The Indiana Family and Social Services Administration

Indiana Adult Mental Health Habilitation Services (AMHH)

October 15, 2014

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AMHH Training Outline

- Overview of AMHH Program Introduction
- AMHH Program service requirements and recipient rights
- AMHH Program eligibility
- AMHH application process
- AMHH services review

Section 1: Adult Mental Health Habilitation Program Introduction

- 1915 (i) State Plan Home and Community-Based benefit for Adults
  - 5 years with option to renew for an additional 5 year period
  - No limit on number of eligible individuals or length of their ongoing services

- Purpose of 1915 (i)
  - Accommodate needs of adults with serious mental illness (SMI)

Habilitation Versus Rehabilitation

- **The distinction of whether a service is *rehabilitative* versus *habilitative* is often more rooted in an individual's level of functioning and needs than in the actual service provided**.

- Rehabilitative Services focus on "restoring function" where as habilitative services, as defined by section 1915(c) (5) (c) are defined as : designed to assist participants in acquiring, retaining and improving the Self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings.

- Many of the services are similar to MRO but the treatment approach along with the recipient goals and objectives will be habilitation focused vs. rehabilitation

MRO VS. AMHH

- MRO (Rehab) vs AMHH (Hab) IICP's
  - Distinction between the IICP treatment goals
    - MRO has an expectation that the individual will steadily improve level of functioning over time (Rehabilitation Goals) (***for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level***)
    - The AMHH IICP expectation will be that the individual goals address reinforcement, management, adaptation and/or retention of a level of functioning (Habilitation goals) (***activities that are designed to assist individuals in acquiring, retaining, and improving the skills necessary to reside successfully in community settings)***

Services are For:

- Adults that have reached maximum benefit from rehabilitative treatment
- Individuals that who want habilitation services to help them maintain the gains made from rehabilitation
- Individuals who are at risk of institutionalization without intense home and community based services

Reasoning for AMHH Services

- Adults with SMI can be served at lower cost and in community settings
- Focus is on how to adapt and manage their illness to prevent institutionalization
- Adults with SMI can reach or maintain the highest level of independence and functioning

Section 2: AMHH Services

- An AMHH services recipient will be authorized to receive AMHH services on an approved individualized integrated care plan (IICP) for one year (360 days) from the Start Date of the eligibility determination

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

Home and Community-based Setting Requirements

- The setting is integrated in, and facilitates the individual's full access to, the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, like individuals without disabilities
- The setting is selected by the recipient among all available alternatives and identified in the IICP
- A recipient's essential personal rights of privacy, dignity and respect, and freedom from coercion and restraint are protected
- Individual initiative, autonomy, and independence in making major life choices, including but not limited to, daily activities, physical environment, and with whom to interact are optimized and not regimented
- Individual choice regarding services and supports, and who provides them, is facilitated

(Settings outside of the clinic/office or institutions)

Locations Not Considered Home or Community-based:

- Nursing facility
- Institution for mental diseases
- Intermediate care facilities for intellectually disabled
- Hospitals
- Clinics (e.g., doctor's office or community mental health center)
- Any other location that has the qualities of an institutional or clinic-based setting

Covered AMHH Service Requirements

- Be provided to an individual determined by the State Evaluation Team as eligible for AMHH services
- Be a service documented in the recipient's IICP, as approved by the State Evaluation Team
- Be a covered AMHH service, as described in this training and provider manual
- Be provided in a manner that is within the scope and/or limitations of the AMHH service, including provider qualifications
- Be supported in clinical documentation as a service that:
  - Continues to promote stability for the AMHH recipient; and
  - Enables the recipient to move toward obtaining the habilitative goals identified in the individual's IICP

Crisis Intervention

- Is a covered service for **ANY** Medicaid recipient, even though not on AMHH service array

- MRO & AMHH programs are mutually exclusive, but both include the Medicaid service of crisis intervention

- Not considered an MRO service even though it is in the MRO manual

Section 3: AMHH Providers

- DMHA approved and Medicaid enrolled provider agencies that meet specific AMHH standards and criteria
- Provide the opportunity for participants to receive access to full continuum of mental health services
- Expected to provide services in a manner that will ensure the health and safety of those individuals
- AMHH Provider Agency must ensure that the agency staff members meet the specific criteria and standards required for the AMHH service(s) they provide

(Full explanation of all requirements in **Section 3 of the AMHH Draft Provider Manual which is forthcoming**)

AMHH Providers (Cont'd)

- CMHC's are approved AMHH providers as they meet the following criteria:
  - CMHC is willing and able to provide AMHH services as described in the Medicaid approved state plan amendment and the AMHH provider manual and employees staff members meeting the required standards and qualifications to provide AMHH services
  - Agency is in good standing with FSSA, including maintaining good standing as a DMHA-certified CMHC
  - Agency has acquired a national accreditation by an entity approved by DMHA
  - Provider agency is an enrolled Medicaid provider that offers a full-continuum of care
  - Provider agency must maintain documentation in accordance with Medicaid requirements defined under 405 IAC 1-5-1 and 405 IAC 1-5-3
  - Employ individual providers that are eligible to provide AMHH services

(Refer to Agency Staff Requirements in Section 3 of Provider Manual)

Section 4: AMHH Recipient Rights

- AMHH providers shall ensure that all AMHH recipients in their care retain the following rights:

  - To receive appropriate behavioral health services in accordance with standards of professional practice, **appropriate to the recipient's needs and designed** to afford the individual a reasonable opportunity to maintain or improve his or her condition.

  - To participate in the planning of the IICP and crisis plan

  - Right to refuse treatment, including medication

AMHH Recipient Rights (Cont'd)

- Being treated with consideration, dignity and respect, free from mental, verbal and physical abuse, neglect
- Freedom of choice regarding AMHH service provider(s)
- Freedom to change AMHH service provider
- Confidentiality and protection of personal identifying and treatment-related information (HIPAA)

AMHH Recipient Rights (cont'd)

- Each eligible AMHH provider agency is required to ensure a written statement of rights is provided to each recipient

- The statement shall include:

  - The toll-free consumer service line number and the telephone number for Indiana protection and advocacy

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

AMHH Recipient Rights (cont'd)

- Grievance, Complaints and Incident Reporting
  - Provider agencies are required to:
    - Assist recipients in understanding their rights and options regarding filing a grievance or complaint within their agency and to DMHA
    - Follow the DMHA policy for grievances and complaints
    - Provider agencies are required to follow the DMHA policy on incident reporting.
    - DMHA incident report forms are being updated so AMHH recipients can be identified and all reports directed to the AMHH State Evaluation Team

Section 5: AMHH Program Eligibility

- Eligibility Determination and Conflict of Interest
  - To ensure no conflict of interest, the responsibility for AMHH program eligibility determination and approval of AMHH services, in all cases, is retained by the DMHA State Evaluation Team
  - Members of the State Evaluation Team are prohibited from having any financial relationships with the applicant/recipient requesting AMHH services, their families or the provider agency selected to provide AMHH services
  - AMHH provider agencies are required to have written policies and procedures available for review by the state which clearly defines and describes how conflict of interest requirements are implemented and monitored within the agency, protecting the individuals applying for AMHH services and the integrity of the AMHH services program

Eligibility Criteria

- Target Group Criteria
  - Medicaid enrolled adults
  - Age 35 or over
  - Have recommendation for intensive community based care on the Adult Needs and Strengths Assessment (ANSA) by scoring level 4 or higher
  - Meets ANSA algorithm which is based on a combination of scores that looks at strengths and risk factors

(See Section 4 of the Provider Manual)

Eligibility Criteria (Cont'd)

- AMHH eligible diagnoses include**:**
  - Schizophrenic Disorders (295.XX)
  - Major Depressive and Bipolar Disorders (296.XX)
  - Delusional Disorder (297.1)
  - Psychotic Disorder NOS (298.9)
  - Obsessive-Compulsive Disorder (300.3)

(See List of All Applicable Codes in **Appendix B and Section 4 of the AMHH Draft Provider Manual)**

Eligibility Criteria (Cont'd)

– Needs-based Criteria

- Without ongoing habilitation services as demonstrated by written attestation by a psychiatrist or Health Services Provider in Psychology (HSPP), the person will likely deteriorate and be at risk of institutionalization (e.g., acute hospitalization, State hospital, nursing home, jail)

- Must demonstrate the need for significant assistance in major life domains related to their mental illness (e.g., physical problems, social functioning, basic living skills, self-care, and potential for harm to self or others)

Eligibility Criteria (Cont'd)

- Needs-based Criteria (Cont'd)
  - Must demonstrate significant needs related to his/her behavioral health
  - Must demonstrate significant impairment in self-management of his/her mental illness or demonstrate significant needs for assistance with mental illness management
  - Must demonstrate a lack of sufficient natural supports to assist with mental illness management
  - The individual is not a danger to self or others at the time the application for AMHH services program eligibility is submitted for State review and determination

Section 6: Home and Community-Based Residence

- Residence Requirements
  - AMHH services will be furnished to individuals who reside in their home or in the community:
    - Eligible recipient resides in their own home or apartment not owned, leased, or controlled by a provider.
    - Reside in a setting that meets CMS 2249 final rule on Home and Community Based Settings.
    - Eligible recipient resides in a home or apartment that is owned, leased or controlled by a provider

Home and Community-Based Residence

- The emphasis is on engaging each individual in being an active member in the community at large.

- To justify that all AMHH services are home and community-based, a distinction must be made between where the person lives and where the person receives services.

- Services are designed to be delivered in community settings including, but not exclusively in the individual's home.

Home and Community-Based Residence

- AMHH Recipients and Residential Facility Standards and Expectations

  - Depending upon the person's level of need and functioning, he/she may choose to live in full-time supervised settings, settings that provide less than full-time supervision or settings that provide no on-site supervision: Only those settings that are approved 1915(i) settings

  - The decision for the choice for place of residence is based on the individual's identified needs, goals and resources
    - If a member does not reside in this home and community based per CMS final rule, the member will not be eligible to utilize AMHH or any HCBS program

  - The IICP reflects his/her aspirations and goals towards an independent lifestyle and how the residential setting contributes to empowering the individual to continue to live successfully in the community

  - Residential setting must be **home-like** (an atmosphere with patterns and conditions of everyday life that are as close as possible to those of individuals without a diagnosis of mental illness)

Home and Community-Based Residence

- Standards for AMHH recipients living in a DMHA-certified residential setting:
  - Individual/single occupancy dwellings or residences which support multiple individuals
  - DMHA-certified residential settings in which some individuals may choose to live will promote opportunities to assist and support each individual to grow and develop skills needed to continue to live in the community
  - While in a DMHA-certified residential facility, the provider's responsibility is to ensure the resident's involvement in decisions that affect his/her care, daily schedules and lifestyles
  - The overall atmosphere of the setting is conducive to the achievement of optimal independence, safety and development by the resident with his/her input

Home and Community-Based Residence

- Standards for Residential Setting (Cont'd):
  - The location of the facility is made to provide residents reasonable access to the community at large including but not limited to agency, medical, recreational, and shopping areas, by public or agency-arranged transportation
  - The location, design, construction, and furnishings of each residence shall be consistent with a family/personal home (home-like)
  - The majority of services and behavioral health care is provided in locations outside of the residence, such as in the community at large or in a clinic setting
  - Residents are afforded the opportunity to engage in community-based programs that assist the individual in achieving goals including employment

AMHH Resident Rights and Responsibilities

- Recipients living in a DMHA-certified residential setting have the following rights:
  - The environment is safe
  - Each resident is free from abuse and neglect
  - Each resident is treated with consideration, respect, and full recognition of the resident's dignity and individuality
  - Each resident is free to communicate, associate, and meet privately with persons of the resident's choice as long as the exercise of these rights does not infringe on the rights of another resident and any restriction of this right is a part of the resident's individual treatment plan
  - Each resident has the right to confidentiality concerning personal information including health information
  - Each resident is free to voice grievances and to recommend changes in the policies and services offered by the agency

AMHH Resident Rights and Responsibilities

– Rights Cont'd

- Each resident has the right to manage personal financial affairs or to seek assistance in managing them unless the resident has a representative payee or a court appointed guardian for financial matters
- Each resident shall be informed about available legal and advocacy services, and may contact or consult legal counsel at the resident's own expense
- Each resident shall be informed of DMHA's toll free consumer service number
- Each resident has the right to privacy in their sleeping or living unit

AMHH Resident Rights and Responsibilities

- Rights Cont'd
  - Each resident has the right to units having lockable entrance doors, with appropriate staff having keys to doors
  - When sharing living units, each resident has a choice of roommates
  - Each resident has the freedom to furnish and decorate their sleeping or living units
  - Each resident is able to have visitors of their choosing at any time
  - The setting is physically accessible to each resident
  - Each resident will be free from restraints, restrictive interventions, and seclusion
  - Any modification of the resident's rights must be supported by a specific assessed need and documented in the person-centered IICP (i.e. Not infringing rights of others)

AMHH Resident Rights and Responsibilities

- If choice on a Residential Setting right can not be accommodated:

  - Must document choice is offered and if it can't be supported the provider will need to:
  - Document the reason why
  - Document plan on how they will work together with consumer to move toward facilitating their choice in the future

DMHA-Certified Residential Facility Settings

- Supervised group living facility
- Transitional residential services facility
- Semi-independent living facility defined under IC 12-22-2-3
- Alternative family homes operated solely by resident householders

Section 7: AMHH Application Process

- Referrals to AMHH services can come from any source:
  - CMHC's or other treatment providers may identify individuals who appear to meet target group criteria
  - Individuals may notify their provider of an interest in the home and community based services
  - Family members
  - www.in.gov/fssa/dmha/index.htm- will give info on eligibility criteria and all services, provider agencies, locations where to apply, and how to access assessments and services.
  - When contacting the state, an individual will be given a list of AMHH provider agencies that are eligible to assist them in completing the application and evaluation for AMHH services

AMHH Services Program Application

- AMHH Referrals
  - Only a DMHA approved Medicaid enrolled AMHH provider may submit AMHH referrals
  - The AMHH provider will review the target group eligibility criteria and service options with an individual interested in exploring AMHH services as a treatment option
  - Together, the individual and provider will determine whether to complete an application for AMHH services
  - Services will not be provided for any individual who has not completed an AMHH application and/or does not meet all AMHH eligibility criteria, as determined by the DMHA State Evaluation Team

AMHH Services Program Application

- Provider Requirements for AMHH evaluation
  - The AMHH provider agency must ensure the agency staff member providing the face-to-face AMHH evaluation meets the following minimum qualifications:
    - Possess at least a Bachelor's degree in social sciences or related field, with two (2) or more years of clinical experience
    - Completed DMHA and OMPP approved training and orientation for AMHH services and the application process
    - Completed the Adult Needs and Strengths Assessment (ANSA) Certification training
    - Must be a certified ANSA user with supervision by an ANSA super-user

AMHH Services Program Application

- Evaluation for AMHH Eligibility:
  - Reviewing AMHH criteria with the applicant
  - Completion of the AMHH application
  - Initial AMHH evaluation (including ANSA completed within 60 days prior to submission of AMHH application)
  - Development of the proposed AMHH Individualized Integrated Care Plan (IICP)

AMHH Services Program Application

- Assessment for AMHH Eligibility Criteria and Need
  - Review, discussion and documentation of the applicant/recipient's desires, needs, and goals. Goals are recovery/habilitative in nature with outcomes specific to the habilitative needs identified by the applicant/recipient
  - Review of psychiatric symptoms and how they affect the applicant/recipient's functioning and ability to attain desires, needs and goals
  - Review of the applicant/recipient's skills and the support needed for the applicant/recipient to participate in a long-term recovery process, including stabilization in the community and ability to function in the least restrictive living, working, and learning environments
  - Review of the applicant/recipient's strengths and needs, including medical, behavioral, social, housing, and employment

AMHH Services Program Application

- Supporting Documentation includes but not limited to:
  - Historical and current health status
  - Behavioral health issues
  - Current living situation
  - Functional needs
  - Family functioning
  - Vocational/employment status
  - Social functioning
  - Living skills

AMHH Services Program Application

- Supporting documentation (Cont'd)
  - Self-care skills
  - Capacity for decision making
  - Potential for self-injury or harm to others
  - Substance use/abuse
  - Participation in MRO services and the outcomes for those services
  - Medication adherence

AMHH Services Program Application

- AMHH Individual Integrated Care Plan Development (IICP)

  - The agency provider staff member, the applicant, and the applicant's choice of interested persons will jointly develop a proposed IICP

  - That includes identified strengths, needs, applicant's desired goals and services (including proposed AMHH services) deemed necessary to address the documented goals

  - These should connect to the needs and strengths identified in the ANSA

AMHH Services Program Application

- Informed Choice of Providers
  - The following information must be provided to the applicant during the AMHH application process:
    - Explanation of the applicant's right to an Informed Choice of Providers
    - Provide the applicant with a randomized listing of DMHA-approved AMHH provider agencies (recipient's county of residence and contiguous counties)
    - Inform applicant that an AMHH provider agency listing is also posted on the Indiana Medicaid website at www.indianamedicaid.com, as well as the DMHA webpage at http://www.in.gov/fssa/dmha/2876.htm.
    - Inform the applicant of their right to elect to change an AMHH provider at any time during enrollment in AMHH services; and that the current AMHH provider is expected to assist the individual in transitioning service delivery to the newly selected AMHH provider

AMHH Services Program Application

- Completion of the AMHH Application
  - The application must be completed in its entirety and include the following **attestations (indicated with a signature):**
    - **Psychiatrist or Health Services Provider in Psychology (HSPP) attestation** regarding the imminent likelihood that without ongoing habilitation services the applicant will likely deteriorate and be at risk of institutionalization (e.g. acute hospitalization, State hospital, nursing home, jail); services and IICP are deemed appropriate and medically necessary; and applicant is not a danger to self or others at the time this application is submitted
    - Signature of care coordinator and ANSA Super User
    - Program requirements including financial requirements have been reviewed with applicant
    - **Applicant's signature** verifying the applicant participated in the development of the IICP, crisis plan, and is requesting AMHH services on the IICP
    - The proposed IICP is individualized to meet the applicant's needs
    - **Applicant was informed of their AMHH Provider Choice** and selected the provider(s) for AMHH services on the IICP
    - **Applicant has been given choice of services**

AMHH Services Program Application

- Submission of AMHH Application
  - The following is required for a complete application submission via DARMHA:
    - Completed and signed AMHH application
    - Completed and signed proposed AMHH IICP
    - Signed attestations
    - ANSA LON and eligible diagnosis
    - Supporting documentation necessary to demonstrate applicant's level of need meeting AMHH criteria, and need for requested services

AMHH Services Program Application

- Incomplete Application Submissions
  - AMHH application submissions with **insufficient information** will not be processed by the State Evaluation Team
  - Application will be returned to provider to complete/add missing information
  - If not completed within 7 calendar days, application will be automatically denied
  - Responsibility for AMHH program eligibility determination and approval of the IICP proposed services in all cases is retained by the Independent State Evaluation Team in order to ensure no conflict of interest in the final determinations

Section 8: Person Centered Planning and Care Plan (IICP) Development

- The IICP is a habilitative-focused plan of care that integrates all components and aspects of care that are:
  - Deemed medically necessary
  - Supported by recipient's identified needs
  - Are clinically indicated
  - Are provided in the most appropriate setting to achieve the applicant/recipient's goals

Person Centered Planning and Care Plan (IICP) Development

- The applicant/recipient has authority to determine who is included in the process (in their team?)
- IICPs require staff and applicant/recipient signatures as well as clinical documentation of recipient's participation
- Developed with each applicant/recipient through a collaboration that includes the applicant/recipient, identified community supports (family/nonprofessional caregivers) and all individuals/agency staff involved in assessing and/or providing care for the applicant/recipient

Person Centered Planning and Care Plan (IICP) Development

- The provider agency staff member must ensure the IICP development is driven by a **person-centered planning process** that includes the following IICP standards:

  - Identifies the applicant/recipient's physical and mental health support needs, strengths and preferences and desired outcomes
  - Takes into account the extent of, and need for, any family or other supports for the individual, and neither duplicates nor compels natural supports
  - Prevents the provision of unnecessary or inappropriate care
  - Identifies the AMHH service(s) the applicant/recipient is assessed to need
  - Is guided by best practices and research on effective strategies for improved health and quality of life outcomes

Person Centered Planning and Care Plan (IICP) Development

- The following components must be documented on the IICP:

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

  - Individuals or teams responsible for treatment, coordination of care, linkage, and referrals to internal or external resources and care providers to meet identified needs

  - A comprehensive listing of all specific treatments and services that are requested by the applicant/recipient, as well as a description of how that service will be used to address goals identified in the IICP

  (See IICP example attached)

Person Centered Planning and Care Plan (IICP) Development

- As a part of the completed application, the state also requires documentation, signed by the **applicant/recipient** that **attests** to the following:

  - The applicant/recipient is an active participant in the planning and development of the AMHH IICP and crisis plan
  - The applicant/recipient is requesting AMHH services on the IICP
  - The applicant/recipient received a randomized list of eligible AMHH service provider agencies in his/her community to choose the AMHH provider
  - The applicant/recipient has selected the provider(s) of his or her choice to deliver the AMHH service on the IICP

Person Centered Planning and Care Plan (IICP) Development

- MRO (Rehab) vs AMHH (Hab) IICP's
  - Distinction between the IICP treatment goals
    - MRO has an expectation that the individual will steadily improve level of functioning over time (Rehabilitation Goals)
    - The AMHH IICP expectation will be that the individual goals address reinforcement, management, adaptation and/or retention of a level of functioning (Habilitation goals)

Person Centered Planning and Care Plan (IICP) Development

- Applicant/Recipient Refusal To Sign IICP

  - Must document on the plan of care that the recipient agreed to the plan but refused to sign the plan

  - Must document in the clinical record progress note that a planning meeting with the applicant/recipient did occur and that the IICP reflects the recipient's choice of services and agreement to participate in the services identified in the IICP

  - The progress note must further explain any known reasons why the applicant/recipient refused to sign the plan and how those will be addressed in the future.

Person Centered Planning and Care Plan (IICP) Development

- Crisis plan
  - Crisis plan must be maintained in clinical chart
  - Effectiveness must be routinely monitored and **reviewed at every IICP review**
  - The AMHH provider must ensure that **all treatment team members and providers have the most up-to-date documentation** to support the recipient in the event of a crisis

Person Centered Planning and Care Plan (IICP) Development

- Crisis plan- Should include:

  - The plan should reflect the **choice and preferences** of the recipient and family/caregiver, if applicable

  - Potential crises are **identified and documented during the IICP development process**, using identified needs indicated on the **ANSA** tool (and family/caregiver reports of past crisis situations, if applicable)

  - Indicators of emerging risks, impending crises, and reduced levels of risk are identified in the plan

  - Strategies to which the recipient has **responded well in the past are noted**, as well as action steps to prevent or mitigate crises

Person Centered Planning and Care Plan (IICP) Development

- Crisis plan- Should include (Cont'd):

  - Action steps include identifying **the person responsible for each particular action** noted on the crisis plan (i.e., family, natural supports, and formal supports), including a **back-up and contingency plan** if the identified resource or individual cannot be accessed during the crisis

  - Specific AMHH services **may be added to the IICP** to build coping skills, defuse crises, or provide support during a crisis (e.g., Respite, Peer Support)

  - **Other community resources and supports** are identified and included in the crisis plan

Section 9: AMHH Eligibility Determination & Service Authorization

- DMHA State Evaluation Team
  - Responsible for determining AMHH eligibility for the following:
    - Applicant's need and eligibility for enrollment in AMHH program
    - Need for and types of AMHH services applicant/recipient is eligible to receive
    - Authorization for changes/renewal of AMHH services

Eligibility Determination & AMHH Service Authorization

- The DMHA State Evaluation Team reviews and approves or denies all proposed AMHH eligibility and services

- Process (See AMHH Eligibility Determination flow chart)

  - The DMHA approved AMHH provider agency submits:

    - Completed ANSA scores input into DARMHA within last 60 days, as well as an eligible diagnosis
    - AMHH application
    - A proposed IICP

Eligibility Determination & AMHH Service Authorization

- Process (Cont'd)
  - Upon receipt of the AMHH application the DMHA State Evaluation Team will:
    - Review application for sufficient documentation of need
    - Verify individual meets all target group and needs-based eligibility criteria for AMHH services.
    - Review IICP

Eligibility Determination & AMHH Service Authorization

- IICP is reviewed for the following:

  - IICP includes the applicant's strengths and needs, as supported by the clinical documentation and ANSA.
  - *Goals* and *objectives* are linked to the applicant's identified needs
  - *Interventions* support the *goals, objectives* and needs.
  - Evidence provided that the applicant will benefit from habilitation services.
  - Evidence that the IICP submitted is individualized and driven by the applicant's needs and preferences.
  - AMHH services proposed are supported by the IICP and clinical documentation submitted with the AMHH application.
  - A listing of non-AMHH services and supports that will be used to assist in meeting the applicant's identified needs not met by AMHH services alone.

Eligibility Determination & AMHH Service Authorization

– Process (Cont'd)

- The state evaluation team will make the eligibility determination
- If determined eligible, an authorization notification will be sent to the referring AMHH provider notifying them of the AMHH eligibility determination and the AMHH services approved on the proposed IICP
- The authorization notification will be generated by HP and will include the following information:
  - In the case of an initial AMHH eligibility determination, a start and end date for AMHH eligibility will be presented. The start of AMHH services and end date for MRO services (if applicable) will be consecutive dates so there will be no lapse in service delivery.
  - Start and End dates for AMHH eligibility and AMHH services approved by the State Evaluation Team.
  - AMHH services approved, including the procedure code, modifiers and number of units approved.

Eligibility Determination & AMHH Service Authorization

Process (Cont'd)

- **If determined ineligible** for AMHH services, denial letters will be sent to the applicant and provider informing them that their application for services has been denied, or that specific services requested on the proposed IICP of an AMHH eligible recipient were denied. **It is the provider's responsibility to inform the applicant of the denial and their appeal rights.**
- The denial letter will include the reason for denial, appeal rights and process
- Provider will assist recipient/applicant in following appeals process if needed
- In the event that an **applicant is deemed eligible** for AMHH services, **but one or more of the services** requested on the proposed IICP are **denied**
  - An authorization notification will indicate that a portion of the AMHH application was approved
  - AMHH provider can assist the applicant in understanding the reasons for the denial
  - AMHH referring provider will receive both the approval and denial notifications in the form of an authorization notification

Eligibility Determination & AMHH Service Authorization

- Eligibility Period
  - The recipient will be authorized for the AMHH services on the approved IICP for one year from the Start Date of the eligibility determination
  - The Provider Agency is required to:
    - Continually monitor the recipient's progress in care and any change in status that might impact the recipient's eligibility for AMHH services
    - Update the IICP should the recipient's needs change requiring a different mix in services
    - Track the end date of AMHH services and submit an **AMHH renewal applicati**on and updated IICP prior **30-60 days prior to the end date** (if recipient chooses, continues to meet AMHH criteria and would benefit from renewal of AMHH services)
    - **During the 11th month (within 30-60 days of end date) a new ANSA and renewal application are necessary in order to prevent lapse in service**

Interruption of AMHH Services

- May occur when recipient leaves the community:
  - AMHH services may not be billed during the period of service interruption
  - Authorized service units will remain available for the eligibility period
  - Immediate access when the recipient returns to the community
- If recipient does not return to community during eligibility period:
  - The recipient must reapply for AMHH services prior to or upon reintegration into the community, with the assistance of an AMHH service provider agency
  - AMHH service eligibility & service requests may be applied for while an individual is in an institutional setting and preparing for a discharge back into the community with the provider agency completing the ANSA and AMHH application specifying the discharge date
  - AMHH services are not reimbursable until the applicant has returned to a community-based setting.

Termination of AMHH Services

- At the end of the eligibility period:
  - If client either decides not to go forward with applying for another year of eligibility, or is no longer eligible when re-applying for another year
  - ANSA needs to be completed within last 60 days of AMHH service period and input into DARMHA
  - The day after the end date of AMHH services, DARMHA will initiate data being sent to HP to determine MRO eligibility

Termination of AMHH Services

- During the eligibility period:
  - Recipient chooses to end AMHH services
  - ANSA needs to be completed or one was completed in the last 60 days and input into DARMHA
  - Provider discharges recipient from AMHH services in DARMHA
  - DMHA will put end date of AMHH services into DARMHA to complete discharge
  - DARMHA will initiate the day after the end date to auto-generate the eligibility determination data to be sent to HP

Termination of AMHH Services

- During the eligibility period (Cont'd):
  - If efforts to coordinate transition to another services program (such as MRO) by provider are unsuccessful:
    - The provider agency must document in the clinical record the attempts made to coordinate transition to other services
    - Complete an ANSA assessment (if possible) and input the results into DARMHA so MRO eligibility can be determined and auto-generated the day following the end date of AMHH services.
    - Provider discharges recipient from AMHH services in DARMHA
    - DMHA will put end date of AMHH services into DARMHA to complete discharge
    - Day after end date, DARMHA will auto-generate data file to be sent to HP to determine MRO eligibility

Section 10: Requests for Additional AMHH Service Authorization

- Request to **modify/add services to current IICP**
  - In the event that a recipient's needs change and additional AMHH services are deemed appropriate
  - Additional services may be requested, but not additional units of service
  - For additional AMHH services:
    - Provider Agency completes updated application and IICP
    - Provider agency will submit the completed AMHH application packet and supporting documentation to the DMHA State Evaluation Team through DARMHA for review and eligibility determination on requested services

Requests for Additional AMHH Authorization

- Upon receipt of the **Modification Application**, the State evaluation team will:
  - Review application packet and supporting documentation
  - Verify individual continues to meet all target group and needs-based eligibility criteria for AMHH services
  - Review of the updated IICP

Requests for Additional AMHH Authorization

- **Modification/Adding Services** Process (Cont'd)
  - The state evaluation team will make an eligibility determination for the requested service(s)
  - If determined eligible for additional AMHH services, an eligibility determination letter and IICP service approval will be sent and include a start date for the modified AMHH eligibility (end date remains unchanged from first determination)
  - If determined ineligible for an addition of AMHH service(s), denial letters will be sent to the applicant and providers. Provider is responsible for informing the applicant of the denial and informing them of their appeal rights.
  - The letters will include the reason for denial, appeal rights and process
  - Provider will assist recipient/applicant in following appeals process if needed
  - Current approved AMHH services will continue

Section 11: AMHH Services Program Renewal of Eligibility

- **(Mirror's initial application process and requirements)**

- **AMHH Renewal Evaluation** will be conducted at least every twelve (12) months
  - The re-evaluation will include, but is not limited to, all of the following:
    - A face-to-face holistic clinical and bio-psychosocial assessment by a DMHA approved service provider
    - Administration of the ANSA within 30-60 days of AMHH end date to determine if the recipient still meets the level of need and needs-based criteria
    - Assessment of the recipient's progress towards meeting treatment goals of the IICP
    - Evaluation of the recipient strengths, needs and functional impairments
    - Documentation that the recipient still meets financial, target group eligibility and needs based criteria
    - Updated IICP

AMHH Services Program Renewal of Eligibility

- Upon receipt of the **Renewal Application**, the State evaluation team will:
  - Review application packet and supporting documentation
  - Verify individual continues to meet all target group and needs-based eligibility criteria for AMHH services
  - Review the updated IICP

AMHH Services Program Renewal of Eligibility

- **Renewal** Process (Cont'd)
  - The state evaluation team will make an eligibility determination for the program and requested services
  - Any approval or denial of AMHH services will be communicated by email to the applicant or his/her authorized representative and the referring provider
    - Approvals are mailed by HP
    - Denials are emailed to the provider and mailed to the applicant/guardian/AR
  - If determined eligible for ongoing AMHH services, an eligibility determination letter and IICP service approval will be sent
  - If determined ineligible for ongoing AMHH services, denial letters will be sent to the applicant/guardian/AR and providers. Provider is responsible for informing the applicant of the denial and informing them of their appeal rights.
  - Denial letters will include the reason for denial, appeal rights and process
  - Provider will assist recipient/applicant/and/or guardian/authorized rep in following appeals process if needed

AMHH Services Program Renewal of Eligibility

– **Renewal** Process (Cont'd)

- With a denial, the MRO process will initiate for eligibility for an MRO package the day after the end date of AMHH services

- Going forward as usual an ANSA reassessment must be completed within 60 days of the end of the MRO service package

Section 12: Transition Requirements for the AMHH Services Program

- Between providers
  - Assist in linking the recipient with the recipient-selected provider agency of choice and transfer of clinical documentation (with a signed consent)
  - May include last assessment, current treatment plan and progress notes, crisis plan, etc.
  - Communicate with the new provider agency regarding the services already utilized out of the authorized AMHH services
  - The authorization for AMHH services belongs to and follows the AMHH recipient
  - Authorized service units and the AMHH eligibility period will not change
  - The new provider agency must follow the process for requesting additional services to meet any needs that arise. Refer to provider manual *Section 10: Requests for Additional AMHH Services Authorization*

Section 13: Clinical and Administrative Documentation

- The documentation required to support billing for AMHH services must:
  - Focus on habilitation
  - Emphasize the recipient's strengths
  - Reflect recipient's progress toward the goals reflected in the IICP
  - Be updated with every recipient encounter that billing is submitted for reimbursement
  - Be written and signed by the provider rendering services (and cosigned if applicable)
  - Follow general documentation requirements outlined in this manual section

General Documentation Requirements

•Each specific AMHH service may have its own unique documentation requirements in addition to the general requirements

•General documentation requirements apply to all AMHH services.

•Documentation standards specific to each AMHH service are detailed, along with the **service definition**, **scope**, **limitations and exclusions**, in subsequent sections of this manual

•Providers are responsible for understanding and adhering to the requirements and limitations for each service they are qualified to provide

General Documentation Requirements:

- **All documentation** is subject to **review by the Centers for Medicare & Medicaid Services (CMS) and the State**, or its designees

- **Eligibility for claims payment** under the AMHH program is based on the provider maintaining the **required documentation**

- The provider is subject to **denial of payment** or recoupment for paid claims for services if the provider **does not have adequate documentation** to support the AMHH service billed

General Documentation Requirements

- (Same as MRO) Documentation for each encounter must include:
  - Type of service being provided
  - Name and qualifications of the staff providing the service
  - Location or setting where the service was provided
  - Focus of the session or service delivered to or on behalf of the recipient
  - Individual symptoms or issues addressed during the session
  - Duration of the service (actual time spent with the recipient)
  - Service location specifications

General Documentation Requirements

- For purposes of AMHH service delivery in a community-based setting, the following clarifications are provided:
  - A community setting is a nonclinical, office-based, non-institutional setting (examples of an institution include, but are not limited to, jail, agency locations, State Operated Facilities)
  - A residential setting is any setting in which a consumer resides or sleeps

General Documentation Requirements

- Documentation for each encounter must include (Cont'd):
  - Start and end time of the service
  - Recipient's IICP goal(s) being addressed during the session
  - Progress made toward recovery goals (*Note: Individualized goals will be habilitative in nature and progress may be framed as sustained maintenance of skills or functioning allowing the individual to live in the community in the least restrictive environment possible.*)
  - Date of service rendered (including month, day, and year)
  - The content of the documentation must support the amount of time billed.

Additional requirements for selected service types

- **Group Setting Documentation Requirements** for each encounter:
  - All items under general requirements
  - Focus of the group or session
  - Recipient's level of activity in the group session

***noting that the recipient was present in the group is not sufficient!

Additional requirements for selected service types

- **Services Without the Consumer Present Documentation Requirements** for each encounter:
  - All items under general requirements
  - Who attended the session and his or her relationship with the consumer
  - How the service benefits the consumer and assists the consumer in reaching his or her recovery and habilitation goals

AMHH Service Array

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

Adult Day Service

- The activities reimbursable as adult day services consist of a **community-based group program** designed to meet the needs of adults with significant behavioral health impairments, as identified in the IICP.

- These **comprehensive, non-residential programs provide health, wellness, social, and therapeutic activities in a structured, supportive environment.** The services provide supervision, support services, and personal care as required by the IICP.

Adult Day Services

- Include:
  - Care planning
  - Treatment
  - Monitoring of weight, blood glucose level, and blood pressure
  - Medication administration
  - Nutritional assessment and planning
  - Individual or group exercise training
  - Training in activities of daily living (ADL's)
  - Skill reinforcement on established skills
  - Other social activities

Adult Day Service

Provider Qualifications:

- A licensed professional, except for a licensed clinical addiction counselor
- A Qualified Behavioral Health Professional (QBHP)
- Other Behavioral Health Professional (OBHP)

Adult Day Service

Provider Qualifications (Cont'd):

- Medication administration providers must meet one of the following qualifications in order to administer medication in the adult day service program:
  - A licensed physician
  - An authorized health care professional (AHCP)
  - A registered nurse
  - A licensed practical nurse (LPN)
  - A medical assistant who has graduated from a two year clinical program
- A certified dietician providing nutritional assessment and planning services must meet qualifications, as defined in IC 25-14.5-1-4.

(These are not required activities, but if provided, they must be provided by qualified staff)

Adult Day Service Program Standards:

- The service **requires face-to-face** contact with the recipient in which the recipient is the focus of the service.
- Recipient **goals must be designed to facilitate community integration, employment, and use of natural supports**.
- Therapeutic services include **clinical therapies, psycho-educational groups, and habilitative activities.**
- **Documentation must support how the service benefits the recipient, even when service is provided in a group setting.**

Adult Day Service Program Standards:

- Medication administration must be provided within the scope of practice, as defined by federal and State law. Refer to the *Indiana Professional Licensing Agency* for additional information.
- Nutritional assessment and planning services must be delivered by a certified dietician and provided within the scope of practice, as defined in state and federal law. Refer to the *Indiana Professional Licensing Agency* for additional information.
- Each day of service must be appropriately documented.
- At a minimum, a weekly review and update of the recipient's progress toward habilitative goals will occur and be documented in the recipient's clinical record.

Adult Day Service Program Standards:

- Direct service providers must be **supervised by a licensed professional**

- **Clinical oversight** must be provided by a licensed **physician**, who is **on-site at least once a week and available to program staff when not physically present**

- Documentation requirements are the same as AIRS with the exception that medication administered must be documented at the time of dispensing per agency policies and procedures.

- Agencies must have and implement **policies and procedures that require either a daily or weekly progress note** that contains all required documentation elements.

Adult Day Service Exclusions:

- Formal **educational or vocational** services are considered non-reimbursable/non-covered.

- Services **shall not be reimbursed when provided in a residential setting**, as defined by DMHA.

- Additional exclusions as outlined in the *Non-Covered Services* subsection in *Section 2: AMHH Services*.

Adult Day Service Unit Limitations:

- The service is offered in **half day units**
- **A single half-day** (1/2 day) day unit is defined as **one unit** of a **minimum of three (3) hours** to a **maximum of five (5) hours/day**
- **Two units** are defined as **more than five (5) hours** to a **maximum of 8 hours/day**
- A **maximum of two half-day (1/2 day) units/day** is allowed **up to 5 days per week (52 weeks per year)**

Respite Care

- (New Service)
- Service Definition:
  - Services provided to **recipients** who are **unable to care for themselves and are living with a non-professional (unpaid) caregiver**
  - These services are furnished on a **short-term basis** because of the **non-professional caregiver's absence or need for relief**
  - These services **can be provided in** the recipient's **home** or place of residence, in the caregiver's home, or in a non-private **residential setting** (such as a group home or adult foster care)
  - A person who lives in a provider **residential setting is not eligible for Respite** – only individuals who live with a non-professional caregiver

Respite Care

Provider Qualifications:

- A licensed professional, except for a licensed clinical addiction counselor
- A Qualified Behavioral Health Professional (QBHP)
- Other Behavioral Health Professional (OBHP)

Respite Care (Cont'd)

Provider Qualifications:

Providers administering medication and support services under this section must meet one of the following qualifications:

- A licensed physician
- Advanced Nurse Practice Nurse (APN)
- Physician Assistant (PA)
- Registered Nurse (RN)
- Licensed Practical Nurse (LPN)

Respite Care

Program Standards:

- Recipient must be living with a **non-professional (unpaid) caregiver**
- Location of service and level of professional care is based on the needs of the recipient receiving the service including regular monitoring of medications or behavioral symptoms as identified in the IICP
- Service must be provided in the **least restrictive environment available** and ensure the health and welfare of the recipient
- Medication administration and medical support services provided within respite care must be provided within the scope of practice as defined by federal and state law.

Respite

- Documentation

  - Daily progress note following Medicaid standards

  - Documents activities during respite period and recipient's behaviors and responses

  - In addition to standard documentation requirements, document the following in the service notes:

    - Primary location of services rendered.
    - The reason for the respite service.

Respite Care Exclusions:

- Shall not be used as a substitute for regular care to allow the recipient's caregiver to attend school, hold a job or engage in employment or employment search related activities
- Service provided to a recipient living in a DMHA-certified residential facility
- Service provided to a recipient living in supportive housing
- Any service that meets the definition of hospice services
- Respite care provided by any relative who is the primary caregiver of the recipient; or anyone living in the recipient's residence

Respite Care

Limitations:

- *Hourly Respite Care*: Offered at an hourly rate for services **billed up to seven (7) hours per day** for a **maximum of seventy-five (75) hours (300 units) per year.**

- *Daily Respite Care*: Offered at a daily rate for services **billed eight (8) to twenty-four (24) hours within the same day**. Daily respite care may be provided for **up to fourteen (14) consecutive days** for a **maximum of twenty-eight (28) days during any year.**

Therapy and Behavioral Support Services

- Six service types under Therapy and Behavioral Support

  - Therapy and Behavioral Support Services – Individual Setting
  - Therapy and Behavioral Support Services – Family/Couple with Recipient Present (Individual Setting)
  - Therapy and Behavioral Support Services – Family/Couple without Recipient Present (Individual Setting)

  - Therapy and Behavioral Support Services – Group Setting
  - Therapy and Behavioral Support Services – Family/Couple with Recipient Present (Group Setting)
  - Therapy and Behavioral Support Services – Family/Couple without Recipient Present (Group Setting)

Therapy and Behavioral Support Services

- **Provider Qualifications:**

- A licensed professional, except for a licensed clinical addiction counselor
- A Qualified Behavioral Health Professional (QBHP)

Therapy and Behavioral Support Services

- **Program Standards:**

  - The **face-to-face interaction** with the recipient, family members or non-professional caregivers supporting the recipient.
  - The **recipient must be the focus of the treatment**; and the service must address a goal(s) identified in the IICP.
  - **Documentation must support how the service specifically benefits the identified recipient**
  - Must demonstrate **progress toward and/or achievement of individual treatment goals**
  - Goals must be **habilitative** in nature
  - **Observation of the recipient** in their environment for **purpose of care plan development**
  - **Development of** a person centered behavioral support plan and subsequent revisions which may be a part of the **IICP**

Therapy and Behavioral Support Services

- Program Standards(Cont'd)
  - Allowable activities include but are not limited to:
    - Assertiveness
    - Stress reduction techniques
    - The acquisition of socially accepted behaviors
    - Implementation of a behavior support plan for staff, family members, roommates, and other appropriate individuals

Therapy and Behavioral Support Services

- **Exclusions:**
  - **Service provided in a clinic setting** is not billable as an AMHH service; but **may qualify for reimbursement under the Medicaid Clinic Option.**
  - Additional exclusions as outlined in the *Non-Covered Services* subsection in *Section 2: AMHH Services*.

Therapy and Behavioral Support Services

- **Limitations:**

- ***Individual therapy*** *and behavioral support services*, including combination of all three **(3) subtypes** (individual, family/couple with and without the recipient present), may be provided for a maximum of **twenty-four (24) hours (96 units) per year**

- ***Group therapy*** *and behavioral support services*, including combination of all three **(3) subtypes** (group, family/couple, with and without the recipient present), may be provided for a maximum of **thirty (30) hours (120 units) per year.**

- *****This is the only service that does not roll up all subtypes under a single number of service units allowed.**

Supported Community Engagement Services

- (New Service)

- Service Definition:

  - Services that engage a recipient in **meaningful community involvement activities** such as **volunteerism or community service**

  - These **include teaching concepts to encourage attendance, task completion, problem solving and safety**

  - Services are **aimed at** the general result of **community engagement**

  - Services are habilitative in nature and **shall not include explicit employment objectives**

Supported Community Engagement Services

- **Provider Qualifications:**

  - A licensed professional
  - A qualified behavioral health professional (QBHP)
  - Other behavioral health professional (OBHP)

Supported Community Engagement Services

- **Program Standards:**
  - Requires **face-to-face** contact with the recipient in a **community setting**
  - Service is **provided to recipients who may benefit from community engagement** and are **unlikely to achieve this involvement without the provision of support.**
  - Assisting the recipient in **developing a relationship with community organizations specific to that individual's interests and needs**.
  - Involves **collaboration with an organization** to develop an individualized training **plan that identifies specific supports required, organizational expectations, training strategies, timeframes and responsibilities.**

Supported Community Engagement Services

- **Program Standards:**

Allowable activities are **geared for the purpose of achieving a generalized skill or behavior** that **may prepare the recipient for an employment setting**, and may include **teaching concepts** such as:

- Attendance
- Tasks completion
- Problem solving
- Safety

Services must be explicitly identified in the IICP and **related to goals** identified by the recipient and may include activities such as:

- How to use public transportation
- Work-task analysis
- Use of assistive technology device/adaptive equipment

Supported Community Engagement Services

- **Exclusions:**
  - **Reimbursement paid to the recipient for performing activities covered under the service**. If a provider chooses to compensate a recipient for job-related activities, the provider must use non-Medicaid funding and must be able to document the funding source.
  - **Training in specific job tasks** or activities that include explicit employment objectives.
  - **Services provided to recipients who are currently competitively employed**.
  - Any service that is **available as vocational rehabilitation services** funded under the Rehabilitation Act of 1973.
  - **Services provided in a group setting**

Supported Community Engagement Services

- **Limitations:**

  - Supported community engagement services may be provided up to a maximum of **eighteen (18) hours (72 units) per month.**

Home and Community-Based (HCB) Habilitation and Support Services

- (Similar to MRO Skills Training and Development)
- Service Definition:
  - **Individualized face-to-face services** directed at the health, safety and welfare of the recipient
  - Assisting in the **management, adaptation and/or retention of skills** necessary to support recipients to **live successfully in the most integrated setting** appropriate to the recipient's needs
  - Assist recipient to **gain an understanding of/and self management of behavioral and medical health conditions**.
  - Services are **provided in the recipient's home (living environment)** or **other community based settings** outside of a clinic/office environment

Home and Community-Based (HCB) Habilitation and Support Services

Six separate services under HCB Habilitation and Support

- Individual Setting
- Family/Couple with the Recipient Present (Individual Setting)
- Family/Couple without the Recipient Present (Individual Setting)
- Group Setting
- Family/Couple with Recipient Present (Group Setting)
- Family/Couple without Recipient Present (Group Setting)

Home and Community-Based (HCB) Habilitation and Support Services

Provider Qualifications:

- A licensed professional, except for a licensed clinical addiction counselor
- A Qualified Behavioral Health Professional (QBHP)
- Other Behavioral Health Professional (OBHP)

Home and Community-Based (HCB) Habilitation and Support Services

- **Program Standards:**
  - Service requires **face-to-face contact** with the recipient, family, couple, or group in which the **recipient is the focus of service delivery.**
  - Assist the recipient in **gaining an understanding** of the **self-management of behavioral and medical health conditions.**
  - **Training and education to instruct a parent/ caregiver** about treatment appropriate for the recipient; improve the ability of parent/caregiver to provide care to, or for, the recipient.
  - ***Skills training*** as used in this service description means: Assisting in the reinforcement, management, adaptation and retention of skills necessary to live successfully in the community.

Home and Community-Based (HCB) Habilitation and Support Services

- Services may include, but are not limited to the following:
  - **Skills training** in food planning and preparation, money management, maintenance of living environment
  - Training in appropriate **use of community services**
  - Training in skills needed to **locate and maintain a home**
  - Recipients are **expected to benefit** from services
  - Services must be **goal-oriented** and related to the IICP
  - **Activities include:** implementation of the IICP, assistance with personal care, coordination and facilitation of medical and non-medical services to meet healthcare needs

Home and Community-Based (HCB) Habilitation and Support Services

- **Exclusions:**
  - Job coaching
  - Activities purely for recreation or diversion.
  - Academic tutoring.
  - Services may not be provided to professional caregivers.
  - Skill building activities not identified in the IICP.
  - Additional exclusions as outlined in the *Non-Covered Services* subsection in *Section 2: AMHH Services*.

Home and Community-Based (HCB) Habilitation and Support Services

Limitations:

- HCB Habilitation and Support, including **ALL subtypes** (individual, group, family/couple, with and without recipient present) may be provided for up to a total of **2 hours per day** (eight units per day)

Addiction Counseling (Substance-Related Disorders) Services

- (Similar to MRO Addiction Counseling)
- Service Definition:
  - Series of **time-limited, structured, face-to-face sessions** that work toward the goals identified in the IICP
  - Provided at the **recipient's home** (living environment) or at **other locations outside the clinic setting**

May be provided for recipients with a substance use or substance-related disorder with any of the following:

- Minimal or manageable medical conditions.
- Minimal withdrawal risk.
- Emotional, behavioral, and cognitive conditions that will not prevent the recipient from benefitting from this level of care.

Addiction Counseling

- Six separate services under Addiction Counseling
  - Addiction Counseling – Individual Setting
  - Addiction Counseling – Family/Couple with Recipient Present (Individual Setting)
  - Addiction Counseling – Family/Couple without Recipient Present (Individual Setting)
  - Addiction Counseling – Group Setting
  - Addiction Counseling – Family/Couple with Recipient Present (Group Setting)
  - Addiction Counseling – Family/Couple without Recipient Present (Group Setting)

Addiction Counseling Services

- **Provider Qualifications:**

  - A licensed professional- including Licensed Clinical Addiction Counselors (LCAC)

  - A qualified behavioral health professional (QBHP)

Addiction Counseling

- Program Standards:
  - Documentation must support how Addiction Counseling benefits the recipient
  - The **face-to-face** interaction may be with **the recipient, family members or non-professional caregivers** supporting the recipient.
  - Addiction Counseling consists of regularly scheduled sessions

Addiction Counseling

- Service Standards (Cont'd):
  - Addiction Counseling may include the following:
    - Education on addiction disorders
    - Skills training in communication, anger management, stress management, relapse prevention
  - Referral to community recovery support programs as available

Addiction Counseling

- **Exclusions:**

  - Services to recipients with **withdrawal risk or symptoms whose needs cannot be managed at this level** of care; or recipients who **require detoxification** services.

  - Addiction counseling sessions that consist of **only education** services are considered non-reimbursable/non-covered.

  - Services **provided to professional caregivers** are considered non-reimbursable/non-covered.

  - Additional exclusions as outlined in the *Non-Covered Services* subsection in *Section 2: AMHH Services*.

Addiction Counseling

- **Limitations:**

  - Addiction counseling services, **including all subtypes** (individual, group, and family/couple, with and without recipient present) may be provided for a **maximum of sixty-four (64) hours (64 hourly units) per year.**

Peer Support Services

- Service Definition:

  - Peer support services are **provided by DMHA-certified recovery specialists (CRS)** who **provide structured, scheduled activities** that support the following for the recipient:

    - **Socialization**
    - **Recovery/Habilitation**
    - **Self-advocacy**
    - **Development of natural supports**
    - **Maintenance of community living skills**

Peer Support Services

Provider Qualifications:

- Services must be provided by an individual meeting the DMHA training and competency standards for a CRS.

- Individuals providing peer recovery services **must be under the supervision of a licensed professional or a qualified behavioral health profession (QBHP).**

Peer Support Services

- Program Standards:

  Peer Support Services must:

  - Be provided **face-to-face** with the recipient.
  - Be a **structured and scheduled** activity.
  - Assist recipient in **obtaining a specific treatment goal** in the IICP.
  - **Documentation** must support **how the service specifically benefits the recipient.**
  - May only be provided on an individual basis – not in group

Peer Support Services

- Program Standards:
  - Service includes the following activities:
    - Assisting the recipient with **developing a self-care plan**; and other formal **mentoring** activities aimed at increasing the active participation of the recipient in person-centered planning and delivery of individualized services.
    - Assisting the recipients with the **development of psychiatric advanced directives.**
    - **Supporting the recipient in problem-solving related to reintegration into the community.**
    - Educating the recipient and **promoting participation in recovery, habilitation, and anti-stigma activities.**

Peer Support Services

Exclusions:

- Services that are **purely recreational or diversionary** in nature, or do not support community integration goals,
- **Services provided in a group setting**
- Activities that are billed under the Home and Community Based Habilitation and Support Services and Care Coordination services are not billable as peer support

Limitations:

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

Care Coordination

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

Care Coordination

- Service Definition (Cont'd)
  - Care coordination may include:
    - **Needs Assessment**
      - » Identifying the recipient's needs for any medical, educational, social, or other service areas.
      - » Taking recipient history and completing the related documentation
      - » Gathering of information from other sources, such as family members or medical providers
    - **IICP Development**
      - » The development of a written IICP based upon the information collected through the assessment phase
      - » **IICP identifies the habilitative activities and assistance needed to accomplish the objectives**
    - **Referral/Linkage**
      - » Activities that **link the recipient with medical, social, educational providers,** and/or other programs and services that are capable of **providing necessary habilitative services**

Care Coordination

- Service Definition (Cont'd)
  - **Monitoring/Follow-up**
    - » **Face to face contact** must occur **at least every 90 days**
    - » Contacts and related activities are necessary to **ensure the individualized integrated care plan is effectively implemented and adequately addresses the needs** of the recipient
    - » Activities and contacts may be with the recipient, family members, non-professional caregivers, providers, and other entities
    - » To help **determine if services are being furnished in accordance with a service plan of the recipient, the adequacy of the services** in the IICP, and **changes in the needs or status** of the recipient
    - » This function includes **making necessary adjustments in the IICP** and service arrangement with providers.
  - **Evaluation:**
    - » The care coordinator must periodically reevaluate the recipient's progress toward achieving the individualized integrated care plan's objectives
    - » Time devoted to formal supervision of the case between care coordinator and licensed supervisor are included activities, and should be documented accordingly and billed under one provider only

Care Coordination

Provider Qualifications:

- A licensed professional
- A qualified behavioral health professional (QBHP)
- Other behavioral health professional (OBHP)

Care Coordination

- **Program Standards:**
  - Provide **direct assistance** in gaining access to needed **medical, social, educational, and other services**
  - Limited **referrals to services**, and **activities or contacts necessary to ensure that the IICP is effectively implemented** and adequately addresses the mental health and/or addiction needs of the eligible recipient
  - Coordinator must **reevaluate recipient's progress** with a **face-to- face contact** with the recipient **at least every ninety (90) days**
  - The time devoted to **formal supervision of the case between the care coordinator and a licensed supervisor is** considered **an included** care coordination **activity**; and should be **documented accordingly**; but **billed under one provider only.**

Care Coordination

- **Exclusions:**
  - Services provided in a group setting
  - **The actual or direct provision of medical services or treatment**. Examples include, but are not limited to:
    - » Training in daily living skills.
    - » Training in work skills and social skills.
    - » Grooming and other personal services.
    - » Training in housekeeping, laundry, cooking.
    - » Transportation services.
    - » Individual, group, or family therapy services.
    - » Crisis intervention services.
  - **Services that go beyond assisting the recipient** in gaining access to needed services. Examples include, but not limited to:
    - » Paying bills and/or balancing the recipient's checkbook.
    - » Traveling to and from appointments with recipients

Care Coordination

- **Limitations:**
  - Care coordination services may be provided for a maximum of **200 hours (800 units) per year**.

Medication Training and Support

– (Similar to MRO Med Training and Support)

Service Definition:

- Medication training and support services involve **face-to-face** contact with the **recipient, family members or other non-professional caregivers** for the purpose of:
- Monitoring medication compliance
- Providing education and training about medications
- Monitoring medication side effects
- Providing other nursing or medical assessments
- Medication Training and Support also includes certain related non face-to-face activities

Medication Training and Support

- Six separate services under Medication Training and Support
  - Medication Training and Support – Individual Setting
  - Medication Training and Support – Family/Couple with Recipient Present (Individual Setting)
  - Medication Training and Support – Family/Couple without Recipient Present (Individual Setting)
  - Medication Training and Support – Group Setting
  - Medication Training and Support – Family/Couple with Recipient Present (Group Setting)
  - Medication Training and Support – Family/Couple without Recipient Present (Group Setting)

Medication Training and Support

- **Provider Qualifications:**
  - A licensed physician.
  - An authorized health care professional (AHCP).
  - A licensed registered nurse (RN).
  - A licensed practical nurse (LPN).
  - A medical assistant (MA) who has graduated from a two year clinical program.

Medication Training and Support

- **Program Standards:**

  - The medication training and support services must be provided within the scope of practice as defined by federal and state law.

- **Face-to-face contact** in that includes:
  - » Monitoring medication compliance.
  - » Monitoring self-administered prescribed medications
  - » Monitoring medication side effects (i.e., weight, blood glucose level, and blood pressure).
  - » Providing education about medications
  - » Providing other nursing or medical assessments.

Medication Training and Support

- **Program Standards:**
  - When provided in a clinic setting, medication training and support services **may complement, but not duplicate, activities associated with medication management activities available under the Clinic Option**.
  - When provided in residential settings, Medication Training and Support may include components of medication management services.

Medication Training and Support

- **Program Standards(Cont'd)**
  - The service may also include the following activities that are **not required to be provided face-to-face with the recipient** (*Note:* **these activities may not be provided in a group setting):**
    - Transcribing physician or AHCP medication orders
    - Setting or filling medication boxes
    - Consulting with the attending physician or AHCP regarding medication-related issues
    - Ensuring linkage that lab and/or other prescribed clinical orders are sent.
    - Ensuring that the recipient follows through and receives lab work and services pursuant to other clinical orders
    - Follow up reporting of lab and clinical test results to the recipient and physician

Medication Training and Support

– **Program Standards (Cont'd)**

- Documentation must support how the service benefits the recipient
- Medication Training and Support must demonstrate movement toward and/or achievement of recipient treatment goals identified in the individualized integrated care plan (IICP)
- Medication Training and Support goals are habilitative in nature

Medication Training and Support

- **Exclusions:**

- If Clinic Option medication management, counseling, or psychotherapy is provided and medication management is a component, then Medication Training and Support **may not be billed separately for the same visit by the same provider.**

- **Coaching and instruction regarding recipient self-administration** of medications is **not reimbursable** under Medication Training and Support, **but may be billed as Skills Training and Support**

Medication Training and Support

- Exclusions (Cont'd):
  - The following **non face-to-face services are excluded for Family/Couple with or without in Group Setting**:
    - Transcribing physician or AHCP medication orders.
    - Setting or filling medication boxes.
    - Consulting with the attending physician or AHCP regarding medication-related issues.
    - Ensuring linkage that lab and/or other prescribed clinical orders are sent.
    - Ensuring that the recipient follows through, and receives lab work and other clinical orders.
    - Follow up reporting of lab and clinical test results to the recipient and physician
  - Medication Training and Support **may not be provided to professional caregivers**

Medication Training and Support

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

AMHH Time Documentation

- Staff must document actual time spent delivering services in a 24-hour period within the recipient's clinical record.

- Provider agency must total actual time delivering the same service on the same day by all provider types for each recipient.

- Minutes of service do not have to be consecutive to be billed together.

ROUNDING MINUTES TO UNITS

– Providers must round the total actual time each day, as described previously, to the nearest whole unit when calculating reimbursement. Providers should refer to the HCPCS code for each service for information on the unit increment that is used for each service.

Refer to AMHH Draft Provider Manual for Examples

AMHH Time Documentation

15-Minute Unit (Same as MRO)

- If staff delivers a service for **eight or more minutes, or the total daily minutes for the service add up to eight or more minutes,** the provider may **round up to one 15-minute unit**. If staff delivers a service for **seven minutes or less, or the total daily minutes for the service add up to seven minutes** or less, the provider **rounds down to zero units** and therefore may not bill for the service. Providers **must add actual time** together (as described in *Time Documentation*) **before rounding**.

AMHH Time Documentation

One-Hour (60 Minutes) Unit (Same as MRO)

- If staff delivers a service for **45 or more minutes, or the total of minutes for the day for one service add up to 45** or more minutes, the provider **rounds up to the one hour unit**. If staff delivers a service for **44 minutes or less, or the total of minutes for the day for one service add up to 44 minutes or less**, the provider **rounds down to zero units** and therefore may not bill for this service.

AMHH Time Documentation

HALF DAY EQUALS THREE-HOUR (180 MINUTES) UNIT

- **Adult Day** services the only AMHH service that may be billed in **half-day units of three-hour to five hours**.

- To be reimbursed for Adult Day services, a provider must deliver a minimum of three up to five consecutive hours of the service.

- Up to 20 minutes in break-time may occur within the three-hour block of time.

- If more than 3 consecutive hours are provided up to a 60 minute break is allowed in addition to the 20 minute breaks. The 60-minute break may not be billed as a component of the service.

AMHH Time Documentation

Second Half-day unit of service:

Adult Day service allows for up to 2 half-day units of service to be billed in one day . The second unit (half–day) may be billed if more than one unit equaling five hours has been delivered and an additional three hours of the service is provided. The second unit of service may include an additional 20 minute break within the three hour block of time.

Modifiers for AMHH Services

Modifier	Service Description
U1	Group setting
HR	Family/couple with client present
HS	Family/couple without client present
UB	Face-to-face encounter

Midlevel Provider Modifiers

- **Midlevel provider modifiers should not be used** when submitting AMHH services claims. The use of midlevel provider modifiers results in the **denial of the AMHH services claim.**

PLACE OF SERVICE CODES

- AMHH services can be rendered in the following locations with the place of service code listed:
- 12 – Home
- 99 – Other unlisted facility (such as employment or a community place)

Claims Information

Mailing Address for Claims

AMHH claims are sent to the standard medical claim address:

HP CMS-1500 Claims

P.O. Box 7269

Indianapolis, IN 46207-7269

Additional Addresses and Telephone Numbers

Providers should direct questions about filing claims to Customer Assistance at (317) 655-3240 in the Indianapolis local area or toll-free at 1-800-577-1278. The addresses and telephone numbers are also available on the *IHCP Quick Reference* on. www.indianamedicaid.com.

Additional Information

AMHH Draft Provider Manual

- AMHH Acronyms and Definitions
- List of Services and codes
- List of Diagnoses
- Codes and Rate Table

HANDOUTS

- AMHH Application packet
- IICP example
- Flow charts