

**Application for**

**Section 1915(b)(4) Waiver**

**Fee-for-Service**

**Selective Contracting Program**

November 9, 2017

v1.0

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**Application for Section 1915(b)(4) Waiver  
Fee-for-Service (FFS) Selective Contracting Program**

**Face sheet**

The **State** of **Indiana** requests a waiver/amendment under the authority of section 1915(b) of the Act. The designated Medicaid Agency will directly operate the waiver.

The **name of the waiver programs are:** Adult Mental Health Habilitation (AMHH) and Behavioral and Primary Healthcare Coordination Services (BPHC)

**Type of request.** This is:

- an initial request for new waiver. All sections are filled.  
 a request to amend an existing waiver, which modifies Section/Part \_\_\_\_  
 **a renewal request**

## Section A is:

- replaced in full  
 carried over with no changes  
 changes noted in **BOLD**.

## Section B is:

- replaced in full  
 changes noted in **BOLD**.

**Effective Dates:** This waiver/renewal/amendment is requested for a period of 5 years beginning **10/01/2018** and ending **09/30/2023**.

This waiver may be considered for a five year period because it meets the requirements of Section 2601 of the Affordable Care Act as outlined in SMDL #10-022 dated November 9, 2010.

State Contact: **The State contact person for this waiver is Timothy Hawkins, Office of Medicaid Policy and Planning, and can be reached by telephone at 317-233-2947, or email at [timothy.hawkins@fssa.in.gov](mailto:timothy.hawkins@fssa.in.gov).**

## Section A – Waiver Program Description

### Part I: Program Overview

#### **Tribal Consultation:**

Describe the efforts the State has made to ensure that Federally-recognized tribes in the State are aware of and have had the opportunity to comment on this waiver proposal (if additional space is needed, please supplement your answer with a Word attachment).

The proposed change does not negatively impact the Tribes or any tribal members. The changes proposed are administrative in nature. **AI/AN members who qualify for managed care programs have the option to opt out of managed care and into fee for service. Indiana has one Federally-recognized tribe, the Pokagon Band of Potawatomi Indians. The Medical Director and Chief for the tribe was provided a letter and official notice. The 1915(b)(4) document was posted for tribal notice on November 27, 2017 for 60 days.**

#### **Program Description:**

Provide a brief description of the proposed selective contracting program or, if this is a request to amend an existing selective contracting waiver, the history of and changes requested to the existing program. Please include the estimated number of enrollees served throughout the waiver (if additional space is needed, please supplement your answer with a Word attachment).

This fee-for-service selective contracting 1915(b)(4) waiver operates concurrently with the CMS-approved Indiana 1915(i) State Plan **Benefit** for Adult Mental Health Habilitation (IN 12-003) and the Indiana 1915(i) State Plan **Benefit** for Behavioral and Primary Healthcare Coordination (IN 13-013), **with an original effective date of April 1, 2014.**

The proposed renewal includes the *Behavioral and Primary Healthcare Coordination* (BPHC) service program. While this program is separate from the AMHH services program it focuses on providing recipients with the supports needed to remain in the community. Additionally, the BPHC service is provided by the same HCBS providers who deliver AMHH services.

#### *BPHC service program*

BPHC consists of coordination of healthcare services to manage the healthcare needs of the individual. BPHC includes logistical support, advocacy and education to assist individuals in navigating the healthcare system. BPHC consists of activities that help recipients gain access to needed behavioral and physical health services, manage health conditions, schedule and keep medical appointments, obtain and maintain a primary medical provider and facilitate communication across providers. This includes direct assistance in gaining access to services, coordination of care within and across systems, oversight of the entire case, and linkage to appropriate services. BPHC includes:

- Assessment of the eligible recipient to determine service needs.
- Development of an individualized integrated care plan (IICP).

- Referral and related activities to help the recipient obtain needed services.
- Monitoring, follow-up and evaluation.

BPHC does not include the delivery of medical, clinical, or other direct services.

BPHC is provided only to individuals meeting specific BPHC eligibility criteria, as follows:

The target group includes adults who:

- Are age 19 or over with an eligible primary mental health diagnosis;
- Meet all eligibility criteria defined for BPHC services;
- Are not enrolled in the 1915(c) services.

Financial eligibility includes:

- Individuals who are Medicaid eligible, meet the needs-based criteria for the 1915(i) BPHC benefit & have income that does not exceed 150% FPL
- Individuals who are not otherwise eligible for Medicaid, meet the needs-based criteria & have income that does not exceed 150% FPL
  - Through a block of income disregard, the State effectively increases the income threshold for this group to 300% FPL.

Applicant's meeting BPHC target group and financial eligibility criteria must also meet all of the following needs-based criteria:

- The recipient must demonstrate needs related to management of his/her behavioral and physical health.
- The recipient must demonstrate impairment in self-management of physical and behavioral health services.
- The recipient has received a recommendation for intensive community based care on the uniform assessment tool defined by the State (the Adult Needs and Strengths Assessment- ANSA) with a Level of 3 or higher.
- The recipient demonstrates a health need which requires assistance and support in coordinating behavioral and physical health treatment.

The State Evaluation Team will process applications based on target group and needs-based eligibility criteria and authorize the BPHC service on the Individualized Integrated Care Plan (IICP) for six months from the Start Date of the eligibility determination.

**The State estimates that approximately 3000 unique enrollees will be served under the 1915(i) BPHC benefit in the renewal first year.** There will be new admissions as well as discharges each year.

#### Adult Mental Health Habilitation (AMHH) service program

AMHH services are recommended by a physician or other licensed professional, within the scope of his or her practice, for the habilitation of a mental disability and the restoration or maintenance of an individual's best possible functional level. Services are provided for individuals and their families, or groups of adult persons who are living in the community and who need aid on a routine basis for serious mental illness or co-occurring mental illness and addiction disorders. Services are designed to assist in the

habilitation of the individual's optimum functional ability in daily living activities. This is accomplished by assessing the individual's needs and strengths, developing an Individualized Integrated Care Plan (IICP) outlines objectives of care, including how services assist in delivering appropriate home and community-based habilitation services to the individual, as well as assisting the individual in reaching his/her habilitative goals.

Indiana has elected to provide services for the following reasons:

- Adults with serious mental illness who are limited in their ability for self-care and independence can remain integrated in their community with an appropriate level of supervision, services, and supports.
- Services are designed to meet the needs of this special population by assisting in the reinforcement, management, adaptation and/or retention of skills necessary to live successfully in the community. Adults with Serious Mental Illness (SMI) can be served at a lower cost in community settings.
- Focus is on how to assist and support each individual to adapt and manage their mental health illness to improve quality of life in the community and decrease the need for institutionalization.

Services are intended to benefit adults who:

- Have reached maximum benefit from rehabilitative treatment;
- Do not have access to habilitation services to help them retain and maintain treatment gains already made;
- Are at great risk of institutionalization without habilitation focused services and supports.

Once determined to be eligible for AMHH services by the State Evaluation Team (SET) (meeting target group and needs-based eligibility criteria), the recipient is authorized to receive the AMHH services as approved by the SET on the Individualized Integrated Care Plan (IICP) for a maximum of one year (365 days) from the start date of the eligibility determination as long as the recipient continues to receive Medicaid benefits and to meet other AMHH eligibility criteria. The following are covered services, in the 1915(i) State Plan Amendment (SPA) (TN: 12-003):

- Adult day services
- Home and community-based habilitation and support
- Respite care
- Therapy and behavior support services
- Addiction counseling
- Peer support services
- Supported community engagement services
- Care coordination
- Medication training and support

**The State estimates that approximately 50 adults will be served under the AMHH 1915(i) benefit in the first year of the renewal.** There will be new admissions as well as discharges each year.

*AMHH and BPHC Service Providers*

**Division of Mental Health and Addiction (DMHA)** certified Community Mental Health Centers (CMHCs) are permitted by the State's Medicaid agency to provide AMHH and/or BPHC services. CMHCs must meet all provider agency standards. The CMHC must ensure all direct care agency staff members providing AMHH or BPHC services meet all standards required for the service being provided.

**The Family and Social Services Administration is the single state Medicaid agency.** The Indiana Office of Medicaid Policy and Planning (OMPP) is **the Medical Assistance Unit** responsible for administrative and quality oversight; and the DMHA is **the operating agency responsible for the day to day administration of the AMHH and BPHC services program.**

Indiana is requesting a renewal of the existing waiver of regulations requiring Indiana to open up delivery of AMHH/BPHC services to all providers in the state. Indiana has elected to utilize its statewide array of CMHCs for the following reasons:

- DMHA-certified and approved CMHCs meet extensive standards for quality, access, coordination and continuity of care in order to operate as a CMHC.
- CMHCs must provide a full-continuum of services for their assigned and designated geographical area. That requirement provides recipients easy access to behavioral health services coordinated within the provider agency that a recipient may need to live safely in the community.
- All CMHCs are enrolled Medicaid providers and must adhere to Medicaid policy, regulations, and standards.
- The CMHCs in Indiana provide statewide coverage for the provision of mental health and addiction services. The majority of Indiana counties have more than one CMHC represented.
- CMHCs are required to participate in the state mandated quality, performance and outcomes monitoring, and reporting that is standardized across all CMHCs. This provides a consistent method for monitoring and assuring the provision of high quality services delivered in an efficient manner that meets the unique needs of all members.

**Waiver Services:**

Please list all existing State Plan services the State will provide through this selective contracting waiver.

The State elects to include the following AMHH services according to the scope, limitations and standards outlined in the 1915(i) AMHH state plan benefit:

- 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)

Indiana elects to include the BPHC program and service according to scope, limitations, and standards outlined in the 1915(i) BPHC **benefit**.

#### **A. Statutory Authority**

1. **Waiver Authority**. The State is seeking authority under the following subsection of 1915(b):



1915(b)(4) - FFS Selective Contracting program

2. **Sections Waived.** The State requests a waiver of these sections of 1902 of the Social Security Act:

- a.  Section 1902(a) (1) – Statewide
- b.  Section 1902(a) (10) (B) - Comparability of Services
- c.  Section 1902(a) (23) - Freedom of Choice
- d.  Other Sections of 1902 – (please specify)

## B. Delivery Systems

1. **Reimbursement.** Payment for the selective contracting program is:

- the same as stipulated in the State Plan
- is different than stipulated in the State Plan (please describe)

2. **Procurement.** The State will select the contractor in the following manner:

- Competitive procurement
- Open cooperative procurement
- Sole source procurement
- Other (please describe):

All AMHH and BPHC service provider agencies must be certified by DMHA as a Community Mental Health Center (CMHC) and be an enrolled Medicaid provider.

## C. Restriction of Freedom of Choice

1. **Provider Limitations.**

- Beneficiaries will be limited to a single provider in their service area.
  - Beneficiaries will be given a choice of providers in their service area.
- (NOTE: Please indicate the area(s) of the State where the waiver program will be implemented)

As a DMHA-approved AMHH/BPHC provider agency, each CMHC is an enrolled Medicaid provider that offers a full continuum of behavioral health care services. The care coordinator explains the process for making an informed choice of provider(s) and answers beneficiary's questions. The beneficiary is also advised that choice of providers and provider agencies is ongoing for the duration of the program. As a service is identified, a list is generated of qualified providers and presented to the applicant/recipient for selection. A listing of approved providers is also posted on the Indiana Medicaid website at [www.indianamedicaid.com](http://www.indianamedicaid.com). The beneficiary and family members may interview potential service providers before selection of a provider.

Indiana has certified CMHCs across the State which provide AMHH/BPHC recipients access to a provider agency in or relatively close to their home or community. Additionally, many of the CMHCs operate multiple satellite offices across the state. Most

counties in the state, other than very rural ones, have more than one CMHC offering services within the same county. This provides most AMHH/BPHC recipients with freedom of choice of multiple service provider agencies. AMHH/BPHC recipients retain the freedom of choice regarding the provider agency staff member(s) providing the AMHH/BPHC service(s).

## 2. **State Standards.**

Detail any difference between the state standards that will be applied under this waiver and those detailed in the State Plan coverage or reimbursement documents.

There is no difference in the State standards. The proposed waiver does not change the AMHH/BPHC provider/service standards and expectations outlined in the Indiana 1915(i) benefit.

### **D. Populations Affected by Waiver**

(May be modified as needed to fit the State's specific circumstances)

#### AMHH Service Populations

This waiver does not change the target population, as defined in the 1915(i) AMHH benefit and addressed above under the "Program Description" section. **DMHA estimates that approximately 50 adults will be served under the 1915(i) AMHH benefit in the first year of the renewal.** There will be new admissions as well as discharges each year.

1. **Included Populations.** The following populations are included in the waiver:
  - Section 1931 Children and Related Populations
  - Section 1931 Adults and Related Populations
  - Blind/Disabled Adults and Related Populations
  - Blind/Disabled Children and Related Populations
  - Aged and Related Populations
  - Foster Care Children
  - Title XXI CHIP Children
  
2. **Excluded Populations.** Indicate if any of the following populations are excluded from participating in the waiver:
  - Dual Eligibles
  - Poverty Level Pregnant Women
  - Individuals with other insurance
  - Individuals residing in a nursing facility or ICF/MR
  - Individuals enrolled in a managed care program
  - Individuals participating in a HCBS Waiver program
  - American Indians/Alaskan Natives
  - Special Needs Children (State Defined). Please provide this definition.  
Click here to enter text.
  - Individuals receiving retroactive eligibility
    - Other (Please define): Click here to enter text.

*BPHC Service Populations*

This waiver does not change the target population, as defined in the 1915(i) BPHC benefit and addressed above under the “Program Description” section. **DMHA estimates that approximately 3000 unique enrollees will be served under the 1915(i) BPHC benefit in the first year.** There will be new admissions as well as discharges each year.

**1. Included Populations. The following populations are included in the waiver:**

- Section 1931 Children and Related Populations
- Section 1931 Adults and Related Populations
- Blind/Disabled Adults and Related Populations
- Blind/Disabled Children and Related Populations
- Aged and Related Populations
- Foster Care Children
- Title XXI CHIP Children

**2. Excluded Populations. Indicate if any of the following populations are excluded from participating in the waiver:**

- Dual Eligibles
- Poverty Level Pregnant Women
- Individuals with other insurance
- Individuals residing in a nursing facility or ICF/MR
- Individuals enrolled in a managed care program
- Individuals participating in a HCBS Waiver program
- American Indians/Alaskan Natives
- Special Needs Children (State Defined).
- Individuals receiving retroactive eligibility
- Other (Please define):

**Part II: Access, Provider Capacity and Utilization Standards**

**A. Timely Access Standards**

Describe the standard that the State will adopt (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State has adopted) defining timely Medicaid beneficiary access to the contracted services, *i.e.*, what constitutes timely access to the service?

1. How does the State measure (or propose to measure) the timeliness of Medicaid beneficiary access to the services covered under the selective contracting program?

The State requires CMHCs to develop and implement written policies and procedures for timely intake, so as to ensure access to appropriate mental health and addiction services, supports, screening and comprehensive assessments. While these policies and procedures are agency-specific, the agency is responsible to ensure the policies and procedures fall

in-line with national accreditation requirements. During agency site visits, State staff review and monitor the agency's delivery of AMHH and BPHC services and evaluate the agency's compliance with these policies and procedures.

Each application for AMHH and BPHC services has a "date stamp" for when received by DMHA and another for when services are approved. The approved services have a start date which is usually the day after the approval. Recipients may request that services begin on a future date, due to their specific circumstances, such as hospitalization, etc. When this occurs, the evaluators may establish a start date consistent with the recipient's preference.

The State monitors the *access to care* timeframes as a part of the AMHH and BPHC program quality assurance reviews. The State Quality Improvement Specialist conducts regularly scheduled service quality audits to ensure agency compliance with the State's expectation.

Individuals who contact DMHA for assistance understanding or accessing AMHH and BPHC services are referred to a member of the State Evaluation Team for information about:

- AMHH and BPHC services and the primary goal of the service programs.
- Eligibility to receive AMHH and/or BPHC services.
- A list of approved provider agencies local to the individual inquiring about AMHH and/or BPHC services.

The individual is provided assistance with locating a provider of choice to begin the application process, if desired.

All persons accessing services through a CMHC must be provided information about the agency's grievance and complaint procedures. These persons are also given information about the process to lodge a formal complaint about service delivery, including access to services. When a complaint is filed, DMHA investigates the complaint, and if indicated implements a corrective action to ensure the provider agency completes appropriate steps to return to compliance with all AMHH and BPHC standards and expectations.

2. Describe the remedies the State has or will put in place in the event that Medicaid beneficiaries are unable to access the contracted service in a timely fashion (if additional space is needed, please supplement your answer with a Word attachment).

AMHH and BPHC providers are required to provide or make provisions for services and supports to meet the recipient's identified needs. If a particular service is not accessible within a timely manner, the provider is required to offer alternative services or supports to meet the recipient's identified needs, until such time the requested service becomes available. The provider is required to link the recipient with another CMHC so they can receive the requested services.

When it is determined a provider agency is out of compliance, a corrective action is issued and the entity must submit a corrective action plan within 30 days. This plan must show the steps the provider agency will take to ensure agency staff members are completing the required steps indicated in the plan to assure remediation. The plan may

include additional training, adjusting case load sizes, and/or setting up a system to monitor service access and utilization.

## **B. Provider Capacity Standards**

Describe how the State will ensure (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State has ensured) that its selective contracting program provides a sufficient supply of contracted providers to meet Medicaid beneficiaries' needs.

1. Provide a detailed capacity analysis of the number of providers (e.g., by type, or number of beds for facility-based programs), or vehicles (by type, per contractor for non-emergency transportation programs), needed per location or region to assure sufficient capacity under the selective contracting program (if additional space is needed, please supplement your answer with a Word attachment).

Based on the analysis of number of persons needing AMHH and BPHC services across the state, there are some areas where the potential need for AMHH/BPHC services is greater than in others. However, this analysis indicates that there is currently a sufficient number of CMHCs in each area to meet Medicaid beneficiaries' needs.

**The State continues to run data applying the AMHH/BPHC eligibility and needs-based criteria on individuals currently in the public mental health system.** In analyzing the resulting data, the State is able to identify the potential number of eligible applicants, residence location, and the agencies in those areas that are eligible to provide AMHH/BPHC services to potential applicants. There are 25 CMHCs covering all 92 counties across the state, assuring there is adequate coverage of AMHH/BPHC provider agencies. Each county has one or more AMHH/BPHC provider agencies for recipients to access care.

2. Describe how the State will evaluate and ensure on an ongoing basis that providers are appropriately distributed throughout the geographic regions covered by the selective contracting program so that Medicaid beneficiaries have sufficient and timely access throughout the regions affected by the program.

All 92 counties in Indiana have at least one CMHC provider delivering care in the geographical area, and many have multiple providers delivering care within the same county.

DMHA utilizes information gathered from analysis of Indiana's Medicaid Management Information System (MMIS) database, site reviews and recipient complaints to evaluate the need to expand provider agencies and/or provide training and/or corrective actions to assist provider agencies in increasing efficiencies for timely access to AMHH and/or BPHC services.

When "timely access" is identified as an AMHH/BPHC provider agency issue, the State uses a *request for corrective action* and provides technical assistance and training in order to assist the agency in correcting the issue. If the issue is not remediated satisfactorily, further sanctions are applied, up to and including decertification of the

agency as an AMHH/BPHC provider. In the event of such an outcome, DMHA will assign another AMHH/BPHC provider agency for that area, to ensure continued recipient access to AMHH and/or BPHC services.

### **C. Utilization Standards**

Describe the State's utilization standards specific to the selective contracting program.

The State expects that each recipient receives all services authorized by the SET in the amounts needed to address the recipient's specific identified needs. As this utilization standard is very individual specific, determination of appropriate utilization of services will be made during regular monitoring visits and routine utilization data reviews.

1. How will the State (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State) regularly monitor(s) the selective contracting program to determine appropriate Medicaid beneficiary utilization, as defined by the utilization standard described above?

Provision of AMHH and/or BPHC services is dictated by service, scope and limitations of the service. The scope and limitations of each service is documented in the SPA for each program. The service needs of the recipient are documented in the AMHH and/or BPHC evaluation and the individualized integrated care plan (IICP). DMHA monitors utilization of services during provider agency site visits and utilization data reviews to ensure the provision of services meets AMHH/BPHC standards for utilization. Site visits to monitor quality and compliance are conducted by the SET at least annually. Utilization data and results of the site visit are compiled and maintained for DMHA and OMPP review. Quality assurance data is collected and reviewed quarterly and is concurrent with the Quality Improvement measures outlined in the SPA.

2. Describe the remedies the State has or will put in place in the event that Medicaid beneficiary utilization falls below the utilization standards described above (if additional space is needed, please supplement your answer with a Word attachment).

DMHA issues corrective actions against any provider agency failing to follow AMHH/BPHC policy, standards, and regulations.

## **Part III: Quality**

### **A. Quality Standards and Contract Monitoring**

1. Describe the State's quality measurement standards specific to the selective contracting program (if additional space is needed, please supplement your answer with a Word attachment).

a. Describe how the State will (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State):

- i Regularly monitor(s) the contracted providers to determine compliance with the State's quality standards for the selective contracting program.
- ii Take(s) corrective action if there is a failure to comply.

The performance measures used to monitor and assure compliance with AMHH/BPHC quality standards are the same as noted in the 1915(i) SPA and include analysis of claims data, review of all IICPs, provider site visits and tracking and monitoring

incident reports. DMHA issues corrective action against any provider agency not in compliance with AMHH and/or BPHC standards and expectations.

2. Describe the State's contract monitoring process specific to the selective contracting program.
  - a. Describe how the State will (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State):
    - i Regularly monitor(s) the contracted providers to determine compliance with the contractual requirements of the selective contracting program.
    - ii Take(s) corrective action if there is a failure to comply.

The State holds the AMHH/BPHC provider agencies accountable for following all AMHH/BPHC policy, regulations and standards. Indiana monitors provider agencies for compliance with AMHH/BPHC standards through the following methods:

- a) DMHA conducts on-site reviews with the AMHH provider agencies on a regularly-scheduled cycle, or as needed based upon indicators of service delivery issues such as complaints or serious events. DMHA samples client records including case notes, IICPs, monitoring records, and documentation of serious events. DMHA conducts a review of the agency's policies and business processes including recipient's freedom of choice, recipient's right to lodge complaints, and provider agency compliance with AMHH/BPHC standards and expectations.
- b) DMHA monitors incidents, recipient complaints and administrative reviews related to AMHH/BPHC services. DMHA staff review the data on a regular basis to identify trends or issues that may require training, policy clarification, process improvement, or other follow-up. The data is maintained and summarized annually.
- c) A written corrective action is utilized by DMHA to notify a provider agency of areas identified by DMHA as requiring correction and remediation. The provider agency is required to submit a plan of correction to DMHA within 30 days. The plan of correction is monitored by DMHA to assure correction occurs and that remediation is effective in addressing any issues identified. DMHA will conduct follow-up reviews when significant issues have been discovered, there is a pattern of complaints regarding the AMHH/BPHC services provided, or there is failure to make progress on remediation actions identified in the plan of correction.

### **B. Coordination and Continuity of Care Standards**

Describe how the State assures that coordination and continuity of care is not negatively impacted by the selective contracting program.

Indiana elects to utilize its DMHA-certified CMHCs as AMHH/BPHC providers, not only because the CMHCs provide state-wide access to 1915(i) services, but also because of the strict adherence to quality standards for the provision of mental health and addiction services that CMHCs are required to uphold. CMHCs are required to provide a full-continuum of care to eligible consumers, including AMHH/BPHC recipients, and are able to offer a wide array of services that the AMHH/BPHC recipient may require based upon his/her individualized needs. The CMHCs are expected to ensure continuity and coordination of all care provided to the recipient. The State understands the eligible

recipient meeting criteria for AMHH and/or BPHC services will most likely require other types of services (such as Medicaid Clinic Option services) in addition to AMHH/BPHC services, to support him/her safely in the community. The CMHCs are best positioned in the state to provide the timely access or linkage to those additional services and supports when indicated.

## **Part IV: Program Operations**

### **A. Beneficiary Information**

Describe how beneficiaries will get information about the selective contracting.

AMHH/BPHC recipients receive information about their respective service rights at the time they are assessed for AMHH/BPHC services, and at any time a service is denied, terminated, or reduced. If recipients are concerned with the eligibility decision, they may request a fair hearing to dispute a denial or approval of services, or file a formal grievance or complaint with DMHA.

### **B. Individuals with Special Needs?**

The State has special processes in place for persons with special needs.

Participants who are enrolled in AMHH and/or BPHC programs are identified as having special needs based on their mental illness. A requirement of AMHH/BPHC services is that the recipient's IICP must be developed for each recipient, based upon the identified recipient strengths and needs. The IICP indicates the services that are necessary to meet the needs identified in the recipient's assessment are for the direct benefit of the recipient, and must be related to the recipient's mental health disability. Each AMHH/BPHC recipient also must have a crisis plan, which is created for each recipient during development of the IICP, which addresses the recipient's preferences if a crisis situation should arise. The crisis plan must address a safety plan and contingencies for emergencies.

## **Section B – Waiver Cost-Effectiveness & Efficiency**

### **Efficient and economic provision of covered care and services:**

1. Provide a description of the State's efficient and economic provision of covered care and services.

AMHH/BPHC recipients benefit from the State's CMHCs being eligible providers of AMHH/BPHC services for the following reasons:

- *A single point of entry into the AMHH and/or BPHC service programs.* CMHCs are recognized in the community as a provider of state funded public behavioral health services. AMHH/BPHC candidates are familiar with the CMHCs if currently using other state plan behavioral health services.
- *Increased continuity and coordination of care.* CMHCs are required to provide a full-continuum of care, meaning the recipient has timely and coordinated access



to a vast array of behavioral health services and supports that may be necessary to support the recipient so they may live safely within the community.

- *Standardization of processes.* CMHCs are trained and proficient in administering the clinical assessment tool used in the AMHH and BPHC evaluation process to identify recipient needs and strengths. Additionally, CMHCs have access to state databases used for claims, clinical assessment reporting, and monitoring benefits for recipients.

2. Project the waiver expenditures for the upcoming waiver period.

*BPHC Services Program*

Indiana requests to continue to maintain and execute a provider agreement with the CMHCs for provision of BPHC services. As illustrated below, selective contracting is not projected to result in a change in program costs, as the rates would be unchanged. However, elimination of selective contracting may result in higher administrative costs to the state and reduced coordination of care.

Year 1 from: **10/1/2018 to 9/30/2019**

Trend rate from current expenditures (or historical figures): **1.0%**

Projected pre-waiver cost:	<b>\$31,608,968</b>
Projected Waiver cost:	<b>\$31,608,968</b>
Difference:	<b>\$0</b>
Projected per-member/per-month (PMPM):	<b>\$878.03</b>

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Year 2 from: **10/1/2019 to 9/30/2020**

Trend rate from current expenditures (or historical figures): **1.0%**

Projected pre-waiver cost:	<b>\$31,925,058</b>
Projected Waiver cost:	<b>\$31,925,058</b>
Difference:	<b>\$0</b>
Projected per-member/per-month (PMPM):	<b>\$886.81</b>

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Year 3 (if applicable) from: **10/1/2020 to 9/30/2021**

Trend rate from previous year: **1.0%**

Projected pre-waiver cost:	<b>\$32,244,309</b>
Projected Waiver cost:	<b>\$32,244,309</b>
Difference:	<b>\$0</b>
Projected per-member/per-month (PMPM):	<b>\$895.68</b>

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Year 4 (if applicable) from: **10/1/2021 to 9/30/2022**

Trend rate from previous year: **1.0%**

Projected pre-waiver cost: **\$32,566,752**  
 Projected Waiver cost: **\$32,566,752**  
 Difference: **\$0**  
 Projected per-member/per-month (PMPM): **\$904.63**

Year 5 (if applicable) from: **10/1/2022 to 9/30/2023**

Trend rate from previous year: **1.0%**

Projected pre-waiver cost: **\$32,892,419**  
 Projected Waiver cost: **\$32,892,419**  
**Difference: \$0**  
 Projected per-member/per-month (PMPM): **\$913.68**

AMHH Services Program

Indiana requests to **continue to maintain and** execute a provider agreement with the CMHCs for provision of AMHH services. As illustrated below, selective contracting is not projected to result in a change in program costs, as the rates would be unchanged. However, elimination of selective contracting may result in higher administrative costs to the state and reduced coordination of care.

Year 1 from: **10/1/2018 to 9/30/2019**

Trend rate from current expenditures (or historical figures): **1%**

Projected pre-waiver cost: **NA**  
 Projected Waiver cost: **\$1,718,002**  
 Difference: **NA**  
 Projected per-member/per-month (PMPM): **\$2,863.34**

Year 2 from: **10/1/2019 to 9/30/2020**

Trend rate from previous year: **1%**

Projected pre-waiver cost: **NA**  
 Projected Waiver cost: **\$1,735,182**  
 Difference: **NA**  
 Projected per-member/per-month (PMPM): **\$2,891.97**

Year 3 (if applicable) from: **10/1/2020 to 9/30/2021**

Trend rate from previous year: **1%**

Projected pre-waiver cost: **NA**  
Projected Waiver cost: **\$1,752,534**  
Difference: **NA**  
Projected per-member/per-month (PMPM): **\$2,920.89**

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Year 4 (if applicable) from: **10/1/2021 to 9/30/2022**

Trend rate from previous year: **1%**

Projected pre-waiver cost: **NA**  
Projected Waiver cost: **\$1,770,060**  
Difference: **NA**  
Projected per-member/per-month (PMPM): **\$2,950.10**

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Year 5 (if applicable) from: **10/1/2022 to 9/30/2023**

Trend rate from previous year: **1%**

Projected pre-waiver cost: **NA**  
Projected Waiver cost: **\$1,787,760**  
Difference: **NA**  
Projected per-member/per-month (PMPM): **\$2,979.60**