

Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for a Renewal to a §1915(c) Home and Community-Based Services Waiver

1. Major Changes

PRTF 1915(c) Waiver

Describe any significant changes to the approved waiver that are being made in this renewal application:

DRA of 2005 § 6063 specifies: "At the end of the demonstration period, the state may allow children enrolled in the demonstration project to continue receiving the Medicaid home and community-based waiver services provided under the demonstration, however, no new children could be added to the project". This 1915(c) HCBS Waiver is solely for the transition of eligible participants on the Community Alternative to Psychiatric Residential Treatment Facility (CA-PRTF) Demonstration Grant services to the Psychiatric Residential Treatment Facilities (PRTF) Waiver services following the expiration of the Grant on September 30, 2012. There are numerous minor editing changes merely to reflect the October 1, 2012 transition from a "grant" to a "waiver". Grant eligibility criteria, services, rates, policies and procedures remain the same for the PRTF Waiver.

THE FOLLOWING ENUMERATES CHANGES BY APPENDIX AND SECTION

MAIN – APPLICATION for 1915(c) HCBS AMENDMENT APPLICATION:

Item 1.B. Program Title: Shows name change from CA-PRTF Grant to PRTF Waiver.

Item 1.H. Dual Eligibility: Checked as applicable.

Item 2. Brief Waiver Description: Updates information to reflect transition under DRA requirements. Intent remains unchanged, but adds a section for Quality Management.

Item 4.C. Waiver of Statewideness: Eliminates request for a waiver of Statewideness.

Item 6.I. Additional Requirements -Public Input: Updates input for transition to the Waiver and new Children's Mental Health Advisory and Quality Improvement Board.

Attachment #1: Transition Plan – Updates plan for the PRTF Waiver.

APPENDIX A: WAIVER ADMINISTRATION AND OPERATION:

A-2. Oversight of Operating Agency Performance. Updates Waiver title; deletes requirement to submit all site visit reports to State Medicaid Agency.

A-3. Use of Contracted Entities: Updates Waiver title and Utilization Management; adds new sections for "Level of Care Re-Evaluation"; "Review of Participant Service Plans"; and "Quality Assurance and Improvement Activities" to reflect administrative functions completed by contracted entities.

A-4. Local/Regional Non-Governmental Non-state Component: Deletes section; (entities included in Item A-3).

A-5. Responsibility for Assessment of Performance: Updates Waiver title and contractor entities.

A-6. Assessment Methods and Frequency: Updates Waiver title; removes A-4 information; updates Utilization Management information.

A-7. Distribution of Waiver Operational and Administrative Functions: Updates Table for current functions; expands Contracted Entity functions; eliminates all Local non-State Entity functions.

QUALITY IMPROVEMENT: Administrative Authority of State Medicaid Agency: Updates Waiver title; removes reference to grant applications/implementation plan no longer applicable under the Waiver; consolidates Grant Advisory Board and Grant Quality Improvement Committee in new Children's Mental Health Advisory and Quality Improvement Board; updates utilization management information. QIS revisions made per CMS request.

APPENDIX B: PARTICIPANT ACCESS and ELIGIBILITY:

No new participants (applications) allowed on this transition waiver after October 1, 2012. No change to targeting criteria or level of care for reevaluations.

B-1-b. Additional Criteria: Explains transition to the Waiver.

B-1-c. Transition due to Maximum Age Limit: Updates Waiver title and information.

B-3-a. Number of Individuals Served: Table: B-3-a. Year 1 projects transitions from the Grant to Waiver. No applicants can be added to Waiver, so number will decrease annually from attrition.

B-3-f. Selection of Entrants to Waiver: Provides information on entrant selection while on Grant (NA on Waiver).

B-6-b. Performing LOC Evaluations/Reevaluation: Provides information on LOC evaluations from prior Grant (NA for Waiver). No change in LOC reevaluations.

B-6-c. Qualifications for Performing Initial Evaluations: Provides information on qualifications from prior Grant, but is NA for Waiver with no applicants.

B-6-d. Level of Care Criteria: Deletes information on transitions from PRTFs (NA for Waiver); updates Waiver title; maintains LOC criteria.

B-6-e. LOC Instruments: Deletes Grant information on implementation of CANS.

B-6-f. LOC Evaluation/Reevaluation: Provides Evaluation information from prior Grant (NA for Waiver). No change in LOC reevaluations process.

B-6-i Timely Reevaluations: Updates information for Grant transition to Waiver

QUALITY IMPROVEMENT: Level of Care: Note B-a-i-a, all initial LOC evaluations done under prior Grant, no applicants on Waiver. The first performance measure deleted as not applicable.

B-a.i. Sub-assurance c: Adds Performance Measure per March 2, 2012 CMS RAI for Grant 5th amendment and revision from 8/3/12 CMS call.

B-b-i Methods of Remediation: Updates initial LOC (NA for Waiver).

B-7-a. Freedom of Choice Procedures: Updates Waiver title. Initial Choices provided under Grant, Freedom of Choice changes remain on Waiver.

B-8. Limited English Proficiency: Updates Waiver title change and information for transition to Waiver.

APPENDIX C: PARTICIPANT SERVICES:

C-1/C-3 SERVICE DEFINITIONS/PROVIDER SPECIFICATIONS:

PRTF Waiver retains the service definitions, provider qualifications and standards as previously approved for the CA-PRTF Grant. Minor editing changes are noted below:

HABILITATION SERVICE:

Definition - Spells out "IDEA" acronym and updates Waiver title.

RESPIRE SERVICE:

Definition – Excludes Respite service while parent/guardian attends school.

Provider Qualifications/Standards - Updates Waiver title; reinstates text emphasizing maintenance of documentation by provider agency inadvertently deleted in the Grant's fifth amendment.

CONSULTATIVE CLINICAL and THERAPEUTIC SERVICES:

Definition- Corrects "Individual" to "Individualized" for the "IEP".

Provider Qualifications/Standards – Updates Waiver title.

FLEX FUNDS SERVICE:

Definition - Deletes purchase of non-recurring set-up expenses for children transitioning from PRTF to start waiver services as NA for Waiver, adds assurances related to need for services to remain in community setting and non duplication of transportation.

Provider Qualifications/Standards - Updates Waiver title.

NON-MEDICAL TRANSPORTATION SERVICES:

Definition – Updates Waiver title.

TRAINING and SUPPORT FOR UNPAID CAREGIVERS SERVICE:

Definition – Updates Waiver title.

Provider Qualifications “Other Standard” – Deletes “in the demonstration grant counties” on first bullet.

WRAPAROUND FACILITATION/CARE COORDINATION:

Definition – Updates Waiver title and minor editing and reformatting to bullet responsibilities. Deletes the 180-day limit for transitioning youth from PRTFs services under Engagement (NA for Waiver); bulleted activity for guiding transition of youth to community from a PRTF; and initial development of Plan of Care (POC) for approval of DMHA. (POC reassessments and approvals continue on PRTF Waiver.)

C-2 GENERAL SERVICE SPECIFICATIONS:

C-2-a. Criminal History/ Background Investigations: Updates Waiver title; minor edit noting use of local law enforcement screen (per C-1/C-3).

C-2-e. Payment for Waiver Services Furnished by Relatives/Legal Guardians: Updates Waiver title.

C-2-f. Open Enrollment of Providers: Updates Waiver title. Notes providers enrolled on Grant on September 30, 2012 will be automatically transitioned to Waiver October 1, 2012. Adds State Operating Agency website link.

QUALITY IMPROVEMENT - Quality Providers: Updates Waiver title. updates PMs following 8/3/12 CMS call.

APPENDIX D: PARTICIPANT-CENTERED PLANNING and SERVICE DELIVERY

D-1-b. Service Plan Safeguards: Updates Waiver title and minor edits. Replaces “Consumer Service Line” with DMHA’s Myshare cite link.

D-1-c. Supporting Participant in Service Plan Development: Updates Waiver title. Deletes text for paid peer mentors (all waiver providers are available for support in service plan development). Adds text from RAI responses.

D-1-d. Service Plan Development Process: Updates Waiver title and minor edits (no change in process).

D-1-e. Risk Assessment/Mitigation: Updates Waiver title.

D-1-f. Informed Choice of Providers: Updates Waiver title. (Initial choice was on the prior Grant.) Choice of providers continues on Waiver.

D-1-g. Making Plan Subject to Medicaid Agency Approval: Updates Waiver title; deletes outdated information.

D-2-a. Service Plan Implementation/Monitoring: Updates Waiver title; deletes “Monitoring Report” information; updates from CMS RAI.

D-2-b. Monitoring Safeguards: Updates Waiver title and minor edits.

QUALITY IMPROVEMENT: Service Plan: Updates Waiver title. Updates from CMS RAI.

APPENDIX F: PARTICIPANT RIGHTS:

F-1. Opportunity to Request Fair hearing: Updates Waiver title and minor clarifications under the new waiver, with no change in policy or procedures. updates from CMS RAI.

F-3-c. Description of Grievance/Complaint System: Updates Waiver title. Updates from CMS RAI.

APPENDIX G: PARTICIPANT SAFEGUARDS

G-1-b. State Critical Event/Incident Reporting: Updates Waiver title; adds law enforcement reports.

G-1-c. Participant Training/Education: Updates Waiver title.

G-1-d. Review/Response to Critical Events or Incidents: Updates Waiver title; replaces QI Committee with new Board; updates per CMS RAI.

G-1-e. Oversight of Critical Incidents/Events: Updates Waiver title; replaces Quality Improvement Committee with new Board.

G-2-a. Use of Restraints/Seclusion: Updates Waiver title.

G-3-b-i. Medication Management Responsibility: Updates Waiver title.

G-3-b-ii State Oversight: Updates Waiver title.

G-3-c-ii. Medication Administration State Policy: Updates Waiver title.

G-3-c-iii. Medication Error Reporting: Updates Waiver title.
G-3-c-iv State Oversight: Updates Waiver title.

QUALITY IMPROVEMENT - Health and Welfare: Updates Waiver title; adds Performance Measure per 3/2/12 CMS RAI for Grant 5th amendment.

APPENDIX H: QUALITY IMPROVEMENT STRATEGY

H-1-a-i. System Improvements: Updates Waiver title; names new consolidated Children's Mental Health Advisory and Quality Improvement Board; updates from CMS RAI.
H-1-b-i. Process for Monitoring/Analyzing Design: Updates name for both Waiver and Board.
H-1-b-ii Process to Evaluate QIS: Updates name change for Board;updates from CMS RAI .

APPENDIX I: FINANCIAL ACCOUNTABILITY

I-1. Financial Integrity: Retains first and last paragraphs; updates remaining information on Program Integrity/Utilization Review; updates Provider Manual web link; updates from CMS RAI.

Quality Improvement: Replaces all Performance Measures and Remediation for consistency with other waivers.

I-2-a. Rate Determination Methods: Updates Waiver title; retains rates from prior Grant for all waiver services.
I-2-b. Flow of Billings: Updates Waiver title.
I-2-d. Billing Validation Process: Updates Waiver title, expands explanation of process (no process change).
I-3-d Payments: Updates to "No"
I-4-a. State Source(s) of the Non-Federal Share of Costs: Updates Waiver title.
I-5-b. Excluding Room/Board Costs: Updates Waiver title.

APPENDIX J: COST NEUTRALITY DEMONSTRATION

J-1: Composite Overview Cost-Neutrality Formula: Updates table for the 5-year Renewal estimates.
J-2-a. Number of Unduplicated Participants Served. Updates all 5 years of Renewal.
J-2-b. Average Length of Stay. Updates Waiver title and length of stay explanation for the Renewal.
J-2-c-i. Factor D Derivation: Updates Waiver title and explanation of projections for the Renewal.
J-2-c-ii. Factor D' Derivation: Updates Waiver title and explanation of projections for the Renewal.
J-2-c-iii. Factor G Derivation: Updates Waiver title and explanation of projections for the Renewal.
J-2-d. Estimate of Factor D: Tables for all 5 years of Renewal have been updated.

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

- A.** The **State of Indiana** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).
B. Program Title (*optional - this title will be used to locate this waiver in the finder*):
Psychiatric Residential Treatment Facilities Waiver
C. Type of Request:renewal [PRTF 1915(c) Waiver]

Requested Approval Period:(*For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.*)

- 3 years 5 years

Waiver Number:IN.03.R02.00
Draft ID: IN.03.02.00

- D. Type of Waiver** (*select only one*):

Regular Waiver

- E. Proposed Effective Date:** (*mm/dd/yy*)

10/01/12

Approved Effective Date: 10/01/12

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (*check each that applies*):

Hospital

Select applicable level of care

Hospital as defined in 42 CFR §440.10

If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR §440.160

Nursing Facility

Select applicable level of care

Nursing Facility As defined in 42 CFR §440.40 and 42 CFR §440.155

If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140

Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150)

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR level of care:

[PRTF 1915(c) Waiver Only] Psychiatric Residential Treatment Facility (PRTF)

If applicable, specify whether the State additionally limits the waiver to subcategories of the PRTF level of care: Not applicable, State does not additionally limit the PRTF Waiver to subcategories of PRTF level of care.

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

Not applicable

Applicable

Check the applicable authority or authorities:

Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I

Waiver(s) authorized under §1915(b) of the Act.

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

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

§1915(b)(1) (mandated enrollment to managed care)

§1915(b)(2) (central broker)

§1915(b)(3) (employ cost savings to furnish additional services)

§1915(b)(4) (selective contracting/limit number of providers)

A program operated under §1932(a) of the Act.

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

	<input type="button" value="↑"/> <input type="button" value="↓"/>
<input type="checkbox"/> A program authorized under §1915(i) of the Act. <input type="checkbox"/> A program authorized under §1915(j) of the Act. <input type="checkbox"/> A program authorized under §1115 of the Act.	
Specify the program:	
	<input type="button" value="↑"/> <input type="button" value="↓"/>

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

- This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

PRTF WAIVER PURPOSE.

Section 6063 of the Deficit Reduction Act (DRA) of 2005 specifies: "At the end of the demonstration period, the state may allow children enrolled in the demonstration project to continue receiving the Medicaid home and community-based waiver services provided under the demonstration; however, no new children could be added to the project".

This 1915(c) Home and Community-Based Services (HCBS) Waiver is solely for the transition of eligible children and youth from the Community Alternative to Psychiatric Residential Treatment Facility (CA-PRTF) Demonstration Grant services to the Psychiatric Residential Treatment Facilities (PRTF) Waiver services following the expiration of the Demonstration Grant on September 30, 2012. The Indiana Division of Mental Health and Addiction (DMHA) and the Indiana Office of Medicaid Policy and Planning (OMPP) seek to continue availability and access to evidence-based, cost-effective intensive community treatment and support for children on the Grant as of September 30, 2012. These children continue to meet the eligibility requirements of serious emotional disturbances (SED), ages 6 through 17, and children with serious mental illness (MI) ages 18 through 20, who are eligible for admission to a psychiatric residential treatment facility (PRTF). This transition waiver will continue to promote Indiana's behavioral health system transformation, to provide intensive community based care for children with high levels of need whose families and/or caretakers and community would be able and willing to safely maintain the youth in a community based setting with adequate and appropriate interventions and support.

GOALS.

Indiana's fundamental transformation goal continues to ensure that children in community settings receive the effective behavioral health services and support, at the appropriate level of intensity, based on their needs and the needs of their families. This PRTF Waiver maintains the re-balancing of resources between PRTF and intensive community-based services for children with SED/youth with serious MI. The PRTF Waiver provides a means for:

- (1) offering specific services designed to reduce the need for out-of-home placements to support children with SED/youth with serious MI;
- (2) controlling financial risk for those children who meet the PRTF level of care; and,
- (3) supporting the development of providers guided by the principles and values of a System of Care; and (4) bringing all agencies who serve children together through a System of Care.

OBJECTIVES.

As authorized under Section 6063 of the DRA of 2005, the PRTF Waiver allows Indiana to transition all eligible children/youth from the CA-PRTF Grant to the PRTF Waiver effective October 1, 2012. Participants are Medicaid-eligible youth who continue to meet PRTF level of care and were enrolled in the CA-PRTF Grant as of September 30, 2012. They were originally identified for the Grant through Indiana's Child and Adolescent Needs and Strengths (CANS) assessment which was implemented in the behavioral health system state-wide July 2007. Due to the limitation imposed by the DRA of 2005 for this transition from the Grant to the PRTF Waiver, waiver participants are limited solely to those individuals who transition to the PRTF Waiver effective October 1, 2012, anticipated to be about 749. No additional individuals will be allowed to apply for or receive HCBS waiver services through this new PRTF Waiver.

ORGANIZATIONAL STRUCTURE.

DMHA was given the authority by the Indiana OMPP (Single State Agency) to administer the original CA-PRTF Demonstration Grant and will continue to administer the PRTF Waiver. The Waiver application and the design have been

jointly developed by the DMHA and the OMPP. The OMPP oversees all executive decisions and activities related to the Waiver. A variety of child service agencies and providers will continue to be recruited to become waiver service providers as needed to support this limited waiver program.

SERVICE DELIVERY METHODS.

Indiana uses a traditional service delivery method rather than self-directed. Intensive community based services are managed and provided through Child and Family Wraparound Teams, following system of care values and principles. The prior existing CA-PRTF Grant program transitioned youth in residential care to intensive community-based care. The Grant also served eligible children/youth remaining in community-based care. As of the October 1, 2012 transition, the Waiver will continue to serve eligible children in the community who were previously diverted or discharged from PRTFs.

QUALITY MANAGEMENT:

Indiana's quality management process for the PRTF Waiver includes monitoring, discovery and remediation processes to ensure the waiver is operated in accordance with federal and state requirements; to ensure participant health and welfare; to ensure participant goals and preferences are part of the person centered planning process and reflected in the Plan of Care (POC) and as the basis to identify opportunities for ongoing quality improvement.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

- A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).
- E. Participant-Direction of Services.** When the State provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

<input type="radio"/> Yes. This waiver provides participant direction opportunities. Appendix E is required.
<input type="radio"/> No. This waiver does not provide participant direction opportunities. Appendix E is not required.
- F. Participant Rights.** Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.
- G. Participant Safeguards.** Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.
- H. Quality Improvement Strategy.** Appendix H contains the Quality Improvement Strategy for this waiver.
- I. Financial Accountability.** Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.
- J. Cost-Neutrality Demonstration.** Appendix J contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

- A. Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in Appendix C that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in Appendix B.

B. Income and Resources for the Medically Needy. Indicate whether the State requests a waiver of §1902(a)(10)(C)(i) (III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):

- Not Applicable**
 No
 Yes

C. Statewideness. Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act (*select one*):

- No**
 Yes

If yes, specify the waiver of statewideness that is requested (*check each that applies*):

- Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.

Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

- Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.

Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

- A. Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
 2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
 3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

- D. Choice of Alternatives:** The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
 2. Given the choice of either institutional or home and community based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1) (ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

- D. Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community- based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Improvement.** The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.
- I. Public Input.** Describe how the State secures public input into the development of the waiver:
While the PRTF Waiver is new, it is a transition from the pre-existing CA-PRTF Grant, which initiated a series of focus groups with youth, families and advocates and with providers and other stakeholders in 2007.
- A CA-PRTF Advisory Board was formed that included membership from family members, consumers, Advocacy organizations, mental health, juvenile justice, Department of Child Services, Office of Medicaid Policy and Planning, education, family organizations, grant access representatives, grant providers and other community stakeholders. Under the new PRTF Waiver, the role of this advisory board, now called Children's Mental Health Advisory Board, will remain the same. It will continue to meet quarterly and will encompass Children's mental health needs and all aspects of the PRTF Waiver and the related sustainability plan.
- Public input is also requested when new and updated policies and procedures are proposed. These are posted on the DMHA Grant website at <http://myshare.in.gov/FSSA/dmha/caprtf/PoliciesProcedures> for public review and comment for a minimum of thirty (30) calendar days. This includes the requested information on the transition and implementation of the new PRTF Waiver program. Following the comment period, all policies and procedure comments are reviewed, finalized and reposted on the website.
- J. Notice to Tribal Governments.** The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.
- K. Limited English Proficient Persons.** The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State:

Indiana

Zip:

Phone:

 Ext: TTY

Fax:

E-mail:

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Indiana**

Zip:

Phone: 8.

Fax:

AuthorizingExt: TTY

E-mail:

Signature

This document, together with
Appendices A through J,
constitutes the State's request

for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are **readily** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments. Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:

State Medicaid Director or Designee

Submission Date:

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name:**First Name:****Title:****Agency:****Address:****Address 2:****City:****State:****Indiana****Zip:****Phone:**Ext: TTY

Fax:**E-mail:**

(317) 234-7382

**Attachment #1:
Transition Plan**

Pat.Casanova@fssa.in.gov

Specify the transition plan for the waiver:

In preparation for the October 1, 2012 transition from the CA-PRTF Demonstration Grant to the PRTF Waiver, DMHA is hosting 3 Provider Forums around the State to which families/consumers have been invited. During these Forums, DMHA is presenting a Bulletin (also posted for comment August 1, 2012) that summarizes all changes related to the transition from the Demonstration Grant to the PRTF Waiver. In addition, notices are being sent to all active CA-PRTF Grant recipients to notify them of their transition from the Demonstration Grant to PRTF Waiver. The Bulletin and Letter will also be posted on DMHA's SharePoint Website for at least 30 days.

Following the transition to the PRTF Waiver, the following circumstances or changes would lead a participant to "lose eligibility" for the Waiver:

- 1) Increase in level of youth functioning that no longer meets LOC criteria;
- 2) Decrease in level of youth functioning that results in a need for youth placement out of the home due to safety and feasibility concerns;
- 3) Youth no longer meets eligibility criteria for Medicaid (funding stream);
- 4) Youth is arrested and that results in their commitment to Department of Corrections;
- 5) Youth/Family move out of State; or
- 6) Youth reaches 21st birthday.

When a participant loses eligibility from the PRTF Waiver, the transition will be discussed in the Child and Family Team meetings and documented in the meeting minutes. Behavioral Health needs will continue to be met by the flexible community based services that may be provided under the Medicaid Rehabilitation Option (MRO) for Medicaid recipients.

The PRTF Waiver and State Plan services are authorized based on the CANS level of need. Youth leaving the PRTF Waiver and transitioning to community based services will have access to Medicaid Clinic Option (MCO) or Medicaid Rehabilitation Option (MRO) services based on their level of need. Services available through MCO or MRO include but are not limited to: Case Management, Individual Counseling and Therapy, Individual Family/Couple Counseling, Group Counseling and Therapy, Medication Training and Support, Skills Training and Development, Addiction Counseling and Intensive Outpatient Treatment.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

- 1. State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

- The waiver is operated by the State Medicaid agency.**

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (*select one*):

- The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

- Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.**

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

(Complete item A-2-a).

- The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:

Division of Mental Health and Addiction, Indiana Family and Social Services Administration

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

- a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

- b. Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

DMHA's responsibilities include formal oversight of administrative and operational functions at the local level (Access Sites and Systems of Care) as well as the approval of all service providers. This oversight includes quarterly on-site visits by either one or more of the DMHA staff assigned to the project or an individual or agency that contracts with DMHA. These on-site visits include, but not limited to, observing team meetings, review of provider recruitment activities, review of all public information materials, review of all referrals/requests for services, record reviews, and audits of claims. OMPP has the option to request information related to on-site visits to ensure compliance with operational and administrative functions.

A Memorandum of Understanding between the Office of Medicaid Policy and Planning (OMPP) and the Division of Mental Health and Addiction (DMHA) formalizes the roles and responsibilities of both entities. The OMPP oversees all executive decisions and all activities related to the PRTF Waiver by reviewing and approving the 1915(c) application, evaluation plan, operational processes including policies, rules, regulations and bulletins, and providing ongoing consultation. OMPP participates with the Advisory Board and any other related stakeholder work groups. OMPP is also involved in the quality assurance processes, receiving and reviewing evidence-based reports related to the grant which includes information on the Community Mental Health Centers under the contract monitored by DMHA.

The OMPP oversees the performance of the DMHA operation of the PRTF Waiver in the following ways:

- Meet at least monthly with the DMHA PRTF Waiver program manager and other DMHA staff to review progress, identify areas of concern and resolve issues to ensure successful implementation of the PRTF Waiver;
- Review and approval of Medicaid Claims for waiver services through the MMIS subject to OMPP review;
- Review and approve all changes to rules, policies, or standards proposed by DMHA (at the time of the development of proposed changes);
- Review and approve the Waiver implementation plan amendment requests and renewals proposed by DMHA (for OMPP's submission of the amendment or renewal to CMS);
- Review all rate policies developed by DMHA for waiver services (whenever rates are set or changed);
- Review of the execution of the Memorandum of Understanding with DMHA at quarterly meetings;
- Review of CMS Management reviews with DMHA and assistance with corrective action;
- Participate in Quality Management processes;
- Active participant on the Children's Mental Health Advisory Board which meets quarterly (consolidation of the prior Grant Advisory Board and Quality Improvement Committee);
- Monitor waiver expenditures against approved levels;
- Execute the Medicaid provider agreement with DMHA; and
- Approve PRTF Waiver service payment rates.

Appendix A: Waiver Administration and Operation

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

- Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.*

There are several entities that have responsibilities for conducting waiver operational and administrative functions. The Office of Medicaid Policy and Planning (OMPP) and the Division of Mental Health and Addiction (DMHA) work with the following contracted entities to ensure all functions are conducted efficiently.

PARTICIPANT WAIVER ENROLLMENT FUNCTIONS:

The DRA Section 6063 requirements for this new PRTF Waiver specify, no new participants will be allowed to enroll into the Waiver after October 1, 2012. Only the eligible participants on the CA-PRTF Demonstration Grant program when it expires September 30, 2012 will be allowed to transition to the new PRTF Waiver effective October 1, 2012. These individuals will be grandfathered into the Waiver program based on their prior enrollment on the CA-PRTF Grant program. Under the PRTF Waiver, there will be no new participant waiver enrollment functions such as processing waiver applications, determining eligibility and level of care. (Refer to the Table at Appendix A-7, "Medicaid Agency" and "Other State Operating Agency" are checked as responsible for the existing enrollment of the eligible participants.)

UTILIZATION MANAGEMENT FUNCTIONS:

The waiver auditing function is incorporated into the Surveillance Utilization Review (SUR) functions of the contract between the Medicaid agency and SUR Contractor, as detailed in Appendix I-1. The Office of Medicaid Policy and Planning (OMPP) has expanded its Program Integrity (PI) activities using a multi-faceted approach to SUR activity that includes provider self-audits, desk audits and on-site audits. The Fraud and Abuse Detection System (FADS) team analyzes claims data allowing them to identify providers and/or claims that indicate aberrant billing patterns and/or other risk factors.

The PI audit process utilizes data mining, research, identification of outliers, problematic billing patterns, aberrant providers and issues that are referred by other divisions and State agencies. In 2011, the State of Indiana formed a Benefit Integrity Team comprised of key stakeholders that meets bi-weekly to review and approve audit plans, provider communications and make policy/system recommendations to affected program areas. The SUR Unit also meets with all waiver divisions on a quarterly basis, at a minimum, and receives referrals on an ongoing basis to maintain open lines of communication and aid in understanding specific areas of concern such as policy clarification.

The SUR Unit offers education regarding key program initiatives and audit issues at waiver provider meetings to promote ongoing compliance with Federal and State guidelines, including all Indiana Health Coverage

Programs (IHCP) and waiver requirements.

LEVEL OF CARE RE-EVALUATION, REVIEW OF PARTICIPANT SERVICE PLANS and AUTHORIZATION OF WAIVER SERVICES:

DMHA is the operating agency that writes and manages the individual contracts for entities responsible for reviewing and approving LOC evaluation and POC. Staff within DMHA provides direct supervision and oversight of the contracted entities.

DMHA contractors review and approve Level of Care Re-evaluation and any changes to the Plan of Care (Service plan). One hundred percent of annual LOC re-evaluations are reviewed. The Plan of Care is effective for one year from the initial approval date and may be updated during the year by the Child/Family Team to address ever changing needs. The Level of Care Re-evaluation is required annually and is done using a CANS reassessment conducted by the Wraparound Facilitator and approved by a DMHA contractor.

DMHA contractors review the individual service plan (Plan of Care) against documented services rendered and services that were billed. All annual Plan of Care redeterminations are reviewed. A designated percentage of Annual Levels of Care are reviewed by the contracted entities as well for accuracy.

QUALIFIED PROVIDER ENROLLMENT FUNCTION:

The OMPP has a fiscal agent under contract which is obligated to assist the OMPP in processing approved Medicaid Provider Agreements to enroll approved eligible providers in the Medicaid Management Information System for claims processing. This includes the enrollment of DMHA approved PRTF Waiver providers. The fiscal agent also conducts provider training and provides technical assistance concerning claims processing. The Medicaid Fiscal Agent contract defines the roles and responsibilities of the Medicaid fiscal contractor.

QUALITY ASSURANCE and IMPROVEMENT ACTIVITIES:

The DMHA has contracted with individuals responsible for conducting quality assurance and improvement activities. These contractors work closely with DMHA staff, Medicaid, providers and the local community to affirm all participants are receiving services based on Waiver policies, procedures, Wraparound Principles and System of Care philosophy. They conduct quality improvement reviews of Wraparound Facilitators and various providers. They observe Child and Family team meetings, speak with families and participants and review participants' plans of care, crisis plans and any other documentation to ensure that services are adequately documented and the plan reflects child and/or family needs, goals and choices. Contractors' activities and observations are documented on quality assurance review forms including any need for corrective action and follow up requirements for the entity being reviewed.

- No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

- 4. Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

- Not applicable**
- Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:
 - Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

- Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that

sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities. Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

The operating agency, the Indiana Division of Mental Health and Addiction (DMHA), is responsible for assessing all contracted entities in their performance of operational and administrative functions, quality management, provider development and education, and training activities.

The OMPP is also responsible for oversight of waiver audit functions performed by the Surveillance and Utilization Review contractor.

OMPP, in collaboration with DMHA, is responsible for assessment of the Medicaid Fiscal Agent's enrollment into the MMIS of providers that have:

1. been approved by DMHA for the PRTF Waiver; and
2. fully executed Medicaid Provider Agreements.

The OMPP, in collaboration with DMHA is responsible for the performance of the Medicaid Fiscal Agent's provision of training and technical assistance concerning PRTF Waiver requirements.

Appendix A: Waiver Administration and Operation

6. Assessment Methods and Frequency. Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

Operational and administrative functions are shared between OMPP, DMHA, and contracted entities. Some functions have been identified as requiring state level responsibility (see chart Appendix A-7) while others require direct participation by the contracted entity. Performance based contracts are written with individuals and/or organizations with whom DMHA contracts for waiver operational and administrative functions. The PRTF Waiver related functions included in the contracts are addressed in Appendices A-3.

Administrative and Operational Functions:

The methodology used by DMHA to assess the performance of the contracted entities in carrying out operational and administrative and quality improvement functions includes written reports to document specific activities related to the functions addressed in A-3. Contracted entities are responsible for completing quarterly reports regarding the number of LOC's and POC's submitted, approved, denied or returned for more information. These reports are reviewed by DMHA and shared internally, as well as with the Children's Mental Health Advisory Board. Where DMHA determines that performance is unacceptable, plans of correction are required of the contracted entities. DMHA maintains copies of all of these reports for Medicaid review.

Utilization Management Functions:

The State of Indiana employs a hybrid Program Integrity (PI) approach for oversight of the waiver programs, incorporating oversight and coordination by a dedicated waiver specialist position within the Surveillance and Utilization Review (SUR) Unit, as well as engaging the full array of technology and analytic tools available through the Fraud and Abuse Detection System (FADS) Contractor arrangements. The Office of Medicaid Policy and Planning (OMPP) has expanded its PI activities using a multi-faceted approach to SUR activity that includes provider self-audits, desk audits and on-site audits. SUR is required to complete an initial assessment of each provider type annually. Then, based on the assessment information and/or referrals, audits are completed as needed. The FADS team analyzes claims data allowing them to identify providers and/or claims that indicate aberrant billing

patterns and/or other risk factors.

In 2011, the State of Indiana formed a Benefit Integrity Team comprised of key stakeholders that meets bi-weekly to review and approve audit plans, provider communications and make policy/system recommendations to affected program areas.

Throughout the entire Program Integrity process, oversight is maintained by OMPP. While the FADS Contractor may be incorporated in the audit process, no audit is performed without the authorization of OMPP. OMPP's oversight of the contractor's aggregate data will be used to identify common problems to be audited, determine benchmarks and offer data to peer providers for educational purposes, when appropriate.

Qualified Provider Enrollment Function:

DMHA tracks all provider enrollment requests and receives information directly from the MMIS Fiscal Agent contractor regarding provider enrollment activities as they occur for monitoring of completion, timeliness, accuracy and to identify issues. Issues are shared with the OMPP.

DMHA and/or OMPP attend the MMIS Fiscal Agent's scheduled Provider Training sessions required in OMPP's contract with the Fiscal Agent. These provider trainings include sessions for HCBS waiver providers. DMHA may also participate in the Fiscal Agent's individualized provider training for providers having problems.

Appendix A: Waiver Administration and Operation

- 7. Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a 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.

Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Participant waiver enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Waiver enrollment managed against approved limits	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Waiver expenditures managed against approved levels	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Level of care evaluation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Review of Participant service plans	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Prior authorization of waiver services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Utilization management	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Qualified provider enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Execution of Medicaid provider agreements	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Establishment of a statewide rate methodology	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Rules, policies, procedures and information development governing the waiver program	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of Waiver policies/procedures approved by OMPP prior to implementation. Numerator: Total number policies and procedures developed and approved. Denominator: Total number implemented.

Data Source (Select one):

Other

If 'Other' is selected, specify:

PRTF Waiver Policy and Procedure Review Log

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of identified LOC findings of non-compliance for LOC redeterminations that were appropriately remediated by DMHA within specified time frames. Numerator: Total number of LOC redeterminations appropriately remediated by DMHA within the specified time frames. Denominator: Total number of LOC timeliness issues identified.

Data Source (Select one):

Other

If 'Other' is selected, specify:

PRTF Waiver LOC for QI Reporting

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="text"/>	
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:
Number and percent of non-compliant individual approved Plans of Care (POC) appropriately remediated by DMHA within specified timeframe. Numerator: Number of approved POC's with issues identified that were appropriately remediated. Denominator: Total number of non-compliant approved POCs found.

Data Source (Select one):

Other

If 'Other' is selected, specify:

INsite POC Tracking Data Report

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of Waiver provider enrollment activities processed by the Medicaid Fiscal Contractor for compliance within required contract timeframes.

Numerator: Total number of provider enrollment activities processed within required timeframes. **Denominator:** Total number of provider enrollment activities processed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

IndianaAIM Waiver Provider Enrollment Weekly Activity Log

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input checked="" type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:

	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:

Number and percent of Data Reports specified in the MOU that were provided by DMHA on time and in the correct format. Numerator: Number of Data Reports provided timely and in format. Denominator: Number of Data Reports due.

Data Source (Select one):

Other

If 'Other' is selected, specify:

DMHA Administrative Authority Quality Management Report

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input type="checkbox"/> Other	<input type="checkbox"/> Annually	

Specify: <input type="text"/>		<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of provider findings appropriately remediated by DMHA following identification of failure to maintain required qualifications and standards.
Numerator: Total number of qualification/standards issues appropriately remediated.
Denominator : Total number of provider issues identified for remediation.

Data Source (Select one):

Other

If 'Other' is selected, specify:

DMHA Certification List

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review

<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

Medicaid staff meet with the PRTF Waiver Program Director/Team at least monthly to answer questions, identify areas of concern, and resolve issues to ensure the success of the Waiver. OMPP works with DMHA to ensure that problems are addressed and corrected. These items are documented through meeting minutes between the OMPP and DMHA as well as through the analysis of the data aggregation as outlined in the Quality Improvement sections of the Waiver. Between scheduled meetings, problems are regularly addressed through written and/or verbal communications to ensure timely remediation.

The Medicaid agency exercises oversight over the performance of the waiver function by DMHA, contractors and providers by on-going review and approval of waiver, revisions to the plan, policies, as well as participation on the Children’s Mental Health Advisory Board (which combines the previous CA-PRTF Grant Advisory Board and the CA-PRTF Grant Quality Improvement Committee). This board continues to meet quarterly.

Medicaid staff attend on-going, on-site reviews and meetings with DMHA staff to assure that local systems of care are operating in accordance with the Waiver. Medicaid staff also participate with DMHA in all conference calls with CMS pertaining to the Waiver.

In 2011, the State of Indiana formed the Benefit Integrity Team comprised of key stakeholders. This team meets biweekly to review and approve SUR related audit plans, provider communications and make policy/system recommendations to affected program areas.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

- No
- Yes

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to a group or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each of the subgroups in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
<input type="radio"/> Aged or Disabled, or Both - General					
	<input type="checkbox"/>	Aged			<input type="checkbox"/>
	<input type="checkbox"/>	Disabled (Physical)			
	<input type="checkbox"/>	Disabled (Other)			
<input type="radio"/> Aged or Disabled, or Both - Specific Recognized Subgroups					
	<input type="checkbox"/>	Brain Injury			<input type="checkbox"/>
	<input type="checkbox"/>	HIV/AIDS			<input type="checkbox"/>
	<input type="checkbox"/>	Medically Fragile			<input type="checkbox"/>
	<input type="checkbox"/>	Technology Dependent			<input type="checkbox"/>
<input type="radio"/> Mental Retardation or Developmental Disability, or Both					
	<input type="checkbox"/>	Autism			<input type="checkbox"/>
	<input type="checkbox"/>	Developmental Disability			<input type="checkbox"/>
	<input type="checkbox"/>	Mental Retardation			<input type="checkbox"/>
<input checked="" type="radio"/> Mental Illness					
	<input checked="" type="checkbox"/>	Mental Illness	18	20	
	<input checked="" type="checkbox"/>	Serious Emotional Disturbance	6	17	

b. Additional Criteria. The State further specifies its target group(s) as follows:

No new children will be targeted for the PRTF Waiver. The prior existing CA-PRTF Grant targeted both children age 6 through 17 with Serious Emotional Disturbances (SED) and youth/young adults age 18 through 20 with serious Mental Illness (MI). Eligible children/youth transitioning to and served under the PRTF Waiver must continue to meet the following targeted groups:

The CA-PRTF Grant targets both children age 6 through 17 with Serious Emotional Disturbances (SED) and youth/young adults age 18 through 20 with serious Mental Illness (MI), defined as follows:

CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE

Indiana defines Children with Serious Emotional Disturbance (440 Indiana Administrative Code 8-2-4) as follows:

An individual who is seriously emotionally disturbed child is an individual who meets the following requirements:

- (1) The individual is less than eighteen (18) years of age.
- (2) The individual has a mental illness diagnosis under Diagnostic and Statistical Manual of Mental Disorders, 4th edition, published by the American Psychiatric Association (DSM IV).
- (3) The individual experiences significant functional impairment in at least one (1) of the following area:
 - (A) Activities of daily living.
 - (B) Interpersonal functioning.
 - (C) Concentration, persistence, and pace.
 - (D) Adaptation to change.

(4) The duration of mental illness has been, or is expected to be, in excess of twelve (12) months. However, individuals who have experienced a situational trauma, and who are receiving services in two (2) or more community agencies, do not have to meet the duration requirement.

Note, "situational trauma" includes trauma related to sexual, physical or emotional abuse, neglect, medical trauma, natural disaster, witness to family or community violence, witness or victim of crime, significant loss, and war or terrorism affected trauma exposure that results in adjustment problems for the individual. Adjustment problems may occur at any time subsequent to exposure to trauma. Resulting symptoms and functional impairments may range from those consistent with post traumatic stress disorder to less, but significant symptoms and functional impairments such as anxiety, conduct behaviors, social functioning, school achievement, physical health, and delinquency.

ADULTS WITH MENTAL ILLNESS

Indiana defines Adults with Serious Mental Illness (440 IAC 8-2-2).

An adult who is seriously mentally ill in an individual who meets the following requirements:

- (1) The individual is eighteen (18) years of age or older.
- (2) The individual has a mental illness diagnosis under the Diagnostic and Statistical Manual of Mental Disorders, 4th edition, published by the American Psychiatric Association (DSM IV).
- (3) The individual experiences significant functional impairment in two (2) of the following areas:
 - (A) Activities of daily living.
 - (B) Interpersonal functioning.
 - (C) Concentration, persistence and pace.
 - (D) Adaptation to change.
- (4) The duration of the mental illness has been, or is expected to be, in excess of twelve (12) months. However, adults who have experienced a situational trauma do not have to meet the duration requirement.

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit (*select one*):

- Not applicable. There is no maximum age limit**
- The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Wraparound Facilitators will hold child and family team meetings prior the youth's 21st birthday in order to transition participants to other sources of services and support. Transition plans will be provided to the Indiana Division of Mental Health and Addiction (DMHA) to confirm that adequate support in the community will be available to each PRTF Waiver participant aging off of the PRTF Waiver. Behavioral health needs will continue to be met by the flexible community based services that may be provided under Medicaid Rehabilitation Option (MRO) for Medicaid recipients (age 18+) including activities of daily living (ADL) training, case management, crisis intervention, medication management, Assertive Community Treatment (ACT), as well as individualized therapy. These services can be provided in other locations in the community, including in the individual's home, and may extend beyond the clinical treatment of a person's mental illness such as helping the individual to acquire the skills that are essential for everyday functioning.

For youth who are receiving PRTF Waiver services and are nearing their 21st birthday, a transition plan will be initiated at least 3 months prior to their birthday. Since the community based mental health system has intensive community based services for adults (ages 18 to older adults), a continuum of community based services are available. The young adult most likely will already be receiving some mental health and/or addiction treatment services (as needed) in the adult service system. Coordination of services will be transitioned to an "adult" case manager.

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual (*select one*) Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

The limit specified by the State is (*select one*)

- A level higher than 100% of the institutional average.**

Specify the percentage:

- Other**

Specify:

- Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

The cost limit specified by the State is (*select one*):

- The following dollar amount:**

Specify dollar amount:

The dollar amount (*select one*)

- Is adjusted each year that the waiver is in effect by applying the following formula:**

Specify the formula:

- May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.**
- The following percentage that is less than 100% of the institutional average:**

Specify percent:

Other:

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. Participant Safeguards. When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant (*check each that applies*):

- The participant is referred to another waiver that can accommodate the individual's needs.**
- Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

Other safeguard(s)

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	<input type="text" value="749"/>
Year 2	<input type="text" value="459"/>
Year 3	<input type="text" value="281"/>
Year 4	

Waiver Year	Unduplicated Number of Participants
	173
Year 5	106

- b. **Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: (*select one*):

- The State does not limit the number of participants that it serves at any point in time during a waiver year.
- The State limits the number of participants that it serves at any point in time during a waiver year.

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4	
Year 5	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

- c. **Reserved Waiver Capacity.** The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State (*select one*):

- Not applicable. The state does not reserve capacity.
- The State reserves capacity for the following purpose(s).

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

- d. **Scheduled Phase-In or Phase-Out.** Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule (*select one*):

- The waiver is not subject to a phase-in or a phase-out schedule.
- The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.

- e. **Allocation of Waiver Capacity.**

Select one:

- Waiver capacity is allocated/managed on a statewide basis.
- Waiver capacity is allocated to local/regional non-state entities.

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

- f. Selection of Entrants to the Waiver.** Specify the policies that apply to the selection of individuals for entrance to the waiver:

In compliance with Section 6063 of the DRA, no new entrants to the PRTF Waiver are allowed after October 1, 2012. This waiver is solely for the transition of eligible children and youth from the CA-PRTF Demonstration Grant to the PRTF Waiver services following the expiration of the Demonstration Grant on September 30, 2012. The Waiver will continue availability and access to community-based services for children on the Grant as of September 30, 2012.

(NOTE: B-3-e above is completed showing waiver capacity is allocated/managed on a statewide basis which is how the preceding CA-PRTF Grant was managed. In the absence of any new entrants, B-3-e and B-3-f are not applicable under this limited PRTF Waiver program.)

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

- 1. State Classification.** The State is a (*select one*):

- §1634 State
 SSI Criteria State
 209(b) State

- 2. Miller Trust State.**

Indicate whether the State is a Miller Trust State (*select one*):

- No
 Yes

- b. Medicaid Eligibility Groups Served in the Waiver.** Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- Low income families with children as provided in §1931 of the Act
 SSI recipients
 Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121
 Optional State supplement recipients
 Optional categorically needy aged and/or disabled individuals who have income at:

Select one:

- 100% of the Federal poverty level (FPL)
 % of FPL, which is lower than 100% of FPL.

Specify percentage:

- Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)
- Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)
- Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)
- Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)
- Medically needy in 209(b) States (42 CFR §435.330)
- Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)
- Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)

Specify:

§1902(a)(10)(A)(i)(I)

§1902(a)(10)(A)(i)(VII) of the Act.

§1902(a)(10)(A)(ii)(I), 42 CFR 435.222 & §1905(a)(i) of the Act. Reasonable Classifications of Children under Age 21 are specified in Medicaid State Plan Supplement 1 to Attachment 2.2A

§1902(a)(10)(A)(ii)(VIII) of the Act.

§1925 of the Act.

Special home and community-based waiver group under 42 CFR §435.217) Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed

- No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.**
- Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

- All individuals in the special home and community-based waiver group under 42 CFR §435.217**
- Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

Check each that applies:

- A special income level equal to:**

Select one:

- 300% of the SSI Federal Benefit Rate (FBR)**
- A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

- A dollar amount which is lower than 300%.**

Specify dollar amount:

- Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
- Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
- Medically needy without spend down in 209(b) States (42 CFR §435.330)**
- Aged and disabled individuals who have income at:**

Select one:

- 100% of FPL
- % of FPL, which is lower than 100%.

Specify percentage amount:

- Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 4)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

- a. Use of Spousal Impoverishment Rules.** Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217 (*select one*):

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 4)

- b. Regular Post-Eligibility Treatment of Income: SSI State.**

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 4)

- c. Regular Post-Eligibility Treatment of Income: 209(B) State.**

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 4)

- d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules**

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan.. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

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

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is:

- ii. Frequency of services.** The State requires (select one):

- The provision of waiver services at least monthly**
 Monthly monitoring of the individual when services are furnished on a less than monthly basis

If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

- b. Responsibility for Performing Evaluations and Reevaluations.** Level of care evaluations and reevaluations are performed (*select one*):

- Directly by the Medicaid agency**
 By the operating agency specified in Appendix A
 By an entity under contract with the Medicaid agency.

Specify the entity:

- Other**
Specify:

Under Section 6063 of the DRA, there will be no new entrants following the October 1, 2012 transition of CA-PRTF Grant participants to the PRTF Waiver following the expiration of the Demonstration Grant on September 30, 2012.

However, prior to September 30, 2012, all initial evaluations were performed under the CA-PRTF Grant by the DMHA approved Access Site identified in each county. The reevaluation will continue to be performed by the Wraparound Facilitator assigned to each participant.

- c. Qualifications of Individuals Performing Initial Evaluation:** Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Pursuant to Section 6063 of the DRA, there will be no new entrants to the PRTF Waiver after October 1, 2012. This waiver is solely for the transition of eligible children and youth from the CA-PRTF Demonstration Grant to the PRTF Waiver services following the expiration of the Demonstration Grant on September 30, 2012.

All initial evaluations were completed under the Grant by a certified CANS user who met one of the following

qualifications:

- A psychiatrist;
- A physician;
- A licensed psychologist or a psychologist endorsed as a health service provider in psychology (HSPP);
- A licensed clinical social worker;
- A licensed mental health counselor;
- A licensed marriage and family therapist;
- An advanced practice nurse under IC 25-23-1-1(b)(3) who is credentialed in psychiatric or mental health nursing by the American Nurses Credentialing Center;
- A licensed independent practice school psychologist; or
- An individual who has a Bachelor's degree plus two years clinical experience or masters degree or doctoral degree in social work, psychology, counseling, nursing or other mental health field who does not have a license to practice independently and who practices under the supervision of one of the above mentioned persons.

- d. Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

Indiana is maintaining the same Level of Care Criteria and procedure for the transition from the CA-PRTF Grant to the PRTF Waiver effective October 1, 2012. Only those participants meeting the criteria are eligible for the transition and ongoing reevaluations under the Waiver.

The Child and Adolescent Needs and Strengths (CANS) for Indiana (ages 5 to 17) (Lyons, 1999) assessment tool is used to assess the child and caregiver's needs and strengths. The tool can be found at <http://dmha.in.gov/DARMHA/mainDocuments.aspx>. Patterns of CANS scores (behavioral health needs, functioning, safety/risks, caretaker needs and strengths) have been used to develop a Behavioral Health Decision Model (algorithm). This algorithm implements the criteria for the level of care and is used to indicate the appropriate intensity of behavioral health services. On the CANS, an item score of "3" means immediate or intensive action is needed and an item score of "2" means action is needed.

The CANS is also used for youth 18 to 20 years old with the following instructions for rating the Caretaker Strengths and Needs:

If the youth has family or an unpaid caregiver, rate that person or persons regarding their ability to fulfill the caregiver functions.

If the youth does not have a caregiver, rate the youth's ability to fulfill the following caregiver functions/items: Supervision, Knowledge, Organization, Residential, and Stability. Mark the remaining Caregiver Items "NA".

This allows the Behavioral Health Algorithm to function for older youth who need more intensive levels of service.

The specific CANS decision model for the PRTF Waiver is as follows -- All three criteria must be met:

1. Two or more ratings of '3' or three or more ratings of at least a '2' on the following behavioral/emotional needs:

Psychosis

Impulse/Hyperactivity

Depression

Anxiety

Oppositional

Conduct

Adjustment to Trauma

Anger Control

Substance Use

Eating Disturbance

2. Two or more ratings of '3' or three or more ratings of at least a '2' on any of the following risk behaviors

Suicide Risk

Self Mutilation

Other Self Harm

Danger to Others

Sexual Aggression
Runaway
Delinquency
Fire Setting
Social Behavior

3. A rating of '3' or two or more ratings of at least a '2' on the following Caregiver needs

Supervision
Involvement
Knowledge
Organization
Social Resources
Residential Stability
Physical
Mental Health
Substance Abuse
Developmental
Family Stress

A child/youth who is residing in a PRTF or in the community with a CANS recommendation of Level 5 or 6 meets level of care criteria.

Historically, children who had not been admitted to a PRTF, were determined eligible for the CA-PRTF Grant if their CANS pattern of scores resulted in an indicated need for PRTF intensity of services. The PRTF LOC decision model for admission to a PRTF requires that intensive community based services have been tried first; otherwise, the child is referred back to intensive community based care. However, children who clinically meet the criteria for the CANS' PRTF option in the decision model, but who have not been involved in intensive community based services, were also determined as eligible for the CA-PRTF Grant and continue to be eligible for the October 1, 2012 transition from the Grant to the PRTF Waiver.

e. **Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care (*select one*):

- The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
- A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

Currently there is no formal tool used to determine level of care for PRTF. Eligibility (prior authorization) is determined by a Medicaid contractual entity using the criteria outlined in the Medicaid Bulletin BT200404 issued on 2/27/2004.

The 2/27/2004 Bulletin enumerates the admission criteria for PRTFs, which include the following factors:

- Individual's mental disorder is rated as severe or complex;
- Multiple disruptive behaviors;
- Serious family functioning impairments;
- Prior failure of acute and/or emergency treatment to sufficiently ameliorate the condition;
- Symptom complexes showing a need for extended treatment in a residential setting due to a threat to self or others;
- Impaired safety issues; and
- Need for long-term treatment modalities.

There is no specific assessment instrument utilized. Children are evaluated by PRTFs, which contact the Medicaid contractor, to prior authorize admission.

With the implementation of the prior CA-PRTF Grant, a PRTF LOC was developed, primarily using an algorithm, a pattern of ratings from the CANS. To show outcomes of the determinations were comparable, in March, 2007, the Medicaid contractor, Health Care Excel, used the CANS to rate children who had been admitted to Indiana's PRTFs. They all met the CANS' clinical threshold for treatment in a PRTF. Therefore, Indiana believes that youth currently admitted to PRTFs also meet this level of care on the CANS.

- f. Process for Level of Care Evaluation/Reevaluation:** Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

Under Section 6063 of the DRA, only eligible participants on the CA-PRTF Grant are allowed to transition from the Grant to the PRTF Waiver October 1, 2012. No new participants will be allowed. Therefore, there will be no initial level of care evaluations under the PRTF Waiver. For historical purposes, initial level of care evaluations were performed by the DMHA approved Access Site identified for the county.

The reevaluation is performed by the participant's identified Wraparound Facilitator. The process is the same as the evaluations and reevaluations previously performed under the CA-PRTF Grant. The process includes:

1. Legal guardian, child/youth and anyone else identified by the family meet with the Wraparound Facilitator to complete the CANS assessment tool.
2. The Wraparound Facilitator enters the CANS data into the Data Assessment Registry for Mental Health and Addiction (DARMHA) to generate the report that includes level of care algorithm (level of care determination).
3. The Wraparound Facilitator sends a copy of the evaluation/reevaluation report to DMHA for approval or termination of the PRTF Waiver slot.

- g. Reevaluation Schedule.** Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule (*select one*):

- Every three months
- Every six months
- Every twelve months
- Other schedule

Specify the other schedule:

- h. Qualifications of Individuals Who Perform Reevaluations.** Specify the qualifications of individuals who perform reevaluations (*select one*):

- The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.
- The qualifications are different.

Specify the qualifications:

- i. Procedures to Ensure Timely Reevaluations.** Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care (*specify*):

Level of Care Re-determinations are required annually. The LOC reevaluations are tracked through an electronic case management system. Wraparound Facilitators are notified prior to the level of care expiration in order to begin reevaluation activities and schedule a Child and Family Team meeting to complete the reevaluation. State Division of Mental Health and Addiction (DMHA) staff track LOC reevaluations and monitor as part of a quality management processes.

Reevaluations for individuals transitioned from the CA-PRTF Grant to the PRTF Waiver will continue on the same annual time frame schedule previously established and in effect as of September 30, 2012 under the CA-PRTF Grant. This will ensure consistent and timely annual reevaluations.

- j. Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

The evaluations and re-evaluations will be maintained for a minimum of three years in the office of the Indiana DMHA.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

i. Sub-Assurances:

- a. **Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.**

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

- b. **Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.**

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of enrolled participants with reevaluations of level of care performed annually. Numerator: Total number of active waiver participants with reevaluations completed on or before their annual review date. Denominator: Total number of active participants due for reevaluation.

Data Source (Select one):

Other

If 'Other' is selected, specify:

INsite database reports

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	

		<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

c. *Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.*

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of LOC evaluators trained and certified annually to demonstrate reliability using the level of care tool. Numerator: Total number of LOC evaluators trained and approved annually. Denominator: Total number of LOC evaluators.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Data Assessment Registry for Mental Health and Addiction (DARMHA)

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of levels of care completed following State's procedures for timeliness. Numerator: The total number of participants sampled whose level of care followed State's procedures for timeliness. Denominator: the total number of participants sampled.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:

		<input type="text"/>
	<input type="checkbox"/> Other Specify:	<input type="text"/>

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: Contracted Entity	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
 Issues related to the initial Level of Care assessments were remediated under the prior CA-PRTF Grant. (There are no applications processed following the October 1, 2012 transition to the new PRTF Waiver.)

According to policy, the Wraparound Facilitator must submit the Level of Care re-evaluation 30 calendar days prior to the Level of Care end date. When Level of Care is late, DMHA immediately approves a temporary continuance of services. DMHA escalates the issue to the Wraparound Facilitator for notification within 5 business days. The QI site coach addresses the issue at the next visit or with a telephone call. Corrective action is taken if the issue is not addressed within 30 calendar days. Business rules in place in the INsite Case Management system allow only a certified Wraparound Facilitator to enter the Level of Care in INsite to ensure accuracy and compliance with qualifications, policies and procedures.

- ii. **Remediation Data Aggregation**
Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

- No
 Yes

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:

- i. informed of any feasible alternatives under the waiver; and
- ii. given the choice of either institutional or home and community-based services.

- a. Procedures.** Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Under the PRTF Waiver, there are no applicants. However, freedom of choice was provided under the prior CA-PRTF Grant. The applicant/participant/parent/guardian signed and dated a "Statement of Freedom of Choice" indicating a choice of either services in a PRTF setting or home and community-based services at the point of application and at each Level of Care re-determination. Therefore, all individuals transitioning from the Grant to the Waiver October 1, 2012 will have been provided with freedom of choice. And this freedom of choice is ongoing under the Waiver after October 1, 2012.

At the time of each annual plan of care update, an updated Freedom of Choice statement is signed by the legal representative or participant. To ensure an informed choice when the Statement of Freedom of Choice is signed, the Waiver Wraparound Facilitator (at re-determinations) is responsible for explaining the array of services available in a PRTF setting as well as the feasible alternatives available through the PRTF Waiver. The information provided also includes an explanation of the potential differences in the child's Medicaid eligibility between services provided in a PRTF setting and in the community-based PRTF Waiver setting. (Only the PRTF setting allows the disregard of parental income and resources when determining the Medicaid eligibility and possible spend-down for the child.)

In addition, the participant/parent/guardian are informed that participants in the PRTF Waiver cannot receive their traditional Medicaid services through Medicaid's risk-based managed care system, which may have an impact for children who may benefit from receiving services through the risk-based program.

- b. Maintenance of Forms.** Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

Forms will be maintained at the local agency or provider that provides Wraparound Facilitation.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
The Division of Mental Health and Addiction (DMHA) will address the needs of youth and families with limited English proficiency (LEP) in a variety of ways:

1. The CA-PRTF Grant Application Form (transferred from the Grant to the new PRTF Waiver for each participant) asks about the preferred language of communication.
2. Linguistic and cultural issues are assessed through the Child and Adolescent Needs and Strengths (CANS) Assessment which informs the Plan of Care.
3. DMHA has special contractual arrangements for community based services to individuals who are deaf.
4. CA-PRTF Access Gatekeepers (for prior Grant applications) and ongoing PRTF Waiver service providers are expected to have oral interpretation available for most common languages in their service areas. For example, for children and families whose primary language is Spanish, bilingual providers are preferred. In the selection of interpreters and translators, their competency will be assessed through their ability to communicate information in both languages, and their mode of interpretation. Oral interpretation will be achieved either through:
 - (a) bilingual staff, contractual interpreters, telephone interpreters; or
 - (b) the use of family/friends as interpreters only when /if person needing the service is aware of the option of one provided at no cost.
 A recipient will not be required to use a family member as an interpreter.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

- a. Waiver Services Summary.** List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:

Service Type	Service		
Statutory Service	Habilitation		
Statutory Service	Respite		
Other Service	Consultative Clinical and Therapeutic Services		
Other Service	Flex Funds		
Other Service	Non-Medical Transportation		
Other Service	Training and Support for Unpaid Caregivers		
Other Service	Wraparound Facilitation/Care Coordination		
Other Service	Wraparound Technician		

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Habilitation

Alternate Service Title (if any):

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

Habilitation services enhance participant functioning, life and social skills; prevent or reduce substance use/abuse; increase client competencies and build child and family’s strengths and resilience, and positive outcomes. This is accomplished through developing skills in identification of feelings; anger and emotional management; how to give and receive feedback; criticism and praise; problem-solving; decision making; assertive behavior; learning to resist negative peer pressure and develop pro-social peer interactions; improve communication skills; optimize developmental potential; address substance abuse and use issues; build and promote positive coping skills; learn how to have positive interactions with peers and adults, encourage therapeutic/positive play with or without parents/guardians, encourage positive community connections, and develop non-paid, natural supports for child and family . Activities are to be conducted face-to-face with the client and address the needs of the participant. Habilitation services do not include services that are mandated under Individuals with Disabilities Education Act (IDEA) or covered under the Rehabilitation Act of 1973.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Habilitation services will be limited to three (3) hours maximum daily up to thirty (30) hours of services per participant per month.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community Mental Health Centers (CMHC) and Community Service Agencies (CSA)
Individual	Individuals meeting other standards

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Habilitation

Provider Category:

Agency

Provider Type:

Community Mental Health Centers (CMHC) and Community Service Agencies (CSA)

Provider Qualifications**License** (*specify*):

None

Certificate (*specify*):

CMHCs certified as a CMHC by the Division of Mental Health and Addiction (DMHA) (440 IAC 4.1-2-1).

CSAs accredited by a AAAHC, COA, URAC, CARF, ACA, JCAHO, or NCQA

Other Standard (*specify*):

All non-accredited CSAs must receive approval from the PRTF Waiver Team based on meeting the following individual standards.

All provider agencies must maintain documentation that all the following individual standards are met:

Agency Individual providing the direct habilitation service must reside within a one county area from the participant's place of residence to ensure participant's health and welfare in a crisis situation;

- At least 21 years of age;
- High school diploma or equivalent;
- 3 years paid, volunteer or personal experience with children with SED/youth with serious MI as defined by DMHA;
- Completion of DMHA approved training program;
- Attend and actively participate in child and family team meetings for all participants assigned to provider;
- Fingerprint based national and state criminal background screen;
- Local law enforcement screen;
- Indiana Department of Child Services abuse registry screens;
- Five panel drug screen or compliance with the Federal Drug-Free Workplace Act of 1988 by meeting the same requirements established for Federal grant recipients specified under 41 U.S.C. 10 Section 702(a)(1);
- Meet the requirements as a Non-Medical Transportation provider based on provider specifications found in Appendix C-1/C-3 of this document for Non-Medical Transportation; and,
- Individual providing the Habilitation service must be supervised by a Health Service Provider in Psychology (HSPP) as defined by IC 25-33-1; Licensed Marriage and Family Therapist (LMFT); Licensed Clinical Social Worker (LCSW); or Licensed Mental Health Counselor (LMHC) under IC 25-23.6. Supervision must include a minimum of one (1) hour face to face supervision for every 30 hours of services provided. The supervisor must be independent of the Child and Family team. Supervision times must be adequately documented in the participant's file and signed by the Habilitation provider and the licensed individual providing the supervision. Supervision times are not billable to the Waiver.

Verification of Provider Qualifications**Entity Responsible for Verification:**

DMHA

Frequency of Verification:

Initially and at least every three years, Community Mental Health Centers and accredited Community Service Agencies must submit verification of qualifications to DMHA.

Initially and at least every two years, non-accredited Community Service Agencies must submit verification of qualifications to DMHA

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Statutory Service

Service Name: Habilitation

Provider Category:

Individual

Provider Type:

Individuals meeting other standards

Provider Qualifications**License (specify):**

None

Certificate (specify):

None

Other Standard (specify):

The individual providing the direct habilitation service must reside within a one county area from the participant's place of residence to ensure participant's health and welfare in a crisis situation and must meet the following standards:

- At least 21 years of age;
- High school diploma or equivalent;
- 3 years paid, volunteer or personal experience with children with SED/youth with serious MI as defined by DMHA;
- Completion of DMHA approved training program;
- Attend and actively participate in child and family team meetings for all participants assigned to provider;
- Fingerprint based national and state criminal background screens;
- Local law enforcement screen;
- Indiana Department of Child Services abuse registry screens;
- Five panel drug screen;
- Meet the requirements as a Non-Medical Transportation provider, based on provider specifications found in Appendix C-1/C-3 of this document for Non-Medical Transportation; and,
- Obtain supervision by a Health Service Provider in Psychology (HSPP) as defined by IC 25-33-1; Licensed Marriage and Family Therapist (LMFT); Licensed Clinical Social Worker (LCSW); or Licensed Mental Health Counselor (LMHC) under IC 25-23.6. Supervision must include a minimum of one (1) hour face to face supervision for every 30 hours of Habilitation services provided. The supervisor must be independent of the Child and Family team. Supervision times must be adequately documented in the participant's file and signed by the Habilitation provider and the licensed individual providing the supervision. Supervision times are not billable to the Waiver.

Verification of Provider Qualifications**Entity Responsible for Verification:**

DMHA

Frequency of Verification:

Individual providers must submit verification of qualifications to DMHA initially and at recertification at least every two years.

Appendix C: Participant Services**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

Respite Care services are provided to participants unable to care for themselves and are furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the participant.

Respite Care may be provided on an hourly basis or a daily basis. The service may be planned and provided on a routine basis (such as daily, weekly, monthly, or semi-annually), or may be unplanned when a caregiver has an unexpected situation requiring assistance in caring for the participant.

Respite Care may also be provided as an emergency in response to a crisis situation in the family. A crisis situation is one where the individual's health and welfare would be seriously impacted in the absence of the Crisis Respite Care.

Respite Care services may be provided in the participant's home or private place of residence, or any facility licensed by the Indiana Family and Social Services Administration, Division of Family Resources or by the Indiana Department of Child Services as specified in the provider specifications found in Appendix C-1/C-3 of this document.

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

Respite Care may be provided on an hourly basis (billable in 15-minute units) for less than 7 hours in any one day; or at the daily rate for 7 to 24-hours in any one day. Crisis Respite Care is provided for a minimum of 8 to 24 hours billable at a daily rate. Twenty-four hour Respite Care can not exceed 14 consecutive days.

Refer to Appendix C-2-e for requirements related to the provision of Respite Care by providers who are related to the CA-PRTF participant.

Respite can not be provided as a substitute for regular childcare to allow the parent/guardian to hold a job or attend school.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Twenty-four hour a day Respite Care service may not exceed 14 consecutive days.

(There are no monthly or annual limits on the number of hours of Respite or the number of 14-consecutive day Respite stays to meet the needs of the persons who normally provide care for the participant, as authorized on the participant's Plan of Care.)

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individuals meeting Other Standards, including Relatives allowed under C-2-e
Agency	Community Mental Health Center; Community Service Agency; Facility licensed by the FSSA, Division of Family Resources or the Department of Child Services, including Medicaid Certified PRTFs

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Individual

Provider Type:

Individuals meeting Other Standards, including Relatives allowed under C-2-e

Provider Qualifications

License (specify):

None

Certificate (specify):

None

Other Standard (specify):

The individual providing the direct Respite care must reside within a one county area from the participant's place of residence to ensure the health and safety of the participant in a crisis situation and must meet the following standards:

- At least 21 years of age;
- High school diploma or equivalent;
- Two years paid, volunteer or personal experience with children with SED/youth with serious MI as defined by DMHA;
- Completion of DMHA approved training program;
- Attend and actively participate in child-family team meetings when deemed clinically necessary by the Wraparound Facilitator;
- Fingerprint based national and state criminal background screen;
- Local law enforcement screen;
- Indiana Department of Child Services abuse registry screen;
- Five panel drug screen; and
- Meet the requirements as a Non-Medical Transportation provider based on provider specifications found in Appendix C-1/C-3 of this document for Non-Medical Transportation.

Verification of Provider Qualifications

Entity Responsible for Verification:

DMHA

Frequency of Verification:

Individual providers must submit verification of qualifications to DMHA initially and at recertification at least every two years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency

Provider Type:

Community Mental Health Center; Community Service Agency; Facility licensed by the FSSA, Division of Family Resources or the Department of Child Services, including Medicaid Certified PRTFs

Provider Qualifications

License (*specify*):

Respite service may be provided in the following facilities:

- 1) Emergency shelters licensed under 465 IAC 2-10;
- 2) Foster Homes licensed under IC 31-27-4 including Special Needs and Therapeutic Foster Homes only when the Licensed Child Placing Agency (LCPA) is the PRTF Waiver approved agency provider. DMHA has the authority to request a copy of the home study that was conducted on the foster parent providing PRTF Waiver Respite Care services;
- 3) Other child caring institutions licensed under IC-31-27-3;
- 4) Child Care Centers licensed under IC 12-17.2-4;
- 5) Child Care Homes licensed under IC 12-17.2-5-1;
- 6) School Age Child Care Project licensed under IC 12-17-12;
- 7) Psychiatric Residential Treatment Centers licensed under 465 IAC 2-11-1 as a private secure residential facility for Medicaid certification under 405 IAC 5-20-3.1.

Certificate (*specify*):

Community Mental Health Centers certified as a Community Mental Health Centers by the Division of Mental Health and Addiction (DMHA) (440 IAC 4.1-2-1).

Community Service Agencies (CSA) accredited by AAAHC, COA, URAC, CARF, ACA, JCAHO, or NCQA.

Other Standard (*specify*):

All non-accredited CSAs must receive approval from the PRTF Waiver Team based on meeting the following individual standards:

All provider agencies must maintain documentation that all the following individual standards are met:

Agency Individual providing the direct Respite care must reside within a one county area from the participant's place of residence to ensure participant's health and welfare in a crisis situation.

- At least 21 years of age;
- High school diploma or equivalent;
- Two years paid, volunteer or personal experience with children with SED/youth with serious MI as defined by DMHA ;
- Completion of DMHA approved training program;
- Attend and actively participate in child-family team meetings when deemed necessary by the Wraparound Facilitator;
- Fingerprint based national and state criminal background screen;
- Local law enforcement screen;
- Indiana Department of Child Services abuse registry screens; and
- Five panel drug screen or compliance with the Federal Drug-Free Workplace Act of 1988 by meeting the same requirements established for Federal grant recipients specified under 41 U.S.C. 10 Section 702(a)(1); and,
- Meet the requirements as a Non-Medical Transportation provider based on provider specifications found in Appendix C-1/C-3 of this document for Non-Medical Transportation.

Verification of Provider Qualifications

Entity Responsible for Verification:

DMHA

Frequency of Verification:

Initially and at least every three years, Community Mental Health Centers and accredited Community Service Agencies must submit verification of qualifications to DMHA.

Initially and at least every two years, non-accredited Community Service Agencies must submit verification of qualifications to DMHA.

Initially and at the time of licensure, licensed facilities must submit verification of qualifications to DMHA.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Consultative Clinical and Therapeutic Services

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

Consultive Clinical and Therapeutic Services that are not covered by the State Plan and are necessary to improve the participant's independence and inclusion in their community and to assist unpaid caregivers and/or paid support staff in carrying out individual treatment/support plans. Home or community based consultation activities are provided by professionals in psychology, social work, counseling and behavior management. The service includes assessment, development of a home treatment/support plan, training and technical assistance to carry out the plan, monitoring of the participant and other providers in the implementation of the plan. Crisis counseling and family counseling may be provided. This service may be delivered in the participant's home, in the school, or in the community as described in the Plan of Care to improve consistency across service systems.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

No limits

(This service may coordinate intervention planning in the school setting, but would not duplicate services that would be provided through an Individualized Education Plan (IEP) for children in special education.)

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community Service Agencies and Community Mental Health Centers
Individual	Individuals meeting licensing qualifications

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Consultative Clinical and Therapeutic Services

Provider Category:Agency **Provider Type:**

Community Service Agencies and Community Mental Health Centers

Provider Qualifications**License (specify):**

Agency staff providing the services must meet the following licensing requirements:

Health Service Provider in Psychology (HSPP) as defined in IC 25-33-1, or in accordance with the provisions of IC 25-23.6, is one of the following:

Licensed Marriage and Family Therapist;

Licensed Clinical Social Worker; or

Licensed Mental Health Counselor.

Certificate (specify):

Community Mental Health Centers certified as a Community Mental Health Center by the Division of Mental Health and Addiction (DMHA) (440 IAC 4.1-2-1).

Community Service Agencies accredited by AAAHC, COA, URAC, CARF, ACA, JCAHO, or NCQA

Other Standard (specify):

Non-accredited Community Service Agencies must receive approval from PRTF Waiver Team based on licensure of individuals providing services.

Agencies must maintain documentation that individuals providing the service meet licensing requirements and the following standards:

- Indiana Department of Child Services abuse registry screens;
- Fingerprint based national and state criminal background screens;
- Local law enforcement screen;
- Five panel drug screen or compliance with the Federal Drug-Free Workplace Act of 1988 by meeting the same requirements established for Federal grant recipients specified under 41 U.S.C. 10 Section 702(a)(1); and
- Participate in Child/Family Team meetings when there is a clinical need identified by the Wraparound Facilitator.

Verification of Provider Qualifications**Entity Responsible for Verification:**

DMHA

Frequency of Verification:

Initially and at least every two years, non-accredited Community Service Agencies must submit verification of qualifications to DMHA.

Initially and at least every three year, Community Mental Health Centers and accredited Community Service Agencies must submit verification of qualifications to DMHA.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service**Service Name: Consultative Clinical and Therapeutic Services****Provider Category:**Individual **Provider Type:**

Individuals meeting licensing qualifications

Provider Qualifications**License (specify):**

Health Service Provider in Psychology as defined in IC 25-33-1.

Or, under the provisions of IC 25-23.6:
 Licensed Marriage and Family Therapist;
 Licensed Clinical Social Worker; or
 Licensed Mental Health Counselor.

Certificate (*specify*):

None

Other Standard (*specify*):

The individual must meet the following standards:

- Fingerprint based national and state criminal background screens;
- Local law enforcement screen;
- Five panel drug screen;
- Indiana Department of Child Services abuse registry screens; and
- Participate in the Child/Family Team meetings when there is a clinical need identified by the Wraparound Facilitator.

Verification of Provider Qualifications

Entity Responsible for Verification:

DMHA

Frequency of Verification:

Individual providers must submit verification of qualifications to DMHA initially and at recertification at least every two years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Flex Funds

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

Service Definition (*Scope*):

Flex funds are utilized to purchase any of a variety of one-time or occasional goods and/or services needed for participants when the goods and/or services cannot be purchased by any other funding source, and the service or good is directly related to the enrolled child's Plan of Care. Flex fund services and/or supports must be described in the person's Plan of Care. The use of Flex Funds on an expenditure must be tied directly to a specified need documented on the Plan of Care, supported by the rationale as to how that expenditure will assist the participant to remain in the home and/or community. The service rationale must also be related to one or more of the following outcomes: success in school; living at the person's own home or with family; development and maintenance of personally satisfying relationships; prevention of or reduction in adverse outcomes, including arrests, delinquency, victimization and exploitation; and/or becoming or remaining a stable and productive member of the community.

Flex Funds may be used to purchase bus passes or alternate methods of public transportation to enable participants and their families to gain access to approved PRTF Waiver services and other community services, activities and resources. The purchase of bus passes or alternate methods of transportation will not duplicate

services delivered under Transportation services in the waiver and/or Medicaid State Plan services.

All uses of flex funds must be specified in the Plan of Care and approved prior to being incurred. Claims for flex funds will be submitted through the regular claims process. Documentation must also be included in the clinical record regarding the unavailability of any other funding source for the goods and/or services, the necessity of the expenditure and the outcomes affected by the expenditure. The documentation must also include the wraparound team determination that the expenditure is appropriate and needed in order to achieve the treatment goals and that the expenditure will not supplant normal family obligations.

Flex funds may not be used for purely diversional or recreational activities or items, or for room and board.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Flex Funds are limited to \$2,000.00 per participant per year.

Service Delivery Method (*check each that applies*):

- Participant-directed as specified in Appendix E
 Provider managed

Specify whether the service may be provided by (*check each that applies*):

- Legally Responsible Person
 Relative
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community Mental Health Centers and Accredited Community Services Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Flex Funds

Provider Category:

Agency

Provider Type:

Community Mental Health Centers and Accredited Community Services Agencies

Provider Qualifications

License (*specify*):

None

Certificate (*specify*):

Community Mental Health Centers must be certified as a Community Mental Health Center by the Division of Mental Health and Addiction (DMHA) (440 IAC 4.1-2-1).

Other Standard (*specify*):

A Community Service Agency must be approved by DMHA as meeting the requirements of a PRTF Waiver Wraparound Facilitator provider based on provider specifications found in Appendix C-1/C-3 of this document.

Verification of Provider Qualifications

Entity Responsible for Verification:

DMHA

Frequency of Verification:

Initially and at least every three years, Community Mental Health Centers and accredited Community Service Agencies must submit verification of qualifications to DMHA.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Non-Medical Transportation

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

Transportation services are available to enable PRTF Waiver participants and their families to gain access to PRTF Waiver services and other community services, activities, and resources as specified in the Plan of Care. Transportation may be provided to/from school if the school does not provide transportation; to an approved after school or week-end therapeutic activity; to an approved summer camp; and, other similar services or activities. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State Plan, defined at 42 CFR 440.170(a) and does not replace them. Transportation services under the PRTF Waiver are offered in accordance with the participant's Plan of Care. Federal financial participation is available for the cost of transportation to a training event or conference. Whenever possible, family, friends, neighbors, or community agencies which can provide this service at no charge are utilized.

Refer to Appendix C-2e for requirements related to Non-Medical Transportation providers who are a relative or legal guardian of the PRTF Waiver participant.

Transportation services may not be provided for purely recreational or diversional activities or for any reason not directly tied to the child's plan of care.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Transportation services are limited to a maximum of \$1,000.00 per participant per year.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community Mental Health Centers (CMHC) and Community Service Agencies (CSA)
Individual	Family, Legal Guardian, Foster Parent, Friend or Associate

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Non-Medical Transportation

Provider Category:

Agency

Provider Type:

Community Mental Health Centers (CMHC) and Community Service Agencies (CSA)

Provider Qualifications

License (specify):

None

Certificate (specify):

Community Mental Health Centers must be certified as a CMHC by the Division of Mental Health and Addiction (DMHA) (440 IAC 4.1-2-1).

Community Service Agencies accredited by AAAHC, COA, URAC, CARF, ACA, JCAHO, or NCQA.

Other Standard (specify):

All non-accredited CSAs must receive approval from the DMHA based on meeting the following individual standards.

All provider agencies must maintain documentation that each employee providing Transportation service meets the following individual standards:

- Valid driver's license;
- Current auto insurance;
- Safe driving record;
- Maintained vehicles used to provide Transportation services;
- Providers who are not the Custodial Parent, Legal Guardian or Foster Parent (Refer to Appendix C-2-a. and e.) must have a fingerprint based national and state criminal background screen;
- Providers who are not the Custodial Parent, Legal Guardian or Foster Parent (Refer to Appendix C-2-a. and e.) must have a local law enforcement screen;
- Providers who are not the Custodial Parent, Legal Guardian, or Foster Parent (Refer to Appendix C-2-b. and e.) must have an Indiana Department of Child Services child abuse registry screen; and,
- Providers who are not the Custodial Parent, Legal Guardian or Foster Parent (Refer to Appendix C-2 e.) must have a five panel drug screen or in compliance with the Federal Drug-Free Workplace Act of 1988 by meeting the same requirements established for Federal grant recipients specified under 41 U.S.C. 10 Section 702(a)(1).

Verification of Provider Qualifications

Entity Responsible for Verification:

DMHA

Frequency of Verification:

Initially and at least every two years, non-accredited Community Service Agencies must submit verification of qualifications to DMHA.

Initially and at least every three years, Community Mental Health Centers and accredited Community Service Agencies must submit verification of qualifications to DMHA.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Non-Medical Transportation

Provider Category:

Individual ▾

Provider Type:

Family, Legal Guardian, Foster Parent, Friend or Associate

Provider Qualifications**License (specify):**

No requirement to be licensed as a transportation provider, but individual must have a valid driver's license

Certificate (specify):

None

Other Standard (specify):

The individual must meet the following standards:

- Individual drivers must have an appropriate valid driver's license, auto insurance, safe driving record and maintained vehicle;
- Providers who are not the Custodial Parent or Legal Guardian, or Foster Parent (Refer to Appendix C-2-a. and e.) must have a fingerprint based national and state criminal background screen;
- Providers who are not the Custodial Parent or Legal Guardian, or Foster Parent (Refer to Appendix C-2-a. and e.) must have a local law enforcement screen;
- Providers who are not the Custodial Parent, Legal Guardian, or Foster Parent (Refer to Appendix C-2-e.) must have a five panel drug screen; and
- Providers who are not the Custodial Parent, Legal Guardian, or Foster Parent (Refer to Appendix C-2-b. and e.) must have an Indiana Department of Child Services child abuse registry screen.

Verification of Provider Qualifications**Entity Responsible for Verification:**

DMHA

Frequency of Verification:

Individual providers must submit verification of qualifications to DMHA initially and at recertification at least every two years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service ▾

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Training and Support for Unpaid Caregivers

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

Service Definition (Scope):

Training and Support for Unpaid Caregivers is an activity or service that educates, supports, and preserves the family and caregiver unit. Training and Support activities and the providers of these activities are based on the family/caregiver's unique needs and are identified in the plan of care. Activities may include, but are not limited to the following: teaching practical living skills; parenting skills; home management skills; use of community resources; child development; record-keeping skills to assist all caregivers; development of informal support; decision-making skills; conflict resolution; and, coping skills; as well as assistance with gaining knowledge, insight, and empathy in regard to the participant's illness, and increasing confidence, stamina and

empowerment.

Training and Support for Unpaid Caregivers may be delivered by the following types of resources: non-profit, civic, faith-based, professional, commercial, and government agencies and organizations; community colleges, vocational schools, universities, lecture series, workshops, conferences, seminars, on-line training programs; Community Mental Health Centers, and other qualified community service agencies.

For purposes of this service, "Unpaid Caregiver" is defined as any person, family member, neighbor, friend, co-worker, or companion who provides uncompensated care, training, guidance, companionship, or support to a PRTF Waiver participant.

Reimbursement is available for non-hourly Training and Support for Unpaid Caregivers for the costs of registration/conference training fees, books and supplies associated with the training and support needs outlined in the plan of care. Hourly reimbursement is available for one-on-one training by providers of this service as specified in the plan of care including the individual provider's attendance at the child-family team meeting.

Reimbursement is not available for the costs of travel, meals, and overnight lodging.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Hourly service (billed in quarter hour units) is limited to a maximum of two hours per day (\$120 per day). There is no annual limit for hourly Training and Support for Unpaid Caregivers.

The maximum annual limitation for non-hourly Training and Support for Unpaid Caregivers is \$500.

Reimbursement is not available for the costs of travel, meals, and overnight lodging.

Service Delivery Method (*check each that applies*):

- Participant-directed as specified in Appendix E
 Provider managed

Specify whether the service may be provided by (*check each that applies*):

- Legally Responsible Person
 Relative
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community Mental Health Centers , Wraparound Facilitation Provider Agency, and Community Service Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Training and Support for Unpaid Caregivers

Provider Category:

Agency

Provider Type:

Community Mental Health Centers , Wraparound Facilitation Provider Agency, and Community Service Agencies

Provider Qualifications

License (*specify*):

None

Certificate (*specify*):

Community Mental Health Centers certified as a CMHC by the Division of Mental Health and Addiction (440 IAC 4.1-2-1).

Other Standard (*specify*):

Wraparound Facilitation provider agency must be approved by DMHA to provide Wraparound Facilitation.

Other Community Service Agencies that have not been approved as a Wraparound Facilitation provider must:

- Have a current contract with systems of care agencies; or
- Be enrolled as a waiver provider approved by the Division of Disability and Rehabilitative Services to provide Family and Caregiver Training under Indiana's Home and Community-Based Services Waivers.

All provider agencies must obtain and maintain documentation that all Other Standard are met by the individuals providing the service:

- At least 21 years of age;
- High school diploma or equivalent;
- Two years paid, volunteer or personal experience with children with SED/youth with serious MI as defined by DMHA;
- Completion of DMHA approved training program;
- Be a resident of the same System of Care region as the participant/primary caregiver;
- Attend and actively participate in Child-Family Team meetings when providing support to the unpaid caregiver within the activities included in the service definition as approved by the Wraparound Facilitator;
- Fingerprint based national and state criminal background screen;
- Local law enforcement screen;
- Indiana Department of Child Services abuse registry screen; and
- Five panel drug screen or compliance with the Federal Drug-Free Workplace Act of 1988 by meeting the same requirements established for Federal grant recipients specified under 41 U.S.C. 10 Section 702(a)(1).

Verification of Provider Qualifications**Entity Responsible for Verification:**

DMHA

Frequency of Verification:

Initially and at least every three years, Community Mental Health Centers and accredited Community Service Agencies must submit verification of qualifications to DMHA.

Initially and at least every two years, non-accredited Community Service Agencies must submit verification of qualifications to DMHA.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Wraparound Facilitation/Care Coordination

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.

● **Service is not included in the approved waiver.**

Service Definition (*Scope*):

Wraparound Facilitation is a comprehensive service comprised of a variety of specific tasks and activities designed to carry-out the wraparound process. Children/youth who participate in the PRTF Waiver must receive WF. Wraparound is a planning process that follows a series of steps and is provided through a Child and Family Wraparound Team. The Wraparound Team is responsible to assure that the participant's needs and the entities responsible for addressing them are identified in a written Plan of Care. The individual who facilitates and supervises this process is the Wraparound Facilitator (WF). Each WF will maintain a caseload of no more than 10 children, regardless of source(s) of funding (grant, local system of care, etc.).

The WF is responsible for:

- Completing a comprehensive re-assessment of the individual at least annually;
- Working in full partnership with team members to develop a revised and annual plans of care;
- Overseeing implementation of the revised plan;
- Identifying providers of services or family based resources; facilitating Child and Family Team meetings; and
- Monitoring all services authorized for a child's care.

PRTF Waiver services are authorized for payment based on the plan of care. The WF assures that care is delivered in a manner consistent with strength-based, family driven, and culturally competent values. The WF:

- Offers consultation and education to all providers regarding the values and principles of the model;
- Monitors progress toward treatment goals;
- Ensures that necessary data for quality evaluation is gathered and recorded; and
- Ensures that all PRTF Waiver related documentation is gathered and reported to DMHA as per requirements.

The wraparound model involves 4 stages (Miles, Bruner, Osher & Walker, 2006):

1. **Engagement:** The family meets the WF. Together they explore the family's strengths, needs, and culture. They talk about what has worked in the past and what they expect from the wraparound process. The WF engages other team members identified by the family and prepares for the first child/family team meeting.
2. **Planning:** The WF informs the team members about the family's strengths, needs, and vision for the future. The wraparound team does not meet without the family present. The team decides what to work on, how the work will be accomplished, and who is responsible for each task. Plan of Care (POC) development is facilitated by the WF and the WF is responsible to write the POC and obtain approval of the POC from DMHA. The WF also facilitates a plan to manage crises that may occur.
3. **Implementation:** Family and team members meet regularly (at least monthly). Meetings are facilitated by the Wraparound Facilitator who also assures that the family guides the family/team meetings. The team reviews accomplishments and progress toward goals and makes adjustments. Family and team members work together to implement plan.
4. **Transition:** As the family team nears the goals, preparations are made for the family to transition out of formal wraparound and PRTF Waiver services. The family and team decide how the family will continue to get support when needed and how wraparound can be re-started if necessary.

The Wraparound Facilitator:

- Completes CANS Reassessments every six months to monitor progress.
- If the WF is not an Other Behavioral Health Professional (OBHP), as defined in 405 IAC 5-21.5-1(d), he/she arranges for a OBHP to complete the annual PRTF LOC re-evaluations with active involvement of the Child and Family Wraparound Team;
- Guides the engagement process by exploring and assessing strengths and needs;
- Facilitates, coordinates, and attends family and team meetings;
- Guides the planning process by informing the team of the family vision (no team meeting without family);
- Guides the crisis plan development, monitors the implementation and may intervene during a crisis;
- Authorizes and manages Flex Funding as identified in the Plan of Care;
- Assures that the work to be done is identified and assigned to a team member;
- Assures that the written Plan of Care that was developed, written and approved by the Division of Mental Health and Addiction under the prior existing CA-PRTF Grant is appropriate for continuation under the PRTF Waiver;
- Reassesses, amends, and secures on-going approval of Plan of Care;
- Communicates and coordinates with local Division of Family Resources (DFR) regarding continued Medicaid

eligibility status;

- Monitors cost-effectiveness of Medicaid services;
- Monitors and supervises the Wraparound Technician; and,
- Guides the transition of the youth from the PRTF Waiver.

Wraparound Facilitation does not duplicate Wraparound Technician services or any other Grant or state plan Medicaid service. Every child/family will have a WF. The WF may perform the tasks identified for a Wraparound Technician. This will occur when the caseload does not warrant an added person to perform all the duties of the Wraparound Technician. Both WF and Wraparound Technician services include assistance to participants in gaining access to services (PRTF Waiver, medical, social, educational and other needed services). The difference between these two services is related to the complexity of the activities. The WF manages the entire wraparound process and ensures that all reassessments are completed; ensures that the plan of care is completed (including a crisis plan) and is approved; guides all team members to ensure that the family vision is central to all services; manages the flex fund; and supervises the Wraparound Technician.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

No limits

Service Delivery Method (*check each that applies*):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (*check each that applies*):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community Service Agency, Community Mental Health Center

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Wraparound Facilitation/Care Coordination

Provider Category:

Agency

Provider Type:

Community Service Agency, Community Mental Health Center

Provider Qualifications

License (*specify*):

None

Certificate (*specify*):

Certified by the Division of Mental Health and Addiction (DMHA). Approved accreditation by a nationally recognized accrediting body (AAAH, COA, URAC, CARF, ACA, JCAHO, or NCQA)

Other Standard (*specify*):

Participation in a local system of care which includes both a governing coalition and service delivery endorsing the values and principles of a system of care; and

Documentation that individual Wraparound Facilitators meet the following standards:

- An Other Behavioral Health Professional as defined in 405 IAC 5-21.5-1(d); or Bachelor's degree in human service field with minimum of 3 years of clinical or management experience in human service field and demonstrated 2 or more years of clinical intervention skills ;
- Demonstrated skill in team building and development; ability to work with effectively with other community professionals;

- Strong oral and written communication skills;
- Other DMHA required training;
- Fingerprint based national and state criminal background screens;
- Local law enforcement screen;
- State and local Child Protective Services registry screen; and,
- Five panel drug screen or compliance with the Federal Drug-Free Workplace Act of 1988 by meeting the same requirements established for Federal grant recipients specified under 41 U.S.C. 10 Section 702(a)(1).

Verification of Provider Qualifications

Entity Responsible for Verification:

DMHA

Agency will maintain personnel records verifying standard credentials for individual Wraparound Facilitators.

Frequency of Verification:

Initially and at least every three years, Community Mental Health Centers and accredited Community Service Agencies must submit verification of qualifications to DMHA.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Wraparound Technician

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

Service Definition (Scope):

The Wraparound Technician applies the theories and concepts of the wraparound process and the resulting Plan of Care to the child/youth's day to day activities. Wraparound Technicians are guided and supervised by the Wraparound Facilitator. They discuss progress with other team members, providers, and family and make recommendations to the Wraparound Facilitator and team.

- Participate in Child and Family Team meetings;
- Monitor progress by communicating with the family and child, as well other team members and the Wraparound Facilitator. The timetable for and the mode of communication should be determined with the family;
- Assist the family and child with gaining access to services and assure that families are aware of available community-based services and other resources such as Medicaid State Plan services, Vocational Rehabilitation programs, educational, and public assistance programs;
- Monitor use of service and engage in activities that enhance access to care, improve efficiency and continuity of services, and prevent inappropriate use of services;
- Monitor health and welfare of the child/youth;
- May provide crisis intervention;
- May facilitate Medicaid certification and enrollment of potential providers identified by the family to provide demonstration project services.

Wraparound Technician may not duplicate Wraparound Facilitation or any other Grant or state plan Medicaid service. However, the Wraparound Technician functions may be provided by the same individual who provides Wraparound Facilitation services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

No limits

Service Delivery Method (*check each that applies*):

- Participant-directed as specified in Appendix E
 Provider managed

Specify whether the service may be provided by (*check each that applies*):

- Legally Responsible Person
 Relative
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community Service Agency and Community Mental Health Center

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Wraparound Technician

Provider Category:

Agency

Provider Type:

Community Service Agency and Community Mental Health Center

Provider Qualifications

License (*specify*):

None

Certificate (*specify*):

Certified by the Division of Mental Health and Addiction (DMHA).

- Agency accredited by a nationally recognized accrediting body: AAAHC, COA, URAC, CARF, ACA, JCAHO, or NCQA;
- Agency already in process of accreditation by one of aforementioned accrediting bodies plus three (3) years experience under the same agency name serving children with SED/youth with SMI;
- Agency registered with the State of Indiana as a Professional Corporation plus three (3) years experience under the same agency name serving children with SED/youth with SMI; or
- Agency that has four (4) years experience under the same agency name working with children with SED/youth with SMI.

Other Standard (*specify*):

Participation in a system of care including both a governing coalition and service delivery endorsing the values and principles of a system of care; and

Documentation that individual Wraparound Technicians meet the following standards:

Bachelor's degree in human services or related field;

- A minimum of 1 year full time, paid DMHA approved work experience in providing services to children with serious emotional disturbances and/or youth aged 18 through 20 with a serious mental illness, including assessment, care plan development, linking services, and monitoring;
- Other DMHA required training;
- Participation in child-family team meetings;
- Fingerprint based national and state criminal background screens;
- Local law enforcement screen;

- State and local Child Protective Services registry screens; and,
- Five panel drug screen or compliance with the Federal Drug-Free Workplace Act of 1988 by meeting the same requirements established for Federal grant recipients specified under 41 U.S.C. 10 Section 702(a)(1).

Verification of Provider Qualifications

Entity Responsible for Verification:
DMHA

Agency will maintain personnel records verifying standard credentials for individual Wraparound Technicians.

Frequency of Verification:

Initially and at least every three years, Community Mental Health Centers and accredited Community Service Agencies must submit verification of qualifications to DMHA.

Initially and at least every two years, non-accredited Community Service Agencies must submit verification of qualifications to DMHA.

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

Not applicable - Case management is not furnished as a distinct activity to waiver participants.

Applicable - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

As a waiver service defined in Appendix C-3. *Do not complete item C-1-c.*

As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option). *Complete item C-1-c.*

As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management). *Complete item C-1-c.*

As an administrative activity. *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

	<input type="button" value="▲"/> <input type="button" value="▼"/>
--	--

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (*select one*):

No. Criminal history and/or background investigations are not required.

Yes. Criminal history and/or background investigations are required.

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

- a) A criminal background investigation is required for all PRTF Waiver providers except non-medical transportation providers who are the custodial parent, foster parent or legal (court appointed) guardian of the participant.
- b) Fingerprint based national and state criminal background investigations and local law enforcement screen are required, which includes local reports. Individuals and agencies are responsible for obtaining the investigations by utilizing the Indiana State Police website.
- c) All individual providers and non-accredited agencies must provide mandatory investigations to DMHA at the time of DMHA's initial provider approval and must provide updated investigations to DMHA at least every two years. Accredited agencies are required to maintain investigations in personnel files which are subject to DMHA inspection.

b. Abuse Registry Screening. Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

- No. The State does not conduct abuse registry screening.**
- Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

- a) The Indiana Department of Child Services maintains the abuse registry.
- b) A child abuse registry screening is required for all providers except non-medical transportation providers who are the custodial parents, foster parents or legal (court appointed) guardians.
- c) All individual providers and non-accredited, non-licensed agencies must provide mandatory abuse registry screenings to DMHA at the time of DMHA's initial provider approval and must provide updated investigations to DMHA at least every two years. Accredited agencies are required to maintain investigations in personnel files which are subject to DMHA inspection.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

- No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

- No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of *extraordinary care* by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.

Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

- The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

Non-Medical Transportation Services may be provided by a custodial parent, foster parent, or legal guardian if the Treatment Team determines that no other providers or resources are available for this service. When custodial parents/foster parent/legal guardians are utilized for Non-Medical Transportation, that individual must:

be approved by DMHA as a PRTF Waiver provider;
be selected by the family/child to provide the service; and
maintain the qualifications required for this service.

All Non-Medical Transportation Service provided by a custodial parent, foster parent or legal guardian must be documented by date, time, duration, purpose and the documentation must be submitted to the Wraparound Facilitator. The Wraparound Facilitator and/or Wraparound Technician verifies monthly reports submitted against the approved Non-Medical Transportation amount listed in the Notice of Action.

Respite Services may be provided by any relative related by blood, marriage, or adoption who is not the legal guardian and who does not live in the home with the child. Respite providers who are relatives must meet the following:

- Approved by DMHA as a PRTF Waiver provider;
- Selected by the family/child to provide the service; and
- Maintain the qualifications required for Respite service.

Respite Care may not be provided by parents for a participant who is a minor child, or by any relative who is the primary caregiver of the participant.

When relatives provide Respite Services, the Wraparound Technician will verify that the services were provided by making an unannounced visit to the respite site during the time the respite service is scheduled.

- Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

Other policy.

Specify:

- f. Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Note: All eligible Medicaid providers enrolled on the CA-PRTF Grant as of September 30, 2012 are approved to automatically transition to the PRTF Waiver on October 1, 2012 to ensure continuity of services through the transition from the Grant to the Waiver.

Indiana provides for continuous, open enrollment of waiver service providers by posting the certification applications and service enrollment information/linkages on the FSSA/DMHA website (<http://myshare.in.gov/FSSA/dmha/caprtf/FamilyConsumers>).

Once completed certification packets are received by DMHA, they will be processed within 30 working days.

DMHA is dedicated to the development of effective intensive community based services for children with that level of need. One of the DMHA PRTF Waiver Team staff focuses on workforce development for waiver services. This individual focuses on recruitment, certification, timely enrollment of providers by the Medicaid Fiscal Contractor, and retention of effective PRTF Waiver providers. Information is posted on the FSSA/DMHA website. Informational meetings are held locally to recruit and assist potential providers in becoming certified and enrolled.

Under the prior existing CA-PRTF Grant, Community Mental Health Centers, advocacy agencies, professional organizations, parents, previous SED Waiver providers, and other child and social service providers were notified of procedures to become a CA-PRTF Grant provider. Under the PRTF Waiver, local Wraparound Facilitators and Wraparound Facilitation Technicians are trained to recruit local providers to become waiver providers, especially agencies or individuals identified by the child/family as potential service providers.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

i. Sub-Assurances:

- a. Sub-Assurance:** *The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.*

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of licensed, certified or accredited agencies meeting waiver standards prior to approval and enrollment as a Waiver service provider.

Numerator: Total number of approved providers with documentation meeting eligibility requirements. Denominator: Total number of licensed/certified/accredited providers approved.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of licensed/certified/accredited agency providers recertified timely. Numerator: Total number of licensed/certified/accredited agencies with timely updated recertification. Denominator: Total number of licensed/certified/accredited approved providers due for recertification.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify:	

Per frequency
schedule set out in
C-3 for each
Provider Validation

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:
 Number and percent of licensed/certified/accredited agency providers continuing to meet waiver recertification requirements. Numerator: Total number of licensed/certified/accredited agencies that continue to meet requirements for recertification. Denominator: Total number of licensed/certified/accredited approved providers due for recertification.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified

		Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: Per frequency schedule set out in C-3 for each Provider Validation	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

b. Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

**Performance Measure:
Number and percent of non-licensed/non-certified/non-accredited agency providers and individual providers meeting waiver standards prior to approval**

and enrollment as Waiver service providers. Numerator: Total number of approved providers with documentation of eligibility. Denominator: Total number of non-licensed/non-certified/non-accredited agency and individual providers approved.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="text"/>	
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:
Number and percent of non-licensed/non-certified/non-accredited agency providers and individual providers continuing to meet waiver recertification requirements
Numerator: Total number of approved providers that continue to meet requirements. **Denominator:** Total number of non-licensed/non-certified/non-accredited agency providers and individual providers due for recertification.

Data Source (Select one):
Record reviews, off-site
 If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify:	

At least every 2 years

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

Number and percent of non-licensed/non-certified/non-accredited agency providers and individual providers re-certified timely. Numerator: Total number of agency providers and individual providers with timely updated recertification. Denominator: Total number of non-licensed/non-certified/non-accredited approved agency providers and individual providers due for recertification.

Data Source (Select one):

Record reviews, off-site
 If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:

	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>
	<input checked="" type="checkbox"/> Other Specify: At least every two years	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>

- c. **Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.**

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of PRTE Waiver providers meeting ongoing DMHA training requirements. Numerator: Number meeting ongoing DMHA training requirements. Denominator: Total number of providers reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Training sessions

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 5%
<input checked="" type="checkbox"/> Other Specify: Contracted Agency	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: Contracted Agency	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

DMHA writes a recommendation for correction along with the method and timeline by which the provider must confirm the compliance for all identified problems. The information is documented on a Provider Review Form which is kept in providers' files. Providers must correct the identified deficiency within the established timeline. If the deficiency is not corrected within the established timeline, DMHA will take the necessary steps to decertify the provider from participation in the PRTF Waiver.

In the instance where the health or welfare of a participant is jeopardized, inappropriate billing, or fraud or criminal activity is involved, the DMHA may, in accordance with 405 IAC 1-1-6d (Provider Sanctions) issue sanctions up to and including decertification.

If the provider is to be decertified, the Wraparound Facilitator will offer participants/families served by the decertified provider a choice of other eligible providers in the area to assure continuity of services. If there are no eligible providers in the area, DMHA will work with the Wraparound Facilitator to find a provider as soon as possible.

- ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party(check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

- No

Yes

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

- Not applicable-** The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- Applicable -** The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

- Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

- Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

- Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

- Other Type of Limit.** The State employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Child and Family Plan of Care

- a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (*select each that applies*):

- Registered nurse, licensed to practice in the State**
 Licensed practical or vocational nurse, acting within the scope of practice under State law
 Licensed physician (M.D. or D.O)
 Case Manager (qualifications specified in Appendix C-1/C-3)
 Case Manager (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

- Social Worker.**

Specify qualifications:

- Other**

Specify the individuals and their qualifications:

The Wraparound Facilitator has the responsibility for the development of the Child and Family Plan of Care. The qualifications are addressed in Appendix C-1/C-3 for Wraparound Facilitation.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

- b. **Service Plan Development Safeguards.** *Select one:*

- Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
 Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Language contained in the prior existing CA-PRTF Grant Statement for Freedom of Choice ensured that the participant/parent/guardian was fully informed of the services available in the PRTF setting and the feasible alternatives under the CA-PRTF demonstration project. Under the PRTF Waiver, the participant/parent/guardian continues to make an informed, voluntary choice. If a participant/parent/guardian chooses the Wraparound Facilitation agency to provide other PRTF Waiver services, the Wraparound Facilitator (WF) must disclose any potential conflicts of interest including his/her employment by the agency that is also enrolled to provide PRTF Waiver services in addition to Wraparound Facilitation and Wraparound Technician services.

The Wraparound Facilitator cannot provide any direct PRTF Waiver services other than Wraparound Facilitation and Wraparound Technician. This process is directly monitored by the DMHA through the plan of care review process. The Wraparound Facilitator cooperates fully with the participant/parent/guardian's right to change PRTF Waiver services providers at any time. This includes the option for the participant/parent/guardian to choose a different entity or individual to develop the plan of care. The Wraparound Facilitator cooperates with all federal and state oversight inquiries and requests related to health and welfare of PRTF Waiver participants. Wraparound Facilitators are required to give PRTF Waiver participants/parents/guardians information about their grievance/complaint options and access to the DMHA

website at (<http://myshare.in.gov/FSSA/dmha/caprtf/FamilyConsumers> (refer to Appendix F-3-c).

Participants/parents/guardians receiving PRTF Waiver services receive a written document from DMHA that explains their rights to exercise freedom of choice of providers and the required content of the Plan of Care: CANS Assessment which includes assessment of risks, crisis plan, objectives and services related to needs and strengths identified in CANS, frequency and duration of services. A listing of approved and enrolled PRTF Waiver service providers is available at www.indianamedicaid.com. Additional information is available from a designated DMHA PRTF Waiver Staff Member.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

- c. Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

All PRTF Waiver services will adhere to the wraparound model of service delivery. Engagement and involvement of the family in the service plan development is fundamental to the definition of Wraparound Facilitation and to the Child and Family Wraparound Team paradigm. Wraparound Facilitation by definition is a variety of specific tasks and activities designed to engage the family in the planning process that follows a series of steps and is provided through a child and family wraparound team. Prior to meeting with the Child and Family team, the Wraparound Facilitator prepares the child and family for the team meeting by discussing the team process, explaining the meaning of wraparound services, assisting the child and family in identification of strengths, beliefs, and traditions that make the family unique, assisting the child/family in identifying who should be on the team (including friends and other advocates that are not providing services), and selecting a peer mentor to support the child/family if they so choose.

The wraparound team is responsible to assure that the participant's needs and the entities responsible for addressing them are identified in a written Plan of Care. The individual who facilitates and supervises this process is the Wraparound Facilitator. Children/youth who participate in the PRTF Waiver must receive Wraparound Facilitation.

In the wraparound process, the family decides who will be part of their team. No Child and Family Team meeting is held without the family. The plan of care is developed within the Child and Family Team process.

Assurance that the family is being appropriately supported and has the authority to determine who will be involved in the process is evaluated through the use of the "Wraparound Fidelity Index" described below.

The Wraparound Fidelity Index 4.0 (WFI-4) is a set of four interviews that measures the nature of the wraparound process that an individual family receives. The WFI-4 is completed through brief, confidential telephone or face-to-face interviews with four types of respondents: caregivers, youth (11 years of age or older), wraparound facilitators, and team members. It is important to gain the unique perspectives of all these informants to understand fully how wraparound is being implemented. A demographic form is also part of the WFI-4 battery. The WFI-4 interviews are organized by the four phases of the wrap-around process (Engagement and Team Preparation, Initial Planning, Implementation, and Transition as described in Appendix D-1-d). In addition, the 40 items of the WFI interview are keyed to the 10 principles of the wraparound process, with four items dedicated to each principle. In this way, the WFI-4 interviews are intended to assess both conformance to the wraparound practice model as well as adherence to the principles of wraparound in service delivery. The State is considering implementation of the Wraparound-EZ which is a self report version of the same fidelity tool.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

- d. Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and

other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

a.) Development, Participation and Timing of the Plan:

Note: All initial Plans of Care were developed, submitted and approved by DMHA under the prior existing CA-PRTF Grant program. To ensure timely continuation of services through the transition to the PRTF Waiver, all approved Plans of Care in effect September 30, 2012 will transition to the new PRTF Waiver October 1, 2012.

The participant-centered PRTF Waiver Plan of Care (POC) continues to be developed, implemented and monitored through the Child and Family Wraparound Team. Although the Wraparound Facilitator (WF) has responsibility for writing the POC, it is developed and finalized with the child and family and others in the Child and Family Team.

The POC development begins with the Child and Adolescent Needs and Strength (CANS) assessment which is completed by a certified CANS user with the child and family during the level of care (LOC) determination process. The CANS assessment uses information from other assessments, recent services and other child service agencies (child welfare, juvenile justice or education) to identify needs and strengths of the family which is the foundation for the POC. The Crisis Intervention Plan is the section of the POC that addresses identified risks, safety concerns or behavior issues.

The POC includes Wraparound Facilitation and any other services needed to engage the child and family or meet a participant's needs. DMHA determines eligibility for the PRTF Waiver POC services within 5 business days of receipt of the POC.

b.), c.), d.) and f.)

Engagement is Phase One of the wraparound process. The Wraparound Facilitator educates the child and family about the team process and PRTF Waiver services. The Child/Family Team includes the Wraparound Facilitator, the participant/family/guardian and grant providers chosen by the family. Team membership may vary over time. Friends, educators, providers, informal caregivers, probation officer, child protective services family case manager, therapist, clergy, and/or anyone else requested by the family may also be on the Team. The Wraparound Facilitator assists the family with identifying Child/Family Team members and holds a team meeting. Under the prior existing CA-PRTF Grant, the Wraparound Facilitator was required to hold a team meeting within 45 days of the participant's Grant approval.

Plan development is Phase Two of wraparound process. The Child/Family Team uses the CANS to assist the family in identifying and prioritizing needs to be addressed. The plan of care is expanded to include needs identified by the Child/Family Team. The plan of care is submitted to DMHA for approval every time a change is made by the Team.

Wraparound Facilitation is a strategy to organize and coordinate the design and delivery of all services. The Child/Family Team is assembled by a Wraparound Facilitator for a specific child and family to develop a plan for coordinating efforts and resources that results in a unified intervention plan to meet the needs of the child. These services may be diverse and cross a number of life-domains including family support, behavior management, therapy, school related services, habilitation, medical services, crisis services, and independent and interpersonal skills development.

The two primary forms of assessment are the CANS and child/family interviews. The Child/Family Team reviews the CANS to identify the child's strengths and needs upon which all services are based. Prior to and during this discussion with the Team, the child/family/guardian are provided feedback regarding the strengths and needs identified on the CANS; summary of the goals, objectives, preferences that have been identified by the child/family/guardian; and the array of services that are available for the child/family/guardian. Included is information regarding the child's and caretaker's health status. From this discussion the child/family/guardian and the other Team members reach agreement regarding the Plan of Care. If the child has entered a short-term stay in a PRTF, the POC may address transition back to the community with waiver and educational (through IDEA) services in place to effectively support the child and family. For children residing in the community, the plan focuses on stabilization, safety, improving symptoms and functioning, and building resilience or capacities of child and family.

The POC is effective for one year from the initial approval date (which was determined under the prior existing CA-PRTF Grant) and may be updated during the year by the Child/Family Team to address changing needs. In addition to monthly Child/Family Team meetings to monitor the plan's implementation and progress, a CANS Reassessment is completed as necessary but not more than 6 months after the initial CANS to more formally identify progress and areas of changing need. This reassessment is facilitated by the WF with the child and family, informed by the Team. The semi-annual CANS reassessment may result in a modification to the POC. A revised POC is required

annually. This follows a required re-determination for PRTF level of care using the CANS reassessment. The CANS reassessment is available to celebrate successes, identify ongoing or new needs and modify the intervention plan.

The PRTF Waiver POC follows a prescribed format that addresses needs (from the CANS) with specific objectives and services. The family's desired outcomes (objectives) are included in the POC. Frequency and duration of the waiver services are identified. The family chooses waiver providers from a menu of available local approved/enrolled waiver providers. These providers are identified on the POC. The menu of PRTF Waiver services and the list of enrolled waiver providers are shared by the WF and are posted on the Indiana Medicaid website at www.indianamedicaid.com. The POC process is participant centered through linkage of services to behavioral and physical health needs of the child, as well as the child and family strengths, incorporation of the child and family's desired outcomes, and providing choice of providers.

A Crisis Plan is required for each participant in PRTF Waiver services. Discussion about a Crisis Plan begins with the CANS assessment as emergent needs and risks for the child and others are identified during the assessment. In the PRTF Level of Care document, the qualified Level of Care evaluator signs a statement that the child can be safely served through intensive community based services. Appropriate clinical interventions are initiated at this time through the usual service system to address emergent needs. As part of the Phases One and Two of the wraparound process, a formal Crisis Plan is developed with the child and family. Potential crises or risk situations are discussed; effective past interventions are identified and listed as strategies. Resources for the child and family are identified. Specific PRTF Waiver services may be planned to build coping skills, defuse or provide support during crises. Other community resources and supports are also identified and included in the Crisis Plan. Seclusion and restraint are not allowed interventions. If an unauthorized seclusion, restraint or restrictive intervention is used, an incident report to DMHA is required. This automatically triggers a review of the Crisis Plan and POC and re-evaluation of the ability to safely serve the participant through intensive community based services.

e.) The Wraparound Facilitator is responsible for the coordination of services and facilitates participant access to non-waiver services when needed. The Wraparound Facilitator is aware of other formal and informal supports and services through the Child/Family Team process. Other expected Medicaid services are noted on the plan. The child may be using some Medicaid State Plan services. If there is a history of Medicaid claims, this information is used to estimate continued use of other Medicaid services if still appropriate to address the child's needs. These may include pharmacy services, other behavioral health services, health and dental care. If a child has an IEP or educational needs, how these will be addressed through school interventions as required by IDEA or an IEP is documented. Coordination with educational services related to a child's behavioral health needs is essential to good outcomes. Consistency and coordination with any other involved child service system (child welfare or juvenile court) is also addressed. The primary mechanism for coordination between multiple service providers is through inclusion of representatives from the other providers on the Wraparound Team (education, probation, child welfare, primary care, therapists.) When these other providers are unable to actively participate in team meetings, the Wraparound Facilitator and/or Wraparound Technician maintains contact (at whatever frequency is indicated – daily, weekly, monthly, quarterly – based on the POC) with these other systems in order to engage them in the Child and Family Team process, enhance communication, and link service plans.

The PRTF Waiver Plans of Care are submitted to DMHA by the WF through an FSSA electronic waiver management system (INsite). DMHA reviews and approves or requests modification of the POC within 5 business days. WF addresses concerns, and if needed, submits a revised POC within another 5 business days. DMHA reviews the revised POC within 5 business days. Approved POCs become the prior authorization for PRTF Waiver services. The FSSA electronic management system communicates with the OMPP Medicaid Fiscal Agent contractor which processes the Medicaid and PRTF Waiver claims. A DMHA PRTF Waiver staff member will be dedicated to monitoring this process and providing technical assistance to WF to ensure timeliness and appropriate plans.

g.) Phase Three of Wraparound involves implementation, monitoring services and outcomes, and modification of the POC as needed. The POC specifies who is responsible for each intervention or service and who is responsible for on-going monitoring of the plan. The Wraparound Facilitator is ultimately responsible for all plan development, implementation, and monitoring, including knowledge of when the participant and/or family needs or preferences change.

Modifications to the POC are made as needed. Changes in the POC may be made based on the participant/family/guardian's request for a change in one or more PRTF Waiver services and/or service providers. As stated above, the POC must be updated at least annually in conjunction with a re-determination of eligibility for PRTF Waiver services.

Phase Four (final phase) of Wraparound is the Transition Phase. This phase begins when the Child/Family Team

agrees that many needs have been addressed and the participant/family can transition out of PRTF Waiver services. The Wraparound Facilitator helps the Child/Family Team develop a transition plan for the participant/family. This plan includes any remaining needs to be addressed and strengths of the participant/family and the Team identifies resources that will continue to be available to the participant/family after grant services have ended.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

- e. Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

During the PRTF Waiver Level of Care determination process, risks are assessed using the Child and Adolescent Needs and Strength (CANS) assessment tool. Appropriate clinical interventions are initiated at this time through the usual service system to address emergent needs. Early in the wraparound process, during engagement and intervention planning, a formal Crisis Plan is developed with the child and family. Potential crises are identified and documented during the service development process. Strategies to which the child has responded well in the past are noted as well as action steps to prevent or mitigate the crisis. Action steps also include the responsible party for the particular action. Specific PRTF Waiver services may be planned to build coping skills, defuse or provide support during crises. Other community resources and supports are also identified and included in the Crisis Plan. Indicators of emerging risks and/or impending crisis and reduced levels of risk are identified in the plan. The emphasis is on identifying and defusing situations, ensuring safety, and debriefing the situation to maximize the learning opportunity for the child and family.

Telephone support to the family and/or child may be arranged. Home based providers may also provide support, coach caretakers, help child become calm or intervene to defuse the crisis. Emergency/crisis respite care is frequently utilized for crisis situations in the home. Several appropriate providers are identified in case one is unable to provide services during the crisis.

The Crisis Plan is an integral part of the overall Plan of Care. Effectiveness must be routinely monitored in the Child and Family Team meetings. The cultural and personal preferences of the child and family are identified and incorporated into the plan of care.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

- f. Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Participant/family/guardian is informed in writing of the choice of eligible PRTF Waiver providers for each waiver service identified on the Plan of Care.

As a service is identified, a list is generated in randomized sequence of local service providers and is presented to the participant/family/guardian by the WF. A listing of approved/enrolled PRTF Waiver providers is also posted on the Indiana Medicaid website at www.indianamedicaid.com. Participants and family members may interview potential service providers and make their own choice. If the participant or parent/guardian chooses a provider that is not approved, the DMHA will assist in approving any eligible, willing provider and enrolling them as a provider of PRTF Waiver services.

During Team Meetings, the WF must ensure the participant/family/guardian is aware of the option to change eligible providers. This includes the option to change WFs. The participant/family/guardian can request an updated PRTF Waiver provider list at any time to select a different waiver provider(s).

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

- g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The Indiana Office of Medicaid Policy and Planning (OMPP) will retain 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 will review each service plan submitted to ensure that the plan addresses all pertinent issues identified through the assessment, including physical health issues.

The OMPP will review and approve the policies, processes and standards for developing and approving PRTF Waiver Plans of Care. Based on the terms and conditions of this PRTF Waiver, the Medicaid agency may review and overrule the approval or disapproval of any specific Plan of Care acted upon by the DMHA serving in its capacity as the operating agency for the PRTF Waiver program.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

- h. Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- Every three months or more frequently when necessary
- Every six months or more frequently when necessary
- Every twelve months or more frequently when necessary
- Other schedule

Specify the other schedule:

- i. Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following (*check each that applies*):

- Medicaid agency
- Operating agency
- Case manager
- Other

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

- a. Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

a. Service Plan Implementation and Monitoring.

(a) The Wraparound Facilitator (WF) with the help of the Wraparound Technician (WT) (if available and needed) is responsible to monitor and oversee the implementation of the service plan. The WF will facilitate at least one monthly Child and Family Team. PRTF Waiver providers become members of the Team in addition to other members identified by the family. In each team meeting, current concerns of the child and family, progress, implementation of the POC and Crisis Plan are reviewed. On a weekly basis or, more often as needed, the WF

and/or WT are in contact with the family through home or community based visits or by phone to monitor progress and implementation of the POC and to address immediate needs. The WF and WT also remain in frequent contact with other PRTF Waiver service providers to coordinate care, monitor progress and implementation of the POC. During each of these contacts, monitoring includes assessment of the service plan implementation as well as the welfare and safety of the child.

(b & c) The monitoring and follow-up methods used by the WF and WT include conversations with the parent and child and providers to monitor the frequency and effectiveness of the services through monthly team meetings and weekly phone and face-to-face contacts. Are the services being provided as planned? Are the services meeting the needs of the child and family to care for the child? Verbal inquiry and face-to-face assessment of the child's health and wellbeing are a part of each team meeting, phone conversation and interim contacts. Implementation and effectiveness of the crisis plan is reviewed routinely in monthly team meetings. Are the backup plans adequate? The WF or WT assists the family and child with gaining access to non waiver services and assures that families are aware of available community-based services and other resources such as Medicaid State Plan services, Vocational Rehabilitation programs, educational, and public assistance programs.

The contracted entity responsible for reviewing LOC, also reviews the POC, services delivery, clinical treatment, outcomes and crisis plan each time a request for a POC is submitted for a participant. If problems are indicated during the review, the POC is denied and the Wraparound Facilitator is informed of the denial and asked to resubmit a corrected POC that meets Service Plan standards. DMHA is notified of POCs that are denied.

Every POC reviewed by the contracted entity responsible for monitoring LOC is documented (date of review and outcome of review). All POCs resulting in a Denial are sent to DMHA and a copy is placed in the case file. All case file reviews are maintained onsite at DMHA and are available for review by DMHA and OMPP. Processes for gathering QIS information through site and case reviews for purposes of monitoring compliance and outcomes also provides DMHA and OMPP feedback on the following: LOC, Service Plan development and comprehensiveness, Re-evaluations, and participant freedom of choice.

b. Monitoring Safeguards. *Select one:*

- Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Wraparound Facilitators and Wraparound Technicians are usually employed by the same entity or may be the same person in some communities. This should not result in a conflict as the Wraparound Technician does the day-to-day monitoring on the Wraparound Facilitator's behalf. Individuals performing Wraparound Technician duties have the responsibility to monitor service plan implementation and report to the Wraparound Facilitator while the Wraparound Facilitator has the final responsibility to engage the child/family; use the CANS assessment to develop care plans; form the Child and Family Wraparound Team; develop and report an appropriate crisis plan and overall Plan of Care with the Team; monitor the overall wellbeing and health of the child; and, implementation of the Plan.

In situations where the Wraparound Facilitator and/or Wraparound Technician is employed by the same agency that is chosen by the participant/family/guardian to provide another PRTF Waiver service, the WF will disclose any potential conflicts of interest including his/her employment by the agency that has been chosen to provide other PRTF Waiver services. The Wraparound Facilitator and Wraparound Technician may not directly provide other PRTF Waiver services.

The Wraparound Facilitator cooperates fully with the participant's/family's/guardian's right to change PRTF Waiver services providers at any time. Families are informed in writing that they have a choice of providers and are given a list of providers in random order from which to choose. Families may recommend providers and if eligible, the Division of Mental Health and Addiction will assist with the certification and enrollment of the particular provider. The Wraparound Facilitator and Wraparound Technician will cooperate with all federal and state oversight inquiries or requests related to health and welfare of the participant.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

i. Sub-Assurances:

- a. Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.**

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of approved plans of care that address personal goals.

Numerator: Total number of plans of care addressing goals. Denominator: Total number of approved plans of care.

Data Source (Select one):

Other

If 'Other' is selected, specify:

INsite database

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>

	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of approved crisis plans that comprehensively address health and safety risk factors. Numerator: Total number of comprehensive crisis plans. Denominator: Total number of approved crisis plans.

Data Source (Select one):

Other

If 'Other' is selected, specify:

INsite data base

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =

<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

b. Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how

themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of participants with assessment and plan of care development in compliance with wraparound service delivery policies and procedures. Numerator: Total number in compliance. Denominator: Total number sampled.

Data Source (Select one):

Other

If 'Other' is selected, specify:

D-a.i.b. PM#1a Record Reviews, on-site

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% Confidence Level, 5% Confidence Interval.
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Source (Select one):

Other

If 'Other' is selected, specify:

D-a.i.b. PM#1b Wraparound Fidelity Index

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% Confidence Level, 5% Confidence Interval
<input checked="" type="checkbox"/> Other Specify: Contract Agency	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: 100% of all completed WFI Interviews are reviewed
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: Contract Agency (For Data Source #1b)	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	<input type="checkbox"/> Other Specify: <input type="text"/>

c. *Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.*

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of participants whose plans were reviewed, and revised as warranted, on or before annual review date. Numerator: Total number of participants whose plans were updated annually. Denominator: Total number of Waiver participants due for annual plan of care.

Data Source (Select one):

Other

If 'Other' is selected, specify:

INsite database

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>

	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- d. **Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.**

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of participants with services delivered in accordance with the plan of care. Numerator: Total number of participants with services delivered

in accordance with the plan of care. Denominator: Total number of participants sampled.

Data Source (Select one):

Other

If 'Other' is selected, specify:

INsite Data Base

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% Confidence Level, 5% Confidence Interval
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:
Number and percent of participants satisfied with services offered. Numerator:
Total number of satisfied participants. Denominator: Total number sampled.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Youth Satisfaction Survey - Families (YSSF)

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: 33% sampled with 100% review of all YSSF Interviews
	<input type="checkbox"/> Other Specify:	

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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

- e. *Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.*

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of participants who signed a freedom of choice statement indicating they were afforded choice between waiver services and institutional services. Numerator: Total number of participants with a signed freedom of choice form. Denominator: Total number of participants .

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review

<input type="checkbox"/> State Medicaid Agency		
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of participants who signed a Choice of Service Statement indicating they were afforded choice of eligible services. Numerator: Total

**number of participants with a signed Choice of Service Statement. Denominator:
Total number of participants sampled.**

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% Confidence Level, 5% Confidence Interval
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other	<input checked="" type="checkbox"/> Annually

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
Specify: <input type="text"/>	
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of participants who signed a provider pick list indicating they were afforded choice of providers. Numerator: Total number of participants with a signed provider pick list. Denominator: Total number of participants.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% Confidence Level, 5% Confidence Interval.
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify:	

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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

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b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

DMHA identifies problems with service plans and addresses them on an individual basis. Remedies include additional training for Wraparound Facilitator, on-site observations, and meetings with family members or participants. All identified problems will be documented in a corrective action plan that includes means for remediation on specific problem generated by DMHA. DMHA follows-up on problems until resolution.

- ii. **Remediation Data Aggregation**

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	<input checked="" type="checkbox"/> Annually

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability (from Application Section 3, Components of the Waiver Request):

- Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested (select one):

- Yes. The State requests that this waiver be considered for Independence Plus designation.**
- No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services**E-2: Opportunities for Participant Direction (1 of 6)**

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services**E-2: Opportunities for Participant-Direction (2 of 6)**

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services**E-2: Opportunities for Participant-Direction (3 of 6)**

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services**E-2: Opportunities for Participant-Direction (4 of 6)**

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services**E-2: Opportunities for Participant-Direction (5 of 6)**

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services**E-2: Opportunities for Participant-Direction (6 of 6)**

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix F: Participant Rights**Appendix F-1: Opportunity to Request a Fair Hearing**

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice (s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

PRTF Waiver participants and their families are informed of the opportunity to request a fair hearing under 42 CFR Part 432, Subpart E through printed materials about the PRTF Waiver which are provided to DMHA on the website and distributed by the local access sites and wraparound facilitators at the time of application (under the prior CA-PRTF Grant program), and subsequent care planning and Level of Care re-determination (annually) under the PRTF Waiver. A family or participant may request a fair hearing within 30 days of receiving a Notice of Action. The Wraparound Facilitator provides the family/participant with a copy of the Notice of Action and explains their appeal rights. Additional assistance with the process is available through the Office of Hearings and Appeals.

Indiana provides official notices as outlined below:

NOTICE of ACTION: (State Form 46015-HCBS Form 5)

This is a written statement that was given to participants by the Access Site (in the case of denial of eligibility at application under the prior existing CA-PRTF Grant) or subsequently by the Wraparound Facilitator (in the case of termination or changes to waiver services) to notify each Medicaid applicant/recipient of any action that affects the individual's Medicaid waiver benefits (as per Federal regulations for the Medicaid program at 42 CFR Part 431, Subpart E). This Notice of Action form is mailed to the participant within 3 days of determination of action to be taken. An "action" includes confirmation or denial of eligibility for waiver services, termination, reduction, or increase of all or any amount of waiver services. This included previous actions taken to approve or deny new applications under the prior existing CA-PRTF Grant. The Notice of Action is a written statement sent to the waiver applicant/recipient that explains:

- The action to be taken;
- The reason(s) for the intended action(s);
- The date the action will take place;
- The specific Federal or State regulation(s) that supports or requires the action being taken. (This is mandatory for adverse actions that terminate, suspend, reduce, or deny waiver services); and
- The individual/parent/guardian's appeal rights, including notification that services will continue during the period while the participant's appeal is under consideration if the appeal was filed in a timely manner.

Notices of adverse action and the opportunity for fair hearing are kept by the local Wraparound Facilitation agency and the waiver operating agency, DMHA.

A Description of the Agency's Procedure(s) for Informing Eligible Individuals (or Their Legal Representatives) of the Feasible Alternatives Available Under the Waiver and the opportunity to request a Fair Hearing if not given the choice of home and community based services as an alternative to PRTFs:

It is the responsibility of the PRTF Waiver Services Wraparound Facilitator to inform the individual/parent/guardian of the services available in a psychiatric residential treatment facility (PRTF) setting and the array of services available to meet that individual's needs through the PRTF Waiver program as an option to PRTF services. This freedom to choose was provided in writing at the time of application and is updated through the ongoing Team meetings.

A Description of How the Parent (or Legal Representative) is Offered the Opportunity to Request a Fair Hearing Under 42-CFR Part 431, Subpart E:

The Notice of Action (State Form 46015-HCBS Form 5): Federal regulations for the Medicaid program require that each Medicaid applicant/recipient be informed of any action that affects the individual's Medicaid benefits. An "Action" may be a denial of eligibility, denial of request for a new or additional services, termination, reduction, or suspension of eligibility or any amount of covered services. This is also includes actions taken to approve or deny new applicants.

State Form 46015-HCBS Form 5 is used to notify each Medicaid waiver applicant/recipient/parent/ guardian of any action that affects the individual's Medicaid waiver benefits. An explanation regarding a waiver service recipient's appeal rights and the opportunity for a fair hearing is found on the back of the form. Part 2 "Your Right to Appeal" provides instructions and timelines for individuals regarding the procedures that are necessary in the appeal process.

Documentation of the child and family's choice between grant/waiver and PRTF services is indicated on the LOC application (for prior CA-PRTF Grant) and re-determination. This document is kept in local records and at the DMHA office. It is completed initially at the access site (community mental health center) and annually by the Wraparound Facilitator.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

- a. Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- No. This Appendix does not apply**
- Yes. The State operates an additional dispute resolution process**

- b. Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

	<input type="button" value="▲"/> <input type="button" value="▼"/>
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Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- No. This Appendix does not apply**
- Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

The Division of Mental Health and Addiction (DMHA), Indiana Family and Social Service Administration, is responsible for the operation of the complaint system.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

DMHA has a Family/Consumer Section on the website <http://myshare.in.gov/FSSA/dmha/caprtf/FamilyConsumers>. This section shares information about the Waiver and how to file a complaint. DMHA accepts complaints via email, fax, phone or walk in. If a family member or participant calls or comes to the office with a complaint, a DMHA staff member will assist them with filling out the form. Participants and families may submit complaints to DMHA for any reason or concern they feel requires attention and resolution. When a complaint is received by DMHA, it is logged and an investigation begins within 72 hours by DMHA Waiver staff.

The investigation may include announced or unannounced visits, a request of documentation, or other items deemed necessary as determined by DMHA. If there is a deficiency, DMHA determines the level of severity to warrant an Informal Adjustment, Corrective Action or Decertification. An informal adjustment is reserved for minor deficiencies. Corrective Action is more severe in nature including an indirect threat on the health or welfare of the client. If the deficiencies are extremely severe including the health or welfare of a participant is jeopardized, inappropriate billing or criminal activity is involved, the DMHA may, in accordance with 405 IAC 1-1-6d (Provider Sanctions), sanction up to and including decertification.

Once the investigation is complete a letter of findings (Informal Adjustment, Corrective Action) is submitted to the provider. Providers must correct the identified deficiency within the established timeline. If the deficiency is not corrected within the established timeline, the DMHA will pursue sanctions up to and including decertification.

The Participant is informed of the findings through a letter or via phone call from the DMHA Waiver team.

Participants who elect to file a grievance or complaint are informed that doing so is not a pre-requisite or a substitute for a Fair Hearing.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program. *Select one:*

- Yes. The State operates a Critical Event or Incident Reporting and Management Process** (*complete Items b through e*)
- No. This Appendix does not apply** (*do not complete Items b through e*)

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

- b. State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Indiana state law, Indiana Code 31-33 et al, requires reporting of suspected child abuse or neglect to the Indiana Department of Child Services. The Indiana Department of Child Services (DCS) is the single state agency responsible for administering the federal Child Abuse Prevention and Treatment Act under 42 U.S.C. 5106 et seq.

IC 31-33-5 requires any individual who has reason to believe that a child is a victim of child abuse or neglect to make a report. Staff of a medical or other public or private institution, school, facility, or agency including DMHA and its providers, are required to notify the individual in charge of the institution, school, facility, or agency who shall report or cause a report to be made to the state child protection agency. Reports are to be made immediately. Reporting may be done in person, by phone, or in writing. A report can be filed with the county office of child services or by calling 1-800-800-5556.

Indiana law further defines conditions under which a child may be determined to be “a child in need of services” (CHINS). Under IC 31-34 abuse, neglect and exploitation are defined as: the child's physical or mental health condition is seriously impaired or seriously endangered as a result of the inability, refusal, or neglect of the child's parent/guardian/ custodian to supply the child with necessary food, clothing, shelter, medical care, education, or supervision; the child's physical or mental health is seriously endangered due to injury by the act or omission of the child's parent/guardian/custodian; the child's parent/guardian/custodian allows the child to participate in an obscene performance; or the child's parent/guardian/custodian allows the child to commit a sex offense. If the child is in imminent danger, an investigation is immediately launched by the local DCS office. Time frames for investigation are determined by the DCS.

The Division of Mental Health and Addiction(DMHA) requires that all PRTF Waiver providers comply with state law and notify DCS of alleged child abuse, neglect or exploitation within 24 hours of the event.

PRTF Waiver providers are also required to report to DMHA sentinel and other critical incidents within 24 hours of the incident using an incident report form developed specifically for the CA-PRTF Grant and utilized for the PRTF Waiver.

Reportable events include:

1. A sentinel event is a serious and undesirable occurrence involving the loss of life, limb or gross motor function for a consumer or individual providing waiver services.
2. Other critical events with required reporting include:
 - a. Suicide (the act or an instance of taking one's own life voluntarily and intentionally) or suicide attempt
 - b. Seclusion (the involuntary confinement of an individual alone in a room or an area from which the individual is physically prevented from having contact with others or leaving)
 - c. Use of restraints (any physical, chemical or mechanical intervention that is used to control acute, episodic behavior that restricts the movement or function of the individual or a portion of the individual's body)
 - d. Medication errors that occur when the child is not in the home of a parent/guardian/or other legally responsible adult
 - e. Violation of rights (an act that disregards an agreement or a right) related to the PRTF Waiver.
 - f. A report to Child Protective Services.
 - g. Law Enforcement report involving a child participating in the PRTF Waiver.

- c. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

In written materials from DMHA about PRTF Waiver Services, basic information will be provided to children and families concerning protections from abuse, neglect and exploitation, how participants can notify appropriate authorities when the participant may have experienced abuse, neglect or exploitation. Youth and families will be advised of their rights and given numbers to call for assistance.

At the time the child/parent applied for participation in the CA-PRTF grant, the Wraparound Facilitator provides a list of agencies involved in protecting children and explains the role of each. They are: the Child Abuse Hotline 1-800-800 5556 (to report neglect and abuse); Missing Children (State Police) 1-800-831-8953; Child Support Bureau (to assist with the collection of child support) 1-800-840-8757; DMHA PRTF Waiver Provider Relations staff phone information and PRTF website to report complaints/incidents regarding DMHA providers and services; Family Help -Line 1-800 433-0746 (information; referral and provider locator) and the State Information Center 1-800-457-8283. This information is covered again by the Wraparound Facilitator at the time of Level of Care re-determination or when requested by the family. Specific information regarding resources and services is provided as needs are identified.

Each local (county) office of the Department of Child Services (DCS), Indiana's child protection services, provides information and education based on the needs of their own community. Examples of local training include: presentations and roundtable discussions at local schools on the role of DCS and signs of abuse or neglect; presentations to local government agencies, schools, medical staff, service providers; a visit to the hospital for every child born and follow-up meetings if necessary; annual meeting with a local Migrant Council; relationships and protocols established with schools, faith-based community leaders, law enforcement; city park programs, and other juvenile related community participants; an abuse presentation for all prisoners in one prison who are due to be released; parent support groups as well as support groups for grandparents who are parenting children; information mailed to residents in neighborhoods that are considered high risk; child abuse education events which are advertised through brochures, print; billboard and radio, etc.

- d. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

The Division of Mental Health and Addiction (DMHA) is responsible for overseeing the reporting and response to sentinel and other critical events that affect Waiver participants as described in Appendix G 1a. DMHA reviews all incident reports with 72 hours (3 business days). If the incident involves child abuse or neglect, Child Protective Services is responsible for completing an investigation within 30 days. If DMHA is responsible, the investigation will be completed within 30 days. For incident reports that require an investigation from DMHA, a letter is sent to all relevant parties after completion of the investigation, or within 45 days of receipt of the incident report. For incidents that only require an investigation by Child Protective Services, results are reported based on their policy.

The Indiana Department of Child Services (DCS) is responsible for overseeing and response to reported alleged child abuse, neglect or exploitation. DCS investigations are protected by state statute. When DCS is involved with a child receiving PRTF Waiver services, a DCS caseworker will be part of the Wraparound Team. To the extent allowed by law and in the interest of the child, abuse or neglect incidents will be included in team meeting reviews of the child/family progress and the plan of care.

Written reports for sentinel and critical incidents are required to be faxed to a secure, confidential fax within DMHA within 24 hours of the incident on an Incident Report form. Required information includes: legal name of agency (provider), local address of incident, person reporting, phone, type of program, event, report to Department of Child Services (date of incident, date of report), alleged victim, alleged perpetrator (if applicable), gender, age, role [consumer, householder, staff/volunteer, other (specify)], description of incident and incident resolution. Reports are logged into database by designated DMHA staff. Incidents are categorized to determine if follow-up is needed. For example:

SUICIDE ATTEMPT:

No follow-up Required: Attempt resulting in minimal harm. Attempt had low level of lethality, such as scratch on wrist, not requiring inpatient care.

Follow-up Required: Attempt resulting in significant harm. Attempt requiring immediate medical attention leading to inpatient admission, such as overdose requiring inpatient admission.

All Waiver incident reports are sent to the PRTF Waiver Program Director who reviews and forwards the report to the designated DMHA staff. When DMHA receives an incident report, it is logged in a database maintained by the

Waiver team and an investigation begins within 72 hours by the DMHA Waiver staff. Incident reports are received from various sources including waiver participants, families, providers, wraparound facilitators, PRTF Waiver staff and the public. The requirement and process for reporting sentinel and critical incidents to DMHA are communicated to all providers in writing before the individual is approved as a PRTF Waiver provider. Quarterly reports are made to the Children's Mental Health Advisory Board and OMPP.

The investigation includes determining what specific individuals were involved and ensuring the appropriate authorities were included, the narrative of events that took place and to assure appropriate resolutions both immediately and long term. If any problems arise with the reports or additional information is needed, the Waiver staff seeks assistance from the site coach for the Wraparound agency involved. Additional training and education is done when needed.

The "site coach" is another term used for the DMHA Quality Improvement (QI) Specialists. These are the contracted entities who review and approve LOC and POC for DMHA. Indiana has a total of four (4) Quality Improvement Specialists, each being assigned to a different region or county in the State. They complete their duties by traveling to the different areas they supervise. They do not live in the participant's homes.

All Wraparound Facilitators are assigned to a QI Specialist. Additionally, families may contact the QI Specialist assigned to their county of residence with questions or concerns. QI Specialists are responsible for ongoing review of all POC and Crisis Planning for families in their assigned counties. QI Specialists also conduct quality reviews of a sample of team meetings and case files in their assigned counties to identify areas requiring coaching, education and/or corrective action.

In the event that Child Protective Services has been contacted or a report has been made regarding allegations against a PRTF Waiver provider, the provider must notify the DMHA PRTF Waiver team within 48 hours. Failure to do so is an automatic decertification as a PRTF Waiver provider. Upon notification, DMHA will change the provider's status to Suspended. This means the provider's name will be removed from the pick list and they must stop providing PRTF Waiver services immediately.

The provider must contact the Wraparound Facilitator within 48 hours of being notified of investigation and asked to be removed from all PRTF Waiver cases the provider is currently serving. The Wraparound Facilitator will present a new pick list to the client and their family at this time.

If Child Protective Services determines substantiation of abuse or neglect, the provider will be decertified. If Child Protective Services determines the allegations are unsubstantiated, the provider must submit a new Child Protective Services Background check to the DMHA PRTF Waiver team reflecting this outcome. Once DMHA receives the new background check, the suspension will be removed and the provider's status will be reinstated to Active.

The Indiana Department of Child Services (DCS) is responsible for review and response to reports of alleged abuse, neglect or child exploitation. DCS records aggregate data through the Indiana Child Welfare Information System (ICWIS) regarding reported abuse or neglect of all children in Indiana. ICWIS provides Indiana with child protection services intake, case management, and administrative management capabilities. ICWIS contains risk, needs, strength, assessment tools, and a central statewide client index. This system promotes consistency of policy across the state in assessing risk for abused/neglected children. Aggregate data is utilized in the on-going management of DCS operations. DCS has guidelines and criteria to determine appropriate timeframes for investigation of reports of alleged abuse or neglect. The Indiana Senate Bill 529 of 2005, authorized more staff, established a caseload maximum, called for new worker standards, and improved training of workers.

Although DCS oversees its own activity, responds to trends and patterns, and works with local PRTF Waiver service providers on individual cases, the state DMHA requires PRTF Waiver providers to send DMHA written reports that a DCS report happened.

- e. Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

DMHA is responsible for overseeing the reporting of and response to sentinel events and critical incidents that affect waiver participants, and establishing the process of oversight as described in G-1-d. OMPP is responsible for reviewing and approving the oversight plan and participating in the Children's Mental Health Advisory Board which will review aggregate reports quarterly. Data will be monitored for trends and patterns to avert re-occurrence, utilizing incident reports within the PRTF Waiver program to identify issues for waiver participants and providers at

a system-wide level.

The Indiana Department of Child Services (DCS) is responsible for overseeing the reporting of and response to reports of alleged child abuse, neglect and exploitation. DCS records aggregate data through the Indiana Child Welfare Information System (ICWIS) regarding reported abuse or neglect of all children in Indiana. ICWIS provides Indiana with child protection services intake, case management, and administrative management capabilities. ICWIS contains risk, needs, strength, assessment tools, and a central statewide client index. This system promotes consistency of policy across the state in assessing risk for abused/neglected children. Aggregate data is utilized in the on-going management of DCS operations. (Indiana Senate Bill 529 of 2005, authorized more staff, established a caseload maximum, called for new worker standards, and improved training of workers.)

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 2)

a. Use of Restraints or Seclusion. *(Select one):*

- The State does not permit or prohibits the use of restraints or seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints or seclusion and how this oversight is conducted and its frequency:

The Division of Mental Health and Addiction (DMHA) is responsible for monitoring the unauthorized use of restraints or seclusion for participants in the PRTF Waiver program.

Each Plan of Care includes a behavioral management/crisis plan for the child and family. Understanding the triggers for risk behaviors, deescalating situations and safety for the child and others is emphasized. Child and families assist by identifying interventions that are most helpful to them. This process is documented in the clinical record maintained by the Wraparound Facilitator and available for review by DMHA staff or designees.

To monitor the use of seclusion and restraint, DMHA will require providers to report the use of seclusion or restraint to DMHA within 24 hours as part of the incident reporting process. If service providers assert that seclusion or restraint had to be used to ensure safety of the child or others, the ability of the intensive community based services to safely manage the child in the community will be reassessed and the intervention plan updated by the Team.

- The use of restraints or seclusion is permitted during the course of the delivery of waiver services.**
Complete Items G-2-a-i and G-2-a-ii.

- i. Safeguards Concerning the Use of Restraints or Seclusion.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints or seclusion). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- ii. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints or seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 2)

b. Use of Restrictive Interventions. *(Select one):*

- The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

DMHA is responsible for monitoring the unauthorized use of Restrictive Interventions. The ability of the intensive community based services to safely manage the child in the community will be reassessed and the intervention plan updated by the Team if restrictive interventions are implemented. DMHA will require providers to report the use of interventions to DMHA within 24 hours as part of the incident reporting process.

- The use of restrictive interventions is permitted during the course of the delivery of waiver services**
Complete Items G-2-b-i and G-2-b-ii.

- i. Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

- ii. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- No. This Appendix is not applicable** *(do not complete the remaining items)*
 Yes. This Appendix applies *(complete the remaining items)*

b. Medication Management and Follow-Up

- i. Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Usually the child will be living with a caretaker in a community based setting. Some children and families may use occasional temporary respite services in a foster home or residential facility licensed for that purpose. When the child is residing at home, the caretaker and physician who is prescribing the child's medication have primary responsibility for monitoring participant medication regimens. The physician manages medication through office visits and calls. The caretaker is responsible for administering the medication as prescribed.

When the child is in respite care in a temporary out-of-home setting, medications are administered as prescribed. The Wraparound Facilitator, in cooperation with the Wraparound Technician, will also monitor the medication regimen through discussions in the monthly Child and Family Team meetings, home visits, if indicated, and periodic coordination with the child's psychiatrist and pediatrician or family doctor. Medication management and monitoring will be provided in accordance with 440 IAC 9-2-12.

- ii. Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

The Medicaid Mental Health Quality Advisory Committee (MHQAC) is a statutorily required advisory committee that meets quarterly. The MHQAC implements quality edits to reduce inappropriate prescribing practices, using a prior authorization procedure with utilization edits. They provide clinical guidance on the management of the mental health benefit for Medicaid. The MHQAC regularly conducts clinical reviews of utilization of mental health drugs and utilization edits and policy are updated accordingly. This information is issued in provider bulletins. The MHQAC also provides education to providers who may be identified as prescribing outside of the clinical guidelines. The program is available to practitioners who are prescribing medications that are covered by Medicaid for children receiving PRTF Waiver services.

If the Wraparound Facilitator or Wraparound Technician identify a potential risk to the child based on medication management and are unable to resolve the issue through consultation with the child's physician (s), an Incident Report will be filed with DMHA.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- Not applicable.** *(do not complete the remaining items)*
- Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

- ii. State Policy.** Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Respite Care providers may administer medications to PRTF Waiver participants. Foster care and emergency shelters may be certified to provide respite under the PRTF Waiver. These facilities are licensed through the Division of Child Services (DCS). The state regulations for facility administration of medications are at: 465 IAC 2-10-70 through 74 and 465 IAC 2-13-72 through 74 and include the giving or application of medication, dietary supplements, special variations of diet, and carrying out medical procedures; storage of medication; disposal of medication; prn instructions; recording of administration of medications; and special procedures for psychotropic medications.

iii. Medication Error Reporting. *Select one of the following:*

- Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
Complete the following three items:

(a) Specify State agency (or agencies) to which errors are reported:

Indiana statute and administrative code do not require recording of or reporting of medication errors to a State Agency. For the purposes of the PRTF Waiver, DMHA considers medication errors which occur in a waiver service location that is not the home of a parent/guardian/or other legally responsible adult, to be reportable incidents and are reported to DMHA on an Incident Report form.

(b) Specify the types of medication errors that providers are required to *record*:

Incorrect dose, incorrect route of administration, incorrect medication, and missed medication for more than 24 hours.

(c) Specify the types of medication errors that providers must *report* to the State:

Incorrect dose, incorrect route of administration, incorrect medication, and missed medication for more than 24 hours.

- **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

- iv. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

The Indiana Division of Child Services is responsible for the licensure of emergency shelter and foster homes which may be eligible to provide respite services under the PRTF Waiver.

DMHA will monitor the administration of medication that results in a medication error. Monitoring will occur through the Incident Reporting process.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare

The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of incidents resolved according to policy. Numerator: Total number of incidents resolved according to policy. Denominator: Total number of incidents.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Incident Reports

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):

Performance Measure:

Number and percent of incidents reported within required timeframe by type of incident. Numerator: Total number of incidents reported according to policy.

Denominator: Total number of incidents reported.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Incident Reports

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of Corrective Action Plans (CAPS) associated with complaints that were implemented within prescribed time period. Numerator: Total number of CAPs associated with complaints that were implemented within prescribed time period. Denominator: Total number of CAPS associated with complaints.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Complaint Form

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach(check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify:	

--	--

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The health and welfare of grant participants are monitored at the local level through the Child and Adolescent Needs and Strenths (CANS) assessment and re-assessment, the development of the plan of care and crisis plans, monthly child/family team meetings, plan of care amendments, and weekly contact from the Wraparound Facilitator.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
DMHA investigates each incident with the specific individuals involved to determine events and appropriate interventions.

Resolutions are based on severity of incident and may involve one or more of the following:

1. Additional training for family members or providers;
2. Assistance with development of an appropriate crisis plan;
3. Additional consultation or assistance when needed;
4. Implementation of a Corrective Action Plan;and/or,
5. Decertification of the provider for substantiated abuse and/or neglect.

All events and remediation are documented on an incident report form.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party(check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QMS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I), a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the QMS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

Information regarding quality is channeled into the DMHA PRTF Waiver team through the Quality Improvement Strategy (QIS) discovery activities outlined in the Appendices of the PRTF Waiver. The sources of information; as well as the methods of collection, aggregation, and analysis are varied. Sources include: waiver participants; families; providers; wraparound facilitators; the public; the Children's Mental Health Advisory Board (which combines the previous CA-PRTF Quality Improvement (QI) Committee and CA-PRTF Advisory Board); DMHA and OMPP staff; the Medicaid fiscal agent; Medicaid Management Information System; Surveillance Utilization Review; the INsite database; advocates; other state agencies; and other state and elected officials. DMHA, the operating agency, and OMPP, the Medicaid Agency, have designed the QIS to obtain the most relevant and accurate information in the most efficient manner possible to establish baseline performance, trends, and priorities.

The PRTF Waiver Team has an established bi-weekly meeting time in which problems discovered through QIS are discussed. The team uses unstructured brainstorming techniques to encourage participation of all members, promote many ideas, and build on the ideas of others. Each team member's unique strengths and skills are recognized and judgment is suspended, creating an environment that encourages the exploration of nontraditional methods of problem solving.

The PRTF Waiver Team also examines the following criteria in terms of the quality problem:

- Number participants/families affected by an issue;
- How outcomes are affected by this problem;
- How solving the problem affects outcomes;
- Time and resources needed to remediate the problem;
- Available guidance/best practices that will assist with remediation; and,
- How the remediation affects other stakeholders.

Additionally, issues such as how the outcome will be observed/measured and the period of time that will be needed to observe changes are discussed. It is through these criteria that brainstorming ideas are evaluated.

Lower level problems that have a positive impact with few resources are done immediately by the PRTF Waiver Team. For example, a number of Wraparound Facilitators began reporting that they were having trouble accessing information in the database. It was determined that an error in the software was causing a problem for database users. The database contractor was contacted, the error was corrected, tested, and a bulletin was sent to all access sites within 24 hours regarding the resolution of the issue.

For more complex issues, the PRTF Waiver Team categorizes the issues according to the criteria listed above; however, this discussion includes a more comprehensive identification of barriers:

- Geographic location, providers, systems, resources, etc.;
- Who is responsible; and,
- What activities are needed to overcome the barriers.

These issues, along with the PRTF Waiver Team analyses and recommendations, are discussed in the DMHA/OMPP meetings and taken to the Children’s Mental Health Advisory Board for discussion and input. In some circumstances, it is necessary to form ad hoc committees of Board members to study and work toward the resolution of a system problem. In other cases, if the regulating and/or monitoring capacity of a number of state agencies contributes to a system barrier, the PRTF Waiver Team may propose a workgroup consisting of state agency staff to address and resolve the barrier. OMPP serves on the board, committees, and workgroups to assure Medicaid agency monitoring.

DMHA compiles a spreadsheet each quarter with the results of all of the QIS reviews completed for that quarter. This report is linked to the QIS measures, as outlined in the PRTF Waiver application. The quarterly QIS report is presented quarterly at the Children’s Mental Health Advisory Board, which includes representation by OMPP.

Final recommendations on priority improvements and the implementation of these improvements are based on the consensus of stakeholders and approved by the Medicaid agency. The entity responsible for the implementation depends upon the particular assurance and may involve a number of agencies, contractors and individuals. These entities are directed and monitored by DMHA and/or OMPP.

ii. System Improvement Activities

Responsible Party <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Quality Improvement Committee	<input checked="" type="checkbox"/> Annually
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Other Specify: <input type="text"/>

b. System Design Changes

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State’s targeted standards for systems improvement.

The PRTF Waiver Team is constantly reassessing its quality strategies and reviewing progress through the discovery strategies outlined in the QIS. The PRTF Waiver Team reviews, compares and analyzes new data; and provides status reports at least quarterly to the Children’s Mental Health Advisory Board. Information and commentary is shared with the Board regarding:

- Implemented strategies including measurable improvement in specific areas (or lack of improvement);
- Difference in results in different areas of the state;
- Length of time that is necessary to achieve system improvement in these areas;
- Unforeseen events;
- Reassessment of an intervention; and,
- Termination or permanent adoption of an intervention as part of operations.

Two-way communication with all stakeholders is key, occurs at any time, and takes any form necessary:

phone call, listserv, e-mail, formal bulletin, meeting, conference call, flyer, website, or any combination. DMHA has developed a SharePoint public website at <http://myshare.in.gov/FSSA/dmha/caprtf/default.aspx> to facilitate communications with all stakeholders. In addition to the assessment of system changes that occurs at the established quarterly meetings with the Children's Mental Health Advisory Board, DMHA may include the following:

- Set up ad hoc meetings;
- Visit local access sites to provide support and encourage communication of needs and challenges;
- Provide presentations by the PRTF Waiver staff to entities such as the Mental Health Advisory Committee, professional organizations, residential providers, managed care providers, etc.; and,
- Help inform and encourage on-going communication.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

Through the on-going analysis of data generated including input from participants/families, access points, providers and other stakeholders, DMHA continuously evaluates the effectiveness and relevance of the Quality Improvement Strategy. DMHA staff reviews the format of forms, tables, charts, instructions, etc. to determine if changes need to be made to obtain necessary data or to ease the use of the data collection tool(s). These may be changed at any time. DMHA evaluates the performance measures outlined in the strategy, the responsible party, the frequency, and sampling approach as information is gathered from incident reports, site visits, provider enrollment reports, INsite reports, complaints, fair hearings and fiscal reports. Changes to the strategy are the responsibility of DMHA with input from OMPP, the Children's Mental Health Advisory Board.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Providers in accordance with their service agreement must maintain for the purposes of the service agreement an accounting system of procedures and practices that conforms to Generally Accepted Accounting Principles (GAAP). Indiana does not require Waiver providers to obtain an independent audit.

The OMPP or any other legally authorized governmental entity (or their agents) may at any time during the term of the service agreement and in accordance with Indiana Administrative Regulation conduct audits for the purposes of assuring the appropriate administration and expenditure of the monies provided to the provider through this service agreement. Additionally, DMHA may at any time conduct audits for the purpose of assuring appropriate administration and delivery of services under the service agreement.

The following Program Integrity and SUR activities describe post-payment financial audits to ensure the integrity of Medicaid payments:

(Detailed information on SUR policy and procedures is available in the Indiana Medicaid Health Coverage Programs Provider Manual Chapter 13: Utilization Review at <http://provider.indianamedicaid.com/ihcp/manuals/chapter13.pdf>)

The State of Indiana employs a hybrid Program Integrity (PI) approach to oversight of the waiver programs, incorporating oversight and coordination by a dedicated waiver specialist position within the Surveillance and Utilization Review (SUR) Unit, as well as engaging the full array of technology and analytic tools available through the Fraud and Abuse Detection System (FADS) Contractor arrangements. The Office of Medicaid Policy and Planning (OMPP) has expanded its PI activities using a multi-faceted approach to SUR activity that includes provider self-audits, desk audits and on-site audits. SUR is required to complete an initial assessment of each provider type annually. Then, based on the assessment information and/or referrals, audits are completed as needed. The FADS team analyzes claims data allowing them to identify providers and/or claims that indicate aberrant billing patterns and/or other risk factors.

The PI audit process utilizes data mining, research, identification of outliers, problematic billing patterns, aberrant

providers and issues that are referred by other divisions and State agencies. In 2011, the State of Indiana formed a Benefit Integrity Team comprised of key stakeholders that meets bi-weekly to review and approve audit plans, provider communications and make policy/system recommendations to affected program areas. The SUR Unit also meets with all waiver divisions on a quarterly basis, at a minimum, and receives referrals on an ongoing basis to maintain open lines of communication and aid in understanding specific areas of concern such as policy clarification.

The SUR Waiver Specialist is a Subject Matter Expert (SME) responsible for directly coordinating with the various waiver divisions. This specialist also analyzes data to identify potential areas of program risk and identify providers that appear to be outliers warranting review. The SME may also perform desk or on-site audits and be directly involved in review of waiver providers and programs.

Throughout the entire PI process oversight is maintained by OMPP. While the FADS Contractor may be incorporated in the audit process, no audit is performed without the authorization of OMPP. OMPP's oversight of the contractor's aggregate data will be used to identify common problems to be audited, determine benchmarks and offer data to peer providers for educational purposes, when appropriate.

The SUR Unit offers education regarding key program initiatives and audit issues at waiver provider meetings to promote ongoing compliance with Federal and State guidelines, including all Indiana Health Coverage Programs (IHCP) and waiver requirements.

The following is the link to the Indiana Health Coverage Programs Provider Manual. (The link noted above is direct to Chapter 13 covering Utilization Review.)

<http://provider.indianamedicaid.com/general-provider-services/manuals.aspx>

Under the provisions of the Single Audit Act as amended by the Single Audit Act Amendments of 1996, the State of Indiana utilizes the Indiana State Board of Accounts (SBOA) to conduct the independent audit of state agencies, including the Office of Medicaid Policy and Planning. OMPP routinely monitors audit resolution and provides annual status updates to SBOA.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability

State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

I.1. Number and percent of claims paid during the review period according to the published service rate. Numerator: Number of claims paid during the review period according to the published service rate. Denominator: Number of claims submitted during the review period.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Medicaid Management Information System Claims Data

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: Medicaid Fiscal Intermediary	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

I.2. Number and percent of claims paid during the review period for participants enrolled in the waiver on the date that the service was delivered. Numerator: Number of claims paid during the review period for participants enrolled in the waiver on the date that the service was delivered. Denominator: Number of claims submitted during the review period.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Medicaid Management Information System Claims Data

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: Medicaid Fiscal Intermediary	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other	<input type="checkbox"/> Annually

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
Specify: <input type="text"/>	
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

I.3. Number and percent of claims paid during the review period for services that are specified in the participant’s approved service plan. Numerator: Number of claims paid during the review period due to services having been identified on the approved service plan. Denominator: Number of claims submitted during the review period.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Medicaid Management Information System Claims Data

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: Medicaid Fiscal Intermediary	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Financial issues may be identified by the Fiscal Intermediary, SUR, a Wraparound Facilitator, the public, a provider, contractor, or by DMHA Waiver/OMPP staff.

The State assures financial accountability through a systematic approach to the review and approval of services that are specifically coded as waiver services within the waiver case management system and the MMIS. The MMIS links to the waiver case management system in order to ensure that only properly coded services, that are approved in an individual's plan of care, are processed for reimbursement to providers who are enrolled Medicaid PRTF Waiver providers, as detailed under Item I.b Methods for Remediation.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

Performance Measures I.1, I.2, and I.3: The performance measures in this Appendix will result in a percentage of errors as claims appropriately deny or adjust for valid reasons as addressed in the automated remediation process built into the MMIS.

As part of processing a claim, the MMIS performs electronic edit checks disallowing payments that do not meet criteria for billing HCB waiver services.

When the MMIS receives a claim for waiver services, it first verifies that the required fields of the standard claim form are complete and that the information included in these fields is valid. The claim is validated against member and provider files to ensure their Medicaid enrollment is active on the date the services were rendered.

Next the claims are subjected to pricing review. The claim pricing process calculates the Medicaid-allowed amount for claims based on claim type, published service rate and the member service authorization on file.

Additional system checks are in place to ensure that providers do not perform excessive or unnecessary services without prior approval. If the claim fails any of the system edits, the claim may be systematically denied, cutback or suspended.

If a provider bills more than the published service rate, the MMIS will systematically cut back payment of a claim to pay no greater than the published service rate. Claims requiring medical policy review are placed in

a suspended status by the MMIS. The Resolutions Unit (staff of the fiscal contractor) examines suspended claims and makes a decision based on approved adjudication guidelines for the date of service. The approved guidelines indicate the course of action that must be taken for each edit. These guidelines are based on the medical policies established by the OMPP. Suspended claims are reviewed within 30 days. Documentation and records are not requested from the provider during this process.

Resolutions Unit team members have the following options when processing suspended claims, depending on the edit or audit failed:

- Add or change data (only used when the claim is suspended due to data entry errors by HP)
- “Force” the claim to process by overriding the edit
- Deny the claim
- Put the claim on hold (used when there is a system problem or a pending policy decision)
- Resubmit the claim to MMIS for reprocessing

Providers receive a weekly Remittance Advice (RA) statement about the status of processed claims. The provider should review the reasons the claim was returned, make the appropriate corrections, and then resubmit the claim for processing consideration.

Providers must submit all claims for services rendered within one year of the date of service. When submitting claims beyond the one-year filing limit, the provider can submit the claim electronically or on paper with documentation for justification.

Claims reimbursement issues may be identified by a case manager, the public, a provider, contractor, or state staff. Such inquiries are directed to communicate the issue using one of the following avenues:

Customer Assistance
1-800-577-1278 or
(317) 655-3240 in the Indianapolis local area

Written Correspondence
P.O. Box 7263
Indianapolis, IN 46207-7263

or via email to the OMPP Policy Consideration Unit at Policyconsideration@fssa.in.gov

Provider Relations field consultant
(View a current territory map and contact information online at indianamedicaid.com)

For individual cases, the operating agency and/or the Medicaid Fiscal Intermediary Provider Relations staff or SUR address the problem to resolution. This may include individual provider training, recoupment of inappropriately paid monies and if warranted, placing the provider on prepayment review monitoring for future claims submissions. If there is a billing issue involving multiple providers, OMPP or the operating agency will work with the Medicaid Fiscal Intermediary and/or SUR to produce an educational clarification bulletin and/or conduct training to resolve billing issues.

If the issue is identified as a systems issue, the OMPP Data Unit will extract pertinent claims data to verify the problem and determine if correction is needed. If the problem indicates a larger systemic issue, it is referred to the Change Control Board for a systems fix.

Each party responsible for addressing individual problems maintains documentation of the issue and the individual resolution. Meeting minutes are maintained as applicable. Depending on the magnitude of the issue, it may be resolved directly with the provider or the participant.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

- No
 Yes

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability**I-2: Rates, Billing and Claims (1 of 3)**

- a. Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Rates for the prior existing CA-PRTF Grant were set by the operating agency (the Indiana Division of Mental Health and Addiction) with the assistance of the Medicaid agency-contracted CPA firm, Myers and Stauffer. The established Grant rates in effect for all services at the time of the October 1, 2012 transition to the new PRTF Waiver remain unchanged. In setting the service rates, Indiana utilized a combination of comparable behavioral health services rates provided by federally established systems of care in Indiana; Medicaid state plan behavioral health service rates; and the service rates established under its 1915c Waiver for Children with SED. The rates that are most comparable to the rates for the CA-PRTF services are the rates established for the SED Waiver that began in February 2003. In setting the SED Waiver rates, Indiana modeled the rate setting on the Kansas SED waiver dated November 10, 1997.

Where rates were set higher than comparable rates for Medicaid services to persons with serious mental illness or serious emotional disturbance in Indiana, DMHA factored in the requirements for home-based service delivery, usual and customary charges in the community for professionals with the same credentials, and the level of complexity of needs for the children/families receiving services. Indiana will maintain these same rates for the PRTF Waiver based on the data and methodology originally utilized in 2007 for the CA-PRTF Grant.

WRAPAROUND FACILITATION: \$115 per hour (\$28.75 per 15 minute unit).

This rate was based on the rate for Case Management for individuals with mental illness or emotional disturbances under the Medicaid Rehabilitation Option (MRO). Indiana increased the rate for the prior CA-PRTF Grant by approximately 10% to \$115 from the MRO Case Management rate of \$104.56/hour due to inclusion of management

and assessment responsibilities and the requirement for a higher level of professional qualifications and experience (OBHP or specified experience in implementing the wraparound model).

HABILITATION SERVICES: \$77.04 per hour (\$19.26 per 15 minute unit).

This rate was based on the rate for Activities of Daily Living Training, which is a similar (but not duplicative) State Plan service for individuals with mental illness or emotional disturbance under MRO. It is the rate which was used for Independent Living Skills services on Indiana's SED Waiver, which is also comparable.

TRAINING and SUPPORT for UNPAID CAREGIVERS: \$60 per hour (\$15.00 per 15 minute unit).

The hourly rate is comparable to Family Training and Support on Indiana's SED Waiver. It was originally based on the rate set for "Mentoring" by two well-developed community based service delivery systems in different areas of the state that provide services similar to the waiver and serve a similar population (the Dawn Project and Circle Around Families).

Non-hourly reimbursement is allowed for approved conference/workshop/seminar/training registrations, fees and supplies billed at the rate established for the approved training activity for the unpaid caregiver. Approval of reasonable funding for these non-hourly billings takes into consideration the historical costs of several annual systems of care conferences in Indiana.

RESPITE CARE:

Planned Respite Care:

Respite Routine Daily at \$100 per day for 7 – 24 hours

Respite Routine Hourly at \$16 per hour (\$4.00 per 15-minute units) for Respite Care of less than 7 hours during one 24-hour day.

Crisis Respite Care is billed at \$120 per day for 8 – 24 hours.

The Planned Respite Care daily rate was based on the prevailing rates that the Indiana Department of Child Services reimburses for Respite Care in Therapeutic Foster Homes (\$50-\$90/day) and increased for the additional care and supervision required due to the extraordinary emotional needs of children at the PRTF level of care.

The Crisis Respite Care rate is based on the rates for Respite Care in Indiana licensed crisis shelters, which range from \$90 to \$150/day depending upon the child's needs.

The hourly rate is based on Indiana's SED Waiver rate for hourly respite care.

Respite Care provided in a Medicaid certified PRTF under 405 IAC 5-20-3.1 and licensed under 465 IAC 2-11-1 as private secure residential facility will be billed at the established Medicaid certified PRTF rate for 7-24 hours for planned respite and 8-24 hours for crisis respite.

WRAPAROUND TECHNICIAN: \$94.12 per hour (\$23.53 per 15 minute unit).

This is comparable (but not duplicative) to the State Plan rate for case management for individuals with mental illness or emotional disturbance under MRO.

CONSULTATIVE CLINICAL and THERAPEUTIC SERVICES:

\$90.00 per hour (\$22.50 per 15 minute unit) for Licensed Psychologists (HSPP)

\$70.00 per hour (\$17.50 per 15 minute unit) for other licensed behavioral health providers.

These rates are in line with the MRO Individual Therapy rate of \$85.60. The cost of these services is higher due to the requirement that the services are not office-based but are provided in the child/family home.

NON-MEDICAL TRANSPORTATION: \$20.00 per round trip.

In 2007 a rate of \$10.00 per round trip was based on a rate paid by other Medicaid 1915(c) Waiver programs and the Dawn Project costs which ranged between \$8.91 and \$15.00 This rate was increased in February 2012 due to increased transportation costs.

FLEX FUNDS: The rate is based on actual cost with an annual cap of \$2,000 per child.

This was established using data from the Dawn Project and Circle Around Families' history of similar expenditures. (54% of youth reviewed by Myers & Stauffer used Flex Funds for an annual average of \$1185/child).

PRTF Waiver services and their rates will be provided to the participant/family on a Notice of Action Form #5 generated at the time of the Plan of Care approval. Rates are available to the participants as well as the general

public in written form when requested.

Public comment was not solicited concerning rate determination methods for the PRTF Waiver as there are no proposed changes in the state's methods and standards for setting payment rates for community-based services. Rates were previously addressed through public comment under the prior existing CA-PRTF Grant.

- b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Bills for PRTF Waiver services flow directly from the providers to the Indiana Medicaid Management Information System and payments are made via Medicaid's contracted fiscal agent.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

- c. Certifying Public Expenditures** (*select one*):

- No. State or local government agencies do not certify expenditures for waiver services.**
- Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

Select at least one:

- Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-a.*)

- Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-b.*)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

- d. Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

The Waiver service plan contains Medicaid reimbursable services that are available only under the PRTF Waiver. The PRTF Waiver Unit, within the operating agency, approves a participant's service plan within the State's electronic case management database ensuring approval of only those services which are necessary and reimbursable under the Waiver. The service plan is sent to the state's fiscal agent, via systems interface with the MMIS, serving as the prior authorization for the participant's approved Waiver services. The case management database will not allow the addition of services beyond those services offered under the PRTF Waiver. The case management database

system has been programmed to alert the Waiver Unit when a service plan is being reviewed for a participant whose Medicaid eligibility status is not currently open within an acceptable category as described under Appendix B-4-b. When the appropriate Medicaid eligibility status is in place, the service plan will be approved, and the system will generate the Notice of Action (NOA), which is sent to each authorized provider of services on the Plan. The NOA identifies the individual participant, the service that each provider is approved to deliver, and the rate at which the provider may bill for the service.

The case management database system transmits data, on a daily cycle, containing all new or modified service plans to the Indiana MMIS. The service plan data is utilized by the MMIS as the basis to create or modify Prior Authorization fields to bump against the billing of services for each individual waiver participant.

Providers submit electronic (or paper) claims directly to the MMIS. Claims are submitted with date(s) of service, service code, and billing amount. Reimbursements are only authorized and made in accordance with the Prior Authorization data on file. The MMIS also confirms that the waiver participant had the necessary Level of Care and Medicaid eligibility for all dates of service being claimed.

Documentation and verification of service delivery consistent with paid claims is reviewed during the look behind efforts of the PRTF Waiver Team as well as by the Office of Medicaid Policy and Planning when executing Surveillance Utilization (SUR) activities.

In summary, the participant's eligibility for Medicaid Waiver services is controlled through the electronic case management database system which is linked to the Medicaid claims system. All services are approved within these systems by the operating agency. As part of the 90 day review, the case manager verifies with the participant the appropriateness of services and monitors for delivery of service as prescribed in the service plan. Modifications to the service plan are made as necessary.

The State is currently in the design phase of a new integrated case management system which will mirror the functions previously described with added features and increased process automation. The implementation of the new system is slated for the summer of 2013.

- e. **Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

- a. **Method of payments -- MMIS** (*select one*):

- Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

- b. Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

- Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

- c. Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- No. The State does not make supplemental or enhanced payments for waiver services.**
- Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

- No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish: *Complete item I-3-e.*

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

Answers provided in Appendix I-3-d indicate that you do not need to complete this section.

- The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

- The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

- a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one:*

- Appropriation of State Tax Revenues to the State Medicaid agency
- Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

OMPP's Medicaid Fiscal Contractor identifies eligible children in the PRTF Waiver and sends the information regarding the children and their paid claims to the Indiana Family and Social Service Administration (FSSA) Fiscal Management Office. Every three months, FSSA Fiscal Management sends a bill for the state share of the PRTF Waiver costs to DMHA which transfers the state share through an IGT to the state Medicaid account. All funds from DMHA for this IGT are from state tax revenues.

- Other State Level Source(s) of Funds.

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

- b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One:*

- Not Applicable.** There are no local government level sources of funds utilized as the non-federal share.
- Applicable**

Check each that applies:

- Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

- Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2- c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one:*

- None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- The following source(s) are used**
Check each that applies:
 - Health care-related taxes or fees**
 - Provider-related donations**
 - Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

The State of Indiana excludes Medicaid payment for room and board for individuals under the PRTF Waiver except for the provision of respite care (for 24-hour Respite Care provided out of the home). No room and board costs are figured into allowable provider expenses. There are provider guidelines for usual and customary fee, and the provider agreement states that a provider may only provide services for which the provider is approved. No provider, other than Respite Care is approved to provide room and board . Waiver service providers are paid a fee for each type of direct service provided; no room and board costs are included in these fees.

Based on the method for establishing the fee for each waiver service, the State of Indiana assures that no room and board costs (other than Respite or the costs of live-in caregivers) are included in the established waiver service rates or paid through Medicaid. Indiana provider audit procedures also review provider billing and all allowable costs to further assure no room and board payments are made.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C -3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

- a. Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

- Nominal deductible**
- Coinsurance**
- Co-Payment**
- Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

- a. Co-Payment Requirements.**

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)****a. Co-Payment Requirements.****iii. Amount of Co-Pay Charges for Waiver Services.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)****a. Co-Payment Requirements.****iv. Cumulative Maximum Charges.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)****b. Other State Requirement for Cost Sharing.** Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one:*

- No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration**J-1: Composite Overview and Demonstration of Cost-Neutrality Formula**

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

Level(s) of Care:

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	18548.77	10472.94	29021.71	43815.17	1.00	43816.17	14794.46
2	18551.99	11101.32	29653.31	45567.78	1.00	45568.78	15915.47
3	18546.12	11767.40	30313.52	47390.49	1.00	47391.49	17077.97

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
4	18540.85	12473.44	31014.29	49286.11	1.00	49287.11	18272.82
5	18571.14	13268.57	31839.71	51257.55	1.00	51258.55	19418.84

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

- a. **Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Number Unduplicated Number of Participants (from Item B -3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		PRTF	
Year 1	749	749	
Year 2	459	459	
Year 3	281	281	
Year 4	173	173	
Year 5	106	106	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

- b. **Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

Participant phase-in/phase-out projections have been completed for each of the five PRTF Waiver years.

CMS approved 1,000 unduplicated participants to be served in CA-PRTF Grant year five by September 30, 2012. The participant phase-in/phase-out projections for the new PRTF Waiver start with projected enrollment as of September 30, 2012 on the CA-PRTF Grant, based on the actual Grant program historical lengths of stay. A margin of 30 participants is added to ensure sufficient numbers for transition of all eligible participants from the Grant to the Waiver effective October 1, 2012.

The ongoing PRTF Waiver participant projections assume a lapse rate of 4% each month throughout the five-year period. This is anticipated to provide a margin to ensure sufficient participant positions through the Waiver program.

In compliance with Section 6063 of the DRA of 2005, no additional participants will be added to the Waiver during the five-year request.

Participants are expected to stay on the waiver for a limited time, at which point most are expected to move to the use of non-waiver outpatient services during the five-year Waiver. The average length of stay projections are based on the lapse rate of 4% per month through the five-year Waiver.

Based on recent CA-PRTF Grant participant length of stay experience, the lapse rate appears to be approximately 5% per month. However, as CMS recommended, Indiana needs to ensure a sufficient margin for the transitioning of participants and trending average length of stay for funding of the new PRTF Transition Waiver. Therefore, projections use a lapse rate of 4% per month.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

Estimates of Factor D for each waiver year are illustrated in J-2-d. The basis for the five-year estimates is described below:

Values of Factor D for Waiver year 1 are based on actual paid expenditures during CA-PRTF Grant year 4 (October 1, 2010 – September 30, 2011) projected as follows:

- The Number of Users of each service is adjusted based on projected unduplicated participants, which decreases each year of the Waiver, since these vacated positions cannot be refilled by new waiver applicants.
- Average Units per User is adjusted based on average length of stay.
- Average Cost per Unit is projected using approved rates from the CA-PRTF Grant in effect as of September 30, 2012. This waiver does not anticipate any rate changes through the five-year waiver program.

ii. Factor D' Derivation. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Estimates of Factor D' for each waiver year are illustrated in J-1. The basis for the five-year estimates is described below:

Factor D' was developed based on actual base data of paid Medicaid claims from year 4 of the CA-PRTF Demonstration Grant (October 1, 2010 – September 30, 2011). Because this baseline time period was subsequent to the January 1, 2006 implementation of Medicare Part D, the cost of Part D drugs was already excluded from the base data.

The Factor D' values from Demonstration Grant year 4 were trended at a rate of 6% per year and adjusted for average length of stay of the estimated number of participants (users) who will be on the PRTF Waiver. Average Length of Stay on the PRTF Waiver is projected to be longer than on the CA-PRTF Grant because there will be no new entrants to the Waiver to reduce the length of stay.

iii. Factor G Derivation. The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G values for each waiver year are illustrated in J-1.

Factor G value for Waiver years 1 through 5 is derived from actual experience for residents of PRTF facilities during CA-PRTF Grant Year 4 (October 1, 2010 to September 30, 2011), as documented on the CMS MOD-PRTF Demo 372 Report. This factor is trended at a rate of 4% per year.

iv. Factor G' Derivation. The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' is not amended for PRTF Waiver years 1 through 5:

In CMS' Questions and Answers of October 6, 2006 for the development of the prior Community-Based Alternatives to PRTFs, CMS stated that PRTFs are considered to be Institutions for Mental Disease (IMDs). Based on this, CMS specified that for the computation of Factor G', "FFP is not available for any medical assistance for services under Title XIX for other than psychiatric services".

In May 2012, CMS confirmed this policy has not changed for the transition from the Grant to the Waiver program. Therefore, Indiana is not projecting any costs for Factor G' for waiver years 1 - 5. (Indiana has entered \$1.00 of projected costs, as the Web-based Application will not allow values less than \$1.00.)

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “*manage components*” to add these components.

Waiver Services	
Habilitation	
Respite	
Consultative Clinical and Therapeutic Services	
Flex Funds	
Non-Medical Transportation	
Training and Support for Unpaid Caregivers	
Wraparound Facilitation/Care Coordination	
Wraparound Technician	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Habilitation Total:						5796451.08
Habilitation	.25 Hour	581	518.00	19.26	5796451.08	
Respite Total:						572291.52
Respite Care - Hourly	.25 Hour	142	393.00	4.00	223224.00	
Respite Care - Daily	Day	157	18.00	123.52	349067.52	
Consultative Clinical and Therapeutic Services Total:						676445.00
Consultative Clinical and Therapeutic Services	.25 Hour	250	154.00	17.57	676445.00	
Flex Funds Total:						115326.60
Flex Funds	Unit	274	69.00	6.10	115326.60	
Non-Medical Transportation Total:						480.00
GRAND TOTAL:						13893025.37
Total Estimated Unduplicated Participants:						749
Factor D (Divide total by number of participants):						18548.77
Average Length of Stay on the Waiver:						283

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Non-Medical Transportation	Round Trip	6	4.00	20.00	480.00	
Training and Support for Unpaid Caregivers Total:						98100.00
Training and Support - Other non-hourly	Unit	9	11.00	400.00	39600.00	
Training and Support for Unpaid Caregivers	.25 Hour	150	26.00	15.00	58500.00	
Wraparound Facilitation/Care Coordination Total:						6137118.75
Wraparound Facilitation/Care Coordination	.25 Hour	749	285.00	28.75	6137118.75	
Wraparound Technician Total:						496812.42
Wraparound Technician	.25 Hour	306	69.00	23.53	496812.42	
GRAND TOTAL:						13893025.37
Total Estimated Unduplicated Participants:						749
Factor D (Divide total by number of participants):						18548.77
Average Length of Stay on the Waiver:						283

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Habilitation Total:						3551698.08
Habilitation	.25 Hour	356	518.00	19.26	3551698.08	
Respite Total:						350206.56
Respite Care - Hourly	.25 Hour	87	393.00	4.00	136764.00	
Respite Care - Daily	Day	96	18.00	123.52	213442.56	
Consultative Clinical and Therapeutic Services Total:						413984.34
Consultative Clinical and Therapeutic Services	.25 Hour	153	154.00	17.57	413984.34	
GRAND TOTAL:						8515362.59
Total Estimated Unduplicated Participants:						459
Factor D (Divide total by number of participants):						18551.99
Average Length of Stay on the Waiver:						283

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Flex Funds Total:						70711.20
Flex Funds	Unit	168	69.00	6.10	70711.20	
Non-Medical Transportation Total:						320.00
Non-Medical Transportation	Round Trip	4	4.00	20.00	320.00	
Training and Support for Unpaid Caregivers Total:						62280.00
Training and Support - Other non-hourly	Unit	6	11.00	400.00	26400.00	
Training and Support for Unpaid Caregivers	.25 Hour	92	26.00	15.00	35880.00	
Wraparound Facilitation/Care Coordination Total:						3760931.25
Wraparound Facilitation/Care Coordination	.25 Hour	459	285.00	28.75	3760931.25	
Wraparound Technician Total:						305231.16
Wraparound Technician	.25 Hour	188	69.00	23.53	305231.16	
GRAND TOTAL:						8515362.59
Total Estimated Unduplicated Participants:						459
Factor D (Divide total by number of participants):						18551.99
Average Length of Stay on the Waiver:						283

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Habilitation Total:						2174916.24
Habilitation	.25 Hour	218	518.00	19.26	2174916.24	
Respite Total:						214494.24
Respite Care - Hourly	.25 Hour	53	393.00	4.00	83316.00	
GRAND TOTAL:						5211460.80
Total Estimated Unduplicated Participants:						281
Factor D (Divide total by number of participants):						18546.12
Average Length of Stay on the Waiver:						283

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Care - Daily	Day	59	18.00	123.52	131178.24	
Consultative Clinical and Therapeutic Services Total:						254343.32
Consultative Clinical and Therapeutic Services	.25 Hour	94	154.00	17.57	254343.32	
Flex Funds Total:						43352.70
Flex Funds	Unit	103	69.00	6.10	43352.70	
Non-Medical Transportation Total:						160.00
Non-Medical Transportation	Round Trip	2	4.00	20.00	160.00	
Training and Support for Unpaid Caregivers Total:						35040.00
Training and Support - Other non-hourly	Unit	3	11.00	400.00	13200.00	
Training and Support for Unpaid Caregivers	.25 Hour	56	26.00	15.00	21840.00	
Wraparound Facilitation/Care Coordination Total:						2302443.75
Wraparound Facilitation/Care Coordination	.25 Hour	281	285.00	28.75	2302443.75	
Wraparound Technician Total:						186710.55
Wraparound Technician	.25 Hour	115	69.00	23.53	186710.55	
GRAND TOTAL:						5211460.80
Total Estimated Unduplicated Participants:						281
Factor D (Divide total by number of participants):						18546.12
Average Length of Stay on the Waiver:						283

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Habilitation Total:						1336875.12
GRAND TOTAL:						3207566.24
Total Estimated Unduplicated Participants:						173
Factor D (Divide total by number of participants):						18540.85
Average Length of Stay on the Waiver:						283

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Habilitation	.25 Hour	134	518.00	19.26	1336875.12	
Respite Total:						131916.96
Respite Care - Hourly	.25 Hour	33	393.00	4.00	51876.00	
Respite Care - Daily	Day	36	18.00	123.52	80040.96	
Consultative Clinical and Therapeutic Services Total:						156935.24
Consultative Clinical and Therapeutic Services	.25 Hour	58	154.00	17.57	156935.24	
Flex Funds Total:						26516.70
Flex Funds	Unit	63	69.00	6.10	26516.70	
Non-Medical Transportation Total:						80.00
Non-Medical Transportation	Round Trip	1	4.00	20.00	80.00	
Training and Support for Unpaid Caregivers Total:						22450.00
Training and Support - Other non-hourly	Unit	2	11.00	400.00	8800.00	
Training and Support for Unpaid Caregivers	.25 Hour	35	26.00	15.00	13650.00	
Wraparound Facilitation/Care Coordination Total:						1417518.75
Wraparound Facilitation/Care Coordination	.25 Hour	173	285.00	28.75	1417518.75	
Wraparound Technician Total:						115273.47
Wraparound Technician	.25 Hour	71	69.00	23.53	115273.47	
GRAND TOTAL:					3207566.24	
Total Estimated Unduplicated Participants:					173	
Factor D (Divide total by number of participants):					18540.85	
Average Length of Stay on the Waiver:						283

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Habilitation Total:						821246.40
Habilitation	.25 Hour	82	520.00	19.26	821246.40	
Respite Total:						80481.44
Respite Care - Hourly	.25 Hour	20	394.00	4.00	31520.00	
Respite Care - Daily	Day	22	18.00	123.64	48961.44	
Consultative Clinical and Therapeutic Services Total:						95317.25
Consultative Clinical and Therapeutic Services	.25 Hour	35	155.00	17.57	95317.25	
Flex Funds Total:						16415.10
Flex Funds	Unit	39	69.00	6.10	16415.10	
Non-Medical Transportation Total:						80.00
Non-Medical Transportation	Round Trip	1	4.00	20.00	80.00	
Training and Support for Unpaid Caregivers Total:						12590.00
Training and Support - Other non-hourly	Unit	1	11.00	400.00	4400.00	
Training and Support for Unpaid Caregivers	.25	21	26.00	15.00	8190.00	
Wraparound Facilitation/Care Coordination Total:						871585.00
Wraparound Facilitation/Care Coordination	.25 Hour	106	286.00	28.75	871585.00	
Wraparound Technician Total:						70825.30
Wraparound Technician	.25 Hour	43	70.00	23.53	70825.30	
GRAND TOTAL:						1968540.49
Total Estimated Unduplicated Participants:						106
Factor D (Divide total by number of participants):						18571.14
Average Length of Stay on the Waiver:						284