

**Proposed Rule**  
LSA Document #13-183

DIGEST

Adds 405 IAC 5-21.6 to define Adult Mental Health Habilitation (AMHH) services and terms related to AMHH services; to set out reimbursement for AMHH services; to define behavioral health habilitation services, including the provision of adult day services, home and community-based habilitation and support, respite care, therapy and behavior support services, addiction counseling, peer support services, supported community engagement services, care coordination, and medication training and support; to define eligibility criteria for the AMHH services, standards for services, and provider agency types that may provide AMHH services; and to define authorization requirements for AMHH services. Effective 30 days after filing with the publisher.

IC 4-22-2.1-5 Statement Concerning Rules Affecting Small Businesses

SECTION 1. 405 IAC 5-21.6 IS ADDED TO READ AS FOLLOWS:

**Rule 21.6 Adult Mental Health Habilitation Services Program**

**405 IAC 5-21.6-1 General Provisions**

**Authority:** IC 12-8-6.5-5; IC 12-15

**Affected:** IC 12-13-7-3; IC 12-29; IC 25-23.6-10.5; IC 25-27.5-5

**Sec. 1. (a) Intent and Purpose.** The intent of this rule is to provide home and community-based treatment options to individuals with serious mental illness who may benefit most from a habilitation approach to care to assist in maintaining the individual in the community. Eligibility for services and the provision of services are based upon an individual's meeting specific adult mental health habilitation (AMHH) needs-based criteria. AMHH services will be provided through a state plan and will be delivered by service provider agencies meeting specific state-defined criteria.

*(Office of the Secretary of Family and Social Services; 405 IAC 5-21.6-1; filed)*

**405 IAC 5-21.6-2 Definitions**

**Authority:** IC 12-8-6.5-5; IC 12-15

**Affected:** IC12-13-7-3; IC 12-29; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5

**Sec. 2. (a)** The following definitions apply throughout this rule:

**(b)** “**Adult Mental Health Habilitation**” (AMHH) services refers to medical or remedial services recommended by a physician or other licensed professional, within the scope of his or her practice, for the habilitation of a mental health disability and the restoration or maintenance of an individual’s best possible functional level. Services are clinical and supportive behavioral health services that are provided for individuals, families, or groups of adult persons who are living in the community and who need aid on a routine basis for a mental illness or co-occurring mental illness and addiction disorders.

**(c)** “**Approved Division of Mental Health and Addiction (DMHA) behavioral health assessment tool**” means the state designated assessment tool administered by a qualified individual who is trained and DMHA-certified to administer the tool in order to assist in determining the level of need and functional impairment of an applicant or a recipient.

**(d)** “**Authorized health care professional**” (AHCP), as used in this Rule, means any of the following persons:

**(1)** A physician assistant with authority to prescribe, dispense, and administer drugs and medical devices or services under an agreement with a supervising physician and subject to the requirements of IC 25-27.5-5.

**(2)** A nurse practitioner or clinical nurse specialist, with prescriptive authority and performing duties within the scope of that person’s license and under the supervision of, or under a supervisory agreement with, a licensed physician pursuant to IC 25-23-1.

**(e)** “**AMHH behavioral health habilitation services**” include the following:

**(1)** Adult day services.

**(2)** Home and community-based habilitation and support.

**(3)** Respite care.

**(4)** Therapy and behavior support services.

**(5)** Addiction counseling.

**(6)** Peer support services.

**(7)** Supported community engagement services

**(8)** Care coordination.

**(9)** Medication training and support.

**(f)** “**DMHA**” means the Division of Mental Health and Addiction.

(g) “Detoxification services” means services or activities that are provided to a recipient during his or her withdrawal from alcohol and other addictive drugs, while under the direct supervision of a physician or clinical nurse specialist.

(h) “Habilitation services” mean activities that are designed to assist recipients in acquiring, retaining and improving the following skills necessary to reside successfully in a community setting:

- (1) Self-help;
- (2) Socialization; and
- (3) Adaptive skills.

(i) “Individualized Integrated Care Plan” (IICP) means a treatment plan that:

- (1) integrates all components and aspects of care that are
  - (A) deemed medically necessary,
  - (B) clinically indicated, and
  - (C) provided in the most appropriate setting to achieve the recipient’s goals;
- (2) includes all indicated medical and support services needed by the recipient in order to:
  - (A) remain in the community,
  - (B) function at the highest level of independence possible, and
  - (C) achieve goals identified in the IICP;
- (3) is developed for each recipient;
- (4) is developed with the recipient; and
- (5) reflects the recipient’s desires and choices.

(j) “Level of need” means a recommended intensity of behavioral health services based on a pattern of a recipient’s needs, as determined by using a standardized assessment tool.

(k) “Licensed professional” means any of the following persons:

- (1) A licensed psychiatrist.
- (2) A licensed physician.
- (3) A licensed psychologist or a psychologist endorsed as a health service provider in psychology (HSPP).
- (4) A licensed clinical social worker (LCSW).
- (5) A licensed mental health counselor (LMHC).
- (6) A licensed marriage and family therapist (LMFT).
- (7) A licensed clinical addiction counselor (LCAC), as defined under IC 25-23.6-10.5.

(l) “Medicaid rehabilitation services” means any medical or remedial service recommended by a physician or other licensed practitioner of the healing arts, within the scope of that individual’s practice under State law, for

- (1) maximum reduction of physical or mental health disability and
- (2) restoration to a recipient's best possible level of functioning.

(m) "Nonprofessional caregiver" means any individual who does not receive compensation for providing care or services to a Medicaid recipient.

(n) "Office" refers to the Office of Medicaid Policy and Planning.

(o) "Other Behavioral Health Professional" (OBHP) means any of the following:

(A) An individual with an associate or bachelor degree, or equivalent behavioral health experience,

(1) meeting minimum competency standards set forth by a behavioral health service provider and

(2) supervised by either a licensed professional or a QBHP.

(B) A licensed addiction counselor, as defined under IC 25-23.6-10.5, supervised by either a licensed professional or a Qualified Behavioral Health Practitioner (QBHP).

(p) "Professional caregiver" means an individual who receives payment for providing services and supports to a Medicaid recipient.

(q) "Provider Agency" means any DMHA-approved agency that meets the qualifications and criteria to become an AMHH provider agency, as required by this rule.

(r) "Provider Staff" means to any individual working under a DMHA-approved AMHH provider agency that meets the qualifications and requirements mandated by the AMHH service being provided, as defined in this rule.

(s) "Qualified Behavioral Health Professional" (QBHP) means any of the following:

(1) An individual who has had at least two (2) years of clinical experience treating persons with mental illness under the supervision of a licensed professional, with such experience occurring after the completion of a master's degree or doctoral degree, or both, in any of the following disciplines from an accredited university:

(A) Psychiatric or mental health nursing, plus a license as a registered nurse in Indiana.

(B) Pastoral counseling.

(C) Rehabilitation counseling.

(2) An individual who

(A) is under the supervision of a licensed professional,

(B) is eligible for and working towards professional licensure, and

(C) has completed a master's or doctoral degree, or both, in

any of the following disciplines from an accredited university:

(1) social work from a university accredited by the Council on Social Work Education,

- (2) psychology,
  - (3) mental health counseling, or
  - (4) marital and family therapy.
- (3) A licensed, independent practice, school psychologist under the supervision of a licensed professional.
- (4) An authorized health care professional (AHCP) who is one of the following:
- (A) A physician assistant with the authority to prescribe, dispense, and administer drugs and medical devices or services under an agreement with a supervising physician and subject to the requirements of IC 25-27.5-5.
  - (B) A nurse practitioner or clinical nurse specialist, with prescriptive authority, performing duties within the scope of that person's license and under the supervision of, or under a supervisory agreement with, a licensed physician pursuant to IC 25-23-1.

(t) "Skills training" means services or activities to further the reinforcement, management, adaptation and retention of skills necessary for a recipient to live successfully in the community.

(u) "State Evaluation Team" means the DMHA independent evaluation team that will review and assess all evaluation information and supporting clinical documentation collected for AMHH applicants and recipients and will be responsible for making final determinations regarding the following:

- (1) Eligibility of applicants for AMHH services.
- (2) Authorization for AMHH services for eligible recipients.
- (3) Continued eligibility determination for AMHH recipients.
- (4) Appropriate service delivery to AMHH recipients, as a result of conducting quality improvement reviews of AMHH service provider agencies.

*(Office of the Secretary of Family and Social Services; 405 IAC 5-21.6-2; filed)*

### **405 IAC 5-21.6-3 Applicants and the Application Process**

**Authority:** IC 12-8-6.5-5; IC 12-15

**Affected:** IC12-13-7-3; IC 12-29; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5

**Sec. 3. (a)** In order for an individual to receive services under this rule, an AMHH eligible provider agency, in collaboration with the individual seeking services, must submit an application in the manner required by the Office and the DMHA.

- (b) Each applicant for AMHH services must receive a face-to-face evaluation using
- (1) the DMHA-approved behavioral health assessment tool and
  - (2) the application form developed by the Office and DMHA.

(c) The application form and supporting documentation may include the following information about the applicant:

- (1) Current and historical health status.
- (2) Behavioral health issues.
- (3) Functional needs.

(d) An application must, at a minimum, include documentation indicating the following:

- (1) The applicant is requesting the service(s) listed on the proposed IICP submitted with the application.
- (2) The applicant chose, from a randomized list of eligible AMHH service providers in the applicant's community, a provider to deliver the DMHA authorized AMHH services under this rule.

(e) Upon receipt of the application and supporting clinical documentation, the DMHA state evaluation team will assess the submitted information and determine whether or not the applicant meets the core eligibility criteria for receiving AMHH services.

(f) The responsibility for eligibility determination and approval of all proposed AMHH services included in the IICP is retained by the DMHA state evaluation team, in order to prevent a conflict of interests.

- (g) Any approval or denial of services under this rule will be communicated to
- (1) the applicant or the applicant's authorized representative and
  - (2) the referring provider agency.

*(Office of the Secretary of Family and Social Services; 405 IAC 5-21.6-3; filed)*

#### **405 IAC 5-21.6-4 Eligibility**

**Authority:** IC 12-8-6.5-5; IC 12-15

**Affected:** IC12-13-7-3; IC 12-29; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5

**Sec. 4. (a) An applicant may be eligible for participation in the AMHH services program if the applicant meets all of the following core criteria:**

- (1) The applicant is enrolled in Medicaid.
- (2) The applicant is age thirty-five (35) or older.

- (3) The applicant is unlikely to make improvements in a variety of life domains, with such a determination being based on the state evaluation team’s review of all relevant referral materials.
- (4) Based upon the DMHA-approved behavioral health assessment tool, the applicant has a recommendation for intensive community-based care, as indicated by a rating level of four (4) or higher.
- (5) The applicant has been diagnosed with an AMHH-eligible primary mental health diagnosis, which may include but is not limited to, any of the following general categories:
- (A) Schizophrenic Disorder.
  - (B) Major Depressive Disorder.
  - (C) Bipolar Disorder.
  - (D) Delusional Disorder.
  - (E) Psychotic Disorder.
- (6) The applicant either
- (A) resides in a community-based setting that is not an institutional setting, or
  - (B) will be discharged from an institutional setting back to a community-based setting.
- (7) Based on the behavioral health clinical evaluation, the applicant must meet all of the following needs-based criteria:
- (A) Without ongoing habilitation services, as demonstrated by written attestation from a psychiatrist or a Health Services Provider in Psychology (HSPP) as defined in IC 25-33-1-5.1, the applicant will likely deteriorate and be at risk of institutionalization.
  - (B) The applicant demonstrates the need for significant assistance in major life domains related to the applicant’s mental illness (e.g., physical problems, social functioning, basic living skills, self-care, and potential for harm to the self or to others).
  - (C) The applicant demonstrates significant needs related to the applicant’s behavioral health.
  - (D) The applicant demonstrates
    - (i) significant impairment in self-management of the applicant’s mental illness or
    - (ii) significant needs for assistance with mental illness management.
  - (E) The applicant demonstrates a lack of sufficient natural supports to assist with mental illness management.
  - (F) The applicant is not a danger to the self or others at the time the application for AMHH service eligibility is submitted for State review and determination.
- (b) For purposes of this section, the following definitions apply:
- (1) “Assistance” means any kind of support given, due to a mental health condition or disorder, including but not limited to the following:
- (A) Mentoring.

- (B) Supervision.
  - (C) Reminders.
  - (D) Verbal cueing.
  - (E) Hands-on assistance.
- (2) “Significant” means an assessed need for immediate or intensive action due to a serious or disabling need.

*(Office of the Secretary of Family and Social Services; 405 IAC 5-21.6-4; filed)*

### **405 IAC 5-21.6-5 Eligibility Period; Renewal**

**Authority: IC 12-8-6.5-5; IC 12-15**

**Affected: IC 12-13-7-3; IC 12-29; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5**

**Sec. 5. (a) A recipient who is approved to receive AMHH services under this rule shall be eligible for such services for up to a twelve (12) month period, as long as eligibility and needs-based criteria continue to be met.**

**(b) A reevaluation will be conducted at least every twelve (12) months and shall include the following:**

- (1) A face-to-face holistic clinical and bio-psychosocial evaluation completed by a DMHA-approved AMHH service provider.**
- (2) Administration of the DMHA approved behavioral assessment tool to determine whether the recipient still meets the level of need for intensive community-based services, as demonstrated by a rating level of four (4) or higher.**
- (3) Assessment of the recipient’s progress towards meeting treatment goals on the IICP.**
- (4) Documentation that the recipient continues to meet AMHH financial, target group eligibility and needs-based criteria.**
- (5) An updated referral application.**
- (6) An updated IICP documenting the recipient’s choice of AMHH service(s) and AMHH service providers.**

**(c) The DMHA evaluation team will review and assess the renewal application and reevaluation results to determine whether the recipient continues to meet AMHH eligibility.**

**(d) Any approval or denial of eligibility and services under this rule will be communicated to**

- (1) the applicant or the applicant’s authorized representative and**
- (2) the referring provider agency.**

**405 IAC 5-21.6-6 Clinical Documentation Requirements**

**Authority: IC 12-8-6.5-5; IC 12-15**

**Affected: IC12-13-7-3; IC 12-29; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5**

**Sec. 6. (a) To be reimbursable under this rule, the AMHH service must be supported by clinical documentation that is maintained in the recipient's clinical record.**

**(b) The documentation required to support billing for an AMHH services must meet the following standards:**

- (1) Focus on recovery and habilitation.**
- (2) Emphasize consumer strengths.**
- (3) Reflect progress toward the habilitation goals reflected in the recipient's IICP.**
- (4) Be updated with every recipient encounter when billing is submitted for reimbursement.**
- (5) Be written and signed by the agency staff rendering services.**

**(c) For a recipient participating in any AMHH service, the clinical documentation must contain the following information:**

- (1) The type of service being provided.**
- (2) The names and qualifications of the staff providing the service.**
- (3) The location or setting where the service was provided.**
- (4) The focus of the session or service delivered to or on behalf of the recipient.**
- (5) The recipient's symptoms, needs, goals or issues addressed during the session.**
- (6) The duration of the service (actual time spent).**
- (7) Start and end time of the service.**
- (8) The recipient's IICP goal(s) being addressed during the session.**
- (9) The progress made toward meeting habilitation goals noted on the IICP.**
- (10) The date of service rendered (including month, day, and year).**

**(d) The content of the documentation must support the amount of time billed.**

**(e) For recipients participating in AMHH services in a group setting, documentation must be provided for each encounter and must include the following:**

- (1) The focus of the group or session.**
- (2) The consumer's level of activity in the group session.**
- (3) How the service**
  - (A) benefits the recipient and**
  - (B) assists the recipient in reaching the recipient's habilitation goals.**

**(f) For AMHH services provided on behalf of the recipient without the recipient present, documentation must be provided for each encounter and must include the following information:**

- (1) The name(s) of the person(s) attending the session and each person's relationship to the recipient.**
- (2) How the service**
  - (A) benefits the recipient and**
  - (B) assists the recipient in reaching the recipient's habilitation goals.**

**(g) In addition to the requirements listed in this section, specific requirements for selected service types may be required and are reflected in other sections of this rule.**

*(Office of the Secretary of Family and Social Services; 405 IAC 5-21.6-6; filed)*

### **405 IAC 5-21.6-7 Coverage Requirements; Limits**

**Authority: IC 12-8-6.5-5; IC 12-15**

**Affected: IC12-13-7-3; IC 12-29; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5**

**Sec. 7. (a) For an AMHH service to be reimbursable under this rule, the service must:**

- (1) be listed in this rule as a covered service.**
- (2) be habilitative in nature.**
- (3) promote recipient stability.**
- (4) demonstrate the recipient's movement toward the individual goals identified in the recipient's IICP.**
- (5) continue to provide a benefit to the recipient.**

**(b) The following services are covered under the AMHH services program according to the coverage criteria, limitations, and procedures specified in this rule:**

- (1) Adult day services.**
- (2) Home and community-based habilitation and support.**
- (3) Respite care.**
- (4) Therapy and behavioral support services.**
- (5) Addiction counseling (substance-related disorder).**
- (6) Peer support services.**
- (7) Supported community engagement services.**
- (8) Care coordination services.**
- (9) Medication training and support.**

**(c) The following services will not be covered and are not eligible for reimbursement under this rule:**

- (1) A service provided to the recipient at the same time as another service that is the same in nature and scope, regardless of funding source, including federal, state, local, and private entities.
- (2) A service that is provided while the recipient is in an institutional or non-community-based setting.
- (3) A service provided as a diversionary, leisurely or recreational activity that is not a component of an authorized respite care service.
- (4) A service that is provided in a manner that is not within the scope or limitations of an AMHH service.
- (5) A service that is not documented as a covered or approved service on the recipient's DMHA-approved IICP.
- (6) A service that is not supported by documentation in the recipient's clinical record.
- (7) A service provided that exceeds the defined limits of the service, including service quantity, limits, duration or frequency.
- (8) An activity that is excluded from the service scope or definition.

*(Office of the Secretary of Family and Social Services; 405 IAC 5-21.6-7; filed)*

#### **405 IAC 5-21.6-8 Adult Day Services**

**Authority:** IC 12-8-6.5-5; IC 12-15

**Affected:** IC12-13-7-3; IC 12-29; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5

**Sec. 8. (a)** The services reimbursable as adult day services consist of community-based group programs designed to meet the needs of adults with significant behavioral health impairments as identified in a recipient's IICP. These comprehensive, non-residential programs provide health, wellness, social, and therapeutic activities. The day services are delivered in a structured, supportive environment and provide the recipient with supervision, support services, and personal care as required by the recipient's IICP.

**(b)** Adult day services may include any of the following services as they relate to the recipient's IICP:

- (1) Care planning.
- (2) Treatment.
- (3) Monitoring of weight, blood glucose level, and blood pressure.
- (4) Medication administration.
- (5) Nutritional assessment and planning provided by a certified dietician.
- (6) Individual or group exercise training.
- (7) Reinforcement of established skills and may include activities of daily living.
- (8) Other social activities.

(c) Provider staff of adult day services must meet any of the following qualifications:

- (1) Be a licensed professional, except for a licensed clinical addiction counselor as defined under IC 25-23.6-10.5.
- (2) Be a QBHP.
- (3) Be an OBHP.

(d) The agency staff member providing adult day services must receive supervision by a licensed professional.

(e) Medication administration provided as an adult day service must be delivered within the individual's scope of practice, as defined by federal and state law, by an agency staff member who meets one of the following qualifications:

- (1) A licensed physician.
- (2) An authorized health care professional (AHCP).
- (3) A registered nurse.
- (4) A licensed practical nurse (LPN).
- (5) A medical assistant who has graduated from a two year clinical program.

(f) A certified dietician providing nutritional assessment and planning as a part of the adult day service must meet the qualifications in IC 25-14.5.

(g) Adult day service standards include all of the following requirements:

- (1) The service requires face-to-face contact with the recipient.
- (2) The recipient must be the focus of the service delivered.
- (3) Clinical oversight must be provided by a licensed physician, who is
  - (A) on-site at least once a week; and
  - (B) available to program staff when not physically present on-site.
- (4) Each service must be documented in the recipient's clinical record.
- (5) At least weekly, a designated clinical staff member must
  - (A) review the recipient's progress toward meeting habilitative goals and
  - (B) document the recipient's progress in the clinical record.

(h) Services provided in a residential setting are not reimbursable as adult day services under this rule.

*(Office of the Secretary of Family and Social Services; 405 IAC 5-21.6-8; filed)*

#### **405 IAC 5-21.6-9 Home and Community-Based Habilitation and Support Services**

**Authority:** IC 12-8-6.5-5; IC 12-15

**Affected:** IC12-13-7-3; IC 12-29; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5

**Sec. 9. (a) The services available as home and community-based habilitation and support services are intended to:**

- (1) provide skills training to reinforce established skills (and may include activities of daily living);**
- (2) assist in the management, adaptation and retention of skills necessary to support the recipient's needs; and**
- (3) assist the recipient to gain an understanding of the self-management of behavioral and medical health conditions.**

**(b) The services may be reimbursable as either of the following:**

- (1) Services provided to an individual in either an individual setting or a group setting; and**
- (2) Services provided to family members or other nonprofessional caregivers in an individual or group setting with or without the individual present.**

**(c) The services reimbursable under individual or any other sub-category of the service with the recipient present, must meet the following requirements:**

- (1) Involve face-to-face contact directed at the health, safety and welfare of the individual.**
- (2) Be provided in the individual's home or living environment or other community-based settings outside of a clinic or office environment.**

**(d) The services reimbursable under either a family setting or as a couple, with or without the recipient present, must meet the following requirements:**

- (1) Involve face-to-face contact with family members or nonprofessional caregivers directed at the health, safety and welfare of the recipient and assisting in the acquisition, improvement, and retention of skills necessary to support recipients to live successfully in the community.**
- (2) Include training and education about the treatment regimens appropriate to the recipient to instruct**
  - (A) a parent,**
  - (B) another family member identified in the IICP, or**
  - (C) a primary caregiver.**
- (3) Improve the ability of the parent, family member or primary caregiver to provide care to or for the recipient.**
- (4) Be focused on the recipient and be linked to the needs and goals identified on the recipient's IICP.**

**(e) Agency staff must meet any of the following qualifications to provide services under this section:**

- (1) Be a licensed professional, except for a licensed clinical addiction counselor as defined under IC 25-23.6-10.5.**
- (2) Be a QBHP.**
- (3) Be an OBHP.**

**(f) Home and community-based habilitation and support service standards include the following:**

- (1) Face-to-face contact with the recipient, family members or non-professional caregivers in an individual setting or group setting.**
- (2) Activities that include the following:**
  - (A) Implementation of the IICP;**
  - (B) Assistance with personal care; or**
  - (C) Coordination and facilitation of medical and non-medical services to meet healthcare needs.**
- (3) Services under this subsection may include, but are not limited, to the following:**
  - (A) Skills training in**
    - (i) food planning and preparation,**
    - (ii) money management, and**
    - (iii) maintenance of living environment.**
  - (B) Training in the appropriate use of community services.**
  - (C) Training in skills needed to locate and maintain a home.**
  - (D) Medication-related education and training by non-medical staff.**

**(g) The following services are not reimbursable under this section:**

- (1) Job coaching.**
- (2) Activities purely for recreation or diversion.**
- (3) Academic tutoring.**
- (4) A service provided to a professional caregiver.**

*(Office of the Secretary of Family and Social Services; 405 IAC 5-21.6-9; filed)*

#### **405 IAC 5-21.6-10 Respite Care Services**

**Authority:** IC 12-8-6.5-5; IC 12-15

**Affected:** IC12-13-7-3; IC 12-29; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5

**Sec. 10. (a) The services reimbursable as respite care services are provided to a recipient who is:**

- (1) unable to care for himself or herself; and**
- (2) living with a nonprofessional caregiver.**

**(b) The service provided under this section shall be furnished on a short-term basis because of a nonprofessional caregiver's absence or need for relief.**

**(c) The service may be provided in any of the following locations:**

- (1) A recipient's home or place of residence;**
- (2) A caregiver's home; or**
- (3) A non-private residential setting such as a group home or adult foster care.**

**(d) Provider staff delivering service under this section must meet one of the following qualifications:**

- (1) A licensed professional.**
- (2) A QBHP.**
- (3) An OBHP.**

**(e) Medication administration provided within the respite care service must be provided within the scope of practice, as defined by federal and State law, by an agency staff member who meets one of the following qualifications:**

- (1) A physician;**
- (2) An advanced practice nurse (APN).**
- (3) A physician assistant (PA).**
- (4) A registered nurse (RN).**
- (5) A licensed practical nurse (LPN).**

**(f) Respite care service standards include the following:**

- (1) The recipient must be living with a nonprofessional caregiver.**
- (2) The location of services and the level of professional care are based on the needs of the recipient of the service, including the regular monitoring of medications or behavioral symptoms as identified in the recipient's IICP.**
- (3) Services must be provided in the least restrictive environment available and ensure the health and welfare of the recipient.**
- (4) Services shall not be used as a substitute for regular care in order to allow the recipient's caregiver to attend school, hold a job, or engage in employment or employment search related activities.**
- (5) Respite care must not duplicate any other service being provided under the recipient's IICP.**

**(g) The following services are not reimbursable under this section:**

- (1) Services provided to a recipient living in a DMHA-licensed residential facility.**
- (2) Services provided to a recipient who receives in-home support from a professional caregiver, rather than a non-paid caregiver.**
- (3) Respite care services provided by either of the following:**
  - (A) Any relative who is the primary caregiver of the recipient; or**
  - (B) Anyone living in the recipient's home or residence.**

*(Office of the Secretary of Family and Social Services; 405 IAC 5-21.6-10; filed)*

#### **405 IAC 5-21.6-11 Therapy and Behavioral Support Services**

**Authority: IC 12-8-6.5-5; IC 12-15**

**Affected: IC12-13-7-3; IC 12-29; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5**

**Sec. 11. (a) The services reimbursable as therapy and behavioral support services include the following:**

- (1) Services provided in an individual or a group setting; and**
- (2) Services provided to family members or other nonprofessional caregivers in an individual or group setting, with or without the recipient present.**

**(b) Services provided to a recipient must be**

- (1) time-limited,**
- (2) structured, and**
- (3) provided in a face-to-face session.**

**(c) Services provided must meet the following requirements:**

- (1) Be provided either at home or at locations outside the clinic setting.**
- (2) Be provided in an individual setting or a group setting.**
- (3) Be a face-to-face interaction with recipient, family members or non-professional caregivers supporting a recipient.**
- (4) The recipient must be the focus of the service.**

**(d) Provider staff delivering services under this subsection must meet one of the following qualifications:**

- (1) Be a licensed professional, as defined in this rule, except not a licensed clinical addiction counselor as defined under IC 25-23.6-10.5.**
- (2) Be a QBHP.**

**(e) Therapy and behavioral support service standards include the following:**

- (1) Observation of the recipient and environment for purposes of the development of the IICP.**
- (2) Development of a person-centered behavioral support plan and subsequent revisions which may be a part of the IICP.**
- (3) Therapy and support activities include, but are not limited to, the following:**
  - (A) Assertiveness training.**
  - (B) Stress reduction techniques.**
  - (C) Development of socially accepted behaviors.**
  - (D) Implementation of a behavior support plan for staff, family members, roommates, and other appropriate individuals.**

**(f) The services are not reimbursable under this section if provided in a clinic setting.**

*(Office of the Secretary of Family and Social Services; 405 IAC 5-21.6-11; filed)*

**405 IAC 5-21.6-12 Addiction Counseling Services**

**Authority: IC 12-8-6.5-5; IC 12-15**

**Affected: IC12-13-7-3; IC 12-29; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5**

**Sec. 12. (a) The services reimbursable as addiction counseling services include the following:**

- (1) Services provided to the recipient either individually or in a group setting.**
- (2) Services provided to family members or other nonprofessional caregivers in an individual or group setting, with or without the recipient present.**

**(b) Services shall meet the following standards:**

- (1) Be provided face-to-face with the recipient, family members or nonprofessional caregivers.**
- (2) Be provided by qualified addiction professionals or other clinicians.**
- (3) Include any of the following:**
  - (A) Education on addiction disorders;**
  - (B) Skills training in**
    - (i) communication,**
    - (ii) anger management,**
    - (iii) stress management and**
    - (iv) relapse prevention; or**
  - (C) Referral to community recovery support programs, if available.**

**(c) Services under this section may be provided to adult recipients with:**

- (1) a substance-related disorder; and**
- (2) any of the following:**
  - (A) Minimal or manageable medical conditions;**
  - (B) Minimal withdrawal risk; or**
  - (C) Emotional, behavioral, and cognitive conditions that will not prevent the recipient from benefitting from this service.**

**(d) All services may be provided in an individual or group setting, but the recipient must always be the focus of addiction counseling.**

**(e) Provider staff delivering services under this section must meet one of the following qualifications:**

- (1) A licensed professional as defined under this rule.**
- (2) A QBHP.**

**(f) The following services are not reimbursable under this section:**

- (1) Services provided to a recipient with withdrawal risk or symptoms.**
- (2) Services provided to a recipient**
  - (A) whose needs cannot be managed safely with AMHH services or**
  - (B) who needs detoxification services.**

- (3) Services provided to a recipient who is determined to be at imminent risk of harm to the self or to others.**
- (4) Addiction counseling sessions that consist only of education.**
- (5) Services provided to professional caregivers.**

*(Office of the Secretary of Family and Social Services; 405 IAC 5-21.6-12; filed)*

### **405 IAC 5-21.6-13 Peer Support Services**

**Authority: IC 12-8-6.5-5; IC 12-15**

**Affected: IC12-13-7-3; IC 12-29; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5**

- Sec. 13. (a) The services reimbursable as peer support services must be:**
- (1) provided face-to-face;**
  - (2) structured; and**
  - (3) scheduled activities that promote all of the following:**
    - (A) Socialization,**
    - (B) Recovery,**
    - (C) Self-advocacy,**
    - (D) Development of natural supports, and**
    - (E) Maintenance of community living skills.**
- (b) The provider agency staff member delivering services under this section must meet one of the following qualifications:**
- (1) The DMHA training and competency standards for a certified recovery specialist.**
  - (2) Be an individual under the supervision of:**
    - (A) A licensed professional or**
    - (B) A QBHP.**
- (c) At a minimum, the services provided under this section must include components that:**
- (1) assist recipients with**
    - (A) developing IICPs and**
    - (B) other formal mentoring activities aimed at increasing the active participation of recipients in person-centered planning and delivery of individualized services;**
  - (2) assist recipients with the development of psychiatric advanced directives;**
  - (3) support recipients in problem-solving related to reintegration into the community; and**
  - (4) provide education to recipients and promote the recovery process and anti-stigma activities.**

- (d) The following services are not reimbursable under this section:**
- (1) Services provided in group settings.**
  - (2) Activities billable under home and community-based habilitation services.**
  - (3) Care coordination services.**

*(Office of the Secretary of Family and Social Services; 405 IAC 5-21.6-13; filed)*

#### **405 IAC 5-21.6-14 Supported Community Engagement Services**

**Authority: IC 12-8-6.5-5; IC 12-15**

**Affected: IC12-13-7-3; IC 12-29; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5**

**Sec. 14 (a) Services reimbursable as supported community engagement services must meet the following requirements:**

- (1) Be provided face-to-face with the recipient in an individual setting.**
- (2) Consist of services that engage a recipient in meaningful community involvement in activities such as volunteerism or community service.**
- (3) Consist of services aimed at developing skills and opportunities which lead to improved integration of the recipient into the community through increased community engagement.**

**(b) The provider agency staff member delivering services under this section must meet one of the following qualifications:**

- (1) A licensed professional.**
- (2) A QBHP.**
- (3) An OBHP.**

**(c) Supported community engagement service standards include the following:**

- (1) The service is provided to a recipient:**
  - (A) Who may benefit from community engagement and**
  - (B) Who is unlikely to achieve this involvement without the provision of support.**
- (2) Assistance is provided to the recipient in developing relationships with community organizations specific to the recipient's interests and needs.**
- (3) The service is for the purpose of achieving a generalized skill or behavior that may prepare the recipient for an employment setting and may include, but is not limited to, focus on the following concepts:**
  - (A) Attendance.**
  - (B) Task completion.**
  - (C) Problem solving.**
  - (D) Safety.**

- (d) The following services are not reimbursable under this section:**
- (1) A provider agency's compensation to a recipient.**
  - (2) Training in specific job tasks.**
  - (3) Services provided to a recipient who is currently competitively employed.**
  - (4) Vocational rehabilitation services funded under the Rehabilitation Act of 1973.**
  - (5) Services provided in a group setting.**
  - (6) Services that include explicit employment objectives.**

*(Office of the Secretary of Family and Social Services; 405 IAC 5-21.6-14; filed)*

### **405 IAC 5-21.6-15 Care Coordination Services**

**Authority: IC 12-8-6.5-5; IC 12-15**

**Affected: IC 12-13-7-3; IC 12-29; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5**

**Sec. 15 (a) The services reimbursable as care coordination services consist of services that assist a recipient in gaining access to needed medical, social, educational, and other services, including the following:**

- (1) Direct assistance in gaining access to services.**
- (2) Coordination of care.**
- (3) Oversight of the recipient's care in the AMHH services program.**
- (4) Linkage of the recipient to appropriate services.**

**(b) For purposes of this section, care coordination includes the following services:**

- (1) Needs assessment;**
- (2) IICP development;**
- (3) Referral and linkage;**
- (4) Monitoring and follow-up; and**
- (5) Evaluation.**

**(c) Provider staff delivering services under this section must meet one of the following qualifications:**

- (1) A licensed professional.**
- (2) A QBHP.**
- (3) An OBHP.**

**(d) Agency staff providing services must provide:**

- (1) direct assistance in gaining access to necessary medical, social, educational, and other services; and**
- (2) referrals to services, activities or contacts necessary to ensure that the IICP**
  - (A) is effectively implemented and**

**(B) adequately addresses the mental health or addiction needs, or both, of the eligible recipient.**

**(e) The following services may be provided under the care coordination services identified under subsection (b):**

**(1) A needs assessment consists of identifying the recipient's needs for any medical, educational, social, or other services. Specific assessment activities necessary to form a complete needs assessment of the recipient may include:**

- (A) documenting the recipient's history;**
- (B) identifying the recipient's needs;**
- (C) completing related documentation; or**
- (D) gathering information from other sources, such as:
  - (i) family members or**
  - (ii) medical providers.****

**(2) The IICP development activities include the development of a written IICP based upon the information collected through the needs assessment phase. The IICP shall identify the habilitation activities and assistance needed to accomplish the recipient's objectives.**

**(3) Referral and linkage include activities that help link the recipient with:**

- (A) medical providers;**
- (B) social service providers;**
- (C) educational providers; and**
- (D) other programs and services that are capable of providing habilitative services that meet the recipient's needs.**

**(4) Monitoring and follow-up activities**

**(A) include making contacts necessary to ensure that the IICP is effectively implemented and adequately addresses the needs of the recipient and**

**(B) may include activities and contacts with the following individuals:**

- (i) The recipient.**
- (ii) Family members or others who have a significant relationship with the recipient.**
- (iii) Non-professional caregivers.**
- (iv) Providers.**
- (v) Other entities.**

**(5) Evaluation activities include face-to-face contact with the recipient at least every ninety (90) days for the following reasons:**

**(A) To ensure the IICP is effectively implemented and adequately addresses the recipient's needs.**

**(B) To determine if the services are consistent with the IICP and any changes to the IICP.**

**(C) To make changes or adjustments to the IICP in order to meet the recipient's ongoing needs.**

**(D) To evaluate or re-evaluate the recipient's progress toward achieving the IICP's objectives.**

**(f) The time devoted to formal supervision between the care coordinator and the licensed supervisor to review the recipient's care and treatment shall:**

- (1) be an included care coordination activity;**
- (2) be documented accordingly in the recipient's clinical record; and**
- (3) be billed under only one provider staff member.**

**(g) The following services are not reimbursable under this section:**

- (1) The direct delivery of medical, clinical, or other direct services.**
- (2) Services provided in a group setting, including but not limited to the following:**
  - (A) Training in daily living skills.**
  - (B) Training in work or social skills.**
  - (C) Grooming and other personal services.**
  - (D) Training in housekeeping, laundry, and cooking.**
  - (E) Transportation services.**
  - (F) Individual, group, or family therapy services.**
  - (G) Crisis intervention services.**
- (3) Services that go beyond assisting a recipient in gaining access to needed services including, but not limited to, the following:**
  - (A) Paying bills.**
  - (B) Balancing the recipient's checkbook.**
  - (C) Traveling to and from appointments with a recipient or recipients.**

*(Office of the Secretary of Family and Social Services; 405 IAC 5-21.6-15; filed)*

#### **405 IAC 5-21.6-16 Medication Training and Support Services**

**Authority: IC 12-8-6.5-5; IC 12-15**

**Affected: IC12-13-7-3; IC 12-29; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5**

**Sec. 16 (a) The services reimbursable as medication training and support services include the following:**

- (1) Services provided to the recipient in an individual or in a group setting.**
- (2) Services provided to family members or other nonprofessional caregivers in an individual or a group setting with or without the recipient present.**

**(b) The following services are reimbursable and must be provided face-to-face in either an individual or a group setting:**

- (1) Monitoring medication compliance.**
- (2) Medication training and support.**
- (3) Monitoring medication side effects.**
- (4) Providing other nursing or medical assessments.**

**(c) A provider agency may receive reimbursement for training family members or non-professional caregivers to perform the activities identified in this section.**

**(d) When provided to family members or other non-professional caregivers, the service**

- (1) must focus on and be on behalf of the recipient; and**
- (2) may include the training of family members or non-professional caregivers to:**
  - (A) monitor the recipient's medication compliance;**
  - (B) assist with the administration of prescribed medications; and**
  - (C) monitor side effects, including**
    - (i) weight,**
    - (ii) blood glucose level, and**
    - (iii) blood pressure.**

**(e) Medication training and support may also include the following services that are not required to be provided face-to-face with the recipient:**

- (1) Transcribing medication orders of**
  - (A) a physician.**
  - (B) an AHCP.**
- (2) Setting or filling medication boxes.**
- (3) Consulting with the attending physician or AHCP regarding medication-related issues.**
- (4) Ensuring linkage that lab and other prescribed clinical orders are sent.**
- (5) Ensuring that the recipient follows through and receives lab work and services pursuant to other clinical orders.**
- (6) Follow-up reporting of lab and clinical test results to the recipient and physician.**

**(f) Services provided that are not face-to-face with the recipient must meet the following standards:**

- (1) The recipient must be the focus of the service.**
- (2) Documentation must support how the service benefits the recipient.**

**(g) When provided in a clinic setting, medication training and support may compliment, but not duplicate, activities associated with medication management activities available under the Medicaid Clinic Option.**

**(h) When provided in a residential treatment setting, medication training and support may include components of medication management services as defined under the Medicaid Clinic Option.**

**(i) Provider staff delivering services under this section must meet one of the following qualifications:**

- (1) A licensed physician.**
- (2) An authorized health care professional (AHCP).**

- (3) A licensed registered nurse (RN).**
- (4) A licensed practical nurse (LPN).**
- (5) A medical assistant (MA) who has graduated from a two year clinical program.**

**(j) The services under this section must be provided within the practitioner's scope of practice as defined by federal and state law.**

**(k) The following services are not reimbursable under this section:**

- (1) Medication management, counseling or psychotherapy when medication management is a component of the service.**
- (2) Medication training and support that is billed separately for the same visit by the same provider.**
- (3) Coaching and instruction regarding a recipient's self-administration of medications.**
- (4) Services provided to paid, professional caregivers.**

*(Office of the Secretary of Family and Social Services; 405 IAC 5-21.6-16; filed)*

#### **405 IAC 5-21.6-17 AMHH Provider Agency Requirements**

**Authority: IC 12-8-6.5-5; IC 12-15**

**Affected: IC12-13-7-3; IC 12-29; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5**

**Sec 17. (a) In order to provide AMHH services under this rule, a provider must be authorized by the DMHA as an AMHH services provider agency.**

**(b) Provider agencies under this rule must attest that the individual provider staff member delivering an AMHH service meets the service-specific provider requirements and qualifications as defined within this rule.**

**(c) The DMHA and the Office have deemed state-certified community mental health centers (CMHCs) as being in good standing as DMHA-approved AMHH services provider agencies.**

- (d) Any provider wishing to apply to become an AMHH provider agency must:**
- (1) complete an AMHH provider agency application; and**
  - (2) submit the application to the DMHA for review and consideration.**

*(Office of the Secretary of Family and Social Services; 405 IAC 5-21.6-17; filed)*

#### **405 IAC 5-21.6-18 Fair Hearings and Appeals**

**Authority:** IC 12-8-6.5-5; IC 12-15

**Affected:** 12-13-7-3; IC 12-29; IC 25-23.6-10.5; IC 25-27.5-5

**Sec. 18. (a) Any of the following may appeal an action by the DMHA state evaluation team and request an administrative hearing:**

- (1) An applicant.**
- (2) A recipient of services under this rule.**
- (3) A duly authorized representative of:**
  - (A) an applicant.**
  - (B) a recipient.**

**(b) An individual, an applicant, or a recipient appealing an action under this rule must follow the appeal processes and procedures in 405 IAC 1.1.**

**(c) Administrative hearings and appeals by an applicant or recipient are governed by the procedures, time limits, provisions, and requirements set out in 405 IAC 1.1.**

**(d) In the event that the DMHA state evaluation team denies an applicant eligibility for AMHH services or authorization for a submitted IICP requesting AMHH services, the DMHA state evaluation team shall notify the following individuals of the AMHH denial determination:**

- (1) The applicant.**
- (2) The recipient of AMHH services under this rule.**
- (3) The duly authorized representative of the applicant or the recipient, if applicable.**
- (4) The AMHH provider agency.**

*(Office of the Secretary of Family and Social Services; 405 IAC 5-21.6-18; filed)*

#### **405 IAC 5-21.6-19 Complaints and Grievances**

**Authority:** IC 12-8-6.5-5; IC 12-15

**Affected:** IC 12-13-7-3; IC 12-29; IC 25-23.6-10.5; IC 25-27.5-5

**Sec. 19. (a) Any of the following shall have the right to file a written complaint or a written grievance with the State, the DMHA or the Office:**

- (1) An applicant.**

- (2) A recipient.**
- (3) A duly authorized representative(s) of an applicant or a recipient.**

**(b) A complaint or grievance regarding an AMHH provider agency or a provider shall be accepted by the following means:**

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

**(c) Upon receipt of a complaint or a grievance, the DMHA shall:**

- (1) log the complaint or grievance and**
- (2) initiate an investigation.**

**(d) After the investigation is complete, the DMHA shall notify the individual or the recipient filing the complaint or grievance of the DMHA's findings.**

**(e) The DMHA decision with regard to a complaint or a grievance**

- (1) may not be appealed and**
- (2) does not grant any appeal rights to the individual or the recipient filing a complaint or grievance.**

**(f) The filing of a complaint or grievance is not a pre-requisite to filing an appeal under section 18 of this rule.**

**(g) If the DMHA sends a letter to a provider agency under this section stating its findings regarding a complaint or a grievance of an applicant or a recipient, the following shall apply:**

- (1) The DMHA may require the provider agency to correct an identified deficiency within a timeline established by the DMHA.**
- (2) A provider agency's failure to correct the deficiency within the established timeline may result in sanctions up to, and including, decertification of the provider agency.**

*(Office of the Secretary of Family and Social Services; 405 IAC 5-21.6-19; filed)*

