facility- based respite care. 3) Agency must maintain documentation that the individual providing the service meets the following standards: a. Hold a bachelor's or master's degree in one of the following specialties from an accredited college or university: i. Social work ii. Psychology iii. Sociology iv. Counseling v. Nursing vi. Education vii. Rehabilitation viii. Or related degree if approved by the FSSA/DMHA/OMPP representative b. Have two (2) or more years of one or a combination of the following experience:

		Council for Accredited Certification (ACAC), Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or National Committee for Quality Assurance Accreditation (NCQAA)	i. Clinical ii. Case management iii. Skills building

			iv. Child welfare v. Juvenile justice vi. Education in a K-12 school setting 3) The provider must complete the following office-required service provider training and certifications: a. CMHW services orientation b. Child and adolescent needs and strengths assessment tool SuperUser certification c. Wraparound practitioner training d. Cardiopulmonary resuscitation (CPR) certification 4) Individual has completed security screens including, but not limited to, the following: a. Fingerprint based national and state criminal history background screen b. Local law enforcement screen c. State and local Department of Child Services abuse registry screen d. Five-panel drug screen, or Agency meets same requirements specified under the Federal Drug Free Workplace Act 41 U.S.C. 10 Section 702(a)(1) 6) All approved providers must complete DMHA and OMPP approved training for CMHW services. Wraparound Facilitators and their supervisors must complete the Wraparound Practitioner Training Program. This training allows the state to ensure fidelity to the wraparound service delivery model.

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

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

		authorization of the CMHW agency and at least every three years thereafter.

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

☐	Participant-directed	☑	Provider managed

1b. State plan HCBS.

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

Service Title: Habilitation

Service Definition (Scope)*:*

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

1) Identification of feelings
2) Managing anger and emotions
3) Giving and receiving feedback, criticism, or praise
4) Problem-solving and decision making
5) Learning to resist negative peer pressure and develop pro-social peer interactions
6) Improve communication skills
7) Build and promote positive coping skills
8) Learn how to have positive interactions with peers and adults

Habilitation services are provided face-to-face and one-to-one in the participant's home or in a community-based setting. The setting is determined by the preferences of the participant and must be compliant with federal HCBS settings regulations.

While participating in this service, transportation to and from community-based activities can be requested under this 1915(i) benefit if required and based on an assessed need. Transportation services must not duplicate services offered under the state plan.

Service exclusions include:

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

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

None

Specify limits (if any) on the amount, duration, or scope of this service. 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):*
	Habilitation services will be limited to up to three (3) hours daily and up to thirty (30) hours of services per participant/per month.
☐	Medically needy *(specify limits):*

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Accredited Agency	None	AAAHC, COA, URAC, CARF, ACAC, JCAHO, or NCQA Accreditation	DMHA authorized accredited agencies must receive authorization from DMHA for an individual to provide this service based on the qualifications of the individual. Agencies must maintain documentation that the individual providing the service meets the following requirements and standards: 1) Individual is at least 21 years of age and possesses a high school diploma, or equivalent. 2) Demonstrate a minimum of two (2) years of qualifying experience, as defined by DMHA, working with or caring for youth with serious emotional disturbances (SED) 3) Individual has completed and submitted proof of the following screens: a) Finger-print based national and state criminal history background screen b) Local law enforcement screen c) State and local Department of Child Services abuse registry screen d) Five-panel drug screen, or Agency meets same requirements specified under the Federal Drug Free Workplace Act 41 U.S.C. 10 Section 702(a)(1) 4) Documentation of the following:

			a) Current Driver's License b) Proof of current vehicle registration c) Proof of motor vehicle insurance coverage 5) For every thirty (30) hours of habilitation services provided, the provider must obtain one (1) hour of face-to-face supervision with a DMHA authorized mental health service provider contracted with or employed by the agency that meets one (1) of the following licensure requirements: a) Licensure in psychology (HSPP) as defined in IC 25-33-1. b) Licensed marriage and family therapist (LMFT) under IC 25-23.6-8. c) Licensed clinical social worker (LCSW) under IC 25-23.6-5. d) Licensed mental health counselor (LMHC) under IC 25-23.6-8.5. e) Advanced practice nurse (APN) under IC 12-15-5-14(d) 6) Complete the DMHA required service provider training: a) CMHW services orientation b) CPR certification

Non-Accredited Agency	None	None	DMHA- authorized non-accredited agencies must receive approval from DMHA for an individual to provide this service, based on the qualifications of the individual. Agencies must maintain documentation that the individual providing the service meets the following requirements and standards: 1) Individual is at least 21 years of age and possesses a High school diploma, or equivalent. 2) Demonstrate a minimum of two (2) years of qualifying experience, as defined by DMHA, working with or caring for youth with

			serious emotional disturbances (SED) 3) Individual has completed and submitted proof of the following screens: a) Fingerprint based national and state criminal history background screen b) Local law enforcement screen c) State and local Department of Child Services abuse registry screen d) Five-panel drug screen, or Agency meets same requirements specified under the Federal Drug Free Workplace Act 41 U.S.C. 10 Section 702(a)(1) 4) Documentation of the following: a) Current Driver's License b) Proof of current vehicle registration c) Proof of motor vehicle insurance coverage 5) For every thirty (30) hours of habilitation services provided, the provider must obtain one (1) hour of face-to-face supervision with a DMHA authorized mental health service provider contracted with or employed by the agency that meets one (1) of the following licensure requirements: a) Licensure in psychology (HSPP) as defined in IC 25-33-1. b) Licensed marriage and family therapist (LMFT) under IC 25-23.6-8. c) Licensed clinical social worker (LCSW) under IC 25-23.6-5. d) Licensed mental health counselor (LMHC) under IC 25-23.6-8.5. e) Advanced practice nurse

			(APN) under IC 12-15-5-

			14(d) 6) Complete the DMHA required service provider training: a) CMHW services orientation b) CPR certification
Individual	None	None	The DMHA- authorized CMHW individual providing the service meets the following requirements and standards: 1) Individual is at least 21 years of age and possesses a high school diploma, or equivalent. 2) Demonstrate a minimum of two (2) years of qualifying experience, as defined by DMHA, working with or caring for youth with serious emotional disturbances (SED) 3) Individual has completed and submitted proof of the following screens: a) Fingerprint based national and state criminal history background screen b) Local law enforcement screen c) State and local Department of Child Services abuse registry screen d) Five-panel drug screen, or agency meets same requirements specified under the Federal Drug Free Workplace Act 41 U.S.C. 10 Section 702(a)(1) 4) Documentation of the following: a) Current Driver's License b) Proof of current vehicle registration c) Proof of motor vehicle insurance coverage 5) For every thirty (30) hours of habilitation services provided, the provider must obtain one (1) hour

			of face-to-face supervision with an approved mental health service provider that meets one (1) of the following licensure requirements: a) Licensure in psychology (HSPP) as defined in IC 25-33-1. b) Licensed marriage and family therapist (LMFT) under IC 25-23.6-8. c) Licensed clinical social worker (LCSW) under IC 25-23.6-5. d) Licensed mental health counselor (LMHC) under IC 25-23.6-8.5. e) Advanced practice nurse (APN) under IC 12-15-5-14(d) 6) Complete the DMHA required service provider training: a) CMHW services orientation b) CPR certification

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

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

		authorization of the CMHW agency and at least every two years thereafter.

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

☐	Participant-directed	☑	Provider managed

1c. State plan HCBS.

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

Service Title:	Respite Care

Service Definition (Scope):

Respite Care is a service provided to a participant unable to care for himself/herself. The service is furnished on a short-term basis to provide needed relief to or because of the absence of the caregiver. Respite Care services may be provided as planned (routine) and unplanned (unexpected).

Routine Respite Care may be provided in the following manner:

1) On an hourly basis, billed less than 8 hours in the same day.
2) On a daily basis, as follows:
   - Billed for service provided 8 to 24 hours in the same day.
   - Routine Respite Daily service cannot exceed fourteen (14) consecutive days.
   - A minimum of thirty (30) days must pass after a 14-consecutive-day stay before Daily Respite may be utilized again.
   - Routine Respite Daily service is limited to 40 days per service plan year.

Unexpected Respite Care may be provided on an unplanned basis when a caregiver has an unexpected or emergency situation, and requires assistance in caring for the participant:

1) Unexpected Respite is provided on a daily basis
2) Unexpected Respite cannot exceed fourteen (14) consecutive days.
3) A minimum of thirty (30) days must pass after a 14-consecutive-day stay before Unexpected Daily Respite may be utilized again.
4) Unexpected Respite Daily service is limited to 40 days per service plan year.

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

1) DMHA-authorized CMHW Respite Care provider meeting standards and qualifications for an Individual service provider. Any CMHW-approved facility licensed by the Indiana Family and Social Services Administration or the Indiana Department of Child Services.
2) A relative related by blood, marriage, or adoption, who is not the legal guardian, does not live in the home with the Participant, approved by the Child and Family Team, and meets the standards and qualifications of an Individual CMHW service provider. DMHA will monitor any Respite Care services provided by an authorized relative to ensure the service is being provided as specified by CMHW policy which may include, but is not limited to, an unannounced visit during service provision by a CMHW service provider.

Respite Care services must be provided in the least restrictive environment available and ensure the health and welfare of the participant. A participant who needs consistent 24-hour supervision, with regular monitoring of medications or behavioral symptoms should be placed in a facility under the supervision of a psychologist, psychiatrist, physician or nurse who meets respective licensing or certification requirements of his/her

profession in the state of Indiana.

Excluding facility-based respite, while participating in this service, transportation to and from community-based activities can be requested under this 1915(i) benefit if required and based on an assessed need. Transportation services must not duplicate services offered under the state plan.

Allowed Respite Care service activities include:

1) Assistance with daily living skills
2) Assistance with accessing/transporting to/from community activities
3) Assistance with grooming and personal hygiene
4) Meal preparation, serving and cleanup
5) Administration of medications
6) Supervision
7) Recreational and leisure activities

Service exclusions include:

1) Respite Care provided by:
    a) Parents of a participant who is a minor child
    b) Any relative who is the primary caregiver of the Participant
    c) Anyone living in the Participant's residence
2) Respite services must not be provided as a substitute for regular childcare to allow the parent/caregiver to hold a job, engage in job-related or job search activities; or attend school
3) Respite care must not be provided in an Individual CMHW respite care service provider's residence unless that individual provider is a relative related by blood, marriage, or adoption, who is not the legal guardian, does not live in the home with the Participant, approved by the Child and Family Team, and meets the standards and qualifications of an Individual CMHW service provider. DMHA will monitor any Respite Care services provided by an authorized relative to ensure the service is being provided as specified by CMHW policy which may include, but is not limited to, an unannounced visit during service provision by a CMHW service provider.
4) Respite care shall not be used to provide service to the Participant while he/she is attending school.
5) All services and supports are decided upon by the Child and Family Treatment Team with required input from the participant and family. The state reviews and authorizes services prior to services being rendered by a provider. The Child and Family Treatment Team, with input from the participant and family, monitors all services and supports on a monthly basis during team meetings. The Wraparound Facilitator is responsible for oversight of this process with the Child and Family Treatment Team. Providers are also required to submit monthly summaries listing days of service. DMHA's quality team conducts periodic reviews of providers which includes comparison of service notes, monthly summaries, and claims.

Additional needs-based criteria for receiving the service, if applicable *(specify):*	
None	
Specify limits (if any) on the amount, duration, or scope of this service. 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):*
	Respite provided at Daily Rate (routine and unexpected) 7 to 24 hours in the same day) cannot exceed 14 consecutive days.
☐	Medically needy *(specify limits):*

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Accredited Agency	For facility-based Respite only: 1) Emergency shelters licensed under 465 IAC 2-10; 2) Foster Homes licensed under IC 31- 27-4 and IC 31-27-4-3only when the Licensed Child Placing Agency (LCPA) is the 1915(i) approved agency provider. DMHA will have the authority to	DMHA-approved accreditation as a mental health service provider or AAAHC, COA, URAC, CARF, ACAC, JCAHO, or NCQA Accreditation	Agency must maintain documentation that individual providing the service meets the following requirements and standards: 1) Individual is at least 21 years of age and has a high school diploma, or equivalent. 2) Individual has one (1) year of qualifying experience working with or caring for SED children/youth, as defined by DMHA. 3) Completed with qualifying results the following screens: a) Fingerprint based national and state criminal history background screen b) Local law enforcement screen c) State and local Department of Child Services abuse registry screen d) Five-panel drug screen, or Agency meets same requirements specified under the Federal Drug Free Workplace Act 41 U.S.C. 10 Section 702(a) (1) 4) Documentation of the following: a. Current Driver's License b. Proof of current vehicle registration c. Proof of motor vehicle

	request a copy of the home study that was conducted on the foster parent providing 1915(i) Respite Care services; 3) Other child caring institutions licensed under IC-31- 27-3; 4) Child Care Centers licensed under IC 12- 17.2-4; 5) Child Care Homes licensed under IC 12- 17.2-5-1; 6) School Age Child Care Project licensed under IC 12-17-12; or 7) Psychiatric Residential Treatment Facility (PRTF) licensed under 465 IAC 2-11-1 as a private secure residential facility for Medicaid certification under 405 IAC 5-20-3.1.		insurance coverage All approved providers must complete DMHA and OMPP approved training for CMHW services.

Non-Accredited Agency

	For Facility-based Respite only: 1) Emergency shelters licensed under 465 IAC 2-10; 2) Foster Homes licensed under IC 31-27-4 andIC 31-27-4-3 only when the Licensed Child Placing Agency (LCPA) is the 1915(i) approved agency provider. DMHA will have the authority to request a copy of the home study that was conducted on the foster parent providing 1915(i) Respite Care services;	None	The DMHA- authorized CMHW agency must maintain documentation that individual providing the service meets the following requirements and standards: 1) Individual is at least 21 years of age and has a high school diploma, or equivalent. 2) Individual has one (1) year of qualifying experience working with or caring for SED children/youth, as defined by DMHA. 3) Completed with qualifying results the following screens: a) Fingerprint based national and state criminal history background screen b) Local law enforcement screen c) State and local Department of Child Services abuse registry screen d) Five-panel drug screen, or Agency meets same requirements specified under the Federal Drug Free Workplace Act 41 U.S.C. 10 Section 702(a) (1) 4) Documentation of the following: a. Current Driver's License b. Proof of current vehicle registration c. Proof of motor vehicle insurance coverage All approved providers must complete DMHA and OMPP approved training for CMHW services.
	3) Other child caring institutions licensed		

	under IC-31-27-3; 4) Child Care Centers licensed under IC 12-17.2-4; 5) Child Care Homes licensed under IC 12-17.2-5-1; 6) School Age Child Care Project licensed under IC 12- 17-12; or Psychiatric Residential Treatment Facility (PRTF) licensed under 465 IAC 2-11-1 as a private secure residential facility for Medicaid certification under 405 IAC 5-20-3.1.		
Individual	None	None	The DMHA- authorized CMHW individual providing the service meets the following requirements and standards: 1) Individual is at least 21 years of age and possesses a high school diploma, or equivalent. 2) Demonstrate a minimum of one (1) year of qualifying experience, as defined by DMHA, working with or caring for youth with serious emotional disturbances (SED) 3) Individual has completed and submitted proof of the following screens: a) Fingerprint based national and state criminal history background screen

			b) Local law enforcement screen c) State and local Department of Child Services abuse registry screen d) Five-panel drug screen, or Agency meets same requirements specified under the Federal Drug Free Workplace Act 41 U.S.C. 10 Section 702(a)(1) 4) Documentation of the following: a. Current Driver's License b. Proof of current vehicle registration c. Proof of motor vehicle insurance coverage All approved providers must complete DMHA and OMPP approved training for CMHW services.

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

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

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

☐	Participant-directed	☑	Provider managed

1d. State plan HCBS.

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

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

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

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

Provision of service is available as:

1) An hourly service schedule for training by an approved CMHW service provider to a youth's caregivers, as documented on the participant's POC. In recognition that learning happens in real time, up to two hours per month may be provided via telephone.
2) A non-hourly service that reimburses for the costs of registration/conference training fees, books and supplies associated with the training and support needs, as documented on the participant's POC

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

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

While participating in this service, transportation to and from community-based activities can be requested under this 1915(i) benefit if required and based on an assessed need. Transportation services must not duplicate services offered under the state plan.

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

None

Specify limits (if any) on the amount, duration, or scope of this service. 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):*
	Hourly service (billed in quarter-hour units) is limited to a maximum of two hours (or 8 units) per day. There is no monthly or annual limit for hourly Training and Support for Unpaid Caregivers. The maximum annual limit for non-hourly Training and Support for Unpaid Caregivers is $500. Reimbursement is not available for the costs of travel, meals, or overnight lodging.

☐	Medically needy *(specify limits):*

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Accredited Agency	None	AAAHC, COA, URAC, CARF, ACAC, JCAHO, or NCQA Accreditation	DMHA-approved accreditation as a mental health service provider or DMHA authorized Accredited agencies must receive authorization from DMHA for an individual to provide this service based on the qualifications of the individual. Agencies must maintain documentation that the individual providing the service meets the following requirements and standards: 1) Individual is at least 21 years of age and possesses a high school diploma, or equivalent. 2) Demonstrate a minimum of two (2) years of qualifying experience, as defined by DMHA, working with or caring for youth with serious emotional disturbances (SED), or certification as a Parent Support Provider 3) Individual has completed with qualifying results the following screens: a) Fingerprint based national and state criminal history background screen b) Local law enforcement screen c) State and local Department of Child Services abuse registry screen d) Five-panel drug screen, or Agency meets same requirements specified under the Federal Drug Free Workplace Act 41 U.S.C. 10 Section 702(a)(1) 4) For every thirty (30) hours of Training and Support for the

			Unpaid Caregiver services provided, the provider must obtain one (1) hour of face-to-face supervision with a DMHA authorized mental health service provider employed by or contracted with the agency that meets one (1) of the following licensure requirements: a) Licensure in psychology (HSPP) as defined in IC 25-33-1. b) Licensed marriage and family therapist (LMFT) under IC 25-23.6-8. c) Licensed clinical social worker (LCSW) under IC 25-23.6-5. d) Licensed mental health counselor (LMHC) under IC 25-23.6-8.5. e) Advanced practice nurse (APN) under IC 12-15-5-14(d) 5) Complete the DMHA required service provider training: a) CMHW services orientation b) CPR certification

Non-Accredited Agency	None	None	Agencies must maintain documentation that the individual providing the service meets the following requirements and standards: 1) Individual is at least 21 years of age and possesses a high school diploma, or equivalent. 2) Demonstrate a minimum of two (2) years of qualifying experience, as defined by DMHA, working with or caring for youth with serious emotional disturbances (SED), or certification as a Parent Support Provider. 3) Individual has completed with qualifying results the following screens: a) Fingerprint based national and state criminal history background screen b) Local law enforcement screen

			c) State and local Department of Child Services abuse registry screen d) Five-panel drug screen, or Agency meets same requirements specified under the Federal Drug Free Workplace Act 41 U.S.C. 10 Section 702(a)(1) 4) For every thirty (30) hours of Training and Support for the Unpaid Caregiver services provided, the provider must obtain one (1) hour of face-to-face supervision with a DMHA authorized mental health service provider employed by or contracted with the agency that meets one (1) of the following licensure requirements: a) Licensure in psychology (HSPP) as defined in IC 25-33-1. b) Licensed marriage and family therapist (LMFT) under IC 25-23.6-8. c) Licensed clinical social worker (LCSW) under IC 25-23.6-5. d) Licensed mental health counselor (LMHC) under IC 25-23.6-8.5. e) Advanced practice nurse (APN) under IC 12-15-5-14(d) 5) Complete the DMHA required service provider training: a) CMHW services orientation b) CPR certification

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:		
Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Accredited Agency	DMHA	Verification documentation submitted to DMHA: Initially at point of DMHA authorization of the CMHW agency and at least every three years thereafter.
Non-Accredited Agency	DMHA	Verification documentation submitted to DMHA: Initially at point of DMHA authorization of the CMHW agency and at least every two years thereafter.

		every two years thereafter.

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

1e. State plan HCBS.

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

Services offered to enable participants served under the benefit to gain access to Services based on an assessed need.

SERVICE STANDARDS

Transportation services must follow a written service plan addressing specific needs determined by the participant's plan of care and approved by the state.

This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them.

Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized.

DOCUMENTATION STANDARDS

Assessedneed in the service plan. Services outlined in the service plan. A provider or its agent shall maintain documentation that the provider meets and maintains the requirements for providing services as detailed below.

Additional needs-based criteria for receiving the service, if applicable *(specify):*
None

Services provided under Transportation service will not duplicate services provided under the Medicaid State Plan, early and Periodic Screening, Diagnostic, and Treatment (EPSDT),or any other waiver service.	
(Choose each that applies):	
☑	Categorically needy *(specify limits):*
	This service is limited to transportation to and from facility-based respite.
☐	Medically needy *(specify limits):*

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

Provider Type *(Specify)*:	License *(Specify):*	Certificati on *(Specify):*	Other Standard *(Specify):*

Accredited Agency	For facility-based Respite only: 1) Emergency shelters licensed under 465 IAC 2-10; 2) Licensed Child Placing Agency (LCPA). DMHA will have the authority to request a copy of the home study that was conducted on the foster parent providing 1915(i) Respite Care services; 3) Other child caring institutions licensed under IC-31- 27-3; 4) Child Care Centers licensed under IC 12- 17.2-4;	AAAHC, COA, URAC, CARF, ACAC, JCAHO, or NCQA Accreditation	DMHA authorized accredited agencies must receive authorization from DMHA for licensed facility. Individuals providing the service must be authorized by DMHA. Agencies must maintain documentation that the individual providing the service meets the following requirements and standards: 1) Individual is at least 21 years of age and possesses a high school diploma, or equivalent. 2) Individual has completed and submitted proof of the following screens: e) Finger-print based national and state criminal history background screen f) Local law enforcement screen g) State and local Department of Child Services abuse registry screen h) Five-panel drug screen, or Agency meets same requirements specified under the Federal Drug Free Workplace Act 41 U.S.C. 10 Section 702(a)(1) 3)Documentation of the following: a) Current Driver's License b) Proof of current vehicle registration c) Proof of motor vehicle insurance coverage 4) Complete the DMHA required service provider training: a) CMHW services orientation b) CPR certification

Non- Accredited Agency	For facility-based Respite only: 5) Emergency shelters licensed under 465 IAC 2-10; 6) Licensed Child Placing Agency (LCPA). DMHA will have the authority to request a copy of the home study that was conducted on the foster parent providing 1915(i) Respite Care services; 7) Other child caring institutions licensed under IC-31- 27-3; 8) Child Care Centers licensed under IC 12-17.2-4;	None	DMHA authorized non-accredited agencies must receive authorization from DMHA for licensed facility-based respite care. Individuals providing the service must be authorized by DMHA. Agencies must maintain documentation that the individual providing the service meets the following requirements and standards: 5) Individual is at least 21 years of age and possesses a high school diploma, or equivalent. 4) Individual has completed and submitted proof of the following screens: a) Finger-print based national and state criminal history background screen b) Local law enforcement screen c) State and local Department of Child Services abuse registry screen d) Five-panel drug screen, or Agency meets same requirements specified under the Federal Drug Free Workplace Act 41 U.S.C. 10 Section 702(a)(1) 5) Documentation of the following: a) Current Driver's License b) Proof of current vehicle registration c) Proof of motor vehicle insurance coverage 8) Complete the DMHA required service provider training: a) CMHW services orientation b) CPR certification

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

Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*

DMHA	Accredited agencies must submit verification documentation to DMHA: Initially at point of DMHA authorization of the CMHW agency and at least every three years thereafter.
DMHA	Non-accredited agencies must submit verification documentation to DMHA: Initially at point of DMHA authorization of the CMHW agency and at least every two years thereafter.

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

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

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

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

DMHA will monitor Respite Care services provided by a relative approved to provide the Respite Care service to ensure the service is being provided as specified by CMHW policy and procedure; which may include, but is not limited to, an unannounced visit in the home by a CMHW service provider during service provision.

Participant-Direction of Services

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

1. Election of Participant-Direction. (S*elect 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):*

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.

Requirement	***1a. Service plans address assessed needs of the 1915(i) participants***
Discovery	
Discovery Evidence *(Performance Measure)*	The total number and percent of service plans that identify and address the participant's assessed needs. *N=Number of service plans that identify and address the participant's assessed needs.* *D=Number of service plans submitted*
Discovery Activity *(Source of Data & sample size)*	DMHA Database 100% review
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMHA
Frequency	Continuous and ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMHA 45 days
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	***1b. Service plans are updated annually***
Discovery	
Discovery Evidence *(Performance Measure)*	Total number and percent of participants whose plans of care were reviewed and revised on or before annual review date. *N= Total number of participants whose plans were updated annually.* *D= Total number of participants due for annual POC review.*
Discovery Activity *(Source of Data & sample size)*	DMHA Database 100% review
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMHA
Frequency	Continuous and ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMHA 45 days
Frequency *(of Analysis and Aggregation)*	Annually
Requirement	***1c. Service plans are updated/revised when warranted by changes in the participant's needs.***
Discovery	
Discovery Evidence *(Performance Measure)*	The total number and percent of service plans that were reviewed and revised when warranted by changes in the waiver participant's needs. *N=Number of participants whose plans were reviewed and revised when*

	warranted by changes in the participant's needs. *D=Number of participants enrolled*
Discovery Activity *(Source of Data & sample size)*	DMHA Database 100% review
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMHA
Frequency	Continuous and ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMHA 45 days
Frequency *(of Analysis and Aggregation)*	Annually
Requirement	***1d. Service Plans document choice of services.***
Discovery	
Discovery Evidence *(Performance Measure)*	Total number and percent of participant records with a signed Choice of Service Statement indicating they were afforded choice of eligible services. *N=Total number of participant records with a signed Choice of Service Statement.* *D=Total number of participants.*
Discovery Activity *(Source of Data & sample size)*	DMHA Database 100%

Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMHA
Frequency	Continuous and ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMHA 45 days
Frequency *(of Analysis and Aggregation)*	Annually
Requirement	***1e. Service plans document choice of providers***
Discovery	
Discovery Evidence *(Performance Measure)*	Total number and percent of participant records with a signed provider pick list indicating they were afforded choice of providers. *N=Total number of participant records with a signed provider pick list.* *D=Total number of participants.*
Discovery Activity *(Source of Data & sample size)*	DMHA Database 100%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMHA
Frequency	Continuous and ongoing

Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMHA 45 days
	Frequency *(of Analysis and Aggregation)*	Annually

2. Eligibility Requirements: (a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all individuals 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.

Requirement		***2a. An evaluation for 1915(i) State Plan HCBS eligibility is provided to all individuals for whom there is a reasonable indication that 1915(i) services may be needed in the future.***
Discovery		
	Discovery Evidence *(Performance Measure)*	The number and percent of new enrollees who had an evaluation for CMHW eligibility prior to enrollment. *N=The number of new enrollees who had an evaluation for CMHW eligibility prior to enrollment* *D=The total number of new enrollees*
	Discovery Activity *(Source of Data & sample size)*	DMHA database 100% review
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMHA

	Frequency	Quarterly
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMHA 45 days
	Frequency *(of Analysis and Aggregation)*	Annually

Requirement		***2b. The processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately*** *as determined by the algorithms from Child and Adolescent Needs and Strengths assessment*
Discovery		
	Discovery Evidence *(Performance Measure)*	The number and percent of eligibility reviews completed accurately. *N=The total number of participants' eligibility reviews completed accurately as determined by the algorithms from Child and Adolescent Needs and Strengths assessment* *D=The total number of participants' eligibility reviews.*
	Discovery Activity *(Source of Data & sample size)*	DMHA Database 100%
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMHA
	Frequency	Monthly
Remediation		

	Remediation Responsibilities *(Who corrects, analyzes, and aggregates*	DMHA 45 days

remediation activities; required timeframes for remediation)	
Frequency *(of Analysis and Aggregation)*	Annual

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)*	The number and percent of active CMHW participants whose eligibility was reviewed within 365 days of their previous eligibility review. *N=The total number of CMHW participants whose eligibility was reviewed within 365 days of their previous eligibility review* *D=The total number of CMHW participants whose eligibility was due*
Discovery Activity *(Source of Data & sample size)*	DMHA database 100%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMHA
Frequency	Quarterly
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMHA 45 days

	Frequency *(of Analysis and Aggregation)*	Annually

3. Providers meet required qualifications.

Requirement	***3a. Providers meet required qualifications (initially)***
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of service providers who initially met required licensure and/or authorization standards prior to furnishing CMHW services. *N=Total number of service providers who met required licensure and/or authorization standards prior to furnishing CMHW services.* *D=Total number of newly authorized CMHW service providers initially furnishing CMHW services.*
Discovery Activity *(Source of Data & sample size)*	DMHA database 100%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMHA
Frequency	Continuous and ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMHA 45 days
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	***3b. Providers meet required qualifications (ongoing)***
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of reauthorized providers who met required qualifications prior to reauthorization. *N=Total number of providers reauthorized who met required qualifications prior to reauthorization.* *D=Total number of provider reauthorized.*
Discovery Activity *(Source of Data & sample size)*	DMHA database 100%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMHA
Frequency	Quarterly
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMHA 45 days
Frequency *(of Analysis and Aggregation)*	Annually

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

Requirement	***4a. Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).***
Discovery	
Discovery Evidence	Number and percent of participants whose residential setting meets the home and

	(Performance Measure)	community-based settings requirements prior to enrollment *N=Total number of participants whose residential settings met the home and community-based settings requirement prior to enrollment* *D=Total number of participants enrolled*
	Discovery Activity *(Source of Data & sample size)*	DMHA database
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMHA 100%
	Frequency	Continuous and ongoing
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMHA 90 days
	Frequency *(of Analysis and Aggregation)*	Annually
Requirement		**4b. Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).**
Discovery		
	Discovery Evidence *(Performance Measure)*	Number and percent of participants whose service plans indicate a setting for service delivery that meets the requirements as specified in this SPA and in accordance with 42 CRF 441.710(a)(1) and (2). *N=Total number of participants whose service plans indicate a setting for service delivery that meets the requirements as specified in this SPA and in accordance with 42 CRF 441.710(a)(1) and (2).* *D=Total number of service plans reviewed.*
	Discovery	DMHA Database

	Activity *(Source of Data & sample size)*	100% Review
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMHA
	Frequency	Quarterly
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMHA 45-days
	Frequency *(of Analysis and Aggregation)*	Annually

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

Requirement	**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 reviewed to ensure the SMA retains administrative oversight. *N=Number of data reports provided timely and in correct format.* *D=Number of data reports due.*
	Discovery Activity *(Source of Data & sample size)*	DMHA Administrative Authority Quality Management Report 100% review
	Monitoring	OMPP

	Responsibilities *(Agency or entity that conducts discovery activities)*	
	Frequency	Quarterly
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	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 claims paid during the review period according to the published service rate. *N=Number of claims paid during the review period according to the published service rate.* *D=Number of claims submitted during the review period.*
	Discovery Activity *(Source of Data & sample size)*	Medicaid Management Information System (MMIS) claims data reports 100% review
	Monitoring Responsibilities *(Agency or entity that*	OMPP & Medicaid fiscal contractor

conducts discovery activities)	
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 claims paid during the review period for participants enrolled in the *CMHW services* on the date that the service was delivered. *N=Number of claims paid during the review period for participants enrolled in the CMHW services on the date that the service was delivered.* *D=Number of claims submitted during the review period.*
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)*	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

Requirement 6c:**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 claims paid during the review period for services that are specified in the participant's approved service plan. *N=Number of claims paid during the review period due to services having been identified on the approved service plan.* *D=Number of claims submitted during the review period.*
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 & Medicaid
Frequency	Monthly

Remediation

Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation*	OMPP & DMHA 45 days

	required timeframes for remediation)	
	Frequency *(of Analysis and Aggregation)*	Monthly

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

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

Requirement	***7a. The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.***
Discovery	
Discovery Evidence *(Performance Measure)*	The Number and percent of incidents reported within required timeframe by type of incident. *N= Total number of incidents reported within required timeframes according to policy.* *D=Total number of incidents reported*
Discovery Activity *(Source of Data & sample size)*	DMHA database 100%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMHA
Frequency	Continuous and ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities;*	DMHA 45 days

	timeframes for remediation)	
	Frequency *(of Analysis and Aggregation)*	Annually

Requirement		***7b. The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.***
Discovery		
	Discovery Evidence *(Performance Measure)*	Total number and percent of reports of abuse, neglect, exploitation and unexplained death incidents that were referred to appropriate investigative entities for follow up (e.g. law enforcement, child protective services, etc.). *N=Total number of reports of abuse, neglect, exploitation and unexplained death incidents that were referred to appropriate investigative entities for follow up (e.g. law enforcement, child protective services, etc.).* *D=Total number of reports of abuse, neglect, exploitation and unexplained death incidents submitted.*
	Discovery Activity *(Source of Data & sample size)*	DMHA database 100%
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMHA
	Frequency	Continuous and ongoing
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMHA 45 days

	Frequency *(of Analysis and Aggregation)*	Annually

Requirement		***7c. The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.***
Discovery		
	Discovery Evidence *(Performance Measure)*	The number and percent of reported incidents of abuse, neglect, and/or exploitation where appropriate follow-up (e.g. safety plans, corrective action plans, provider sanctions, etc.) was completed. *N=Total number of reported incidents of abuse, neglect, and/or exploitation individually remediated (e.g. safety plan, corrective action plan, provider sanction, etc.)* *D=Total number of reported incidents of abuse, neglect, and/or exploitation*
	Discovery Activity *(Source of Data & sample size)*	DMHA database 100%
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMHA
	Frequency	Continuous and ongoing
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMHA 45-days
	Frequency *(of Analysis and Aggregation)*	Annually

Requirement	***7d. The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.***
Discovery	
Discovery Evidence *(Performance Measure)*	The number and percent of complaints involving abuse, neglect, and/or exploitation that were individually remediated. *N= Total number of complaints involving abuse, neglect, and/or exploitation that were individually remediated.* *D= Total number of complaints involving abuse, neglect, and/or exploitation.*
Discovery Activity *(Source of Data & sample size)*	Spreadsheet maintained on DMHA private, secure SharePoint Site 100%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMHA
Frequency	Continuous and ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMHA 45-days
Frequency *(of Analysis and Aggregation)*	Annually

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

DMHA will collect and track complaints related to implementation, providers and services offered through the 1915(i). Complaints could be received from consumers, family members, concerned citizens, providers or advocates. Complaints will be categorized as individual issue or system challenge/barrier.

2. Roles and Responsibilities

DMHA and OMPP meet monthly to discuss and evaluate the need for new system changes, as well as the effectiveness of pervious system changes. Additional changes will be made as necessary, including changes in provider training, bulletins, policy changes, and refinements.

3. Frequency

Monthly, Quarterly, and Annually

4. Method for Evaluating Effectiveness of System Changes

DMHA and OMPP meet quarterly to review performance measure data. For performance measure that are trending near or below 86% OMPP and DMHA discuss and plan quality improvement strategies (QIS). After the QIS has been implemented, OMPP and DMHA review performance measure data quarterly to ensure data is trending toward desired outcomes. If data is still not trending in the way anticipated, OMPP and DMHA will reconvene to revise QIS until success is achieved.