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):*

Behavioral and Primary Healthcare Coordination

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:*
	This § 1915(i) State Plan benefit operates concurrently with an approved fee-for-service selective contracting waiver authorized under §1915(b)(4) of the Act, and was effective on 10/01/2018.

Specify the §1915(b) authorities under which this program operates (*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	☑	☐	☐	☐
10Quality assurance and quality improvement activities	☑	☐	☐	

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

Function 4 - Prior Authorization On behalf of the Family and Social Services Administration (FSSA), the State Evaluation Team (SET) reviews all Adult Mental Health Habilitation Prior Authorization requests for Indiana Health Coverage Programs (IHCP) members on a case-by- case basis through the Data Assessment Registry Mental Health and Addiction (DARMHA) system.

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

Function 6 - Qualified Provider Enrollment The contracted entity is DMHA and Medicaid Fiscal Agent Providers interested in providing AMHH services must first apply for certification through DMHA. Next, the provider must enroll as a Medicaid provider with Indiana Health Coverage Programs (IHCP). OMPP contracts with a fiscal agent to process IHCP provider enrollments. The fiscal agent processes the applications, verifies licensure and certification requirements are met, maintains the provider master file, assigns provider ID numbers, and stores National Provider Identifier and taxonomy information. Upon successful completion of the provider enrollment process an enrollment confirmation letter is mailed to the new provider.

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

Function 8 - Establishment of a consistent rate methodology for each State Plan HCBS (Medicaid Actuarial Contractor): The contracted entity is an actuarial service. OMPP has an actuarial service under contract to develop and assess rate methodology for HCBS. The rate methodology for AMHH services is assessed and reviewed at least every five years. The actuarial contractor completes the cost surveys and calculates rate adjustments. OMPP reviews and approves the fee schedule to ensure consistency, efficiency, economy, quality of care, and sufficient access to providers for AMHH services.

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

5. ☑ **Conflict of Interest Standards.** The state assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:

- related by blood or marriage to the individual, or any paid caregiver of the individual
- financially responsible for the individual
- empowered to make financial or health-related decisions on behalf of the individual
- providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *(If the state chooses this option, specify the conflict of interest protections the state will implement):*

The Independent State Evaluation Team (SET) is responsible for determining the 1915(i) eligibility and approving the individualized services requested in the proposed care plan. The members of the SET are prohibited from having any financial relationships with the applicant/recipient requesting services, their families, or the entity selected to provide services. Assessments are completed and proposed plans of care (Individualized Integrated Care Plan – IICP) are submitted by a qualified provider entity to the SET for final eligibility determination and care plan approval. Responsibility for 1915(i) program eligibility determination and approval of the IICP proposed services in all cases is retained by the SET to ensure no conflict of interest in the final determinations. The DMHA-approved AMHH provider agency submits the results from the face-to-face or telehealth according to the Indiana Administrative Code assessment, required supporting documentation, and a proposed care plan to SET for independent review. The SET determines eligibility for 1915(i) services based upon their review of the clinical documentation of the applicant's identified needs and alignment of needs, goals, and recommended services. The State also requires documentation, signed by the applicant/recipient that attests to the following: 1) The recipient and/or legal guardian is an active participant in the planning and development of the 1915(i) IICP. 2) The recipient is the person requesting 1915(i) services on the IICP. 3) The recipient received a randomized list of eligible 1915(i) service provider agencies in his/her community; and has selected the provider(s) of his or her choice to deliver the 1915(i) service on the IICP. 4) The recipient and/or legal guardian was offered a copy of the completed IICP In addition, AMHH provider agencies are required to have written policies and procedures available for review by the State that clearly define and describe how conflict of interest requirements are implemented and monitored. The State ensures compliance through policies designed to be consistent with CMS conflict of interest assurances and through quality assurance activities.

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

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

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

Number Served

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

Annual Period	From	To	Projected Number of Participants
Year 1	6/1/2024	5/31/2025	3000
Year 2			
Year 3			
Year 4			
Year 5			

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

Financial Eligibility

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

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

☑ The State does not provide State plan HCBS to the medically needy.
☐ The State provides State plan HCBS to the medically needy. (*Select one*):
☐ The state elects to disregard the requirements section of 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy. When a state makes this election, individuals who qualify as medically needy on the basis of this election receive only 1915(i) services. ☐ The state does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act.

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

Evaluation/Reevaluation of Eligibility

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

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

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

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

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

Information about 1915(i) services is posted on the DMHA and Office of Medicaid Policy and Planning (OMPP) public websites. These websites summarize the eligibility criteria and note the available services, service provider agencies, locations where potential enrollees may go to apply, and how to access assessments and services. Any provider may identify a potential enrollee who meets the 1915(i) eligibility criteria or individuals may notify their provider of an interest in the 1915(i) service.
Any individual may contact the State for information about BPHC eligibility and the process to apply. The individual is given a list of BPHC-eligible provider agencies that may be chosen to assist in the application process. The agency staff reviews the program information with the applicant, together discuss the options under the program, and determines whether to complete an application.

Each person referred for 1915(i) services will receive a bio-psychosocial needs assessment via face to face or via telehealth, according to Indiana Administrative Code and Federal policies and regulations, by the referring provider including, but not limited to the Adult Needs and Strengths Assessment (ANSA) tool and completion of the 1915(i) referral form developed by OMPP/DMHA.

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

The items are grouped into categories or domains. Once the assessment has been completed, the

agency staff receives a level of need (LON) recommendation based on the individual item ratings.

The number of in-person visits and the percentage of time telehealth will be the delivery method of service will be based on what is clinically appropriate and in agreement with the consumer and/or legal guardian. The use of telehealth should protect against isolating participants by offering services that are in-person and shall be invoked to prioritize and facilitate community integration. As required by 45 CFR 164.308(a)(1)(ii), an accurate and thorough risk analysis shall be conducted for any functions using telehealth services to assess the potential risks and vulnerabilities to the confidentiality, integrity, and availability of patient data. Telehealth services will be delivered in a way that respects the privacy of the individual, especially in instances of toileting, dressing, etc. Video cameras/monitors are not permitted in bedrooms and bathrooms. Participants can turn all telehealth-related devices on/off at their discretion to ensure privacy. The provider responsible for the treatment of the individual is responsible for training participants on the use of any telehealth-related devices both initial and ongoing. Telehealth services shall consider and respond to all accessibility needs, including whether hands-on or physical assistance is needed to render the service. Telehealth services must ensure the health and safety of the individual receiving services by adhering to all abuse, neglect, and exploitation prevention practices that apply to in-person treatment, as well as by providing participants with resources on how to report incidences of abuse, neglect, and exploitation and Federal policies and regulations.

The LON recommendation from the ANSA is not intended to be a mandate for the level of services that an individual receives. There are many factors, including individual preference and choice, which influence the actual intensity of treatment services.

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

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

The agency staff and the applicant jointly develop a proposed plan of care [Individualized Integrated Care Plan (IICP)] that includes desired goals and services requested and deemed necessary to address the goals. Upon completion of the referral packet (including but not limited to the ANSA, referral form, and proposed plan of care (IICP)), the agency staff submits the documents to DMHA through a secure electronic file transfer process.

The State Evaluation Team (SET) is a special team of state employees who are part of DMHA. Upon receipt of the referral packet, the SET reviews all submitted documentation and determines whether the applicant meets the needs-based criteria for 1915(i).

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

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

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

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

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

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

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

All of the following needs-based criteria must be met for BPHC eligibility:
1. The recipient must demonstrate needs related to management of his/her behavioral and physical health.*
2. The recipient must demonstrate impairment in self-management of physical and behavioral health services.**
3. The recipient has received a recommendation for intensive community-based care on ANSA with a Level of 3 or higher).
4. The recipient demonstrates a health need which requires assistance and support in coordinating behavioral and physical health treatment.

*The evaluation for BPHC eligibility will include an assessment to manage a prescription medication regimen and the impact on health symptoms and functioning. Additionally, an individual will be assessed for awareness of co-occurring behavioral and physical healthcare needs and the ability to manage both.
**Impairment in self-management of physical and behavioral health is operationally defined as limited or impaired ability to carry out routine healthcare regimens, including but not limited to, taking medicine as prescribed, keeping medical appointments, maintaining linkage with a primary medical provider, diet, exercise and management of symptoms.

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

State plan HCBS needs-based eligibility criteria	NF (& NF LOC** waivers)	ICF/IID (& ICF/IID LOC waivers)	Applicable Hospital* (& Hospital LOC waivers)

Needs-based eligibility criteria are specified in Item 5 above.	Indiana Law allows reimbursement to NFs for eligible persons who require skilled or intermediate nursing care as defined in 405 IAC 1-3-1 and 1-3-2. 405 IAC 1-3-1(a) Skilled nursing services, as ordered by a physician, must be required and provided on a daily basis, essentially 7 days a week. 405 IAC 1-3-2 (a)	Indiana Law allows reimbursement to ICF/IIDs for eligible persons as defined in 405 IAC 1-1-11. A person may be functionally eligible for an ICF/IID LOC waiver when documentation shows the individual meets the following conditions: 1. Has a diagnosis of intellectual disability, cerebral palsy, epilepsy, autism, or	Dangerous to self or others or gravely disabled. (IC-12-26-1)

	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 or an NF level of care waiver if the need for medical or nursing supervision and attention is determined by any of the following findings from the functional screening: 1. Need for direct assistance at least 5 days per week due to unstable, complex medical conditions. 2. Need for direct assistance for 3 or more substantial medical conditions including activities of daily living.	condition similar to intellectual disability. 2. Condition identified in #1 is expected to continue. 3. Condition identified in #1 had an age of onset prior to age 22. 4. Individual needs a combination or sequence of services 5. Has 3 of 6 substantial functional limitations as defined in 42 CFR 435.1010 in areas of (1) self-care, (2) learning, (3) self-direction, (4) capacity for independent living, (5) language, and (6) mobility.	

*Long Term Care/Chronic Care Hospital

**LOC= level of care

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

The BPHC Program Eligibility, 405 IAC 5-21.8:

- Age 19 or over
- Approved BPHC eligible primary diagnosis; Eligible diagnoses

ICD-10 Code	ICD-10 Description

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

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

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

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

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

F60.3	Borderline personality disorder

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

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

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

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

i.	**Minimum number of services**. The minimum number of 1915(i) State plan services (one or more) that an individual must require in order to be determined to need the 1915(i) State plan HCBS benefit is*:* 1	
ii.	**Frequency of services**. The State requires (select one):	
	○	**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: Three (3) instances of the BPHC service must be provided to each eligible member every 180 days and documented in progress notes.

Home and Community-Based Settings

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

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

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

The state assures that this 1915(i) state plan HCBS benefit will be subject to any provisions or requirements included in HCBS Final Rule.

An ongoing monitoring phase in the state fiscal year (SFY) 2023 due to the fulfillment and completion of State Transition Plan activities in SFY 2022. The State Evaluation Team (SET) will conduct on-site visits to a percentage of each agency's POCO settings that have been identified as a setting that provides HCBS services. In addition to the site visits, CMS requires a supplemental provider self-assessment. The provider self-assessment document will only be completed for the sites identified in the annual Ongoing Monitoring notification letter. The Division of Mental Health and Addiction is collaborating on a shared Corrective Action Plan (CAP) with the Division of Aging, the Division of Disability and Rehabilitation Services, and the Office of Medicaid Policy and Planning to ensure fidelity to HCBS Final Rule across all FSSA agencies implementing Home and Community Based Services.

Person-Centered Planning & Service Delivery

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

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

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

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

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

The agency staff member conducting the assessment must be a certified user of the State required standardized assessment tool, with supervision by a certified super user of the tool. Minimum qualification for the person conducting the independent evaluation are: (1): bachelor's degree in social sciences or related field with two or more years of clinical experience; (2) completion of DMHA and OMPP approved training and orientation for 1915(i) eligibility and determination; and (3) completion of assessment tool Certification training**. The assessment must be completed face to face or via telehealth, according to Indiana Administrative Code. The use of telehealth must achieve the following:**

- The number of in-person visits and the percentage of time telehealth will be the delivery method of service will be based on what is clinically appropriate and in agreement with the consumer and/or legal guardian. The use of telehealth should protect against isolating participants by offering services which are in-person and shall be invoked to prioritize and facilitate community integration.
- As required by 45 CFR § 164.308 (a)(1)(ii), an accurate and thorough risk analysis shall be conducted for any functions utilizing telehealth services to assess the potential risks and vulnerabilities to the confidentiality, integrity, and availability of patient data.
- All telehealth services will be delivered in a way that respects privacy of the individual especially in instances of toileting, dressing, etc. Video cameras/monitors are not permitted in bedrooms and bathrooms. Participants are able to turn all telehealth-related devices on/off at their discretion in order to ensure privacy. The provider who is responsible for the treatment of the individual is responsible for training participants on the use of any telehealth-related devices both initially and on-going.
- Telehealth services shall consider and respond to all accessibility needs, including whether hands-on or physical assistance is needed to render the service.
- Telehealth services must ensure for the health and safety of the individual receiving services by adhering to assessment and abuse, neglect, and exploitation prevention and response practices that apply to in-person treatment.

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

Licensed professional means any of the following persons:

- a licensed psychiatrist;
- a licensed physician;
- a licensed psychologist or a psychologist endorsed as a health service provider in psychology
- (HSPP);
- a licensed clinical social worker (LCSW);

- a licensed mental health counselor (LMHC);
- a licensed marriage and family therapist (LMFT); or
- a licensed clinical addiction counselor, as defined under IC 25-23.6-10.5.

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

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

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

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

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

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

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

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

- Review, discussion and documentation of the applicant/recipient's desires, needs, and goals.
- Goals and recovery, habilitative or rehabilitative based in nature with outcomes specific to the applicant/recipient's needs.
- Goals are identified by the applicant/recipient.
- Review of psychiatric symptoms and how they affect the applicant/recipient's functioning, ability to attain desires and goals, as well as the applicant's ability to self-manage mental and physical healthcare services.
- Applicant/recipient's ability to attain desires, needs and goals and to self-manage health services.
- Review of the applicant/recipient's skills and the support needed for the applicant/recipient to attain desires, needs and goals toward self-managing mental and physical healthcare in order to remain in the community.
- Applicant/recipient's ability to manage his or her health condition and services.

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

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

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

(1) The toll-free consumer service line number and the telephone number for Indiana protection and advocacy.

(2) Document that agency staff provides both a written and an oral explanation of these rights to each applicant/recipient.

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

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

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

The State maintains a network of Community Mental Health Centers (CMHCs). As a DMHA approved BPHC provider agency, each CMHC is an enrolled Medicaid provider that offers a full continuum of behavioral healthcare services, as is mandated by DMHA for all CMHCs, in addition to providing BPHC services as documented in this State Plan benefit. The care coordinator explains the process for making an informed choice of provider(s) and answers questions. The applicant/recipient is also advised that the choice of providers and provider agencies is ongoing for the duration of the program. Therefore, providers within an agency and provider agencies themselves can be changed upon request from the enrollee. A list of qualified BPHC agency providers in randomized sequence is presented by the care coordinator. A listing of approved BPHC provider agencies is also posted on the Indiana Medicaid website at www.in.gov/medicaid. When accessing in.gov/medicaidwebsite, the individual has a choice of a "Member" tab and "Provider" tab. The Member tab notes: *If you are an Indiana Medicaid Member or are interested in applying to becoming a Member, please click the "Member" tab.*

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

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

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

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

The Indiana Office of Medicaid Policy and Planning (OMPP) retains responsibility for service plan approvals made by the Division of Mental Health and Addiction (DMHA). OMPP reviews and approves the policies, processes and standards for developing and approving BPHC plans of care (POC). Based on the terms and conditions of the 1915(i) benefit, OMPP may review and overrule the approval or disapproval of any specific plan of care acted upon by DMHA serving in its capacity as the operating agency. In the instance of a complaint from a 1915(i) provider or applicant/recipient, the IICP submitted to DMHA may be reviewed by OMPP.

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

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

Services

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

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

Service Title:	Behavioral & Primary Healthcare Coordination (BPHC)

Service Definition (Scope):

Behavioral & Primary Healthcare Coordination (BPHC) consists of coordination of healthcare services to manage the healthcare needs of the individual.
The BPHC service includes the following.

- Logistical support, advocacy and education to assist individuals in navigating the healthcare system
  - Activities that help recipients gain access to needed health (physical and behavioral health) services
  - Manage health conditions such as adhering to health regimens
  - Scheduling and keeping medical appointments
  - Obtaining and maintaining a primary medical provider
  - Coordination of care within and across systems
- Assessment of the eligible recipient to determine service needs
- Development of an individualized integrated care plan (IICP)
- Referral and related activities to help the recipient obtain needed services
- Monitoring and follow-up
- Evaluation

The number of in-person visits and the percentage of time telehealth will be the delivery method of service will be based on what is clinically appropriate and in agreement with the consumer and/or legal guardian. The use of telehealth should protect against isolating participants by offering services that are in-person and shall be invoked to prioritize and facilitate community integration.

As required by 45 CFR § 164.308 (a)(1)(ii), an accurate and thorough risk analysis shall be conducted for any functions utilizing telehealth services to assess the potential risks and vulnerabilities to the confidentiality, integrity, and availability of patient data.

All telehealth services will be delivered in a way that respects the privacy of the individual, especially in instances of toileting, dressing, etc. Video cameras/monitors are not permitted in bedrooms and bathrooms. Participants can turn all telehealth-related devices on/off at their discretion to ensure privacy. The provider who is responsible for the treatment of the individual is responsible for training participants on the use of any telehealth-related devices both initial and on-going.

Telehealth services shall consider and respond to all accessibility needs, including whether hands-on or physical assistance is needed to render the service.
Telehealth services must ensure the health and safety of the individual receiving services by adhering to all abuse, neglect, and exploitation prevention practices that apply to in-person treatment, as well as by providing participants with resources on how to report incidences of abuse, neglect, and exploitation and Federal policies and regulations.

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

N/A

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

(Choose each that applies):

☑ Categorically needy *(specify limits):*

The BPHC service is initially offered in 15-minute units up to 48 units/12 hours per 180 days. Additional units are available upon request.

Exclusions:

- Time spent on the initial assessment, referral form and IICP Activities which are billed under MRO Case Management or AMHH Care Coordination
- Direct delivery of medical, clinical, or other direct services

-

☐ Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:			
Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Agency	N/A	DMHA-certified Community Mental Health Center (CMHC)	DMHA-approved BPHC provider agencies must meet DMHA and OMPP-defined criteria and standards, including the following: A) Provider agency has acquired a National Accreditation by an entity approved by DMHA. B) Provider agency is an enrolled Medicaid provider that offers a full-continuum of care. C) Provider agency must maintain documentation in accordance with the Medicaid requirements defined under 405 IAC 1-5-1 and 405 IAC 1-5-3. D) Provider agency must meet all BPHC provider agency criteria, as defined in the 1915(i) benefit and BPHC operating policy. In addition to meeting criteria for a provider agency, the agency must certify the staff providing a BPHC needs assessment, development and adjustments to the IICP, referral and linkage activities, and physician consults must meet the following standards: A) Licensed professional; B) QBHP; or C) OBHP. The agency must certify the staff providing all other BPHC services including coordination across health systems, monitoring and follow-up activities, and re-evaluation of the recipients progress meet the following standards: A) Licensed professional B) QBHP C) OBHP D) Certified Recovery Specialist; or E) Certified Integrated Health Technician (IHT). A Certified Recovery Specialist (CRS) refers to an individual who meets all of the following criteria:

			1. Is maintaining healthy recovery from mental illness; 2. Has completed the CRS Indiana Division of Mental Health and Addiction (DMHA) state-approved training program; 3. Receives a passing score on the certification exam; and 4. Is supervised by a licensed professional or QBHP. A Certified IHT refers to an individual who meets all of the following criteria: 1. Has completed the IHT job specific training from the community mental health center employing the IHT; 2. Receives a passing score on the certification exam; and 3. Is supervised by a licensed professional or Qualified Behavioral Health Professional.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:		
Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Agency	**DMHA**	Initially, and at the time of DMHA certification and renewal.

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

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

Participant-Direction of Services

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

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

☑	The state does not offer opportunity for participant-direction of State plan HCBS.
○	Every participant in State plan HCBS (or the participant's representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
○	Participants in State plan HCBS (or the participant's representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the state. *(Specify criteria):*

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

Indiana does not offer self-directed care.

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

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

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

Participant-Directed Service	Employer Authority	Budget Authority
	☐	☐
	☐	☐

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

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

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

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

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

8. Opportunities for Participant-Direction

a. Participant–Employer Authority (individual can select, manage, and dismiss State plan HCBS providers). (*Select one):*

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

b. Participant–Budget Authority (individual directs a budget that does not result in payment for medical assistance to the individual). (*Select one):*

○	The state does not offer opportunity for participants to direct a budget.
○	Participants may elect Participant–Budget Authority.
	Participant-Directed Budget. *(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including the method for calculating the dollar values in the budget based on reliable costs and service utilization, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the person-centered service plan.):*
	Expenditure Safeguards. *(Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards.*

Quality Improvement Strategy

Quality Measures

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

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

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

Requirement	1a) Service plans address assessed needs of 1915(i) participants
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of IICPs that address recipient needs *N: Total number of IICPs reviewed that address recipient needs* *D: Total number of IICPs reviewed*
Discovery Activity *(Source of Data & sample size)*	100% of IICPs are reviewed and approved through the State's database
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	The Division of Mental Health and Addiction (DMHA) reviews 100% of all Individualized Integrated Care Plans (IICPs) submitted through the Data Assessment Registry Mental Health and Addiction (DARMHA) database. During the review of the IICPs, DMHA ensures the needs of the participants are addressed, the IICP is updated timely, and documentation supports the applicant received a choice of services and providers.
Frequency	Ongoing

Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMHA

	Frequency (of Analysis and Aggregation)	Analysis and aggregation are ongoing. If a corrective action plan (CAP) is needed, it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.

Requirement	1b) Service plans are updated, at least, every 180 days
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of IICPs reviewed and revised within the past 180 days *N: Total number of IICPs reviewed and revised within the past 180 days* *D: Total number of IICPs reviewed*
Discovery Activity *(Source of Data & sample size)*	100% of IICPs are reviewed and approved through the State's database
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMHA
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMHA
Frequency *(of Analysis and Aggregation)*	Analysis and aggregation are ongoing. If a CAP is needed, it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.

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

Discovery Activity *(Source of Data & sample size)*	Record Review – onsite/off site Sample with 95% confidence level with 5% margin of error
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMHA
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMHA
Frequency *(of Analysis and Aggregation)*	Analysis and aggregation are ongoing. If a CAP is needed, it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.

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

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

Requirement	1e. Client and/or legal guardian offered a copy of the IICP
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of clients or legal guardians that were offered a copy of the completed IICP *N: Total number of attestations reviewed with documentation of offered IICP* *D: Total number of attestations reviewed*
Discovery Activity *(Source of Data & sample size)*	Record Review – onsite/off site Sample with 95% confidence level with 5% margin of error
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMHA
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMHA
Frequency *(of Analysis and Aggregation)*	Analysis and aggregation are ongoing. If a CAP is needed, it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.

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

Requirement	2a) An evaluation for eligibility is provided to all applicants
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of new applicants who had anevaluation for BPHC eligibility prior to enrollment that was face to face or telehealth, according to Indiana Administrative Code. *N: Number of new applicants who had a face-to-face or telehealth evaluation for BPHC eligibility prior to enrollment* *D: Total number of new applicants who had a BPHC evaluation prior to enrollment*
Discovery Activity *(Source of Data & sample size)*	Record Review - onsite/off site Sample with 95% confidence level with 5% margin of error
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	. For each BPHC application submitted, providers are required to complete a BPHC evaluation and Adult Needs Strengths Assessment (ANSA), which should be completed face to face or via telehealth, according to Indiana Administrative Code. Information from the evaluation and assessment is submitted along with an IICP with other supporting documentation to DMHA for review for eligibility. The process is the same for the BPHC renewal application, as it is for the initial application. DMHA conducts an annual quality assurance review for each BPHC provider to ensure compliance with all eligibility requirements. DMHA will review the services provided during a package period to ensure the services provided are included in the IICP.
Frequency	Ongoing

Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMHA

Frequency	Analysis and aggregation are ongoing. If a CAP is needed, it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.

	(of Analysis and Aggregation)	

Requirement		2b) The processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately
Discovery		
	Discovery Evidence *(Performance Measure)*	Number and percent of Adult Needs and Strengths Assessments (ANSA) completed according to policy *N: Number of applicants who had anANSA completed face to face or via telehealth, according to Indiana Administrative Code (within 60 days of application submission) for BPHC eligibility prior to enrollment* *D: Total number of new applicants who had an ANSA completed prior to enrollment*
	Discovery Activity *(Source of Data & sample size)*	Record Review - onsite/off site Sample with 95% confidence level with 5% margin of error
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMHA
	Frequency	Ongoing
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMHA
	Frequency *(of Analysis and Aggregation)*	Analysis and aggregation are ongoing. If a CAP is needed, it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.

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

Discovery

Discovery Evidence *(Performance Measure)*	Number and percent of enrolled individuals re-evaluated at least every 180 daysas specified in the approved 1915(i) benefit *N: Number of BPHC re-evaluations completed for enrolled individuals during the past 180 days* *D: Total number of enrolled individuals due for re-evaluation during the past 180 days*
Discovery Activity *(Source of Data & sample size)*	Record Review - onsite/off site Sample with 95% confidence level with 5% margin of error
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMHA
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMHA
Frequency *(of Analysis and Aggregation)*	Analysis and aggregation are ongoing. If a CAP is needed, it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.

Requirement	2d) Service activities are linked to goals, objectives, and/or strategies identified in the IICP.
Discovery	

	Discovery Evidence *(Performance Measure)*	*Number and percent of completed BPHC services linked to goals, objectives, and/or strategies identified in the IICP.* ***N: Number of completed BPHC services linked to goals, objectives, and/or strategies identified in the IICP.*** ***D: Total number of completed BPHC services during the review period.***
	Discovery Activity *(Source of Data & sample size)*	Record Review - onsite/off site Sample with 95% confidence level with 5% margin of error
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMHA
	Frequency	Ongoing
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMHA
	Frequency *(of Analysis and Aggregation)*	Analysis and aggregation are ongoing. If a CAP is needed, it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.

3. Providers meet required qualifications.

Requirement	3a) Providers meet required qualifications
Discovery	

Discovery Evidence *(Performance Measure)*	Number and percent of provider agencies who meet qualifications *N: Number of BPHC provider agencies who meet qualifications at re-certification* *D: Total number of BPHC provider agencies due for recertification*
Discovery Activity *(Source of Data & sample size)*	100% of provider agency applications are reviewed prior to approval
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	. DMHA approves all providers for the BPHC program. The State's 24 DMHA-certified Community Mental Health Centers (CMHCs) are the exclusive providers for the BPHC program. CMHC's must meet all provider agency standards documented in the State Plan benefit and ensure that all direct care agency staff members providing services meet all required qualifications. The services are provided according to the standards and expectations outlined in the State Plan benefit. All providers must be re-certified by DMHA to provide services. The re-certification is required every three (3) years or at the time of re-accreditation.
Frequency	Ongoing

Remediation

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

Requirement	3b) Providers meet required qualifications

Discovery

Discovery Evidence	Number and percent of provider agencies re-certified timely *N: Number of BPHC provider agencies recertified timely*

(Performance Measure)	*D: Total number of BPHC provider agencies recertified*
Discovery Activity *(Source of Data & sample size)*	100% of provider agency re-certification applications are reviewed prior to approval
Monitoring Responsibilities	DMHA

	(Agency or entity that conducts discovery activities)	
	Frequency	Every 3 years or at a time of reaccreditation
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMHA
	Frequency *(of Analysis and Aggregation)*	Analysis and aggregation are quarterly. If a CAP is needed, it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.

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

Requirement	4) Provider owned, controlled, and operated residential settings meet the home and community-based setting requirements as specified in the benefit and in accordance with 42 CFR 441.710(a)(1)-(2)
Discovery	

	Discovery Evidence *(Performance Measure)*	Number and percent of provider owned, controlled, and operated residential settings in compliance with criteria that meets standards for community living *N: Number of provider-owned, controlled, and operated residential settings in compliance with HCBS Settings final rule* *D: Total number of provider-owned, controlled, and operated residential settings*
	Discovery Activity *(Source of Data & sample size)*	100% of provider owned, controlled, and operated residential settings are reviewed to ensure applicants reside in HCBS compliant settings
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	. CMHC's receive assistance provided through DMHA webinars, onsite trainings, and technical assistance calls to increase the understanding of HCBS requirements for providers to successfully implement standards.

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

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

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

	remediation activities; required timeframes for remediation)	
	Frequency *(of Analysis and Aggregation)*	Analysis and aggregation are completed annually. If a CAP is needed from DMHA it must be provided within 30 business days and OMPP will respond in 30 business days for a total of 60 business days.

Requirement		5b) The SMA retains authority and responsibility for program operations and oversight
Discovery		
	Discovery Evidence *(Performance Measure)*	Number and percent of performance measure data reports from DMHA and contracted entities reviewed to ensure administrative oversight. *N: Number of data reports provided in correct format* *D: Total number of data reports due*
	Discovery Activity *(Source of Data & sample size)*	100% review of DMHA Quality Management Reports
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	OMPP
	Frequency	Quarterly
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMHA and OMPP
	Frequency *(of Analysis and Aggregation)*	Analysis and aggregation are completed annually. If a CAP is needed from DMHA it must be provided within 30 business days and OMPP will respond in 30 business days for a total of 60 business days.

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 according to the published rate during the review period *N: Number of claims paid according to the published rate during the review period* *D: Total number of claims submitted during the review period*
Discovery Activity *(Source of Data & sample size)*	Medicaid Management Information System (MMIS) 100% review
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	OMPP and Medicaid Fiscal Contractor
Frequency	Monthly
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	OMPP
Frequency *(of Analysis and Aggregation)*	Analysis and aggregation are completed annually. Corrective Action will follow the process identified in the contract between OMPP and MMIS vendor.

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

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

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

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

Discovery Evidence *(Performance Measure)*	Number and percent of provider agencies who have policies and procedures to prevent incidents of abuse, neglect, exploitation *N: Number of provider agencies with policies and procedures to prevent incidents of abuse, neglect, exploitation* *D: Total number of provider agencies with policies and procedures reviewed*
Discovery Activity *(Source of Data & sample size)*	100% of provider agencies policies and procedures reviewed to ensure health and welfare needs are addressed.
Monitoring Responsibilities	. DMHA reviews policies and procedures for all approved providers for the program to ensure health and welfare needs are addressed. Additionally, DMHA reviews 100% of all incident reports required to be and ensures the incident report is submitted within the required timeframe.

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

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

activities; required timeframes for remediation)	
Frequency *(of Analysis and Aggregation)*	Analysis and aggregation are ongoing. Report submitted to State within 72 hours. State will review plan and respond within 5 business days. If CAP is needed it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.

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

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

Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of incident reports involving seclusions and restraints resolved according to policy *N: Number of incident reports including seclusion and restraints resolved according to policy* *D: Total number of incident reports including seclusion and restraints submitted*
Discovery Activity *(Source of Data & sample size)*	100% review of submitted incident reports
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMHA
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMHA
Frequency *(of Analysis and Aggregation)*	Analysis and aggregation are ongoing. Report submitted to State within 72 hours State will review plan and respond within 5 business days. If a CAP is needed it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.

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

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

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

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

2. Roles and Responsibilities

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

3. Frequency

Monthly, Quarterly, and Annually

4. Method for Evaluating Effectiveness of System Changes

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

Mandatory Coverage for Eligible Juveniles who are Inmates of a Public Institution Post Adjudication of Charges

State/Territory: Indiana

General assurances. State must indicate compliance with all four items below with a check.

☒ In accordance with section 1902(a)(84)(D) of the Social Security Act, the state has an internal operational plan and, in accordance with such plan, provides for the following for eligible juveniles as defined in 1902(nn) (individuals who are under 21 years of age and determined eligible for any Medicaid eligibility group, or individuals determined eligible for the mandatory eligibility group for former foster care children age 18 up to age 26, immediately before becoming an inmate of a public institution or while an inmate of a public institution) who are within 30 days of their scheduled date of release from a public institution following adjudication:

> ☒ In the 30 days prior to release (or not later than one week, or as soon as practicable, after release from the public institution), and in coordination with the public institution, any screenings and diagnostic services which meet reasonable standards of medical and dental practice, as determined by the state, or as otherwise indicated as medically necessary, in accordance with the Early and Periodic Screening, Diagnostic, and Treatment requirements, including a behavioral health screening or diagnostic service.
>
> ☒ In the 30 days prior to release and for at least 30 days following release, targeted case management services, including referrals to appropriate care and services available in the geographic region of the home or residence of the eligible juvenile, where feasible, under the Medicaid state plan (or waiver of such plan).

☒ The state acknowledges that a correctional institution is considered a public institution and may include prisons, jails, detention facilities, or other penal settings (e.g., boot camps or wilderness camps).

PRA Disclosure Statement - This use of this form is mandatory and the information is being collected to assist the Centers for Medicare & Medicaid Services in implementing Section 5121 of the Consolidated Appropriations Act, 2023. Under the Privacy Act of 1974, any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #85). Public burden for all of the collection of information requirements under this control number is estimated to take about 50 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Additional information provided (optional):

☐ No

☒ Yes

The state may determine that it is not feasible to provide the required services during the pre-release period in certain carceral facilities (e.g., identified local jails, youth correctional facilities, and state prisons) and/or certain circumstances (e.g. unexpected release or short-term stays). The state will maintain clear documentation in its internal operational plan regarding each facility and/or circumstances where the state determines that it is not feasible to provide for the required services during the pre-release period. This information is available to CMS upon request. Services will be provided post-release, including the mandatory 30-days of targeted case management, screening, and diagnostic services.

PRA Disclosure Statement - This use of this form is mandatory and the information is being collected to assist the Centers for Medicare & Medicaid Services in implementing Section 5121 of the Consolidated Appropriations Act, 2023. Under the Privacy Act of 1974, any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #85). Public burden for all of the collection of information requirements under this control number is estimated to take about 50 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.