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.

Concurrent Operation with Other Programs:
This §1915(i) State Plan Amendment operates concurrently with an approved fee-for-service selective contracting waiver authorized under §1915(b)(4) of the Act, effective October 1, 2013.

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

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

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

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

The State elects to target this 1915(i) State Plan HCBS benefit to a specific population. 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)

The target group includes Medicaid eligible adults who:

- Are age 35 or over with an eligible primary mental health diagnosis.
- Meet all eligibility criteria defined for 1915(i) services.

The diagnoses used in determining eligibility for the 1915(i) services include the Schizophrenic Disorders (295.xx) and the Major Depressive Disorder and Bipolar Disorders (296.xx) plus Delusional Disorder (297.1), Psychotic Disorder NOS (298.9, and Obsessive-Compulsive Disorder (300.3). The full list of diagnoses for 1915(i) services, TABLE OF MENTAL HEALTH AND ADDICTION DIAGNOSIS CODES, is attached to the SPA.

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

○	The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program *(select one)*:		
	○	The Medical Assistance Unit *(name of unit)*:	
	○	Another division/unit within the SMA that is separate from the Medical Assistance Unit	
		(name of division/unit) This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.	
☒	The State plan HCBS benefit is operated by *(name of agency)*		
	Division of Mental Health and Addiction of the Indiana Family and Social Services Administration		
	a separate agency of the State that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.		

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

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

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

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

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

Numbers 1–6, 8-10 are performed by the Division of Mental Health and Addiction (DMHA)
Numbers 2 and 10 are performed by a behavioral health service provider agency that is enrolled as a Medicaid provider that meets all AMHH provider agency criteria as defined in the "Services" section.
Number 7 is performed by the Medicaid Fiscal Agent.

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

5. ☒ **Conflict of Interest Standards.** The State assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:
   - related by blood or marriage to the individual, or any paid caregiver of the individual
   - financially responsible for the individual
   - empowered to make financial or health-related decisions on behalf of the individual

- providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the State, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified provider in a geographic area, and the State devises conflict of interest protections. *(If the State chooses this option, specify the conflict of interest protections the State will implement):*

The Independent State Evaluation Team is responsible for determining the 1915(i) eligibility and approving the individualized services requested in the proposed care plan. The members of this state team 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 Independent State Evaluation Team 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 Independent State Evaluation Team in order to ensure no conflict of interest in the final determinations. The DMHA approved AMHH provider agency submits the results from the face-to-face assessment , required supporting documentation, and a proposed care plan to the state evaluation team for independent review. The state evaluation team determines eligibility for 1915(i) services based upon their review of the clinical documentation of applicant's identified needs and alignment of needs, goals and recommended services.

The state also requires documentation, signed by the applicant/recipient that attests to the following:
1) The recipient 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.

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

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

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

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

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

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

(ii) Resides in a home or apartment that is owned, leased or controlled by a provider of one or more health related treatment or support services, if such residence meets standards for community living as defined by the State. *(If applicable, specify any residential settings, other than an individual's home or apartment, in which residents will be furnished State plan HCBS. Describe the standards for community living that optimize participant independence and community integration, promote initiative and choice in daily living, and facilitate full access to community services):*

Adult Mental Health Habilitation (AMHH) services are provided in home and community based settings. In this context, home refers to an environment of the consumers choosing, which is a part of the community at large. This may include individual/single occupancy dwellings, or residences which support multiple individuals. The DMHA certified residential settings in which some individuals may choose to live are intended to promote opportunities to assist and support each individual to grow and develop skills needed to continue to live in the community. While in a DMHA certified residential facility, the provider's responsibility is to ensure the resident's involvement in decisions that affect his/her care, daily schedules and lifestyles. The overall atmosphere of the setting is conducive to the achievement of optimal independence, safety and development by the resident with his/her input. The location of the facility is made to provide residents reasonable access to the community at large including but not limited to agency, medical, recreational, and shopping areas, by public or agency-arranged transportation. Please note, the certified residential settings are intended to be homes where the individual lives. The majority of services and behavioral health care is provided in other locations outside of the residence, such as in the community at large or in a clinic setting.

While AMHH services may be provided in the individual's actual home depending on the individual's needs, desires and goals, the emphasis is on engaging each individual in being an active member in the community at large. Because of the importance placed on engaging and supporting individuals in the community, AMHH proposes a specific service to ensure individuals have opportunities for meaningful purpose in the community. This new service is titled Supported Community Engagement. The intent of the program and services is to support and assist individuals to participate in community activities and utilize natural supports and community resources (such as community centers, YMCA/YWCA, churches, schools, health clubs to move them beyond behavioral health settings. To justify that all AMHH services are home and community-based, a distinction must be made between where the person lives and where the person receives services. Services are designed to be delivered in community settings including, but not exclusively in the individual's home. By design, some AMHH services may not be provided in a residential setting.

Many persons eligible for the AMHH services live in their own home or with families or friends in the same manner as any adult who does not have a mental illness. Due to the eligibility criteria for the AMHH services, there are some persons seeking these services who do not have family or friends with whom they can live or are not functioning at a level where their health and safety can be supported in a totally independent setting. Depending upon the person's level of need and functioning, he/she may choose to live in full time supervised settings, settings that provide less than full time supervision or settings that provide no on-site supervision. The responses below relate only to living environments that are not fully independent.

State monitoring: The state maintains the authority to monitor and enforce the adherence to standards by conducting on-site visits to ensure compliance with standards and respond to any complaint or incident reported. In addition to consumer feedback and site visits, data is collected and analyzed per the Quality

Indicator section of this SPA. There are also facility requirements for compliance with fire and safety codes which must be kept up to date. The state will conduct site visits to ensure standards are met. Individuals residing in any DMHA certified residential setting have the freedom to choose how they live and residents' rights are respected and honored.

DMHA standards for residential facilities include the following:

- The location of the residence shall provide opportunities for the resident to participate in community activities and have independent access to community services.
- The residence location in the community shall provide residents with reasonable access to the agency as well as to medical, recreational, and shopping areas by public or agency-arranged transportation.
- The residence shall be located in a suitable residential setting, and the location, design, construction, and furnishings of each residence shall be consistent with a family/personal home (home-like).
- Residents are afforded the opportunity to engage in community based programs that assist the individual in achieving goals including employment. (If an individual demonstrates the interest and desire to become competitively employed, services such as Home and Community Based Habilitation and Supportive Community Engagement are appropriate vehicles to prepare them for potential competitive employment. In addition, as appropriate, individuals are connected to community services that are directly related to employment.)

Prior to an individual's selection of a placement, alternatives are discussed with the individual, family, and guardian. The decision for the choice of placement is based on the individual's identified needs, goals and resources. Once the resident's placement is selected by him/her, an Individualized Integrated Care Plan (IICP) is developed and/or updated with the resident. The IICP reflects his/her aspirations and goals towards an independent lifestyle and how the residential setting contributes to empowering the individual to continue to live successfully in the community.

Each setting is required to have and enforce written policies regarding the resident's rights and responsibilities. . DMHA standards for residential facilities, specific to the residents' personal rights and freedoms, include the following:

- The environment is safe;
- Each resident is free from abuse and neglect;
- Each resident is treated with consideration, respect, and full recognition of the resident's dignity and individuality;
- Each resident is free to communicate, associate, and meet privately with persons of the resident's choice as long as the exercise of these rights does not infringe on the rights of another resident and any restriction of this right is a part of the resident's individual treatment plan;
- Each resident has the right to confidentiality concerning personal information including health information;
- Each resident is free to voice grievances and to recommend changes in the policies and services offered by the agency;
- Each resident has the right to manage personal financial affairs or to seek assistance in managing them unless the resident has a representative payee or a court appointed guardian for financial matters;
- Each resident shall be informed about available legal and advocacy services, and may contact or consult legal counsel at the resident's own expense;
- Each resident shall be informed of DMHA's toll free consumer service number; and
- Each resident shall be free from coercion and restraints, restrictive interventions, and seclusion.

The referring provider is responsible for providing a list of AMHH provider agencies in the geographic area from which the individual may choose a preferred provider. Provider agencies are expected to have and share

with individuals their policies and procedures to select and/or change service delivery providers within the agency, and/or request transfer to a different agency. The IICP and interventions are developed in collaboration with the individual, the treatment team, and when appropriate, the individual's family or guardian.

The State defines "homelike", to the extent feasible, as an atmosphere with patterns and conditions of everyday life that are as close as possible to those of individuals without a diagnosis of mental illness. This includes an environment designed with the purpose and focus to increase the resident's involvement in decisions that affect his/her care, daily schedules and lifestyles to be more similar to his/her peers who live on their own. The overall atmosphere of the setting is conducive to the achievement of optimal development of independence by the residents. The location of the facility is made to provide residents reasonable access to the community at large including but not limited to the agency, medical, recreational, and shopping areas by public or agency-arranged transportation.

DMHA supports a permanent supportive housing model which refers to a housing unit that is linked with community based services. The tenant holds the lease with a landlord and receives services based on need through a community mental health center or community service agency. The tenant's housing is not contingent on the person participating in any mental health or addiction services. The individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the state's landlord tenant law of the state, county, city or other designated entity. Each individual's essential personal rights of privacy, dignity and respect, and freedom from coercion and restraint are protected.
The community residential settings certified by DMHA and identified in the SPA application are designed to provide an array of living options that span the continuum from minimal oversight to highly supervised settings. DMHA through certification and licensure standards requires the individual's participation in planning their care and supports the recovery philosophy that promotes the least restrictive, most appropriate care to safely meet the individual's identified needs and desires.

DMHA certified residential care settings are designed to be a component of an out-patient community based continuum of care. These settings are not a nursing facility, Intermediate Care Facility for Individuals with Intellectual Disability or an Institute for Mental Diseases. The residential care settings do not have any qualities of an institution, nor would they be permitted to be located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or disability-specific housing complex. One of the primary goals of the AMHH services program is to provide services and support to individuals to ensure they live safely and as independently as possible in the community. The program intends to provide opportunities for individuals to get their needs met in community-based settings and to prevent need for and placement in institutional settings.

DMHA and OMPP have a strong partnership with state housing agencies: Indiana Housing and Community Development and Corporation for Supportive Housing. Together, these agencies have facilitated the development of supportive housing integrated into the community to meet the needs of individuals with mental health and addiction disorders.

Description of DMHA Certified Residential Facilities:
"Residential living facility" includes:
(1) a supervised group living facility;
(2) a transitional residential services facility;
(3) a semi-independent living facility defined under IC 12-22-2-3; and
(4) alternative family homes operated solely by resident householders.

AMHH recipients living in a DMHA-certified residential setting have the following rights:

- The right to privacy in his or her sleeping or living unit;
- Lockable entrance doors, with appropriate staff having keys to the doors;
- Freedom to share living units at the recipient's choice;
- When sharing living units, recipients have a choice of roommates;
- Freedom to furnish and decorate his or her personal sleeping or living unit;
- Recipients are able to have visitors of their choosing at any time in the living unit;
- The setting is physically accessible to the recipient; and
- Freedom from restraints, restrictive interventions, and seclusion.
- Any modification of the resident's rights must be supported by a specific assessed need and documented in the person-centered IICP.

1) "Supervised group living facility" or "SGL" means a residential facility that provides a therapeutic environment in a homelike setting to persons with a psychiatric disorder or addiction who need the benefits of a group living arrangement as post psychiatric hospitalization intervention or as an alternative to hospitalization. "Therapeutic living environment" means a living environment:

(A) in which the staff and other residents contribute; and

(B) that presents no physical or social impediments to the habilitation and rehabilitation of the resident.

This setting is designed to assist individuals in their recovery process by offering a safe supportive home like environment. Individuals may come and go as needed to attend work/school, treatment appointments, recreation, etc… On site supervision is required 24/7 in this setting..While individuals would have access to food 24/7, there are typically planned meal times where individuals may eat together. Menus are developed by dieticians to provide healthy meals that are consistent with each individual's dietary needs/restrictions (e.g. diabetic, low sodium). Alternative food is available if an individual chooses not to eat the planned meal. Consumers are given input in the meal planning process.

A certified supervised group living facility serves up to ten (10) consumers in a single family dwelling and up to fifteen (15) consumers in an apartment building (which includes 3 or more dwelling units) or in a congregate residence.

2) "Transitional residential facility" or "TRS" means a twenty-four (24) hour per day service that provides food, shelter, and other support services to individuals with a psychiatric disorder or addiction who are in need of a short term supportive residential environment.

Individuals in this type of setting are provided with less than 24 hour supervision. They have input into house hold activities and may come and go as needed to attend work/school, treatment appointments, recreation, etc… While individuals would have access to food 24/7, there are typically planned meal times where individuals may eat together. Consumers are given input in the meal planning process. Menus are designed by dieticians to provide healthy meals that are consistent with each individual's dietary needs/restrictions (e.g. diabetic, low sodium). Alternative food is available if an individual chooses not to eat the planned meal. Individuals in this setting are likely preparing for or already participating in work or school activities.

A certified transitional residential facility serves fifteen (15) or fewer persons.

3) Semi-independent living facility" or "SILP" means a facility:

(A) that is not licensed by another state agency and serves six (6) or fewer individuals with a psychiatric disorder or an addiction, or both, per residence who require only limited supervision; and

(B) in which the agency or its subcontractor:

(i) provides a resident living allowance to the resident; or

(ii) owns, leases, or manages the residence.

Individuals in this type of setting are provided with a minimum of oversight one hour per week. These settings are typically home like. Individuals have input into house hold activities and may come and go as needed to attend work/school, treatment appointments, recreation, etc… .While individuals would have access to food 24/7, there are typically planned meal times where individuals may eat together. Individuals are given input in the meal planning process. Menus are designed by dieticians to provide healthy meals that are consistent with each individual's dietary needs/restrictions (e.g. diabetic, low sodium). Alternative food is available if an individual chooses not to eat the planned meal. This setting is intended to prepare individuals for independent living settings.

4) "Alternative family for adults (AFA) program" means a program that serves six (6) or fewer individuals who:

(A) have a psychiatric disorder or addiction, or both; and

(B) reside with an unrelated householder.

Individuals in this type of setting are provided with a minimum of oversight two hours per month. These settings are home like. Individuals have input into house hold activities and may come and go as needed to attend work/school, treatment appointments, recreation, etc… While individuals would have access to food 24/7, there are typically planned meal times where individuals may eat together. Individuals are given input in the meal planning process. Menus are designed by dieticians to provide healthy meals that are consistent with each individual's dietary needs/restrictions (e.g. diabetic, low sodium). Alternative food is available if an individual chooses not to eat the planned meal. This setting is intended to prepare individuals for independent living settings or may become permanent housing if this best meets the individual's needs and a less restrictive setting is not wanted or deemed appropriate by the individual or treatment team.

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	07/01/2013	06/30/2014	968
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.

1. ☒ Medicaid Eligible. *(By checking this box the State assures that):* Individuals receiving State plan HCBS are in an eligibility group covered under the State's Medicaid State plan.

2. Income Limits. (*Select at least one*):

☒ Individuals who have income that does not exceed 150% of the Federal Poverty Level (FPL). Individuals with incomes up to 150% of the FPL who are only eligible for Medicaid because they are

receiving 1915(c) waiver services may be eligible to receive services under 1915(i) provided they meet all other requirements of the 1915(i) State plan option. The State has a process in place that identifies individuals who have income that does not exceed 150% of the FPL.

☐ Individuals who have income that does not exceed 300% of Supplemental Security Income (SSI).

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

☒	The State does not provide State plan HCBS to the medically needy.	
○	The State provides State plan HCBS to the medically needy *(select one):*	
	○	The State elects to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy.
	○	The State does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III).

Needs-Based Evaluation/Reevaluation

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

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

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

Persons conducting the state evaluation for eligibility determination and approval of plans of care hold a least a bachelor's degree in social work, counseling, psychology, or similar field and have a minimum of 3 years post degree experience working with individuals with serious mental illness (SMI) and habilitative needs. Supervision of the evaluation team is provided by clinically licensed staff from the fields of social work, psychology, or psychiatry.

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

Information about 1915(i) services is be posted on the DMHA and OMPP public websites. These websites summarize the eligibility criteria and note all available services, service provider agencies, locations where potential enrollees may go to apply, and how to access assessments and services. Any provider may identify potential enrollees who meet the 1915(i) eligibility criteria or individuals may notify their provider of an interest in the home and community based services. Any individual may contact the state for information about AMHH eligibility and the process to apply. The individual is given a list of AMHH eligible provider agencies that may be chosen to assist in the application process. After agency staff reviews the program information with the applicant, the two individuals

discuss the options under this program; and together determine whether to complete an application for 1915(i) services. In deciding whether or not a referral for 1915(i) services is appropriate, the agency staff and applicant review the target group criteria and discuss whether a referral is merited.

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

The ANSA tool consists of items that are rated as:

'0' no evidence or no need for action
'1' need for watchful waiting to see whether action is needed
'2' need for action
'3' need for either immediate or intensive action due to a serious or disabling need

The items are grouped into categories or domains. Once the assessment has been completed, the agency staff receives a level of care decision support recommendation based on the individual item ratings. The level of care recommendation from the ANSA is not intended to be a mandate for the level of services that an individual receives. There are many factors, including individual preferences and choice, which should 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/Documents/ANSAManual_712011.pdf

The referral form and supporting documentation provide specific information about the person's health status, current living situation, family functioning, vocational/employment status, social functioning, living skills, self-care skills, capacity for decision making, living situation, potential for self-injury or harm to others, substance use/abuse, and medication adherence. The referral also includes information about the person's participation in MRO services and the outcomes for those services.

The agency staff and the applicant jointly develop a proposed plan of care (Individualized Integrated Care Plan (IICP)) that includes desired goals and services requested and deemed necessary to address the goals. Please see the section "Supporting the Participant in Plan of Care Development" for further details regarding person- centered care planning. Upon completion of the referral packet (including but not limited to the ANSA, referral form, and proposed plan of care), the agency staff submit the documents to DMHA through a secure electronic file transfer process.

Upon receipt of the referral packet, the state evaluation team reviews all submitted documentation and determine whether or not the applicant is eligible for 1915(i)

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

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

these services may begin immediately.

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

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

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

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

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

All of the following needs-based criteria must be met for 1915(i) eligibility:
1. Without ongoing habilitation services as demonstrated by written attestation by a psychiatrist or Health Services Provider in Psychology (HSPP), the person is likely to deteriorate and be at risk of institutionalization (e.g., acute hospitalization, State hospital, nursing home, jail).
2. The recipient must demonstrate the need for significant assistance** in major life domains related to their mental illness (e.g., physical problems, social functioning, basic living skills, self-care, potential for harm to self or others).
3. The recipient must demonstrate significant needs related to his/her behavioral health.
4. The recipient must demonstrate significant impairment in self-management of his/her mental illness or demonstrate significant needs for assistance with mental illness management.
5. The recipient must demonstrate a lack of sufficient natural supports to assist with mental illness management.
6. The recipient is not a danger to self or others at the time the application for AMHH services program eligibility is submitted for State review and determination.
7. Recipient has received a recommendation for intensive community based care on the uniform community assessment tool defined by the State (the Adult Needs and Strengths Assessment- ANSA with a Level of 4 or higher).

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

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

Needs-Based/Level of Care (LOC) Criteria

State plan HCBS	NF (& NF LOC	ICF/MR (& ICF/MR	Applicable Hospital*

needs-based eligibility criteria	waivers)	LOC waivers)	LOC (& Hospital LOC waivers)
Needs based eligibility criteria are specified in Item 4 above.	Indiana Law allows reimbursement to NFs for eligible persons who require skilled or intermediate nursing care as defined in 405 Indiana Administrative Code 1-3-1 and 1-3-2. 405 IAC 1-3-1(a) Skilled nursing services, as ordered by a physician, must be required and provided on a daily basis, essentially 7 days a week. 405 IAC 1-3-2 (a) Intermediate nursing care includes care for patients with long term illnesses or disabilities which are relatively stable, or care for patients nearing recovery and discharge who continue to require some professional medical or nursing supervision and attention. A person is functionally eligible for either NF 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	Indiana Law allows reimbursement to ICF/MRs for eligible persons as defined in 405 IAC 1-1-11. A person may be functionally eligible for an ICF/MR LOC waiver when documentation shows the individual meets the following conditions: 1.Has a diagnosis of intellectual disability (mental retardation), cerebral palsy, epilepsy, autism, or condition similar to intellectual disability (mental retardation). 2. Condition identified in #1 is expected to continue. 3. Condition identified in #1 had an age of onset prior to age 22. 4. Individual needs a combination or sequence of services. 5. Has 3 of 6 substantial functional limitations as defined in 42 CFR 435.1010 in areas of (1) self-care, (2) learning, (3) self-direction, (4) capacity for independent living, (5) language, and (6) mobility.	Dangerous to self or others or gravely disabled. (IC-12-26-1)

	unstable, complex medical conditions. 2. Need for direct assistance for 3 or more substantial medical conditions including activities of daily living.		

*Long Term Care/Chronic Care Hospital

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

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

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

Person-Centered Planning & Service Delivery

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

1. ☒ There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment is based on:
   - An objective face-to-face assessment with a person-centered process by an agent that is independent and qualified;
   - Consultation with the individual and if applicable, the individual's authorized representative, and includes the opportunity for the individual to identify other persons to be consulted, such as, but not limited to, the individual's spouse, family, guardian, and treating and consulting health and support professionals caring for the individual;
   - An examination of the individual's relevant history, including findings from the independent evaluation of eligibility, medical records, an objective evaluation of functional ability, and any other records or information needed to develop the plan of care;
   - An examination of the individual's physical and mental health care and support needs, strengths and preferences, available service and housing options, and when unpaid caregivers will be relied upon to implement the plan of care, a caregiver assessment;
   - If the State offers individuals the option to self direct State plan HCBS, an evaluation of the ability of the individual (with and without supports), or the individual's representative, to exercise budget and/or employer authority; and
   - A determination of need for (and, if applicable, determination that service-specific additional needs-based criteria are met for), at least one State plan home and community-based service before an individual is enrolled into the State plan HCBS benefit.
2. ☒ Based on the independent assessment, the individualized plan of care:
   - Is developed with a person-centered process in consultation with the individual, and others at the option of the individual such as the individual's spouse, family, guardian, and treating and consulting health care and support professionals. The person-centered planning process must identify the individual's physical and mental health support needs, strengths and preferences, and desired outcomes;
   - Takes into account the extent of, and need for, any family or other supports for the individual, and neither duplicates, nor compels, natural supports;
   - Prevents the provision of unnecessary or inappropriate care;
   - Identifies the State plan HCBS that the individual is assessed to need;

- Includes any State plan HCBS in which the individual has the option to self-direct the purchase or control ;
- Is guided by best practices and research on effective strategies for improved health and quality of life outcomes; and
- Is reviewed at least every 12 months and as needed when there is significant change in the individual's circumstances.

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

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

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

Licensed professional means any of the following persons:

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

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

- an individual who has had at least two (2) years of clinical experience treating persons with mental illness under the supervision of a licensed professional, as defined above, such experience occurring after the completion of a master's degree or doctoral degree, or both, in any of the following disciplines:
  - in psychiatric or mental health nursing from an accredited university, plus a license as a registered nurse in Indiana;
  - in pastoral counseling from an accredited university; or
  - in rehabilitation counseling from an accredited university.
- an individual who is under the supervision of a licensed professional, as defined above, is eligible for and working toward licensure, and has completed a master's or doctoral degree, or both, in any of the following disciplines:
  - in social work from a university accredited by the Council on Social Work Education;
  - in psychology from an accredited university;
  - in mental health counseling from an accredited university; or
  - in marital and family therapy from an accredited university.
- a licensed independent practice school psychologist under the supervision of a licensed

professional, as defined above.

- an authorized health care professional (AHCP), defined as follows:
  - a physician assistant with the authority to prescribe, dispense and administer drugs and medical devices or services under an agreement with a supervising physician and subject to the requirements of IC 25-27.5-5.
  - a nurse practitioner or a clinical nurse specialist, with prescriptive authority and performing duties within the scope of that person's license and under the supervision of, or under a supervisory agreement with, a licensed physician pursuant to IC 25-23-1.

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

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

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

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

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

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

The IICP is developed after completing a holistic clinical and bio-psychosocial assessment. The holistic assessment includes documentation in the applicant/recipient's medical record of the following:
Review, discussion and documentation of the applicant/recipient's desires, needs, and goals. Goals are recovery/habilitative in nature with outcomes specific to the habilitative needs identified by the applicant/recipient.

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

A member of the treatment team involved in assessing the applicant/recipient's needs and desires fulfills the role of care coordinator and be responsible for documenting the IICP with the applicant/recipient's participation. In addition to driving the IICP development, the applicant/recipient of AMHH 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 have mechanisms in place to support the applicant/recipient's choice of care coordinator.

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

Each eligible AMHH provider agency is required to ensure a written statement of rights is provided to each recipient. The statement shall include:
(1) The toll-free consumer service line number and the telephone number for Indiana 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 AMHH provider agencies are accepted by the following means:

(1) The "Family/Consumer" section on the DMHA website;
(2) The "Consumer Service Line" (800-901-1133)
(3) In-person to a DMHA staff member; or
(4) Via written complaint or email that is submitted to DMHA.

The IICP must also include the following documentation:

- Outline of goals that promote stability and potential movement toward independence and integration into the community, treatment of mental illness symptoms, and habilitating areas of functional deficits related to the mental illness.

- Individuals or teams responsible for treatment, coordination of care, linkage, and referrals to internal or external resources and care providers to meet identified needs.
- A comprehensive listing of all specific treatments and services that are requested by the applicant/recipient.

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

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

This 1915(i) State Plan amendment is to run concurrently with the 1915(b)(4) fee-for-service selective contracting waiver (IN-02).

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

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

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

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

The OMPP reviews and approves the policies, processes and standards for developing and approving 1915(i) Plans of Care. In the instance of a complaint from a 1915(i) provider or applicant/recipient, the IICP submitted to DMHA may be reviewed by OMPP. Based on the terms and conditions of the 1915(i), the Medicaid agency may overrule the approval or disapproval of

any specific IICP acted upon by the DMHA serving in its capacity as the administrating agency for the 1915(i).

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

☐	Medicaid agency	☒	Operating agency	☐	Case manager
☐	Other (*specify*)				

Services

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

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):*	
Service Title:	Adult Day Services
Service Definition (Scope):	
Community-based group programs designed to meet the needs of adults with significant behavioral health impairments as identified in the IICPs. These comprehensive, non-residential programs provide health, wellness, social, and therapeutic activities. These services are provided in a structured, supportive environment. The services provide supervision, support services, and personal care as required by the IICP.	
Additional needs-based criteria for receiving the service, if applicable *(specify):*	
Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*	
☒	Categorically needy *(specify limits):* • Adult Day Services may include: o care planning, o treatment, o monitoring of weight, blood glucose level, and blood pressure o medication administration; o nutritional assessment and planning; o individual or group exercise training; o training in activities of daily living; o skill reinforcement on established skills; and o other social activities. • Direct service providers must be supervised by a licensed professional; • Clinical oversight must be provided by a licensed physician, who is on-site at least once a week and available to program staff when not physically present; • Each day of service must be appropriately documented. • At a minimum a weekly review and update of progress toward habilitative goals occurs and is documented in the recipient's clinical record; The service is offered in half day units. A single half-day (1/2 day) day unit is defined as one unit of a minimum of three (3) hours to a maximum of five (5) hours/day. Two units are defined as more than five (5) hours to a maximum of 8 hours/day. A maximum of two half-day (1/2 day)

	units/day is allowed up to 5 days per week. Exclusions: • Recipient receiving MRO services • Recipient receiving inpatient or partial hospitalization through the Clinic Option on the same day • Services shall not be reimbursed when provided in a residential setting as defined by DMHA
☐	Medically needy *(specify limits):N/A*

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

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

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

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Agency	DMHA	Initially and at time of DMHA certification renewal

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

☐	Participant-directed	☒	Provider managed

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

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

Service Definition (Scope):*Definition*

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

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

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

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

- Service requires face-to-face contact in an individual setting.
- Recipients are expected to benefit from services.
- Services must be goal-oriented and related to the IICP.
- Activities include implementation of the individualized support plan, assistance with personal care, coordination and facilitation of medical and non-medical services to meet healthcare needs.
- Services may include, but are not limited to the following:
  - Skills training in food planning and preparation, money management, maintenance of living environment.
  - Training in appropriate use of community services

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

Home and Community Based Habilitation and Support, including all subtypes (individual, group, family/couple, with and without recipient present) may be provided for up to a total of 2 hours per day (eight units per day).

Exclusions:

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

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

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

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

			In addition to meeting criteria for a provider agency, the agency must certify that agency staff providing an AMHH service must meet the following standards for this service, as follows: (A) Licensed professional; (B) QBHP; or (C) OBHP.

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
Agency	DMHA	Initially and at time of DMHA certification renewal

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

☐	Participant-directed	☒	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):*	
Service Title:	Home and Community Based Habilitation and Support – Family/Couple with the Recipient Present – Individual Setting
Service Definition (Scope):*Definition*	
Individualized face-to-face services directed at the health, safety and welfare of the recipient and assisting in the acquisition, improvement, and retention of skills necessary to support recipients to live successfully in the community. Training and education to instruct a parent, or other family member, or primary caregiver about the treatment regimens appropriate to the recipient; and to improve the ability of the parent, family member or primary caregiver to provide the care to or for the recipient. Skills training as used in this service description means: Assisting in the reinforcement, management, adaptation and/ or retention of skills necessary to live successfully in the community.	
Additional needs-based criteria for receiving the service, if applicable *(specify):*	
Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*	
☒ Categorically needy *(specify limits):Insert Program Standards*	

- Service requires face-to-face contact in an individual setting.
- Recipients are expected to show benefit from services,
- Services must be goal-oriented and related to the IICP.
- Activities include implementation of the individualized support plan, assistance with personal care, coordination and facilitation of medical and non-medical services to meet healthcare needs.
- Services may include, but are not limited to the following:
  - Skills training in food planning and preparation, money management, maintenance of living environment.
  - Training in appropriate use of community services
  - Medication-related education and training by non medical staff.

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

Home and Community Based Habilitation and Support, including all subtypes (individual, group, family/couple, with and without recipient present) may be provided for up to a total of 2 hours per day (eight units per day).

Exclusions:

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

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

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

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

			In addition to meeting criteria for a provider agency, the agency must certify that the agency staff providing an AMHH service must meet the following standards for this service, as follows: (A) Licensed professional; (B) QBHP; or (C) OBHP.

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Agency	DMHA	Initially and at time of DMHA certification renewal

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

☐	Participant-directed	☒	Provider managed

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

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

Service Definition (Scope):*Definition*

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

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

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

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

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

- May include, but not limited to the following types of services:
  - Skills training in food planning and preparation, money management, maintenance of living environment.
  - Training in appropriate use of community services
  - Medication-related education and training by non medical staff.

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

Home and Community Based Habilitation and Support, including all subtypes (individual, group, family/couple, with and without recipient present) may be provided for up to a total of 2 hours per day (eight units per day).

Exclusions:

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

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

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

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

			(B) QBHP; or (C) OBHP.

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
Agency	DMHA	Initially and at time of DMHA certification renewal

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

☐	Participant-directed	☒	Provider managed

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

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

Service Definition (Scope):*Definition*

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

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

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

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

- Service requires face-to-face contact in a group setting.
- Recipients are expected to show benefit from services,
- Services must be goal-oriented and related to the IICP.
- Activities include implementation of the individualized support plan, assistance with personal care, coordination and facilitation of medical and non-medical services to meet healthcare needs.
- May include, but not limited to the following types of services:
  - Skills training in food planning and preparation, money management, maintenance of living environment.
  - Training in appropriate use of community services
  - Medication-related education and training by non medical staff.

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

	Home and Community Based Habilitation and Support, including all subtypes (individual, group, family/couple, with and without consumer present) may be provided for up to a total of 2 hours per day (eight units per day). Exclusions: • Recipients receiving MRO services • Recipients in partial hospitalization or inpatient hospitalization on the same day
☐	Medically needy *(specify limits):N/A*

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

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

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

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

Agency	DMHA	Initially and at time of DMHA certification renewal

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

☐	Participant-directed	☒	Provider managed

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

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

Service Definition (Scope)*:Definition*

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

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

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

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

- Service requires face-to-face contact in a group setting.
- Recipients are expected to show benefit from services,
- Services must be goal-oriented and related to the IICP.
- Activities include implementation of the individualized support plan, assistance with personal care, coordination and facilitation of medical and non-medical services to meet healthcare needs.
- May include, but not limited to the following types of services:
  - Skills training in food planning and preparation, money management, maintenance of living environment.
  - Training in appropriate use of community services
  - Medication-related education and training by non medical staff.

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

Home and Community Based Habilitation and Support, including all subtypes (individual, group, family/couple, with and without recipient present) may be provided for up to a total of 2 hours per day (eight units per day).

Exclusions:

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

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

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

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

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Agency	DMHA	Initially and at time of DMHA certification renewal

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

☐	Participant-directed	☒	Provider managed

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

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

Service Definition (Scope)*:Definition*

Training and education in a group setting to instruct a parent, or other family member, or primary caregiver about the treatment regimens appropriate to the recipient; and to improve the ability of the parent, family member or primary caregiver to provide the care to or for the recipient. This service includes individualized face-to-face services with the family or nonprofessional caregivers directed at the health, safety and welfare of the recipient and assisting in the acquisition, improvement, and retention of skills necessary to support recipients to live successfully in the community.

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

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

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

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

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

- Service requires face-to-face contact in a group setting.
- Recipients are expected to show benefit from services.
- Services must be goal-oriented and related to the IICP.
- Activities include implementation of the individualized support plan, assistance with personal care, coordination and facilitation of medical and non-medical services to meet healthcare needs.
- May include, but not limited to the following types of services:
  - Skills training in food planning and preparation, money management, maintenance of living environment.
  - Training in appropriate use of community services
  - Medication-related education and training by non medical staff.

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

Home and Community Based Habilitation and Support, including all subtypes (individual, group, family/couple, with and without recipient present) may be provided for up to a total of 2 hours per day (eight units per day).

Exclusions:

- Recipients receiving MRO services

	• Recipients in partial hospitalization or inpatient hospitalization on the same day
☐	Medically needy *(specify limits):N/A*

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

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

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Agency	DMHA	Initially and at time of DMHA certification renewal

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

☐	Participant-directed	☒	Provider managed

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

Service Title: Respite Care

Service Definition (Scope):*Definition*

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

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

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

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

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

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

Exclusions:

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

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

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

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

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

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
Agency	DMHA	Initially and at time of DMHA certification renewal

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

☐	Participant-directed	☒	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):*	
Service Title:	Therapy and Behavioral Support Services – Individual Setting

Service Definition (Scope):*Definition*

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

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

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

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

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

Individual setting Therapy and Behavioral Support service, including all 3 subtypes (individual, , family/couple, with and without recipient present) may be provided for a maximum of 24 hours (96 units) per year.

Exclusions:

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

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

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

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

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

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Agency	DMHA	Initially and at time of DMHA certification renewal

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

☐	Participant-directed	☒	Provider managed

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

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

Service Definition (Scope):*Definition*

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

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

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

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

	• The Medicaid identified recipient is the focus of the treatment; • Documentation must support how the service specifically benefits the identified recipient. • Therapy / behavioral support services must demonstrate progress toward and/or achievement of individual treatment goals. • Therapy / behavioral support services goals must be habilitative in nature. • Observation of the recipient in their environment for purpose of care plan development. • Development of a person centered behavioral support plan and subsequent revisions which may be a part of the individualized integrated care plan • Allowable training activities include: o Assertiveness; o stress reduction techniques; o the acquisition of socially accepted behaviors • Implementation of the behavior support plan for staff, family members, roommates, and other appropriate individuals Individual setting Therapy and Behavioral Support service, including all 3 subtypes (individual, family/couple, with and without recipient present) may be provided for a maximum of 24 hours (96 units) per year. Exclusions: • Recipients receiving MRO services • Recipients in partial hospitalization or inpatient hospitalization on the same day • Therapy services provided in a clinic setting are not billable under the 1915(i) but may qualify for reimbursement under the clinic option
☐	Medically needy *(specify limits):N/A*

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

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

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

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Agency	DMHA	Initially and at time of DMHA certification renewal

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

☐	Participant-directed	☒	Provider managed

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

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

Service Definition (Scope): *Definition*

Family/Couple Counseling and Therapy without the Recipient Present is a series of time-limited, structured, face-to-face sessions that work toward the goals identified in the individualized integrated care plan. The face-to-face interaction may be with family members or non-professional caregivers in an individual setting. Family/Couple Counseling and Therapy must be provided at home (living environment) or other locations outside the clinic setting.

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

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

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

- The Medicaid identified recipient is the focus of the treatment;
- Documentation must support how the service specifically benefits the identified recipient.
- Therapy / behavioral support services must demonstrate progress toward and/or achievement

of individual treatment goals.

- Therapy / behavioral support services goals must be habilitative in nature.
- Observation of the recipient in their environment for purpose of care plan development.
- Development of a person centered behavioral support plan and subsequent revisions which may be a part of the individualized integrated care plan
- Allowable training activities include:
  - Assertiveness;
  - stress reduction techniques;
  - the acquisition of socially accepted behaviors
- Implementation of the behavior support plan for staff, family members, roommates, and other appropriate individuals

Individual setting Therapy and Behavioral Support service, including all 3 subtypes (individual, family/couple, with and without recipient present) may be provided for a maximum of 24 hours (96 units) per year.

Exclusions:

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

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

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

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

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

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Agency	DMHA	Initially and at time of DMHA certification renewal

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

☐	Participant-directed	☒	Provider managed

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

Service Title: Therapy and Behavioral Support Services – Group Setting

Service Definition (Scope):*Definition*

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

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

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

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

- The Medicaid identified recipient is the focus of the treatment;
- Documentation must support how the service specifically benefits the identified recipient.
- Therapy / behavioral support services must demonstrate progress toward and/or achievement of individual treatment goals.
- Therapy / behavioral support services goals must be habilitative in nature.
- Observation of the recipient in their environment for purpose of care plan development.
- Development of a person centered behavioral support plan and subsequent revisions which may be a part of the individualized integrated care plan

- Allowable training activities include:
  - Assertiveness;
  - stress reduction techniques;
  - the acquisition of socially accepted behaviors
- Implementation of the behavior support plan for staff, family members, roommates, and other appropriate individuals

Group setting Therapy and Behavioral Support service, including all 3 subtypes (group with recipient, and group with family/couple, with and without recipient present) may be provided for a maximum of 30 hours (120 units) per year.

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

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

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

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

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

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Agency	DMHA	Initially and at time of DMHA certification renewal

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

☐	Participant-directed	☒	Provider managed

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

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

Service Definition (Scope)*:Definition*

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

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

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

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

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

	○ the acquisition of socially accepted behaviors • Implementation of the behavior support plan for staff, family members, roommates, and other appropriate individuals Group setting Therapy and Behavioral Support service, including all 3 subtypes (group with recipient, and group with family/couple, with and without recipient present) may be provided for a maximum of 30 hours (120 units) per year. Exclusions: • Recipients receiving MRO services • Recipients in partial hospitalization or inpatient hospitalization on the same day • Therapy services provided in a clinic setting are not billable under the 1915(i) but may qualify for reimbursement under the clinic option
☐	Medically needy *(specify limits):N/A*

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

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

			counselor, as defined under IC 25-23.6-10.5; or (B) QBHP.

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Agency	DMHA	Initially and at time of DMHA certification renewal

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

☐ Participant-directed ☒ Provider managed

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

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

Service Definition (Scope): *Definition*

Family/Couple Counseling and Therapy without the recipient Present is a series of time-limited, structured, face-to-face sessions that work toward the goals of the recipient identified in the individualized integrated care plan. The face-to-face interaction may be with family members or non-professional caregivers in a group setting. Family/Couple Counseling and Therapy must be provided at home (living environment) or other locations outside the clinic setting.

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

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

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

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

	Group setting Therapy and Behavioral Support service, including all 3 subtypes (group with recipient, and group with family/couple, with and without recipient present) may be provided for a maximum of 30 hours (120 units) per year. Exclusions: • Recipients receiving MRO services • Recipient in partial hospitalization or inpatient hospitalization on the same day • Therapy services provided in a clinic setting are not billable under the 1915(i) but may qualify for reimbursement under the clinic option
☐	Medically needy *(specify limits):N/A*

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

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

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

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

☐	Participant-directed	☒	Provider managed

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

Service Title: Addiction Counseling – Individual Setting

Service Definition (Scope):*Definition*

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

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

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

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

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

The combined total of individual and group Addiction Counseling service may be provided for a maximum of 64 hours (units) per year.

Exclusions:

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

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

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

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

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

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover)*:	
Service Title:	Addiction Counseling – Family/Couple with Recipient Present (Individual Setting)
Service Definition (Scope): *Definition*	

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

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

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

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

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

The combined total of individual and group Addiction Counseling service may be provided for a maximum of 64 hours (units) per year.

Exclusions:

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

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

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

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

			AMHH operating policy. In addition to meeting criteria for a provider agency, the agency must certify that the agency staff providing an AMHH service must meet the following standards for this service, as follows: (A) Licensed professional; (B) QBHP.

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Agency	DMHA	Initially and at time of DMHA certification renewal

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

☐	Participant-directed	☒	Provider managed

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

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

Service Definition (Scope):*Definition*

Family/Couple Addiction Counseling without the recipient Present is a series of time-limited, structured, face-to-face sessions that work toward the goals of the recipient identified in the individualized integrated care plan. The face-to-face interaction may be with family members or non-professional caregivers in an individual setting. Family/Couple Counseling and Therapy must be provided at home (living environment) or other locations outside the clinic setting.

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

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

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

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

The combined total of individual and group Addiction Counseling service may be provided for a maximum of 64 hours (units) per year.

Exclusions:

- Recipients with withdrawal risk/symptoms whose needs cannot be managed at this level of

	care or who need detoxification services. • Recipients at risk of harm to self or others. • Addiction Counseling sessions that consist of only education services are not reimbursed. • Addiction Counseling may not be provided for professional caregivers.
☐	Medically needy *(specify limits):N/A*

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

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

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
Agency	DMHA	Initially and at time of DMHA certification renewal

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

☐	Participant-directed	☒	Provider managed

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

Service Title: Addiction Counseling – Group Setting

Service Definition (Scope): *Definition*

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

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

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

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

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

The combined total of individual and group Addiction Counseling service may be provided for a maximum of 64 hours (units) per year.

Exclusions:

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

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

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

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

			entity approved by DMHA. (B) Provider agency is an enrolled Medicaid provider that offers a full-continuum of care. (C) Provider agency must maintain documentation in accordance with the Medicaid requirements defined under 405 IAC 1-5-1 and 405 IAC 1-5-3. (D) Provider agency must meet all AMHH provider agency criteria, as defined in the SPA and AMHH operating policy. In addition to meeting criteria for a provider agency, the agency must certify that the agency staff providing an AMHH service must meet the following standards for this service, as follows: (A) Licensed professional; (B) QBHP.

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Agency	DMHA	Initially and at time of DMHA certification renewal

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

☐	Participant-directed	☒	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):*	
Service Title:	Addiction Counseling – Family/Couple with Recipient Present (Group Setting)
Service Definition (Scope)*:Definition*	
Group Addiction Counseling with the recipient Present is a planned and organized face-to-face service with the recipient and family members or non-professional caregivers where addiction professionals and other clinicians provide counseling intervention in a group setting that works toward the recipient's individualized recovery goals identified in the IICP. Addiction Counseling must be provided at home (living environment) or other locations outside the clinic setting.	
Additional needs-based criteria for receiving the service, if applicable *(specify):*	
Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*	
☒	Categorically needy *(specify limits):Insert Program Standards*

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

The combined total of individual and group Addiction Counseling service may be provided for a maximum of 64 hours (units) per year.

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

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

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

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

			In addition to meeting criteria for a provider agency, the agency must certify that the agency staff providing an AMHH service must meet the following standards for this service, as follows: (A) Licensed professional; (B) QBHP.

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Agency	DMHA	Initially and at time of DMHA certification renewal

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

☐	Participant-directed	☒	Provider managed

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

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

Service Definition (Scope):*Definition*

Group Addiction Counseling without the Recipient Present is a planned and organized face-to-face service with family members or non-professional caregivers where addiction professionals and other clinicians provide counseling intervention in a group setting that works toward the recipient's individualized recovery goals identified in the IICP. Addiction Counseling must be provided at home (living environment) or other locations outside the clinic setting.

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

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

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

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

The combined total of individual and group Addiction Counseling service may be provided for a maximum of 64 hours (units) per year.

Exclusions:

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

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

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

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

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

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

Agency	DMHA	Initially and at time of DMHA certification renewal

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

☐	Participant-directed	☒	Provider managed

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

Service Title: Peer Support Services

Service Definition (Scope):*Definition*

Peer Support Services are face-to-face services that provide structured, scheduled activities that support socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills.

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

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

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

- Peer Support Services must be identified in the IICP
- Services include the following components:
  - assisting individuals with developing self care plans and other formal mentoring activities aimed at increasing active participation in person-centered planning and delivery of individualized services;
  - assisting individuals in the development of psychiatric advanced directives;
  - supporting problem solving related to reintegration into the community; and
  - education and promotion of anti-stigma activities.
- Documentation must support how the service specifically benefits the identified recipient.

Peer Support service may be provided for a maximum of 130 hours (520 units) per year.

Exclusions:

- Services that are purely recreational or diversionary in nature, or do not support community integration goals,
- Group Interventions are not billable as peer support;
- Activities billed under Home and Community Based Habilitation and Support Services and care coordination services are not billable as peer support.

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

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Agency	N/A	DMHA-certified Community Mental Health	DMHA-approved AMHH provider agencies must meet DMHA and OMPP-defined criteria and standards, including

		Center (CMHC)	the following: (A) Provider agency has acquired a National Accreditation by an entity approved by DMHA. (B) Provider agency is an enrolled Medicaid provider that offers a full-continuum of care. (C) Provider agency must maintain documentation in accordance with the Medicaid requirements defined under 405 IAC 1-5-1 and 405 IAC 1-5-3. (D) Provider agency must meet all AMHH provider agency criteria, as defined in the SPA and AMHH operating policy. In addition to meeting criteria for a provider agency, the agency must certify that the agency staff providing an AMHH service must meet the following standards for this service, as follows: (A) Individuals providing the service meet DMHA training and competency standards for Certified Recovery Specialists; and (B) Individual is under the supervision of a licensed professional or QBHP as defined in this document under Section 4 of Person Centered Planning.

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Agency	DMHA	Initially and at time of DMHA certification renewal

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

☐	Participant-directed	☒	Provider managed

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

Service Title:	Supported Community Engagement Services

Service Definition (Scope): *Definition*

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

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

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

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

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

These services shall be provided in a community setting.

This service is offered for up to eighteen hours per month for a total of 72 units per month.

Exclusions:

- If a provider chooses to compensate a recipient for such activities, the provider must use non-Medicaid funding and must be able to document the funding source.
- Training in specific job tasks.
- Recipients who are currently competitively employed.
- Services are not available as vocational rehabilitation services funded under the Rehabilitation Act of 1973.

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

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

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

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

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Agency	DMHA	Initially and at time of DMHA certification renewal

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

☐	Participant-directed	☒	Provider managed

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

Service Title:	Care Coordination

Service Definition (Scope)*:Definition*

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

coordination is on behalf of the recipient, not to the recipient.

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

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

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

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

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

Care Coordination service may be provided for a maximum of 200 hours (800 units) per year.

Exclusions:

- Activities billed under Behavioral Health Reassessment (by a non-physician).
- The actual or direct provision of medical services or treatment. Examples include, but are not limited to:

- Training in daily living skills.
- Training in work skills and social skills.
- Grooming and other personal services.
- Training in housekeeping, laundry, cooking.
- Transportation services.
- Individual, group, or family therapy services.
- Crisis intervention services.
- Services that go beyond assisting the recipient in gaining access to needed services. Examples include, but not limited to:
  - Paying bills and/or balancing the recipient's checkbook.
  - Traveling to and from appointments with recipients.

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

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

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

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
Agency	DMHA	Initially and at time of DMHA certification renewal

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

☐	Participant-directed	☒	Provider managed

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

Service Title:	Medication Training and Support – Individual Setting

Service Definition (Scope):*Definition*

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

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

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

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

- Face-to-face contact in an individual setting that includes monitoring self-administration of prescribed medications and monitoring side effects, including weight, blood glucose level, and blood pressure.
- When provided in a clinic setting, Medication Training and Support may compliment, but not duplicate, activities associated with medication management activities available under the Clinic Option.
- When provided in residential treatment settings, Medication Training and Support may include components of medication management services.
- Medication Training and Support may also include the following services that are not required to be provided face-to-face with the recipient:
  - Transcribing physician or AHCP medication orders.
  - Setting or filling medication boxes.
  - Consulting with the attending physician or AHCP regarding medication-related issues.
  - Ensuring linkage that lab and/or other prescribed clinical orders are sent.
  - Ensuring that the recipient follows through and receives lab work and services pursuant to other clinical orders.
  - Follow up reporting of lab and clinical test results to the recipient and physician.
- The recipient is the focus of the service.
- Documentation must support how the service benefits the recipient.
- Medication Training and Support must demonstrate movement toward and/or achievement

of recipient treatment goals identified in the individualized integrated care plan (IICP).

- Medication Training and Support goals are habilitative in nature

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

Exclusions:

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

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

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

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

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

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Agency	DMHA	Initially and at time of DMHA certification renewal

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

☐	Participant-directed	☒	Provider managed

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

Service Title:	Medication Training and Support – Family/Couple with the Recipient Present (Individual Setting)

Service Definition (Scope):*Definition*

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

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

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

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

- Face-to-face contact in an individual setting with family members or non-professional caregivers in support of the recipient.
- May include training of family members or non-professional caregivers to monitor self-administration of prescribed medications and monitoring side effects, including weight, blood glucose level, and blood pressure.
- When provided in the clinic setting, Medication Training and Support may compliment, but not duplicate, activities associated with medication management activities available under

	the Clinic Option • When provided in residential treatment settings, Medication Training and Support may include components of medication management services. • The recipient is the focus of Medication Training and Support. • Documentation must support how the service benefits the recipient, including when Medication Training and Support is provided in a group setting. • Medication Training and Support results in demonstrated movement toward, or achievement of, the recipient's treatment goals identified by the individualized integrated care plan. • Medication Training and Support goals are habilitative in nature. Medication Training and Support service including all subtypes (individual, group, family/couple, with and without recipient present) may be provided for a maximum of 182 hours (728 units) per year. Exclusions: • If Clinic Option medication management, counseling, or psychotherapy is provided and medication management is a component, then Medication Training and Support may not be billed separately for the same visit by the same provider. • Coaching and instruction regarding recipient self-administration of medications is not reimbursable under Medication Training and Support, but may be billed as Skills Training and Development.
☐	Medically needy *(specify limits):N/A*

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

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

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

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
Agency	DMHA	Initially and at time of DMHA certification renewal

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

☐	Participant-directed	☒	Provider managed

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

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

Service Definition (Scope): *Definition*

Family/Couple Medication Training and Support without the recipient Present involves face-to-face contact with family members or other non-professional caregivers, in an individual setting, for the purpose of monitoring medication compliance, providing education and training about medications, monitoring medication side effects, and providing other nursing and medical assessments. Medication Training and Support also includes certain non face-to-face activities.

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

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

☒	Categorically needy *(specify limits):Insert Program Standards* • Face-to-face contact in an individual setting with family members or non-professional caregivers on behalf of the recipient. • May include training of family members or non-professional caregivers to monitor assist with administration of prescribed medications and monitoring side effects, including weight, blood glucose level, and blood pressure. • When provided in the clinic setting, Medication Training and Support may compliment, but not duplicate, activities associated with medication management activities available under the Clinic Option • When provided in residential treatment settings, Medication Training and Support may include components of medication management services. • The recipient is the focus of Medication Training and Support. • Documentation must support how the service benefits the recipient, including when Medication Training and Support is provided in a group setting. • Medication Training and Support results in demonstrated movement toward, or achievement of, the recipient's treatment goals identified by the individualized integrated care plan. • Medication Training and Support goals are habilitative in nature. Medication Training and Support service including all subtypes (individual, group, family/couple, with and without recipient present) may be provided for a maximum of 182 hours (728 units) per year. Exclusions: • If Clinic Option medication management, counseling, or psychotherapy is provided and medication management is a component, then Medication Training and Support may not be billed separately for the same visit by the same provider. • Coaching and instruction regarding recipient self-administration of medications is not reimbursable under Medication Training and Support, but may be billed as Skills Training and Development.
☐	Medically needy *(specify limits):N/A*

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

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

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

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Agency	DMHA	Initially and at time of DMHA certification renewal

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

☐	Participant-directed	☒	Provider managed

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

Service Title:	Medication Training and Support – Group Setting
Service Definition (Scope): *Definition*	
Group Medication Training and Support involves face-to-face contact with the recipient, in a group setting, for the purpose of providing education and training about medications and medication side effects.	

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

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

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

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

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

Exclusions:

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

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

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

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

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

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
Agency	DMHA	Initially and at time of DMHA certification renewal

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

☐	Participant-directed	☒	Provider managed

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

Service Title:	Medication Training and Support – Family/Couple with the Recipient Present (Group Setting)
Service Definition (Scope): *Definition*	

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

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

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

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

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

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

Exclusions:

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

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

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

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

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

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

☐	Participant-directed	☒	Provider managed

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

Service Definition (Scope): *Definition*

Family/Couple Medication Training and Support without the recipient Present involves face-to-face contact, in a group setting with family members or other non-professional caregivers, for the purpose of providing education and training about medications and medication side effects.

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

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

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

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

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

Exclusions:

- If Clinic Option medication management, counseling or psychotherapy is provided and

medication management is a component, then Medication Training and Support may not be billed separately for the same visit by the same provider.

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

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

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

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

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

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
Agency	DMHA	Initially and at time of DMHA certification renewal

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

☐	Participant-directed	☒	Provider managed

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

O	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):*

O	Participant direction is available in all geographic areas in which State plan HCBS are available.
O	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):*
	N/A

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):*

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

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

- Be developed through a person-centered process that is directed by the individual participant, builds upon the individual's ability (with and without support) to engage in activities that promote community life, respects individual preferences, choices, strengths, and involves families, friends, and professionals as desired or required by the individual;
- Specifies the services to be participant-directed, and the role of family members or others whose participation is sought by the individual participant;
- For employer authority, specifies the methods to be used to select, manage, and dismiss providers;

- For budget authority, specifies the method for determining and adjusting the budget amount, and a procedure to evaluate expenditures; and
- Includes appropriate risk management techniques, including contingency plans that recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assure the appropriateness of this plan based upon the resources and support needs of the individual.

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

7. Opportunities for Participant-Direction

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

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

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

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

	of choice of eligible services	level with 5% margin of error				plan is needed it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.
	4) Number and percent of recipients with documentation of choice of providers	4) Record Review – on site/off site with 95% confidence level with 5% margin of error	4) DMHA	4) Ongoing	4) DMHA	4) Analysis and aggregation are ongoing. If a corrective action plan is needed it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.
Providers meet required qualifications. 9/25/13	1) Number and percent of provider agencies that meet qualifications at time of enrollment	1) 100% of provider agency applications are reviewed prior to approval	1) DMHA	1) Ongoing	1) DMHA	1) Analysis and aggregation are ongoing. If a corrective action plan is needed it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.
	2) Number and percent of provider agencies recertified timely.	2) 100% of provider agency renewal applications are reviewed prior to renewal	2) DMHA	2) Every three years or at time of reaccreditation	2) DMHA	2) Analysis and aggregation are quarterly. If a corrective action plan is needed it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.

The SMA retains authority and responsibility for program operations and oversight.	1) Number and percent of data reports specified in the MOU that were provided by DMHA on time and in the correct format. 2) Number and percent of corrective action plans appropriately and timely remediated by DMHA.	1) 100% review of DMHA data reports 2) 100% review of DMHA log sheet	1) DMHA and OMPP 2) DMHA and OMPP	1) Quarterly 2)Quarterly	1) DMHA and OMPP 2)DMHA and OMPP	1) Analysis and aggregation are completed annually. If a corrective action plan 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. 2) Analysis and aggregation will be annual. If a corrective action plan is needed from DMHA it must be provided within 30 business days and OMPP will respond in 30 business days for a total of 60 business days.
The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.	1) Number and percent of 1915(i) claims paid during the review period according to the published rate. 2) Number and percent of 1915(i) claims paid during the review period for recipients enrolled in the 1915(i)	1) MMIS 100% review 2)MMIS 100% review	1) OMPP and Medicaid Fiscal Contractor 2) OMPP and Medicaid Fiscal Contractor	1) Monthly 2)Monthly	1) OMPP 2) OMPP	1) Analysis and aggregation are completed annually. Corrective Action will follow the process identified in the contract between OMPP and MMIS vendor. 2) Analysis and aggregation are completed annually. Corrective Action will follow the process

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	program on the date the service was delivered. 3) Number and percent of 1915(i) claims paid during the review period for services that are specified in the recipient's approved IICP.	 3)MMIS 100% review	 3) OMPP and Medicaid Fiscal Contractor	 3)Monthly	 3)OMPP	identified in the contract between OMPP and MMIS vendor. 3) Analysis and aggregation are completed annually. Corrective Action will follow the process identified in the contract between OMPP and MMIS vendor.
The State identifies, addresses and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.	1) Number and percent of IICP's that address health and welfare needs of the recipient. 2) Number and percent of incidents reported within required timeframe.	1) 100% of IICP's well be reviewed to ensure health and welfare needs are addressed 2) 100% review of incident reports submitted.	1) DMHA 2) DMHA	1) Ongoing 2) Ongoing	1)DMHA 2) DMHA	1) Analysis and aggregation are ongoing. Incomplete IICP will be returned by the State for additional information within 5 business days with requirement that updated plan is resubmitted within 5 business days for a total of 10 business days. 2) Analysis and aggregation are ongoing. Report submitted to State within 72 hours. State will review plan and respond within 5 business days. If a

						corrective action plan is needed it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.
	3.) Number and percent of incident reports including medication errors, seclusions and restraints resolved according to policy.	3.) 100% review of incident reports submitted	3.) DMHA	3.) Ongoing	3.) DMHA	3.) Analysis and aggregation are ongoing. Report submitted to State within 72 hours. State will review plan and respond within 5 business days. If a corrective action plan is needed it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.
	4.) Number and percent of residential settings in compliance with criteria that meets standards for community living	4.) DMHA conducts annual compliance reviews, using both on-site and desk reviews, for a 5% confidence interval for residential settings in which 1915(i) recipients reside.	4.) DMHA	4) Ongoing	4) DMHA	4.) Analysis and aggregation are ongoing. If a corrective action plan is needed it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.

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System Improvement: *(Describe process for systems improvement as a result of aggregated discovery and remediation activities.)*			
Methods for Analyzing Data and Prioritizing Need for System Improvement	Roles and Responsibilities	Frequency	Method for Evaluating Effectiveness of System Changes
1. DMHA collects and tracks complaints related to implementation, providers and services offered through the 1915(i). Complaints could be received from recipients, family members, concerned citizens, providers or advocates. Complaints are categorized as individual issue or system challenge/barrier. The system challenge/barrier complaints are discussed during bimonthly strategy meetings between DMHA and OMPP. System issues identified in the complaints are prioritized with solutions discussed for highest priority items.	1) DMHA	1) Annual	1. During the bimonthly 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.
2) DMHA reviews and analyzes individual issues related to performance measures to identify any system level trends. DMHA and OMPP	2) DMHA	2) Annual	2. During the bimonthly meeting between DMHA and OMPP, DMHA will share trends identified with OMPP to determine the best way to address the issues (policy change, training) as well as the effectiveness of previous

monitor trends to identify the need for system changes.			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.

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Quality Improvement Strategy

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

	Discovery Activities				Remediation	
Requirement	**Discovery Evidence** *(Performance Measures)*	**Discovery Activity** ***(Source of Data & sample size)***	**Monitoring Responsibilities** *(agency or entity that conducts discovery activities)*	**Frequency**	**Remediation Responsibilities** *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	**Frequency** *of Analysis and Aggregation*
Service plans address assessed needs of 1915(i) participants, are updated annually, and document choice of services and providers.	1) Number and percent of IICP's that address recipient's needs	1) 100% of IICP's are reviewed and approved through the waiver database	1) DMHA	1) Ongoing	1) DMHA	1) Analysis and aggregation are ongoing. If a corrective action plan is needed it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.
	2) Number and percent of IICP's reviewed and revised as warranted on or before annual review date	2) 100% of IICP's are be reviewed and approved through the waiver database	2) DMHA	2) Ongoing	2) DMHA	2) Analysis and aggregation are ongoing. If a corrective action plan is needed it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.
	3) Number and percent of recipients with documentation	3) Record Review – on site/off site with 95% confidence	3) DMHA	3) Ongoing	3) DMHA	3) Analysis and aggregation are ongoing. If a corrective action