



INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Division of Mental Health and
Addiction

Adult Mental Health Habilitation Services

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Section 1: Introduction

Background

The Medicaid waiver program began in 1981 in response to persons residing in nursing facilities that were Medicaid funded but would have been capable of living at home or in a community residential setting if additional supportive services were available, as well as the states' needs to reduce nursing home costs. In the past, Medicaid paid only for institutional long-term care services, such as nursing facilities and group homes.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of the Medicaid State Plan Home- and Community-Based Services (HCBS) vary depending on the specific needs of the target population, the resources available to the state, service delivery system, state goals and objectives, and other state specific factors. A state has the flexibility to design a person-centered program that is cost effective and employs a variety of social and medical service options.

Indiana applies to the CMS for permission to offer Medicaid waivers and State Plan HCBS. The Medicaid State Plan HCBS use federal Medicaid funds (plus state matching funds) for HCBS as an alternative to institutional care, under the condition that the overall cost of supporting people in the home or community is, on average, less than the institutional cost for supporting the same population.

The overall thematic goals of HCBS are to provide individuals with meaningful, culturally competent, and necessary services and supports to live and receive care in their community of choice, to respect the individual's personal beliefs and customs, and to ensure that services are cost effective.

Overview

Medicaid State Plan HCBS allows the Indiana Health Coverage Programs (IHCP), state of Indiana's Medicaid program, to provide services in an individual's home or other community setting that would ordinarily be provided in an institution.

The Indiana Family and Social Services Administration (FSSA) has overall responsibility for the Medicaid State Plan HCBS. Day-to-day administration and operation of individual programs are delegated to divisions within the FSSA.

The Division of Mental Health and Addiction (DMHA) offers two Medicaid State Plan HCBS programs:

- Adult Mental Health Habilitation (AMHH)
- Behavioral and Primary Healthcare Coordination (BPHC)

Information about these two programs is available on the [Adult 1915i Programs](https://www.in.gov/fssa/dmha) webpage of the DMHA website at [in.gov/fssa/dmha](https://www.in.gov/fssa/dmha).

Home- and community-based settings will integrate the following organizational components to ensure individuals are served in a community based on the need of each individual as identified in the person-centered plan:

- The setting is integrated and supports full access of individuals to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources.
- The setting is selected by the individual from setting options, including non-disability-specific settings, and an option is provided for a private unit in a residential setting. Setting options are documented in the person-centered plan and are based on the individual's needs and preferences. For residential settings, options are selected from available resources.

- The setting ensures an individual's right of privacy, dignity, respect, and freedom from coercion and restraint.
- The setting optimizes individual autonomy and independence in making life choices.
- The setting facilitates individual choice regarding services and supports.

Provider Controlled, Owned or Operated Residential Settings

The HCBS program does not exclude provider controlled, owned or operated settings, such as residential facilities or group homes from participating in HCBS. However, in addition to meeting the general components regarding community-based settings listed above, residential settings must meet the following additional conditions:

- A lease or other legally enforceable agreement to protect from eviction
- Privacy in their unit including entrances lockable by the individual (staff may have keys as needed)
- Choice of roommates/living situation
- Freedom to furnish and decorate their unit
- Control of their schedule and activities
- Access to food at any time
- Physical accessibility for the individual
- Visitors at any time

If any of these requirements are limited, the reasons must be documented in the person-centered plan, be based on a specific and individualized need, include the informed consent of the individual, and have an established time limit for the modification including a periodic review.

This module is a resource specifically for AMHH service providers approved by the FSSA DMHA and enrolled as an active IHCP provider.

Section 6086 of the Deficit Reduction Act of 2005 (DRA), Public Law Number 109–171, expanded access to HCBS for the elderly and disabled by adding a new section 1915(i) to the *Social Security Act* (“the Act”). Under section 1915(i), states have the option to amend the state plans to provide HCBS without regard to statewideness or certain other Medicaid requirements. AMHH services are approved by the CMS as 1915(i) HCBS programs and may be provided for five years following CMS approval of the State Plan Amendment (SPA) to provide AMHH services. The CMS initially approved the AMHH HCBS benefit Sept. 25, 2013, with an effective date of Oct. 1, 2013. The DMHA submitted the AMHH renewal application to the CMS and received an approval with an effective date of Oct.1, 2018. The DMHA submitted an additional AMHH renewal application to the CMS and received an approval with an effective date of Oct. 1, 2023.

Indiana adopted the AMHH program to provide home- and community-based opportunities for the care of adults with serious mental illness (SMI), with or without co-occurring substance use disorders, who may benefit most from a habilitative approach to care versus a rehabilitative approach.

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 services provided. Federal law describes Medicaid rehabilitation services as any medical or remedial services recommended by a physician or other

licensed practitioner of the healing arts, within the scope of their practice under state law, for maximum reduction of physical or mental disability and restoration of a member to their best possible functional level. Habilitation services, by comparison, are defined as activities that are designed to assist individuals in acquiring, retaining and improving the following skills necessary to reside successfully in a community setting:

- Self-help
- Socialization
- Adaptive skills

AMHH services are indicated as a service alternative for individuals who have achieved maximum benefit from Medicaid Rehabilitation Option (MRO) services (see the [Medicaid Rehabilitation Option Services](#) provider reference module) and whose needs can be better met through habilitation. Possible candidates for AMHH services are individuals who have reached their capacity for improving their level of functioning but need to retain their current functional level to remain in the community. Habilitation services benefit individuals by providing the skills and supports needed to safely remain in a community-based setting and reduce the risk for institutionalization. Eligibility for AMHH services is determined based on a Medicaid-enrolled individual meeting specific target and needs-based criteria outlined in this module.

AMHH Policies and Procedures

This AMHH provider module gives links to DMHA policies and procedures for the AMHH program, lists DMHA-certified community mental health centers (CMHCs), and documents state and federal expectations for AMHH service providers. It also includes guidance regarding enrollment, service delivery, clinical documentation, billing and determining AMHH member eligibility. This module is intended to be used in conjunction with the following resources:

- [1915\(i\) AMHH State Plan Amendment TN 23-0002](#)
- [Application for 1915\(b\)\(4\) Waiver Fee-for-Service Selective Contracting Program](#) (IN-02)
- [405 IAC 5-21.6](#) (Indiana Administrative Code for AMHH services)
- DMHA updates or policy revisions to the AMHH program or requirements for AMHH providers, available on the [Adult Mental Health Habilitation Services](#) webpage at in.gov/fssa/dmha
- Other IHCP provider reference modules, including [Home- and Community-Based Services Billing Guidelines](#) and [Claim Submission and Processing](#)
- Other communications issued by the CMS or the FSSA DMHA or Office of Medicaid Policy and Planning (OMPP), including those posted on the [IHCP Bulletins](#) webpage at in.gov/medicaid/providers

Approved [AMHH service providers](#) are required to review, understand and follow AMHH program policies and procedures, as well as any subsequent updates or revisions issued by the CMS, DMHA or OMPP. Failure to comply with state and federal regulations associated with the AMHH program and the expectations outlined in this provider module will lead to formal corrective actions, state and federal sanctions, or termination as an AMHH service provider.

Section 2: Adult Mental Health Habilitation Program Overview

Adult Mental Health Habilitation (AMHH) services are medical or remedial services recommended by a physician, psychologist endorsed as a health service provider in psychology (HSPP) or licensed clinician meeting criteria of a qualified behavioral health professional (QBHP) within the scope of their practice for the habilitation of a mental health disability and the restoration or maintenance of an individual's best possible functional level. AMHH services are also clinical and supportive behavioral health services provided for individuals, families or groups of adults who are living in the community and who need aid on a routine basis for mental illness or co-occurring mental illness and substance use disorders.

AMHH services are designed to assist in the habilitation of the individual's optimum functional ability in daily living activities. This goal is accomplished by:

- Assessing the individual's needs and strengths
- Developing an Individualized Integrated Care Plan (IICP) that outlines objectives of care, including how AMHH services will assist in delivering appropriate home- and community-based habilitation services to the individual
- Assisting the individual in reaching their habilitative goals

AMHH services are intended to benefit the following individuals:

- Adults living in home and community-based settings who need routine help with managing serious mental illness (SMI), substance use disorders, or co-occurring mental illness and substance use disorders
- Adults who have reached the maximum benefit from a rehabilitative treatment approach and would be better served with access to a habilitative approach to services to help them maintain and enhance treatment gains
- Adults who have a high need for services and are considered at risk of institutionalization without access to intensive community-based services

Indiana has chosen to make AMHH services available for the following reasons:

- AMHH services will assist adults with SMI, with or without a co-occurring substance use disorder, in reaching or maintaining the highest level of independence and functioning possible through the reinforcement, management, adaptation and retention of skills necessary to live successfully in the community.
- Individuals with SMI who are limited in the ability for self-care and independence are empowered to remain integrated in the community with an appropriate level of supervision, services and supports.
- Services will improve "quality of life" for individuals with SMI living in the community and decrease the need for institutional care.
- AMHH services fill a gap between Medicaid Rehabilitation Option (MRO) and Medicaid outpatient mental health services (as defined under *Indiana Administrative Code 405 IAC 5-20-8*).

Types of AMHH Services

The following AMHH services are available, according to the coverage criteria, limitations and eligibility requirements specified in this module, the AMHH State Plan Amendment (SPA) and 405 IAC 5-21.6:

- Adult Day Services
- Home- and Community-Based Habilitation and Support
- Respite Care
- Therapy and Behavioral Support Services
- Addiction Counseling
- Supported Community Engagement Services
- Care Coordination
- Medication Training and Support

Home- and Community-Based Setting Requirements

As mandated in the Centers for Medicare & Medicaid Services (CMS)-approved 1915(i) AMHH SPA and 405 IAC 5-21.6, AMHH services will be furnished to individuals in their homes or other community-based settings, not in institutions. See [Section 4: AMHH Member Home- and Community-Based Settings Requirements](#) in this module for additional information.

All Division of Mental Health and Addiction (DMHA) provider owned, controlled or operated (POCO) and non-POCO settings are compliant with the setting requirements of the HCBS final rule outlined in the [Home- and Community-Based Services Final Rule Statewide Transition Plan](#) webpage at in.gov/fssa/dmha.

Length of Authorization Period

A Medicaid-eligible AMHH member is authorized to receive AMHH services on an approved IICP for 360 days from the start date of AMHH eligibility, or as determined by the FSSA DMHA State Evaluation Team (SET). Services may be provided according to the DMHA-approved IICP as long as the member continues to meet AMHH eligibility criteria. After an applicant is determined eligible for the AMHH program, the SET approves AMHH services based on review of documentation and the IICP.

AMHH Service Coverage Requirements

For a service to be reimbursable under the AMHH program, it must meet the following minimum criteria:

- Be provided to a member who has an active Medicaid aid category on the date of service
- Be provided to an individual determined by the DMHA SET as eligible for AMHH services
- Be a service proposed on the member's IICP and approved by the SET
- Be a covered AMHH service, as described in this provider module
- Be provided in a manner that is within the scope and limitations of the AMHH service, including provider qualifications
- Be supported in clinical documentation as a service that:
 - Continues to promote stability for the AMHH member
 - Enables the member to move toward obtaining the habilitative goals identified in the individual's IICP

Note: For services that require face-to-face interaction with the member, services delivered via telehealth satisfy this requirement. The services must be covered for telehealth and provided in accordance with the policies and procedures described in the [Telehealth and Virtual Services](#) module.

Noncovered Services

While each AMHH service may have its own exclusions unique to that service, the following services are considered noncovered and are not eligible for reimbursement under the AMHH program:

- A service provided to the member 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 (for example, a Behavioral and Primary Healthcare Coordination (BPHC) or 1915(c) waiver service)

Note: For any service provided simultaneously with another service, only one of the services provided is billable.

- A service provided as a diversion, leisure or recreational activity, unless it is an identified component of an approved Respite Care service
- A service that is provided in a manner that is not within the scope and limitations of the AMHH service
- A service not on the member's IICP
- A service that is on the member's IICP but is not documented as a covered or approved service by the SET
- Without prior authorization (PA) to increase service limits, a service provided that exceeds the limits within the service definition, including service quantity or limit, duration, or frequency
- Any service provided on the same day that the member is receiving inpatient or partial hospitalization through Medicaid
- Time spent on the initial face-to-face assessment, referral and IICP may not be billed under AMHH

Crisis Intervention Services

As noted in 405 IAC 5-21.5-8, services reimbursable as crisis intervention services are short-term emergency behavioral health services, available 24 hours per day, seven days per week.

These services include crisis assessment, planning and counseling specific to the crisis, intervention at the site of the crisis when clinically appropriate, and prehospital assessment. The goal of crisis services is to resolve the crisis and transition the client to routine care through stabilization of the acute crisis and linkage to necessary services. This service may be provided in an emergency room, crisis clinic setting or in the community.

Crisis intervention is a covered service for any Medicaid member; however, it is not a service that is defined in the AMHH SPA. If an AMHH member needs crisis intervention services, they may access these services.

Section 3: AMHH Agency Staff Requirements

Adult Mental Health Habilitation (AMHH) services may be delivered only by service provider agencies meeting specific state-defined criteria. The Indiana Family and Social Services Administration (FSSA) Division of Mental Health and Addiction (DMHA) certifies agencies to provide AMHH services to eligible members. DMHA-approved providers must also be enrolled as authorized Indiana Health Coverage Programs (IHCP) providers with the AMHH specialty.

AMHH-approved IHCP-enrolled providers must meet specific provider standards and criteria developed to ensure that AMHH members receive access to a full continuum of behavioral health services provided in a manner that will ensure the health and safety of those individuals. In Indiana, community mental health centers (CMHCs) in good standing with the DMHA are eligible to be approved as IHCP-enrolled AMHH service provider agencies. The application, as well as provider agency requirements and expectations, are in [Appendix D: CMHC Provider Application and Attestation to Provide AMHH Services](#).

Agency Staff Requirements

A DMHA-approved AMHH provider agency must ensure that the agency staff members providing the AMHH services meet the specific criteria and standards required for the AMHH services they provide. The following sections list agency staff members that may provide AMHH services, as long as the staff member meets the other service-specific criteria required (see *Sections 16-23*) of this module for service-specific provider standards and requirements.

Licensed Professionals

The following licensed professionals are eligible to provide AMHH services:

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

Qualified Behavioral Health Professional (QBHP)

A qualified behavioral health professional (QBHP) is defined as any of the following:

- An individual who has had at least two years of clinical experience treating persons with mental illness under the supervision of a licensed professional, as previously defined, with such experience occurring after the completion of a master's degree or doctoral degree, or both, in any of the following disciplines:
 - In psychiatric or mental health nursing from an accredited university, plus a license as a registered nurse (RN) in Indiana
 - In pastoral counseling from an accredited university
 - In rehabilitation counseling from an accredited university

- An individual who is under the supervision of a licensed professional, as previously defined, is eligible for and working toward licensure, and has completed a master's or doctoral degree, or both, in any of the following disciplines:
 - Social work from a university accredited by the Council on Social Work Education
 - Psychology from an accredited university
 - Mental health counseling from an accredited university
 - Marital and family therapy from an accredited university
- A licensed independent practice school psychologist under the supervision of a licensed professional, as previously defined
- An authorized healthcare professional (AHCP) who is one of the following:
 - A physician's 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 *Indiana Code IC 25-27.5-5*
 - A nurse practitioner or clinical nurse specialist with prescriptive authority and performing duties within the scope of that person's license, under the supervision of or under a supervisory agreement with a licensed physician, pursuant to *IC 25-23-1*

Other Behavioral Health Professional (OBHP)

An other behavioral health professional (OBHP) is defined as any of the following:

- An individual with an associate or bachelor's degree, or two years equivalent behavioral health experience, meeting minimum competency standards set forth by a behavioral health service provider and supervised by a licensed professional (as previously defined) or a QBHP (as previously defined)
- A licensed addiction counselor, as defined under *IC 25-23.6-10.5*, supervised by a licensed professional, as previously defined, or a QBHP (as previously defined)

AMHH Clinical Supervision Standards

When clinical supervision for provider agency staff is required, it is expected that the provider has and implements clearly delineated policies and procedures for defining, implementing and documenting clinical supervision, as defined and required by AMHH service standards. Operational supervision is at the discretion of the AMHH provider agency to define and implement.

Section 4: AMHH Member Home- and Community-Based Settings Requirements

Adult Mental Health Habilitation (AMHH) is a Home- and Community-Based Services (HCBS) program. In accordance with federal regulations for 1915(i) State Plan HCBS programs, service activities must be provided within the individual's home (place of residence) or at other locations based in the community. Service activities cannot be provided in an institutional setting. In addition, members must live in residential settings that meet the requirements of the HCBS settings final rule to be eligible to receive 1915(i) services, including AMHH services.

In January 2014, the Centers for Medicare & Medicaid Services (CMS) published regulations to better define the settings in which states can provide Medicaid HCBS. The [HCBS settings final rule](#) became effective March 17, 2014. Information about the HCBS settings final rule as well as additional guidance and fact sheets are available on the [Home and Community Based Services](#) webpage at cms.gov. According to the CMS final rule on HCBS, service settings must exhibit the following qualities to be eligible sites for delivery of HCBS:

- Are integrated in and support full access to the greater community
- Are selected by the individual from among setting options
- Ensure the individual's rights of privacy, dignity, respect and freedom from coercion and restraint
- Optimize autonomy and independence in making life choices
- Facilitate choice regarding services and providers

There are additional requirements for provider owned, controlled or operated home- and community-based residential settings. These requirements include:

- The individual has a lease or other legally enforceable agreement providing similar protections.
- The individual has privacy in their unit, including lockable doors, choice of roommates and freedom to furnish or decorate the unit.
- The individual controls their own schedule, including access to food at any time.
- The individual can have visitors at any time.
- The setting is physically accessible.

The following are examples of settings that are **not** considered home- or community-based:

- Nursing facility
- Institution for mental diseases (IMD)
- Intermediate care facility for individuals with intellectual disability (ICF/IID)
- Hospital
- Any other location that has the qualities of an institutional setting, which may include, but is not limited to:
 - A setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment
 - A setting that is located in a building on the grounds of, or immediately adjacent to, a public institution
 - Any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS

AMHH Members and Choice of Living Arrangement

Many persons choosing to participate in AMHH services live in their own homes, or with families or friends, in the same manner as any adult who does not have a mental illness. Among persons who may be eligible for AMHH services, though, are some who do not have family or friends with whom they can live, or they are not functioning at a level in which their health and safety can be supported in a totally independent setting. Depending on a person's level of need and functioning, they may choose to live in a full-time supervised setting that provides less than full-time supervision or a setting that provides no on-site supervision.

Before an individual selects residential placement, the community mental health center (CMHC) case manager discusses alternatives with the individual, family and/or guardian, as applicable. The decision for the choice of placement is based on the individual's identified needs, goals and resources. After the individual selects their placement, an Individualized Integrated Care Plan (IICP) is developed or updated with the individual. The IICP reflects the individual's aspirations and goals for an independent lifestyle and how the residential setting contributes to empowering the individual to continue to live successfully in the community.

The Indiana Family and Social Services Administration (FSSA) Division of Mental Health and Addiction (DMHA) supports a permanent supportive housing model that refers to a housing unit that is linked with community-based services. The tenant holds the lease with a landlord and receives services based on need through a CMHC or community service agency. The tenant's housing is not contingent on the person's participating in any mental health or addiction services. At a minimum, the individual has the same responsibilities and protections from eviction that tenants have under the landlord-tenant law of the state, county, city or other designated entity. Each individual's essential personal rights of privacy, dignity, respect and freedom from coercion and restraint are protected.

DMHA-Certified Residential Facility Settings – Standards, Rights and Definitions

The DMHA-certified residential settings in which some individuals may choose to live promote opportunities that help each individual grow and develop skills needed to continue to live in the community. DMHA-certified residential care settings are a component of an outpatient community-based continuum of care, designed to provide living options that span the continuum from minimal oversight to highly supervised settings. These settings are not nursing facilities, ICFs/IID or IMDs. The residential care settings do not have any qualities of an institution, nor would the setting be permitted to be located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or disability-specific housing complex. One of the primary goals of the AMHH service program is to provide services and support to individuals to ensure that they live safely and as independently as possible in the community. The program intends to provide opportunities for individuals to have their needs met in community-based settings and to prevent need for and placement in institutional settings.

The FSSA DMHA and Office of Medicaid Policy and Planning (OMPP) have a strong partnership with state housing agencies: Indiana Housing and Community Development Authority (IHCD) and Corporation for Supportive Housing (CSH). Together, these agencies have facilitated the development of supportive housing integrated into the community to meet the needs of individuals with mental health and substance use disorders. The DMHA, through certification and licensure standards, requires the individual to participate in planning their care, supporting the recovery philosophy that promotes the least-restrictive, most-appropriate care to safely meet the individual's identified needs and desires.

The DMHA expects the following standards to be maintained for AMHH members living in a DMHA-certified residential setting (for specific information regarding standards for DMHA-certified residential facilities, see *Indiana Administrative Code 440 IAC 7.5, Residential Living Facilities for Individuals with Psychiatric Disorders or Addictions*):

- Residential settings should comprise individual- or single-occupancy dwellings or residences. Residential settings should promote opportunities to help each individual grow and develop skills needed to continue to live in the community.
- While the individual lives in a DMHA-certified residential facility, the provider's responsibility is to ensure that the resident is involved in decisions that affect the resident's care, daily schedules and lifestyles.
- The overall atmosphere of the setting is conducive to the resident achieving optimal independence, safety and development, with the resident's input.
- The location of the facility provides reasonable access to the community at large, including but not limited to:
 - The provider agency
 - Medical, recreational and shopping areas
 - Public or agency-arranged transportation
- The location, design, construction and furnishings of each residence must be consistent with a family or personal home (homelike).
- The majority of services and behavioral healthcare is provided in locations outside 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 in achieving goals, including employment.

Within AMHH, the state defines homelike as *an atmosphere with patterns and conditions of everyday life that are as close as possible to those of individuals without behavioral health needs*. This definition includes an environment designed to increase the resident's involvement in decisions that affect their care, daily schedule and lifestyle, so the settings are similar to those of the resident's peers who live on their own. The overall atmosphere of the setting is conducive to the resident achieving independence. The location of the facility provides residents reasonable access to the community at large, including but not limited to the provider agency and medical, recreational and shopping areas via public or agency-arranged transportation.

In addition to the rights and responsibilities listed in *Indiana Code IC 12-27*, an AMHH member living in a DMHA-certified residential setting has the following rights, as documented in *440 IAC 7.5-2-6*:

- 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 IICP.
- 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.
- Residents are not required to participate in research projects.

- 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 must be informed about available legal and advocacy services and may contact or consult legal counsel at the resident's own expense.
- Each resident must be informed of the number for DMHA's toll-free consumer service telephone line.

Any modification of the resident's rights must be supported by a specific assessed need and documented in the person-centered IICP as follows:

- Identify the specific and individualized assessed need.
- Document the positive interventions and supports used prior to any modifications to the person-centered service plan.
- Document less-intrusive methods of meeting the need that have been tried but did not work.
- Include a clear description of the condition that is directly proportionate to the specific assessed need.
- Include regular collection and review of data to measure the ongoing effectiveness of the modification.
- Include established time limits for periodic reviews to determine whether the modification is still necessary or can be terminated.
- Include the informed consent of the individual.
- Include an assurance that interventions and supports will cause no harm to the individual.

The community residential settings certified by the DMHA and identified in the AMHH State Plan Amendment (SPA) as meeting the standard for community living include:

- A supervised group living facility
- A transitional residential services facility
- A semi-independent living program facility defined under IC 12-22-2-3
- Alternative family homes operated solely by resident householders

Supervised Group Living (SGL) Facility

A supervised group living (SGL) facility is defined by the DMHA as a residential facility that provides a therapeutic environment in a homelike setting to persons with a psychiatric disorder or addiction who need the benefits of a group living arrangement as post-psychiatric hospitalization intervention or as an alternative to hospitalization. *Therapeutic environment* means a living environment in which the staff and other residents contribute, and that presents no physical or social impediments to the habilitation and rehabilitation of the resident.

An SGL setting is designed to assist individuals in the recovery process by offering a safe, supportive, homelike environment. On-site supervision is required 24 hours a day, seven days a week in this setting. Individuals may come and go as needed to attend work, school, treatment appointments, recreation and so on. Individuals have access to food 24 hours a day, seven days a week, but there are also typically planned mealtimes when individuals may eat together. Menus are developed by dietitians to provide healthy meals that are consistent with each individual's dietary needs and restrictions (for example, diabetic or low sodium). Alternative food is available if an individual chooses not to eat the planned meal. Clients have input in meal planning.

A certified SGL facility serves up to 10 clients in a single-family dwelling and up to 15 clients in an apartment building (three or more living units) or in a congregate residence.

Transitional Residential Services (TRS) Facility

A transitional residential services (TRS) facility is defined by the DMHA as a 24-hour per day service that provides food, shelter and other support services to individuals with a psychiatric disorder or addiction who are in need of a short-term supportive residential environment.

A certified TRS facility serves 15 or fewer persons. Individuals in this setting are likely preparing for, or already participating in, work or school activities and are not supervised 24 hours a day. Individuals have input into household activities and may come and go as needed to attend work, school, treatment appointments, recreation and so on. Individuals have access to food 24 hours a day, seven days a week, but there are also typically planned mealtimes when individuals may eat together. Menus are developed by dietitians to provide healthy meals that are consistent with each individual's dietary needs and restrictions (for example, diabetic or low sodium). Alternative food is available if an individual chooses not to eat the planned meal. Clients have input in meal planning.

Semi-Independent Living Program (SILP) Facility

A semi-independent living program (SILP) facility is defined by the DMHA as:

- A facility that is not licensed by another state agency and serves six or fewer individuals per residence who have psychiatric disorders or an addiction, or both, and who require only limited supervision
- A facility in which the agency or its subcontractor provides a resident living allowance to the resident; or owns, leases or manages the residence

SILP facility settings are typically homelike. This setting is intended to prepare individuals for independent living settings. Individuals in this type of setting are provided with a minimum of oversight (that is, one hour per week). Individuals have input into household activities and may come and go as needed to attend work, school, treatment appointments, recreation and so on. Individuals have access to food 24 hours a day, seven days a week, but there are also typically planned mealtimes when individuals may eat together. Menus are developed by dietitians to provide healthy meals that are consistent with each individual's dietary needs and restrictions (for example, diabetic or low sodium). Alternative food is available if an individual chooses not to eat the planned meal. Clients have input in meal planning.

Alternative Family for Adults (AFA) Program Homes

An alternative family for adults (AFA) program is defined by the DMHA as *a program that serves six or fewer individuals who have psychiatric disorders or addictions, or both, and reside with an unrelated householder.*

AFA program settings are homelike. The setting is intended to prepare individuals for independent living, or may become permanent housing if the AFA home best meets the individual's needs and a less-restrictive setting is not wanted or deemed appropriate by the individual or treatment team. Individuals in this type of setting are provided with a minimum of oversight (that is, two hours per month). Individuals have input into household activities and may come and go as needed to attend work, school, treatment appointments, recreation and so on. Individuals have access to food 24 hours a day, seven days a week, but there are also typically planned mealtimes when individuals may eat together. Menus are developed by dietitians to provide healthy meals that are consistent with each individual's dietary needs or restrictions (for example, diabetic or low sodium). Alternative food is available if an individual chooses not to eat the planned meal. Clients have input in meal planning.

State Monitoring

The DMHA retains the authority to monitor and enforce adherence to standards by conducting on-site visits to ensure compliance with standards and respond to any complaint or incident reported. In addition to client feedback and site visits, data is collected and analyzed in accordance with the *Quality Indicator* section of the AMHH SPA. There are also facility requirements for compliance with fire and safety codes, which must be up to date. The DMHA conducts site visits to ensure that standards are met. Individuals residing in any DMHA-certified residential setting have the freedom to choose how they live, and residents' rights are respected and honored.

All settings in which an HCBS member resides or receives HCBS services must fully comply with CMS settings regulation. For this reason, setting assessments are not limited to only those provider owned, controlled or operated (POCO) settings owned, controlled or operated by CMHCs. AMHH and BPHC provider agencies must ensure that all settings where HCBS members reside (CMHC POCO, non-CMHC POCO and non-POCO) meet the intent of the regulation. The DMHA SET will make the final determination of the setting compliance.

An Ongoing Monitoring phase commenced in state fiscal year (SFY) 2023 due to the fulfillment and completion of State Transition Plan activities in SFY 2022. The SET conducts on-site visits to a percentage of each agency's POCO settings that have been identified as a setting that provides HCBS services. In addition to the site visits, the CMS is requiring a supplemental provider self-assessment. The provider self-assessment document will only be completed for the sites identified in the annual Ongoing Monitoring notification letter.

Incident Reporting

Incident reporting provides a mechanism for reporting and responding to critical or sentinel incidents occurring in connection with the AMHH program. Provider agencies are required to follow the DMHA requirements on critical incident reporting:

- For POCO residential settings, providers are required to report incidents within 24 hours of the incident.
- For community-based settings, providers are required to report these incidents within 72 hours of becoming aware of the incident.

The DMHA developed the online Critical Incident Reporting portal for submitting incident reports. Providers can access this site by logging in to the [DMHA Provider Portal](#), selecting the **Critical Incident Reporting** tab at the top of the page, and then selecting **Report Critical Incident**. For all critical incidents involving members receiving AMHH services, an incident report must be submitted with the appropriate box selected indicating that the member is receiving AMHH services. The SET uses this data to report to the CMS.

Section 5: AMHH Program Member Eligibility

Adult Mental Health Habilitation (AMHH) services are offered as part of an Indiana Medicaid State Plan option for providing 1915(i) Home- and Community-Based Services (HCBS) to promote and empower independence and integration into the community as an alternative to an institutional level of care. The 1915(i) option allows Indiana to offer HCBS to individuals who are enrolled in Medicaid and meet specific target-group and needs-based eligibility criteria. As defined in the AMHH State Plan Amendment (SPA) and in *Indiana Administrative Code 405 IAC 5-21.6*, Indiana elected to target the 1915(i) State Plan HCBS benefit to a specific population.

Eligibility for the AMHH program is determined by the Indiana Family and Social Services Administration (FSSA) Division of Mental Health and Addiction (DMHA) State Evaluation Team (SET) and is based on the following:

- Target-group criteria
- Financial criteria (enrolled in Medicaid)
- Needs-based criteria

Eligibility Determination and Conflict of Interest

To prevent conflict of interest in the final AMHH eligibility determinations, the responsibility for AMHH program eligibility determination and approval of the proposed AMHH services is in all cases retained by the FSSA DMHA SET. Members of the SET are prohibited from having any financial relationships with the applicant or member requesting AMHH services, the families or the provider agency selected to provide AMHH services.

AMHH provider agencies are required to have written policies and procedures that address conflicts of interest available for review by the state. These policies and procedures must clearly define and describe how conflict of interest requirements are implemented and monitored within the agency to ensure protection of the individuals applying for AMHH services and the integrity of the AMHH program.

Member Eligibility Criteria

The applicant must meet the following target-group and needs-based criteria to be eligible to receive AMHH services.

Target-Group Criteria

AMHH services are targeted for individuals who meet all the following target-group criteria:

- The individual is enrolled in an eligible Indiana Health Coverage Programs (IHCP) Medicaid program.
- The individual is age 19 or older at the time of initial application.
- The individual has an AMHH-eligible primary mental health diagnosis, which may include the following:
 - Schizophrenic disorders (ICD-10 code: F20.xx)
 - Schizoaffective disorders (ICD-10 code: F25.x)
 - Manic episodes (ICD-10 code: F30.xx)
 - Major depressive disorders (ICD-10 code: F33.x)

- Bipolar disorders (ICD-10 code: F31.xx)
- Delusional disorders (ICD-10 code: F22)
- Psychotic disorders, unspecified (ICD-10 code: F29)
- Obsessive-compulsive disorders (ICD-10 code: F42.x)

(See *Adult Mental Health Habilitation Codes*, accessible from the [Code Sets](#) webpage at in.gov/medicaid/providers, for a full listing of AMHH-eligible diagnosis codes.)

Needs-Based Criteria

In addition to meeting the AMHH target-group criteria, the applicant must also meet all the following needs-based criteria to be eligible for AMHH services:

- Without ongoing habilitation services as demonstrated by written attestation by a psychiatrist, health services provider in psychology (HSPP) or a licensed clinician meeting the criteria of a qualified behavioral health professional (QBHP), the applicant is likely to deteriorate and be at risk of institutionalization (for example, acute hospitalization or time spent in a state hospital, nursing home or jail).
- The applicant must demonstrate the need for significant assistance in major life domains related to their mental illness (for example, physical problems, social functioning, basic living skills, self-care, and potential for harm to self or others). *Significant* means an assessed need for immediate or intensive action due to a serious or disabling need. *Assistance* means any kind of support from another person (for example, mentoring, supervision, reminders, verbal cueing or hands-on assistance) needed because of a mental health condition or disorder.
- The applicant must demonstrate significant needs related to their behavioral health.
- The applicant must demonstrate significant impairment in self-management of their mental illness or demonstrate significant needs for assistance with mental illness management.
- The applicant 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 program eligibility is submitted for SET review and determination.
- The individual has a recommendation for intensive community-based care on the Adult Needs and Strengths Assessment (ANSA) tool, with a level 3 or higher. See [Section 6: Member Application for AMHH Program](#) for additional information about the assessment tool.

An applicant not meeting the target-group and needs-based criteria as previously defined will not be eligible to receive AMHH services under the 1915(i) HCBS State Plan option. When applicable, ineligible applicants will be referred to services that may meet their needs.

Section 6: Member Application for AMHH Program

For an individual to receive Adult Mental Health Habilitation (AMHH) services, an Indiana Family and Social Services Administration (FSSA) Division of Mental Health and Addiction (DMHA)-approved AMHH provider agency, in collaboration with the individual seeking services, must refer the individual for evaluation by the State Evaluation Team (SET) via a web-based application process in the manner required by the FSSA Office of Medicaid Policy and Planning (OMPP) and DMHA. AMHH services will not be authorized for any individual who has not successfully completed the AMHH application process or does not meet all AMHH eligibility criteria, as determined by the DMHA SET. This section outlines the referral process and provider agency responsibilities during the application process. For specific instructions for completing the AMHH application, see [Section 10: AMHH Service Eligibility – Initial AMHH Application](#) in this module.

Referrals for AMHH Services

Referrals to AMHH services may come from any source within the community:

- Community mental health centers (CMHCs) or other treatment providers may identify individuals who appear to meet the AMHH target-group and needs-based eligibility criteria.
- Individuals may notify a DMHA-approved AMHH provider of interest in AMHH services.
- An individual's family members or caregivers may inquire about the services and assist the individual in contacting a DMHA-approved AMHH provider.

Note: The AMHH referral process may begin while an applicant is in an institutional setting (for example, in a state-operated facility, or SOF) as part of discharge planning and continuity of care. However, AMHH services may not begin until the individual has been discharged to a community-based setting.

Information about AMHH services may be obtained on the DMHA [Adult Mental Health Habilitation Services](#) webpage at in.gov/fssa/dmha. The webpage provides a summary of eligibility criteria and a description of all available AMHH services, as well as a list of AMHH service provider agencies, locations where potential enrollees may apply, and information about how to access AMHH assessments or services. In addition, any individual may contact the state for information about AMHH eligibility and the application process. In those cases, to help with the application process, the DMHA provides the individual with a list of DMHA-approved AMHH provider agencies.

Before completing the AMHH application process, the DMHA-approved AMHH provider explains the benefits and purpose of the AMHH program and services with the interested applicant. Next, the provider helps determine whether the applicant meets the AMHH target-group and needs-based criteria. If the applicant meets initial eligibility criteria and is interested in pursuing an application for AMHH services, the AMHH provider works with the applicant to complete the AMHH application process.

Provider Agency Responsibilities During the Application Process

Provider agencies have a number of responsibilities during the application process.

Informed Choice of Providers

The DMHA-approved AMHH provider agency is responsible for informing the applicant of their right to select an AMHH provider. During the AMHH application process, the provider agency is responsible for performing the following tasks and documenting the activities intended to educate the applicant regarding the applicant's informed choice of providers:

- Explain the applicant's right to an informed choice of providers, meaning the applicant is informed of their right to interview potential AMHH service providers and decide which agency and which staff within that agency will provide the AMHH services documented on the proposed Individualized Integrated Care Plan (IICP), and to choose which family members or caregivers, if any, will be involved as members of the individual's care team.
- Provide a list of DMHA-approved AMHH provider agencies in the applicant's county of residence and in counties contiguous to the applicant's county of residence. The agency provides a randomized list of DMHA-approved AMHH provider agencies for the applicant to select from when developing the application. The choice is documented via an attestation in the AMHH application.
- Inform the applicant that an AMHH provider agency listing is also posted on the DMHA [Adult Mental Health Habilitation Services](https://in.gov/fssa/dmha) webpage at in.gov/fssa/dmha.
- Inform the applicant of their right to change the AMHH provider staff or agency any time during the applicant's AMHH program eligibility. The current AMHH provider is expected to assist the individual in transitioning service delivery to the newly selected AMHH provider.

Requirement for Face-to-Face Evaluations

Every AMHH applicant is required to receive an individual evaluation that can be conducted face to face or via telehealth, in accordance with the *Indiana Administrative Code* (IAC), as the foundation of the application process. The DMHA-approved behavioral health assessment tool (the Adult Needs and Strengths Assessment, or ANSA) and the application components (Residential Setting Screening Tool or RSST, attestations and development of the IICP) are all used in the application evaluation. A comprehensive biopsychosocial evaluation is conducted by provider agency staff qualified to conduct AMHH assessments; see [Section 8: Behavioral Health Assessment Tool \(ANSA\)](#). The results of the evaluation and the ANSA assessment are included with the AMHH application.

Documentation of the individual evaluation, conducted face to face or via telehealth in accordance with the IAC, must include the following in the applicant's clinical record:

- Clear documentation that the AMHH evaluation with the client was conducted face to face or via telehealth, in accordance with the IAC
- Review, discussion and documentation of the applicant's desires, needs and goals

Note: Goals are habilitative in nature with outcomes specific to the habilitative needs identified by the applicant.

- Review of psychiatric symptoms and how the symptoms affect the applicant's functioning and ability to attain desires, needs and goals

- Review of the applicant's skills and the level of support needed for the applicant 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's strengths and needs, including medical, behavioral, social, housing and employment

Only qualified and trained staff from DMHA-approved AMHH provider agencies may conduct the evaluation required for the AMHH application process. The AMHH provider agency must ensure that the agency staff member providing the AMHH evaluation meets the following minimum qualifications:

- Possesses at least a bachelor's degree in social sciences or related field, with two or more years of clinical experience. Clinical experience may be obtained before or after the attainment of the required degree.
- Has completed the FSSA (DMHA and OMPP)-approved training for the AMHH eligibility determination, application process and service delivery standards. It is the responsibility of the CMHC to ensure that appropriate documentation is in the staff file demonstrating compliance with training requirements.
- Is a certified ANSA user receiving supervision from an ANSA SuperUser.

Proposed AMHH Plan of Care

The provider agency staff member and the applicant, as well as individuals the applicant chose to be an active part of the team, jointly develop a proposed IICP. The proposed IICP includes the applicant's identified strengths and needs, desired goals, and choice of providers and services (including proposed AMHH services) deemed necessary to address the documented goals. For additional information regarding person-centered planning and the AMHH IICP requirements and expectations, see [Section 9: Individualized Integrated Care Plan \(IICP\) Development for AMHH Services](#).

Completing and Processing the AMHH Member Application

The AMHH agency staff member completes and submits the AMHH application via the DMHA's web-based Data Assessment Registry Mental Health and Addiction (DARMHA) system. The application must be completed and submitted in its entirety for eligibility determination by the SET. Elements of the AMHH application include:

- The applicant's identifying and eligibility information
- Current living situation
- Eligible AMHH mental health diagnosis
- Justification of need for program
- The applicant's goals
- The applicant's objectives
- The applicant's requested services (justification not needed for each service)
- Attestations

Note: The AMHH application must be submitted with a completed attestation that includes the dates the required signatures were obtained. The required signatures must have been obtained within 60 calendar days prior to the application being submitted and must be maintained in the AMHH member's clinical record. The signatures are subject to review by the SET during AMHH quality assurance site visits.

For further information about required attestations, as well as instructions on how to complete the AMHH application, see [Section 10: AMHH Service Eligibility – Initial AMHH Application](#).

Historically, AMHH services desired during a package period would be requested at the time of application. Since 2019, all eight services are granted with package approval.

After a complete AMHH application is submitted through the DARMHA, the SET evaluates the application and determines whether the applicant meets eligibility for the AMHH program. Eligibility determinations for the AMHH program are made exclusively by the SET to avoid any potential conflicts of interest with persons performing evaluations, assessments and IICPs. For specific information about SET determinations, see [Section 11: AMHH Service Eligibility and Authorizations](#).

All required fields must be filled out on the AMHH application, or it will not be accepted. If all fields are completed but there is insufficient or inconsistent information for a clinical determination to be made, the SET may deny or pend the application and request additional information from the AMHH provider agency.

If the application is placed in the pending status and the required information is not submitted in DARMHA within seven calendar days of the team's request, the AMHH application will be subject to denial. However, the provider agency may submit an updated AMHH application at a later date for SET consideration. To ensure no conflict of interest in the AMHH clinical eligibility determination, the DMHA SET will retain the authority to determine an applicant's clinical eligibility for the AMHH program and authorization to use the AMHH services.

Note: A crisis plan must be completed at the time of application; however, it does not need to be submitted to the DARMHA. The crisis plan should be kept in the applicant's health record for quality improvement review activities. See the [Crisis Plan](#) section for more information.

Tracking AMHH Application Status

The status of an AMHH application can be tracked in DARMHA. A full listing of the application status codes is found in [Appendix E: AMHH Application Status Codes](#). The status code is updated whenever a new action is taken on an AMHH application. Providers are responsible for monitoring the status of each submitted AMHH application to ensure timely processing. Providers must routinely use this code to track where an application is in the process of program eligibility determination to ensure timely processing of each application. Tracking the progress of an AMHH application is an administrative function, not an AMHH service activity.

Section 7: Completing the HCBS Residential Setting Screening Tool

Members who receive services through the Adult Mental Health Habilitation (AMHH) program are required to live in settings that meet federal Centers for Medicare & Medicaid (CMS) requirements for Home- and Community-Based Services (HCBS) (see [Section 4: AMHH Member Home- and Community-Based Settings Requirements](#) in this module). Members who live in an institutional setting are not eligible to receive AMHH services. Institutional settings are defined as the following:

- *Nursing Home*: Care provided 24 hours a day, seven days a week in a skilled nursing facility
- *Hospital*: Care provided 24 hours a day, seven days a week in an inpatient psychiatric hospital, psychiatric health facility (such as a stress center), general hospital, private adult psychiatric hospital, Veterans Affairs hospital, state-operated facility (SOF) or transitional care hospital
- *Institute for mental disease (IMD)*: Care provided 24 hours a day, seven days a week in an IMD
- *Intermediate care facility for individuals with intellectual disability (ICF/IID)*: Care provided 24 hours a day, seven days a week in an ICF/IID
- *Jail/Correctional Facility*: Home detention, detention center, work release, weekend jail, boot camp, jail, correctional facility or prison

The Residential Setting Screening Tool (RSST) ensures that the residential settings in which applicants for AMHH services live are assessed for compliance with the HCBS settings final rule. The AMHH provider agency, in collaboration with the individual seeking services, must complete the HCBS RSST developed by the Indiana Family and Social Services Administration (FSSA) Office of Medicaid Policy and Planning (OMPP) and the FSSA Division of Mental Health and Addiction (DMHA) for every AMHH application submitted through Data Assessment Registry Mental Health and Addiction (DARMHA).

The RSST is intended to:

- Help members and providers identify the type of *community-based* setting in which a member lives.
- Assess whether that setting meets HCBS criteria, as defined by the HCBS settings final rule.
- Select the appropriate response for the *Current Living Situation* section of the AMHH application in DARMHA.
- Provide required information about the compliance status of the setting (see [Section 10: AMHH Service Eligibility – Initial AMHH Application](#) in this module).

Accessing and Using the RSST

The RSST must be completed during the assessment process for every AMHH application (initial, renewal or modification). The RSST must be completed **before** creating the AMHH application in DARMHA, to ensure that correct information is reported on the AMHH application. A completed copy of the tool, with the member and provider agency staff member signature, must be kept with the member's clinical record for later review by the DMHA State Evaluation Team (SET).

The most current version of the HCBS RSST is available for download on the DMHA [Home- and Community-Based Services](#) webpage at in.gov/fssa/dmha. Specific instructions and directions are located in each section of the RSST.

After the member's identifying information is entered in the top section, the remaining sections of the RSST are completed, in order, until the member's community-based living situation has been accurately

identified and assessed. Both the provider agency staff member and the member must sign, date and print their name in the appropriate section. The outcome from the RSST must be entered into the *Current Living Situation* section of the member's AMHH application in DARMHA (see [Section 10: AMHH Service Eligibility – Initial AMHH Application](#) in this module).

Providers are required to submit an updated RSST to DMHA each time a member moves to a new address within 15 calendar days of the change of address. This new RSST must be kept in the member's clinical record.

Definitions Used in the RSST

The following sections define the terms used in Sections 1–5 of the current RSST (see [Appendix G: HCBS Residential Setting Screening Tool](#)).

Homeless

Homeless is defined as one or both of the following:

- Lacking a fixed, regular and adequate nighttime residence
- The primary nighttime residence is one of the following:
 - A supervised publicly or privately operated shelter designed to provide temporary living accommodation of three or less months
 - A public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings (for example, on the street)

Note: This definition includes members who temporarily reside in homeless shelters.

Private/Independent Home

An individual's private home (owned or leased), or a relative's home (owned or leased) where the individual resides, is considered to be a *private/independent home*. According to the CMS, a state may presume that an individual's private home or a relative's home where an individual resides meets the home- and community-based settings requirements; however, it is still the state's responsibility to ensure that individuals living in a private home or a relative's home have opportunities for full access to the greater community.

Four characteristics must be present at a private/independent home:

- The residence is owned or leased/rented by the member or someone in the member's family for their personal use.
- The residence affords opportunities for full access to the greater community.
- The residence is not owned or operated by an agency that provides AMHH and/or BPHC services.
- The residence is not located in or on the grounds of a hospital, nursing home or other facility that provides inpatient institutional care.

Presumed Institutional Setting

Some residential settings are presumed to have qualities of an institution, based on the following characteristics:

- The residence is located in a publicly or privately owned facility that also provides inpatient institutional care.

- The residence is in a building on the grounds of, or immediately adjacent to, a public institution.
- The residence has the effect of isolating individuals receiving AMHH services from the broader community.

CMHC Provider Owned, Controlled or Operated (POCO) Residential Setting

A *CMHC POCO residential setting* is a specific physical place where a member lives that is owned, leased or co-leased by a CMHC provider of HCBS. Examples of CMHC POCO residential settings are as follows:

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

Non-POCO Residential Setting

The DMHA uses the term *non-POCO residential settings* to refer to settings owned, controlled or operated by either a not-for-profit organization or an independent setting operating authority rather than a CMHC. Examples of these types of residential settings include but are not limited to the following:

- Residential care facilities (RCFs); this category includes unlicensed assisted living facilities (ALFs) and adult family care homes (AFCHs)
- County homes
- Cluster homes or cluster apartments owned by nonprofit agencies

Non-CMHC POCO Residential Setting

A *non-CMHC POCO residential setting* is a specific physical place where a member lives that is owned, leased or co-leased by a provider of HCBS *other than a CMHC*. However, these may be considered POCO residential settings under the authority of other FSSA divisions.

The Indiana FSSA OMPP and Division of Disability and Rehabilitative Services (DDRS) administer five other Medicaid HCBS programs, known as 1915(c) HCBS waivers:

- Community Integration and Habilitation (CIH) Waiver, administered by the DDRS
- Family Supports Waiver (FSW), administered by the DDRS
- Health and Wellness (H&W) Waiver, administered by the DDRS
- Indiana PathWays for Aging (PathWays) Waiver, administered by the OMPP
- Traumatic Brain Injury (TBI) Waiver, administered by the DDRS

A member receiving services under any of these 1915(c) waivers also must live in a setting that is HCBS compliant.

Section 8: Behavioral Health Assessment Tool (ANSA)

The Adult Needs and Strengths Assessment (ANSA) is the Division of Mental Health and Addiction (DMHA)-approved behavioral health assessment tool that identifies an applicant's strengths and needs and is used to help determine an individual's level of need for Adult Mental Health Habilitation (AMHH) services. The tool consists of items grouped into categories (domains) that the provider agency staff member assesses and discusses with the applicant during the face-to-face or telehealth biopsychosocial assessment. The combined ratings resulting from the completed ANSA tool generate a level-of-need recommendation that may be used to support a recommendation for AMHH services.

The level-of-need recommendation from the ANSA tool is not intended to be a mandate for the level of services that an individual receives but is one element used in the final eligibility decision made by the State Evaluation Team (SET). Many factors, including an individual's preferences and choice, influence the actual intensity of the treatment services recommended on the applicant's proposed Individualized Integrated Care Plan (IICP).

To be considered current, the DMHA-approved behavioral health assessment tool (ANSA) must be completed and submitted in the Data Assessment Registry Mental Health and Addiction (DARMHA) within 60 days before submitting the AMHH initial or renewal application. Data from the most recent ANSA at the time the application is created populates the AMHH application, regardless of the "age" of that ANSA. If the ANSA is more than 60 days old, the application will be denied by the SET.

Providers may obtain additional information about the ANSA tool and ANSA training, support and certification by contacting the DMHA. The [DARMHA website](https://dmha.fssa.in.gov/darmha) at dmha.fssa.in.gov/darmha contains the most up-to-date ANSA user manual.

Section 9: Individualized Integrated Care Plan Development for AMHH Services

Person-centered planning is an existing expectation of the Indiana Family and Social Services Administration (FSSA) Division of Mental Health and Addiction (DMHA) for provider agencies in Indiana and is required according to *Code of Federal Regulations 42 CFR part 441.725*. This requirement is supported by community mental health center (CMHC) certification rules, requirements for national accreditation and contracts connected to DMHA funding. The member has the freedom to choose who is included in developing the Individualized Integrated Care Plan (IICP). IICPs require staff and member signatures, as well as clinical documentation verifying the member's participation. This section outlines the requirements for the proposed IICP developed during the AMHH member application process and maintained throughout the member's enrollment in AMHH services.

Staff Requirements

All AMHH IICPs must be developed in collaboration with an AMHH provider agency staff member who meets one of the following minimum certification requirements:

- Licensed professional
- Qualified behavioral health professional (QBHP)
- Other behavioral health professional (OBHP)

For details regarding minimum staffing requirements, see [Section 3: AMHH Agency Staff Requirements](#).

AMHH services psychiatrists, health service providers in psychology (HSPPs) or licensed clinicians (meeting the criteria of QBHPs) must be enrolled in the IHCP as rendering providers and be linked to the AMHH provider agency. The state expects the psychiatrist or HSPP to complete the following:

- Review the AMHH member application and assess the information for accuracy.
- Approve and certify the proposed AMHH diagnosis. See *Adult Mental Health Habilitation Codes*, accessible from the [Code Sets](#) webpage at in.gov/medicaid/providers.
- Attest and deem that the recommended AMHH services on the proposed IICP are clinically indicated and medically necessary and follow the Centers for Medicare & Medicaid Services (CMS) requirements for person-centered planning.
- Attest that without ongoing habilitation services, the applicant will likely deteriorate and be at risk of institutionalization (for example, acute hospitalization, state hospital, nursing home or jail).
- Attest that the applicant is not a danger to self or others at the time of this application.

Freedom of Choice

The AMHH member has freedom of choice regarding the following:

- Whether to participate in the AMHH program
- The team members who participate in the development and implementation of the IICP, regardless of funding sources
- The goals and objectives documented on the proposed IICP

- The AMHH services requested by the member on their proposed IICP, as supported by the member's documented needs, goals and desires
- The selection of DMHA-approved AMHH service providers that will deliver AMHH services

Reminder: AMHH members have the right to request a change of AMHH providers at any time during the AMHH eligibility period.

Developing the Individualized Integrated Care Plan

A proposed AMHH IICP must be developed for each member through a collaboration that includes the applicant or member and their chosen representatives, such as community supports, family and nonprofessional caregivers, natural/unpaid supports, and any individuals and agency staff involved in assessing and providing care for the applicant or member that the member wishes to include in the IICP. The IICP is a habilitative plan of care that integrates all components and aspects of care that:

- Are clinically indicated and deemed medically necessary
- Are supported by the member's identified needs, goals and desires
- Are provided in the most appropriate, least-restrictive Home- and Community-Based Services (HCBS) setting for achieving the applicant's or member's goals
- Include all indicated medical and support services, paid or unpaid, and regardless of funding sources needed by the member to remain in the community and function at the highest possible level of independence

The AMHH staff must ensure that the IICP development is driven by a person-centered planning process that incorporates the following IICP standards:

- Identifies the member's physical and behavioral health support needs, strengths, preferences and desired outcomes
- Takes into account the extent of, and need for, any family or other natural supports for the individual
- Prevents the provision of unnecessary or inappropriate services or care
- Is guided by best practices and research on effective strategies for improved health and quality of life
- Reflects a plan of care developed for the member with the member and represents the member's desires and choices for care

The IICP must include all identified services medically necessary to help the applicant or member continue to reside in the community, to function at the highest level of independence possible, and to achieve their goals. The following must be documented on the IICP:

- The goals the member chose that promote stability and support continued integration into the community, treatment of mental illness, and habilitation of functional deficits related to the mental illness (including co-occurring serious mental illness, or serious mental illness [SMI], and substance use disorders)
- Individuals and teams responsible for treatment, coordination of care, linkage and referrals to internal as well as external resources and care providers to meet identified needs
- Identifies by title the AMHH services the applicant or member needs and has indicated as a desired service on the proposed IICP
- A list of all other services and supports that will be delivered in conjunction with the proposed AMHH services

Note: The primary distinction between the AMHH habilitation services and the Medicaid Rehabilitation Option (MRO) rehabilitation services is the IICP treatment goals. The MRO program's philosophy is that the individual will improve their level of functioning over time. The AMHH philosophy is that the IICP goals address reinforcement, management, adaptation and retention of a level of functioning.

The IICP must be finalized and agreed to, with the informed consent of the applicant or legal guardian in writing, and signed by all individuals and providers responsible for the IICP implementation. A copy of the IICP must be offered to the member and/or legal guardian and other individuals involved in the plan.

Crisis Plan

AMHH members must be deemed stable enough to benefit from intensive home- and community-based habilitation services. However, the target population is generally considered vulnerable and susceptible to crises. To ensure a member's safety and successful utilization of AMHH services, a crisis plan is an important part of treatment planning and a requirement for all members receiving AMHH services. The crisis plan is created based on client-focused triggers and identifies means to deal with potential crises that put the client at risk of hospitalization or institutionalization if the crisis is not mitigated or averted. The plan puts in place supports to help the member avoid or cope with identified triggers that typically result in crises for the member. At the same time the AMHH application is submitted to the DMHA, the AMHH provider agency, in conjunction with the member, must develop and/or update a crisis plan. This crisis plan does not have to be submitted to the DMHA, but it must be maintained in the applicant's electronic medical record for quality improvement review activities. The information and resources in this section will help providers guide the member in developing an individualized crisis plan.

The crisis plan should also pertain to/include non-mental-health/substance-use challenges that create or have created crisis situations in the individual's life. The following is required of the provider agency when developing the crisis plan:

- The crisis plan must be developed with the member/legal guardian (and family or caregiver, if applicable).
- The plan should reflect the choice and preferences of the member/legal guardian (and family or caregiver, if applicable).
- Submission of the crisis plan document to the State Evaluation Team (SET) is optional, but in all cases, the crisis plan must be maintained in the clinical record and made available for review by the DMHA.
- Potential crises that have been identified and documented during the face-to-face or telehealth evaluation and while developing the proposed IICP, as well as the member, family or caregiver reports of past crisis situations, if applicable
- Indicators of emerging risks, impending crises and increased levels of risk
- Crisis-defusing strategies to which the member has responded well in the past, as well as action steps to prevent or mitigate potential identified crises
- Individuals and resources that can help the member complete the steps documented in the crisis plan (for example, family, natural supports, community resources and formal supports). These resources should also include a contingency plan if an identified resource or individual cannot be accessed during the crisis.

Note: AMHH services (for example, Respite Care) may be added to the proposed IICP to build coping skills, defuse crises or provide support during a crisis.

Member's Refusal to Sign the IICP

The IICP must reflect the member's desires and choices. The member's signature, demonstrating their participation in the development of initial and ongoing IICP reviews, is required on the proposed IICP submitted to the SET for review and approval. Infrequently, a member may request services but refuse to sign the IICP for various reasons (thought disorder, paranoia and so on). If a member refuses to sign the IICP, the agency staff member is required to document on the plan of care that the member agreed to the plan but refused to sign it. The agency staff member must also document in the clinical record progress note that a planning meeting with the member did occur and that the IICP reflects the member's choice of services and their agreement to participate in the services identified in the IICP. The progress note must further explain any known reasons why the member refused to sign the plan and how those issues will be addressed in the future.

Ongoing IICP Review

The provider agency is responsible to ensure that a member's progress and movement toward attaining the IICP goals is monitored on a regular basis, and that the IICP continues to reflect the member's identified strengths, needs, goals and preferences. At minimum, the IICP must be reviewed every 90 days as part of the member's regular 90-day treatment review. If additional AMHH services are warranted, an updated proposed IICP requesting new prior authorizations must be submitted to the SET. An IICP cannot be updated without the member's consent and knowledge. Delivery of the proposed new AMHH services may not commence until SET approval has been granted.

Section 10: AMHH Service Eligibility – Initial AMHH Application

For an individual to receive Adult Mental Health Habilitation (AMHH) services, an AMHH provider agency, in collaboration with the individual seeking services, must submit an application as required by the Indiana Family and Social Services Administration (FSSA) Office of Medicaid Policy and Planning (OMPP) and FSSA Division of Mental Health and Addiction (DMHA). This section provides instructions for completing the AMHH application in the Data Assessment Registry Mental Health and Addiction (DARMHA).

Required Activities Before Creating an AMHH Application

Before an AMHH application is created in DARMHA, several activities must be completed, and documentation that the activities occurred must be retained in the applicant's clinical record. These activities include:

- Completion of an evaluation by AMHH qualified staff to determine the applicant's biopsychosocial needs for the program. Evaluations can be face to face or via telehealth according to the Indiana Administrative Code (IAC).
- Completion of an Adult Needs and Strengths Assessment (ANSA) based on an interview with the applicant by a qualified ANSA user. The ANSA interview must be completed face to face or via telehealth by an AMHH provider staff member certified by DMHA, according to [Senate Enrolled Act \(SEA\) 3](#) and the IAC.
- The ANSA must have been completed and submitted in DARMHA within 60 days of the AMHH application submission and must include a recommended level of need (LON).
- Completion of the Home- and Community-Based Services (HCBS) Residential Setting Screening Tool (RSST) with the applicant; see [Section 7: Completing the HCBS Residential Setting Screening Tool](#).

Note: The method of the interview (face to face or via telehealth) must be verified by a progress note entry in the clinical documentation. Signed attestation forms will no longer constitute proof of a method of interview.

AMHH Clinical Eligibility Review Process

The AMHH provider agency electronically submits the AMHH application packet to the DMHA State Evaluation Team (SET) through the DARMHA system for the state's independent review and assessment of the applicant's clinical eligibility for the AMHH service. On receipt of the application, the SET completes the following to determine if the applicant meets clinical eligibility:

1. Reviews the AMHH member application packet for completeness. The following information is required for an AMHH application submission via DARMHA:
 - Applicant information
 - Waiver type
 - Current living situation
 - Eligible AMHH mental health diagnosis
 - Physical health issues

- Justification of need for program
- If application for renewal – assessment of progress toward meeting treatment goals during existing AMHH eligibility period
- Information for the primary contact person for the applicant at the CMHC
- If applicable, applicant’s legal guardian
- Goals
- Objectives
- Attestations

Note: If the DMHA SET pends an application and it is not resubmitted within seven calendar days from the date it was pended, the application may be denied.

2. Verifies that the applicant meets all target-group criteria and needs-based AMHH eligibility criteria (see [Section 5: AMHH Program Member Eligibility](#) for more information about eligibility criteria).
3. Reviews the proposed Individualized Integrated Care Plan (IICP) to ensure that the plan meets the following criteria and supports the need for AMHH services:
 - Goals must be person-centered and address the applicant’s issues to promote stability and continued community integration.
 - Objectives must be habilitative in nature, address the applicant’s needs and identify the steps needed to accomplish the applicant’s goals (reflected in requested services).
 - Any other service that will be used to address mental and physical health needs is also listed as a strategy, as is the purpose of the service.
 - Services being requested should describe how the applicant will attain specified goals and objectives from IICP as well as any other services that may be accessed by the applicant to meet the identified goal/objective.
 - Attestations were signed and dated within 60 days from the date of application submission.

AMHH Application

The first page of the AMHH application is for general applicant information and the second page is the Individualized Integrated Care Plan (IICP) Form. For instructions on completing this application and checking application status and history, see [Appendix C: AMHH Application Screen Shots](#).

Reviewing and Submitting the Application

After completing the AMHH member application (including but not limited to the clinical evaluation, ANSA, electronic application and proposed IICP), the provider agency staff must review the application in its entirety to ensure complete and accurate information has been included. Special attention must be paid to the following areas:

- Ensure that each data element in the applicant data section that is automatically populated from DARMHA has a green check mark beside it. A red “X” by any of the elements indicates that the applicant does not meet the criteria and does not meet the eligibility requirements for the AMHH program. Applications submitted with any red “X” will be denied by the DMHA SET.
- Be sure that all narrative boxes are complete, with sufficient required information.
- Be sure that all required attestations have been checked and physical signatures obtained before submitting the application. A copy of the signed attestations must be maintained in the AMHH member’s clinical record.

The completed, reviewed application is submitted by clicking **Submit** at the bottom of the *IICP Form* page. If any outstanding items need to be addressed, a warning message pops up, alerting the staff completing the application that additional items need correction before submission.

*Note: If an AMHH application is incomplete, unclear or has conflicting information, the SET may pend the application and require additional information or documentation from the provider agency. **The provider agency has seven calendar days from the date the application was pended to submit the required information in DARMHA. If the provider agency does not submit the required information or documentation within seven calendar days, the AMHH application is subject to denial.***

To ensure no conflict of interest in AMHH eligibility determinations in all cases, the DMHA SET retains the authority to determine an applicant's eligibility for AMHH services and to authorize the use of the AMHH services documented on the approved IICP. For more information about the SET review of the AMHH application, eligibility determination and services authorization, see [Section 11: AMHH Service Eligibility and Authorizations](#).

Section 11: AMHH Service Eligibility and Authorizations

Under the direction and supervision of the Indiana Family and Social Services Administration (FSSA) Division of Mental Health and Addiction (DMHA) and FSSA Office of Medicaid Policy and Planning (OMPP), the State Evaluation Team (SET) is exclusively responsible for determining Adult Mental Health Habilitation (AMHH) eligibility and approving AMHH services on the proposed Individualized Integrated Care Plan (IICP). This section describes the SET processes for determining AMHH eligibility and approving AMHH services.

The State Evaluation Team (SET)

The SET assesses all AMHH applications for program and service eligibility. The team is responsible for determining the following:

- Eligibility of an applicant for enrollment and reenrollment in the AMHH program
- Appropriateness of proposed IICP and requested services in meeting the applicant's needs
- Clinical authorization of approved AMHH services

SET Assessment and Determination of Member Eligibility

If an AMHH application is incomplete, unclear or has conflicting information, the SET may pend the application and require additional information or documentation from the provider agency. The provider agency has seven calendar days from the date the application was pended to submit the required information in the Data Assessment Registry Mental Health and Addiction (DARMHA). If the provider agency does not submit the required information or documentation within seven calendar days, the AMHH application is subject to denial.

Following evaluation and review of the application, the SET makes one of two potential AMHH eligibility determinations:

- Approves AMHH program eligibility with full approval of services
- Denies eligibility for AMHH program and all requested services

Determining a Start Date for AMHH Eligibility

The start date for AMHH program and services eligibility is the day following application approval. For approved applicants whose Medicaid Rehabilitation Option (MRO) package ends within 60 days of the date of SET approval, the AMHH start date is the day following the end date of the current MRO service package. This approach ensures that there is no lapse in services for the member.

For approved applicants whose MRO package ends beyond 60 days from the date of SET approval, the start date is set at 15 calendar days from the date the SET approves the AMHH application.

Note: There may be circumstances in which an applicant and provider identify a need to initiate AMHH services sooner than the start date normally determined by the SET. These requests are considered on a case-by-case basis, and the start date is assigned as needed.

For members already receiving AMHH services, the start date for the new AMHH service package is the day following the end date of the current AMHH service package. This approach ensures that there is no lapse in services for the member.

Communication of the SET Eligibility Determination


Approval or denial of AMHH eligibility is communicated to the referring provider agency and the applicant or authorized representative in the following manner:

- *Approval of AMHH program eligibility with full approval of services:* If an applicant is determined eligible for the AMHH program, Gainwell Technologies sends an authorization notification to the referring AMHH provider and the applicant or authorized representative. This notification includes the following information:
 - Start and end dates for AMHH program eligibility and services
 - AMHH services, including the procedure code, modifiers and number of units approved
- *Denial of AMHH program:* If an applicant is determined ineligible for the AMHH program, a denial notification is sent to both the applicant or authorized representative and the referring AMHH provider. This denial notification is generated by the SET and includes the following information:
 - Notification of the reasons the SET determined the applicant is not eligible for the AMHH program
 - Information regarding the applicant's fair hearing and appeals rights

Figures 1 through 3 show a sample AMHH denial notification packet. [Figure 1](#) shows the denial notification form. [Figure 2](#) shows a sample *Appeal Form for AMHH Services*. [Figure 3](#) outlines an applicant's appeal rights.

Figure 1 – Sample Adult Mental Health Habilitation (AMHH) Denial Notification

FSSA/Indiana Division of Mental Health and Addiction Indiana Government Center South 402 W. Washington Street, W353 Indianapolis, Indiana 46204 Office: 317-232-7800 Secure Fax: 317-233-1986	Date: MM/DD/YYYY
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Indiana Medicaid Adult Mental Health Habilitation (AMHH) Services **DENIAL Notification**

Member Information	Provider Information
Member Name	Provider
Member Address	Provider Address
City, State, ZIP	City, State, ZIP
Member ID	Submitted by: (DMHA SET staff)

The Division of Mental Health and Addiction (DMHA) has received your application for the Adult Mental Health Habilitation (AMHH) Services Program. You are receiving this notice because your application has been denied. This notice explains why your application has been determined as not meeting the eligibility criteria for the AMHH program and what your appeal rights are if you do not agree with the determination. **Please contact the provider who assisted in completing and submitting your application to discuss options and next steps.**

DARMHA ID: _____ Application Submit Date: _____ IICP Number: _____

IMPORTANT NOTICE: This document contains Protected Health Information which is governed by the Health Insurance Portability and Accountability Act (HIPAA) and may only be disseminated to authorized individuals.

APPLICATION TYPE:

☐ Initial
 ☐ Modification
 ☐ Renewal

AMHH PROGRAM ELIGIBILITY:

☐ Yes
 ☐ No

The AMHH Program Eligibility, 405 IAC 5-21.6-4, is denied due to the following reason(s):

<input type="checkbox"/> Does NOT meet one or more of the eligibility criteria: <ul style="list-style-type: none"> Age 19 or over AMHH eligible primary mental health diagnosis Medicaid enrolled Reside in a home or community based setting <input type="checkbox"/> No recommendation for intensive community based care: Adult Needs and Strengths Assessment (ANSA) Level of Need (LON) is less than 3 and/or ANSA was completed more than 60 days prior to application submission	<input type="checkbox"/> Does NOT meet one or more of the needs based criteria: <ul style="list-style-type: none"> Demonstrated need for significant assistance in major life domains related to their mental illness Demonstrated significant need related to behavioral health Demonstrated significant impairment in self-management of mental illness, or demonstrated significant need for assistance with mental health management Demonstrated lack of sufficient natural supports to assist with mental illness management Not a danger to self or others
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Appeal Form for Indiana Medicaid Adult Mental Health Habilitation Services

Provider Information
Provider Provider Address City, State, ZIP Submitted by: <i>(DMHA SET staff)</i>

Denial Date	Reason(s) for Denial
MM/DD/YYYY	Reasons for denial

Mail to: Indiana Family and Social Services Administration
Office of Hearings and Appeals, MS 04
402 W Washington St, Room E034
Indianapolis, IN 46204

Fax: 317-232-4412 (Attn: Office of Hearings and Appeals)

I wish to appeal the above decision, for the following reasons:

Signature of Applicant/Guardian: _____ **Date:** _____

Relationship to Applicant: _____

Figure 3 – AMHH Applicant's Appeal Rights

Appeal Rights as an Applicant for Adult Mental Health Habilitation (AMHH)

If you have questions or disagree with the indicated decision, you should discuss this matter with your selected provider.

Right to Appeal and Have a Fair Hearing:

The Denial Notification provides an explanation of the decision made on your application for services or changes in your services. If you disagree with the decision, you have the right to appeal by submitting a request for a fair hearing. If you are currently receiving AMHH Services and your renewal application has been denied, your AMHH Services will continue if your appeal is received within the required time frame described below under "How to Request an Appeal" unless you request to end services.

Can I continue to get benefits when my appeal is pending?

- 1) New services cannot be started but you may keep your current benefits until an Administrative Law Judge (ALJ) issues a decision after an evidentiary hearing. In order to maintain your current benefits, you must file your appeal:
 - a) Within 10 calendar days of the date of the Notice; or
 - b) Before the date that the agency's decision goes into effect, whichever is later.
- 2) Any benefits you receive while your appeal is being decided may have to be paid back if the ALJ determines that the original decision is correct. However, you will only be responsible for paying back benefits provided to you on appeal after the authorization period.

How to Request an Appeal:

- 1) If you wish to appeal this decision, the appeal request must be received by close of business not later than:
 - a) 33 calendar days following the effective date of the action being appealed; or
 - b) 33 calendar days from the date of the notice of agency action, whichever is later.
- 2) To file an appeal, please sign, date and return the enclosed *Appeal Form for Indiana Medicaid Adult Mental Health Habilitation Services*:

Mail to: Indiana Family and Social Services Administration
Office of Hearings and Appeals, MS 04
402 W Washington St, Room E034
Indianapolis, IN 46204

Fax: 317-232-4412 (Attn: Office of Hearings and Appeals)
- 3) If you send a letter rather than this Denial Notification, be sure that the letter contains your full name, address and telephone number where you can be reached. Please attach a copy of this decision to the letter and state the name of the action you are appealing. If you are unable to sign, date and return this form to the above mentioned address, you may have someone assist you in requesting the appeal. A telephone request for an appeal cannot be accepted.
- 4) You will be notified in writing by the Indiana Family and Social Services Administration, Office of Hearings and Appeals of the date, time and location for the hearing. Prior to, or at the hearing, you have the right to examine the entire contents of your case record maintained by the Selected Provider.
- 5) You may represent yourself at the hearing or you may authorize a person to represent you, such as an attorney, relative or other spokesperson. At the hearing, you will have full opportunity to:
 - a) Call witnesses;
 - b) Establish all pertinent facts and circumstances;
 - c) Advance any arguments without interference and question; or
 - d) Refute any testimony or evidence presented.

The SET sends the denial notification to the AMHH provider and the applicant or authorized representative. The denial notification includes information regarding the applicant's fair hearing and appeals rights.

The referring AMHH provider agency is responsible for alerting the applicant or member of the SET's eligibility determination and, in the event of a denial notification, assisting the member in understanding the reasons for the denial and pursuing the fair hearing and appeals process, as applicable.

Providers may access information regarding the status of an AMHH eligibility determination and approval of AMHH services via DARMHA, as well as authorization of AMHH service units, via the [IHCP Provider Healthcare Portal](#) (IHCP Portal), accessible from the homepage at in.gov/medicaid/providers. See the [Provider Healthcare Portal](#) module for information about registering for and using the IHCP Portal.

[Appendix E: AMHH Application Status Codes](#) explains the status codes that are viewable in the “Application Status” drop-down menu of the AMHH application in the DARMHA. The status code is updated whenever a new action is taken on an AMHH application. Providers can use this code to track where an application is in the review and approval process.

AMHH Services – Eligibility Period

The AMHH services eligibility period is 360 days from the start date documented on the AMHH eligibility authorization notification, or as determined by the SET. AMHH service delivery may not begin until the service approval from the SET is authorized, and Gainwell Technologies assigns the member the AMHH services package. AMHH provider agencies will not receive reimbursement for any AMHH services provided without SET approval and authorization, or for services provided outside the AMHH eligibility period, as documented on the authorization notification. The provider agency is required to:

- Continually monitor the member’s progress and benefit from AMHH services, and notify the DMHA if there is any change in status that impacts the member’s eligibility for AMHH services
- Continually monitor the member’s service units to determine if additional AMHH services units are needed. The provider must update the IICP and submit a prior authorization (PA) request in DARMHA for the SET to review and approve the requested AMHH service units.
- Track the end date of the member’s AMHH program and services eligibility and submit an AMHH renewal application at least 30 days (but no more than 60 days) before the end date of the existing AMHH eligibility period – see [Section 12: Renewal of AMHH Program Member Eligibility](#) in this module for additional information.

Note: The AMHH provider agency is responsible to ensure that the AMHH services renewal application is submitted to the SET at least 30 days before the expiration date of the member’s current AMHH eligibility period. In addition, a new ANSA must be completed and submitted within 60 days of creating the AMHH renewal application.

Approval for AMHH Units of Services

The AMHH service approval provides a set number of service units for the approved AMHH service package. AMHH providers must coordinate service delivery to ensure that the AMHH service units are managed in a way to ensure continued service delivery throughout the AMHH eligibility period, based on the member’s needs. If additional service units are needed, the provider must request additional service units through a PA request.

Prior Authorization

PA is available for all AMHH services. AMHH service packages are assigned for 360 days. Within the last 60 days of an assigned service package, a provider may reassess the person and a new service package will be assigned to start the day after the existing package ends. For the majority of members receiving AMHH services, the assigned AMHH service package provides a sufficient number of services and units of service to meet their needs. However, for members that require additional units of services assigned in the service package, a PA request is required.

Interruption of AMHH Services

When AMHH services are interrupted because the member is leaving the community to enter an institutional setting (for example, incarceration, hospitalization and so on), AMHH services are not reimbursable or billable during the service interruption. The AMHH eligibility and authorized service units remain available to the member, in the originally authorized AMHH eligibility period, for immediate access when the member returns to the community from the institutional setting and chooses to restart AMHH services.

If, however, the member does not return to the community during the AMHH eligibility period, the member must reapply for AMHH services before or upon reintegrating into the community, with the assistance of a DMHA-approved AMHH provider agency. To retain continuity of care, AMHH program eligibility and service requests may be applied while an individual is in an institutional setting and preparing for discharge back into the community, so long as the request includes a specific discharge date within 30 days of submitting the application. If approved, AMHH services are not reimbursable until the applicant has returned to a community-based setting.

Termination of AMHH Services

If AMHH services must be terminated before the end of the AMHH eligibility period because the member has asked to terminate AMHH services or no longer meets AMHH criteria, the provider agency must help link the member to services that may be able to meet the individual's needs. (For information about transitioning to MRO services, see [Section 13: Transitions During AMHH Eligibility Period.](#))

If the provider agency's efforts to facilitate a transition in services for the member are not successful, the provider agency must document in the clinical record the attempts made to coordinate transition to other services.

Section 12: Renewal of AMHH Program Member Eligibility

The member's Adult Mental Health Habilitation (AMHH) program and services eligibility period expires 360 days from the date of the AMHH start date, or as otherwise determined by the State Evaluation Team (SET). To continue AMHH services and prevent a lapse in service delivery for an eligible member, the AMHH member, in conjunction with the AMHH provider agency, must reapply for AMHH program eligibility at least 30 days (and no more than 60 days) before the eligibility expiration date.

The AMHH renewal application and evaluation process is the same as the initial AMHH application process outlined in *Sections 6, 7 and 10* of this module, including the following:

- Completing a face-to-face or telehealth holistic clinical and biopsychosocial assessment
 - A qualified Indiana Family and Social Services Administration (FSSA) Division of Mental Health and Addiction (DMHA)-approved AMHH service provider must evaluate the member's strengths, needs and functional impairments.
- Completing the clinical assessment and Adult Needs and Strengths Assessment (ANSA) tool to assess whether the member meets the level of need recommendation and needs-based criteria for AMHH services
 - The assessment and the ANSA must be completed within 60 days of creating the AMHH renewal application.
- Updating the Individualized Integrated Care Plan (IICP), crisis plan and attestations
- Evaluating the member's progress toward meeting established habilitative treatment goals
- Determining if and how the member is receiving benefits from AMHH services
- Submitting the renewal application in the Data Assessment Registry Mental Health and Addiction (DARMHA)

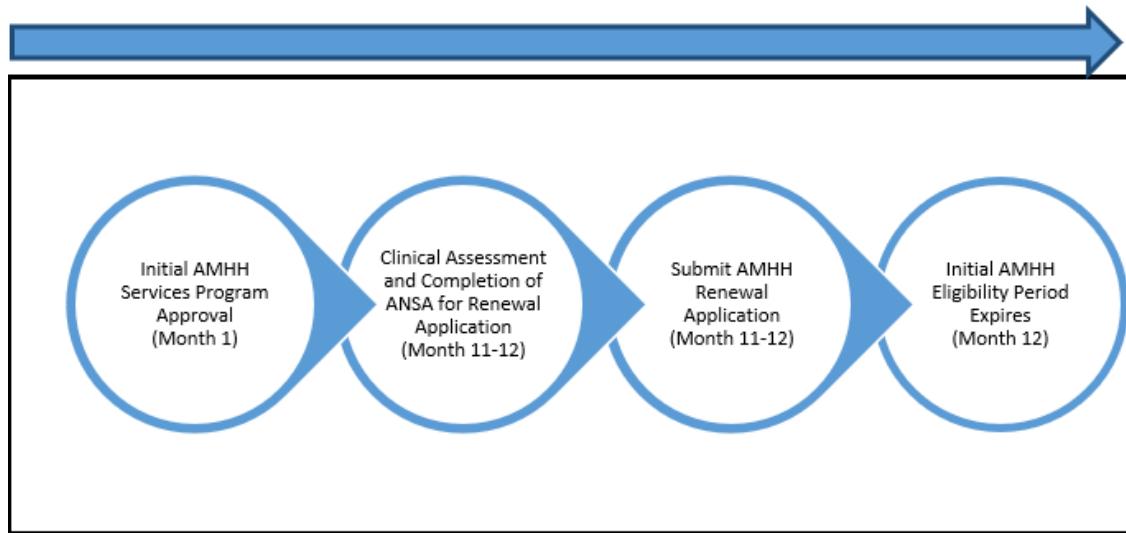
Note: The member, with assistance from the AMHH service provider, must reapply for AMHH program eligibility at least 30 days (but not more than 60 days) before the eligibility expiration date to prevent an interruption in service delivery. See [Figure 4](#) for a timeline for renewing AMHH services.

If an AMHH application is incomplete, unclear or has conflicting information, the SET may pend the application and require additional information or documentation from the provider agency. The provider agency has seven calendar days from the date the application was pended to submit the required information in DARMHA. If the provider agency does not submit the required information or documentation within seven calendar days, the AMHH application is subject to denial.

Approval or denial of continued AMHH eligibility is communicated to the referring provider agency and the applicant or authorized representative, as described in [Section 11: AMHH Service Eligibility and Authorizations](#).

[Figure 4](#) illustrates the AMHH services renewal application timeline.

Figure 4 – AMHH Program – Renewal Application Timeline



Section 13: Transitions During AMHH Eligibility Period

The Adult Mental Health Habilitation (AMHH) provider agency must respect the member's right to freedom of choice regarding program participation and choice of AMHH service providers. The AMHH provider agency must provide the greatest assistance possible to facilitate a transition or change in AMHH service providers at the member's request. It is the responsibility of the AMHH provider agency to coordinate any transition in services for an AMHH member, such as:

- Transition between AMHH provider agency staff members within the same AMHH provider agency
- Transition between AMHH provider agencies
- Transition from AMHH services to other programs, such as Medicaid Rehabilitation Option (MRO), as applicable

Transition Between AMHH Service Provider Staff Within an Agency

AMHH members have the right to choose who provides their services within an agency. Members may request that specific agency staff provide AMHH services, so long as those staff members are appropriately qualified and trained to provide the service. All requests must be honored, whenever possible, to ensure member choice.

Transition Between AMHH Provider Agencies

To assist with a transition between provider agencies, the current AMHH provider agency must engage in the following to maintain continuity of care for the member:

- Provide the member with a randomized listing of AMHH provider agencies in the member's county of residence and contiguous counties, so the member is able to make an informed choice in selecting a new AMHH provider agency
- Assist in linking the member with the new AMHH provider agency, which includes the transfer of clinical information to coordinate care (with a signed consent if the transfer is between provider agencies and not an internal transfer within the same agency). The information transferred may include the member's last assessment, current Individualized Integrated Care Plan (IICP) and progress notes, crisis plan, and so on, which will assist the new provider agency in continuing care with minimum disruption in service delivery.
- Communicate with the new provider agency regarding service unit utilization during the existing AMHH eligibility period

Note: Authorization for AMHH services belongs to and follows the AMHH member, not the provider agency. The number of approved AMHH service units does not change due to a transfer between provider agencies. If additional AMHH services are indicated to meet the member's needs (other than the ones originally approved by the State Evaluation Team [SET]), the new provider agency must follow the process for requesting additional services.

Voluntary Transition From AMHH Services to MRO Services

If AMHH program members choose, they may request to be transitioned to (or back to) a Medicaid Rehabilitation Option (MRO) service package. To assist in a transition to MRO, the AMHH provider agency must engage in the following to maintain continuity of care for the member:

- Complete and submit an Adult Needs and Strengths Assessment (ANSA) reassessment within 60 days of the requested date of transition to MRO. A current (within 60 days) ANSA is necessary for determining MRO eligibility and service package assignment. The ANSA can be completed face to face, or via telehealth, according to [Senate Enrolled Act \(SEA\) 3](#) and the Indiana Administrative Code (IAC).
- Use the Transition to MRO wizard under the *IICP Form* tab to complete the currently approved AMHH application in the Data Assessment Registry Mental Health and Addiction (DARMHA). Submit an email to the SET (amhhservices-fssa@state.in.us) informing them of the need to transfer the AMHH member to (or back to) MRO. The requested date of transition must be no earlier than the date the transition request is submitted and no later than the end of the current AMHH eligibility period. See [Section 10: AMHH Service Eligibility – Initial AMHH Application](#) for instructions.

The SET evaluates the transition request and, when approved, DARMHA sends an AMHH end date to Gainwell Technologies. The following day, DARMHA auto-generates an MRO eligibility request file and sends that to Gainwell Technologies for MRO eligibility determination. If the MRO eligibility criteria and Medicaid status are met (current level of need, active Medicaid ID and diagnosis), Gainwell Technologies generates and authorizes an MRO service package with an effective date the day after the AMHH end date. If the date on the most recent ANSA is more than 60 days before the AMHH package end date provided by DARMHA, Gainwell Technologies does not generate an MRO service package because the date of assessment does not qualify, which may result in a lapse in service authorization for the member. The provider agency will not receive authorization or payment for services delivered between the end of the AMHH service authorization and the beginning of an MRO service package.

Providers may not submit claims for MRO services and AMHH services simultaneously. Services under these two programs are mutually exclusive. It is the provider's responsibility to verify eligibility prior to rendering services to a client. Providers may bill only AMHH services during an AMHH program eligibility period even if an MRO service package is also noted as active. After the AMHH service eligibility and service authorization is end-dated, the member can utilize MRO services if there is an authorized service package in place.

Default Transition From AMHH Services to MRO Services

If the current AMHH eligibility period ends without an approved AMHH renewal request and the most recent ANSA is less than 60 days old, an MRO eligibility request file auto-generates from DARMHA and is sent to Gainwell Technologies for MRO eligibility determination. If the MRO eligibility criteria and Medicaid status requirements are met (including the level of need, active Medicaid ID and diagnosis), Gainwell Technologies generates and authorizes an MRO service package with an effective date the day after the AMHH end date (which will become the AMHH eligibility end date). If the ANSA is more than 60 days old (from AMHH eligibility end date), the provider must complete a new ANSA and submit it to DARMHA to trigger the MRO eligibility request file being sent to Gainwell Technologies for MRO eligibility determination. If neither AMHH nor MRO eligibility is established, the result is a lapse in the member's program eligibility and service authorization. The provider agency will not receive payment for services delivered outside an authorized eligibility period for either program.

*Note: **MRO eligibility determination is contingent on current assessments.** Providers are strongly encouraged to complete an ANSA reassessment within the required time frame (no more than 60 days before the end date of the current service package eligibility end date) to support ongoing or reestablish program eligibility. For additional information regarding MRO eligibility and service packages, see the [Medicaid Rehabilitation Option Services](#) module.*

Section 14: Clinical and Administrative Documentation

The Adult Mental Health Habilitation (AMHH) provider agency must comply with documentation requirements, as defined by the Centers for Medicare & Medicaid Services (CMS), the Indiana Family and Social Services Administration (FSSA) Office of Medicaid Policy and Planning (OMPP) and the FSSA Division of Mental Health and Addiction (DMHA), this AMHH provider module, and *Indiana Administrative Code 405 IAC 1-5*. All clinical record documentation must contain information that reflects the AMHH services provided to the member. The documentation required to support billing for AMHH services must:

- Focus on the member
- Emphasize the member's strengths
- Reflect the member's progress toward the habilitation goals reflected in the Individualized Integrated Care Plan (IICP)
- Be present in the member's medical record for every member encounter for which billing is submitted for reimbursement
- Be written and signed by the provider rendering services (and cosigned if applicable)
- Follow all documentation requirements outlined in this module

For complete service definitions, provider qualifications, program standards and exclusions, see AMHH services outlined in this module (*Sections 16-23*).

Service Location Specifications

It is essential that the location where an AMHH service is provided is clearly documented in the member's clinical record. AMHH is a 1915(i) Home- and Community-Based Services (HCBS) program, and AMHH services must be provided in home- and community-based settings (or via telehealth, when applicable) to be eligible for reimbursement. For more information, see [Section 4: AMHH Member Home- and Community-Based Settings Requirements](#), *Sections 16-23* of this module, the [Home- and Community-Based Services Final Rule Statewide Transition Plan](#) website at in.gov/fssa and *Telehealth and Virtual Services Codes*, accessible from the [Code Sets](#) webpage at in.gov/medicaid/providers. Services delivered via telehealth must be in accordance with the *Indiana Administrative Code* (IAC).

General Documentation Requirements

The AMHH provider agency must comply with the standards for documentation required for each AMHH service provided. Although each AMHH service may have its own unique documentation requirements in addition to the general requirements listed here, this section provides information about general documentation requirements that 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 module (see *Sections 16-23*). Providers are responsible for understanding and adhering to the requirements and limitations for each service they are qualified and authorized to provide. Questions about a service and its requirements may be directed to the State Evaluation Team (SET), which is responsible for completing AMHH quality assurance activities in support of the CMS and FSSA/OMPP requirements for the delivery of AMHH services.

The following applies to each AMHH service that is claimed for reimbursement:

- All AMHH service and eligibility documentation is subject to review by the CMS and the state, or their designees.
- The provider is subject to denial of payment or recoupment for paid claims if the provider does not have adequate documentation to support the AMHH service billed.

The following documentation requirements apply for each AMHH service encounter:

- Date of service rendered (including month, day and year)
- Name and qualifications of the staff member providing the service

*Note: AMHH progress notes **must** include the staff qualifications (such as OBHP, QBHP, LCSW and so on). Degree indication is optional.*

- Type or title of service provided
- Confirmation that service provided is face-to-face or telehealth, according to the IAC (valid telehealth services can be found on *Telehealth and Virtual Services Codes*, accessible from the [Code Sets](https://www.in.gov/medicaid/providers) webpage at [in.gov/medicaid/providers](https://www.in.gov/medicaid/providers))
- Location or setting where the service was provided
- Description of the focus on the member and of the session or service delivered to or on behalf of the member
- Symptoms, issues and/or goals addressed during the session
- Duration of the service (actual time spent with the member or completing the activity)
- Start and end time of the service
- Member's Individualized Integrated Care Plan (IICP) goals addressed during the session
- Progress made toward the habilitation goals
- Strengths of the client utilized during the service or gained as a result of the service

Note: Individualized goals are habilitative in nature. Progress may be described as sustained maintenance or acquiring of skills or functioning, allowing the individual to live in the community in the least-restrictive environment possible.

The content of the documentation must support the amount of time billed. In addition to the requirements listed in this section, additional requirements for specific service types are reflected in the following subsections.

Services Provided in a Group Setting

For members participating in AMHH services provided in a group setting (for example, Adult Day Services can also apply to Home- and Community-Based Habilitation and Support, Therapy and Behavioral Support Services, Addiction Counseling, and Medication Training and Support), documentation provided for each encounter must include:

- All items described listed in the [General Documentation Requirements](#) section
- Focus or topic of the group or session and how it applied to the specific member's goals
- Member's level of engagement and participation in the group session
 - Simply noting whether the member was present in the group does not constitute adequate documentation.

Services Provided Without the Member

For services provided without the member (neither face-to-face nor via telephone), documentation provided for each encounter must include:

- All items described listed in the [General Documentation Requirements](#) section
- The persons who attended the session and their relationship with the member
- How the session addresses the member's goals
- How the service benefits the member

This requirement applies to Home- and Community-Based Habilitation and Support, Therapy and Behavioral Support Services, Addiction Counseling, Care Coordination, and Medication Training and Support services.

Service-Specific Documentation Requirements

The following services have additional documentation requirements, as described. For all other AMHH services, only the general documentation requirements apply.

Adult Day Services

Adult Day Services is a time-limited, nonresidential service provided in a clinically supervised setting for members who require structured habilitative services to maintain their outpatient status. Adult Day Services are curriculum-based and designed to alleviate emotional or behavior problems, with the goal of transitioning the member to a less-restrictive level of care, reintegrating the member into the community, and increasing the member's social connectedness beyond a clinical setting and/or employment. For a complete definition of Adult Day Services, see [Section 16: Adult Day Services](#).

Documentation requirements include, at minimum, weekly reviews with details of daily activities and progress updates that include details of services provided each day in accordance with the following:

- All items listed in the [General Documentation Requirements](#) section
- All requirements noted in the [Services Provided in a Group Setting](#) section
- Member's goals and a transitional plan to reintegrate the member into the community

Note: Providers may opt to use daily documentation versus a weekly review as long as the agency is consistent about which method is used. Daily reviews require all the same documentation elements weekly reviews do.

Respite Care Services

Respite Care services are services provided to members who are unable to care for themselves. These services are furnished on a short-term basis because of a nonprofessional caregiver's absence or need for relief. For a complete definition of Respite Care services, see [Section 18: Respite Care](#). Documentation requirements include:

- All items listed in the [General Documentation Requirements](#) section
- The primary location where services are rendered and the reason for the Respite Care services
- Nature of the services delivered to the member
- Documentation of the activities the member engaged in during the respite and how the member responded

Section 15: Grievances and Complaints

Adult Mental Health Habilitation (AMHH) provider agencies must ensure that all AMHH members in the agency's care retain the following rights:

- To receive appropriate behavioral health services in accordance with standards of professional practice, appropriate to the member's needs and designed to afford the individual a reasonable opportunity to maintain or improve their condition
- To participate in the planning of the Individualized Integrated Care Plan (IICP), including receiving assistance in understanding and being informed of the nature of the treatment program proposed, the known effects of receiving and not receiving such treatment, and alternative treatments, if any
- To refuse to submit to treatment, including medication or services, as an adult voluntary patient
- To be treated with consideration, dignity and respect, free from mental, verbal, and physical abuse or neglect
- To have freedom of choice regarding which Indiana Family and Social Services Administration (FSSA) Division of Mental Health and Addiction (DMHA)-approved AMHH provider agency (or agencies) delivers AMHH services, and the freedom to change AMHH provider agencies at any time during the AMHH services eligibility period
- To have the right to choose to receive services in a non-disability-specific setting selected by the member/family
- To be sure of confidentiality and protection of personal identifying and treatment-related information, as provided under the *Health Insurance Portability and Accountability Act* (HIPAA)

Each DMHA-approved AMHH provider agency is required to ensure that each AMHH participant receives a written statement of rights. In addition to listing the participant's rights, the statement must also include:

- The toll-free telephone numbers for the DMHA Consumer Service Line (800-901-1133) and [Indiana Disability Rights](#) (800-622-4845)
 - For individuals who are deaf, hard-of-hearing or speech impaired, Relay Indiana can be contacted by dialing 711. For more information, call 877-446-8722 or email info@relayindiana.com.
- A place for participants to affirm that they received written and oral explanation of the rights
 - The agency must retain a copy of this affirmation for each applicant/member in their medical record.

Grievance or Complaint-Reporting Policy

The objective of the grievance or complaint-reporting policy is to provide members with a formal process to ensure that the individual can voice concerns, complaints and grievances regarding the AMHH program to the DMHA for review and resolution. Provider agencies are required to help members understand their rights and options regarding filing a grievance or complaint about AMHH services and service delivery to the DMHA. Provider agencies are required to follow the DMHA policy for grievances and complaints located at the [Office of Family & Consumer Affairs](#) webpage at in.gov/fssa/dmha.

Section 16: Adult Day Services

Adult Mental Health Habilitation (AMHH) Adult Day Services consists of community-based group programs designed to meet the needs of adults with significant behavioral health impairments, as identified in members' Individualized Integrated Care Plans (IICPs). These comprehensive, nonresidential 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 member's IICP. AMHH Adult Day Services may include:

- Care planning
- Behavioral health treatment
- Monitoring weight, blood glucose level and blood pressure
- Medication administration*
- Nutritional assessment and planning
- Individual or group exercise training
- Training in activities of daily living (ADLs)
- Skill reinforcement for established skills
- Other social activities

Adult Day Services may also include other social activities, as indicated, to meet identified needs and goals established in the IICP.

**Note: Medication administration and support in Adult Day Services may be provided by a medical assistant graduated from a two-year clinician program and authorized healthcare professional in addition to other qualified professionals.*

Provider Qualifications

The staff that provides AMHH Adult Day Services must have the following qualifications:

- Licensed professional, except for licensed clinical addiction counselors
- Qualified behavioral health professional (QBHP)
- Other behavioral health professional (OBHP)

Medication administration provided as part of AMHH Adult Day Services must be delivered by a provider who meets one of the following qualifications:

- A licensed physician
- An authorized healthcare professional (AHCP)
- A registered nurse (RN)
- A licensed practical nurse (LPN)
- A medical assistant (MA) who has graduated from a two-year clinical program

Nutritional assessment and planning services provided as part of AMHH Adult Day Services activity must be provided by a certified dietician, as defined in *Indiana Code IC 25-14.5-1-4*.

See *Agency Staff Requirements* in [Section 3: AMHH Agency Staff Requirements](#) for additional information about staff member qualifications.

Program Standards

Program standards for AMHH Adult Day Services include the following:

- The services require face-to-face contact with the member, and the member must be the focus of the services delivered.
- The member's goals must be designed to facilitate community integration and use natural supports.
- Therapeutic services include clinical therapies, psychoeducational groups and habilitative activities.
- Documentation must support how the services benefit the member, including when the services are provided in a group setting.
- Medication administration must be provided within the scope of practice of the provider staff member, as defined by federal and state law. For additional information, see the [Indiana Professional Licensing Agency](#) at in.gov/pla.
- 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. For additional information, see the [Indiana Professional Licensing Agency](#) at in.gov/pla.
- Each day of service must be appropriately documented in the member's clinical record.
- At a minimum, a weekly review and update of the member's progress toward habilitative goals must occur and be documented in the member's clinical record. Providers may opt to use daily documentation versus a weekly review summary, as long as the agency is consistent about which method is used. Daily reviews require all the same documentation as weekly reviews.

Requirement for Clinical Oversight

Program standards for AMHH Adult Day Services require that a licensed physician provide clinical oversight of the program. This licensed physician must be on-site at least once a week and available to program staff when not on-site. This requirement is in addition to the general requirement that approved agency staff (QBHP, OBHP and so on) must be supervised by a licensed professional.

Exclusions

General AMHH program exclusions are outlined in *Noncovered Services* in [Section 2: Adult Mental Health Habilitation Program Overview](#). The following exclusions apply and are nonreimbursable or noncovered for AMHH Adult Day Services:

- Formal educational or vocational services are considered nonreimbursable or noncovered.
- Adult Day Services are not eligible for reimbursement if provided in a residential setting, as defined by the Indiana Family and Social Services Administration (FSSA) Division of Mental Health and Addiction (DMHA).
- If services are provided simultaneously with other services, only one of the services provided is billable.

HCPCS Codes

Table 1 shows the Healthcare Common Procedure Coding System (HCPCS) codes for Adult Day Services. For a complete list of AMHH service codes and rates, see [Appendix H: AMHH Service Codes and Rates Table](#).

Table 1 – HCPCS Codes for Adult Day Services

Code	Modifier	Code Description	Limitations
S5101	UB	Day care services, adult; per half day; adult mental health	Maximum is 1 day (2 units) (1 unit = 1/2 day), 5 days per week

Service Unit Description and Limitations

The basic unit of service for AMHH Adult Day Services is a half-day unit. A single half-day unit is defined as providing service for a minimum of three hours to a maximum of five hours per day.

- Two units are defined as the service provided for more than five hours to a maximum of eight hours per day.
- A maximum of two half-day units per day is allowed, up to five days per week, with a maximum of 10 units in a five-day period. A second half-day unit may be billed only when a previous entire half-day unit (five hours, plus 60-minute break) has been provided to the member.

For additional guidance about calculating and billing service time for Adult Day Services, see [Section 24: AMHH Program Billing](#).

Section 17: Home- and Community-Based Habilitation and Support

Adult Mental Health Habilitation (AMHH) Home- and Community-Based Habilitation and Support services are individualized services provided face to face or via telehealth according to Indiana Administrative Code (IAC) that are focused on the member's health, safety and welfare. These services are intended to:

- Provide skills training to reinforce established skills (may include activities of daily living [ADLs])
- Help members manage, adapt and retain skills necessary to support their ability to live successfully in the community-integrated settings most appropriate to their needs
- Help members manage their behavioral and medical health conditions

Home- and Community-Based Habilitation and Support services may be provided to:

- Members individually in individual or group settings
- Family members or other nonprofessional caregivers in individual or group settings, with or without the members present

An “individual setting” means that the activity is meant to benefit one client, even though the activity may include family members and nonprofessional caregivers, and the client may or may not be present during the activity. A “group setting” means the activity is meant to benefit more than one client, even though, again, the activity may include family members and professional caregivers of multiple clients, and the clients may or may not be present during the activity. The benefit to the client must be in accordance with each client's individual treatment goals.

Example 1: An AMHH client, “Juan,” attends a family counseling session with his siblings and mother. Because the session is intended to benefit only Juan, it is considered an individual setting, even though multiple people are present.

Example 2: The families of several clients meet for an orientation session for an upcoming AMHH skills development group, which will be attended by several AMHH clients. Because the group includes and will benefit more than one client, the activity is considered a group setting.

Provider Qualifications

Provider staff of AMHH Home- and Community-Based Habilitation and Support services must have one of the following qualifications:

- Licensed professional, except for a licensed clinical addiction counselor
- Qualified behavioral health professional (QBHP)
- Other behavioral health professional (OBHP)

For additional information on staff member qualifications, see [Section 3: AMHH Agency Staff Requirements](#).

Program Standards

Program standards for AMHH Home- and Community-Based Habilitation and Support services include:

- The services require face-to-face or telehealth (according to the *Indiana Administrative Code* [IAC]) contact. The contact may be with or without the member present, with or without family members and nonprofessional caregivers present, in an individual or group setting.
- The member is expected to show benefit from the services.
- Services must be goal-oriented and related to the Individualized Integrated Care Plan (IICP).
- When provided to family members or caregivers, services must be focused on the member and improve the ability of the parent, family member or primary caregiver to provide care to or for the member.
- Activities include:
 - Implementation of the IICP
 - Assistance with personal care
 - Coordination and facilitation of medical and nonmedical services to meet healthcare needs
 - **When family members and nonprofessional caregivers are present:** Training and education to instruct parents or other family members identified in the IICP or primary (nonprofessional) caregivers about the treatment regimens appropriate to the member
- Services may include, but are not limited to, the following:
 - Skills training in food planning and preparation, money management and maintenance of the living environment
 - Medication-related education and training by nonmedical staff
 - Training in appropriate use of community-based activities, such as riding the bus, going to the library and participating in natural support systems, such as faith-based or social activities in the community
 - Training in skills needed to locate and maintain a home, including:
 - Landlord and tenant negotiations
 - Budgeting to meet housing and housing-related expenses
 - Locating and interviewing prospective roommates
 - Renter's rights and responsibilities

Note: Activities allowed under Home- and Community-Based Habilitation and Support services are intended to focus on the maintenance of basic skills for living in the community.

Activities allowed under Supported Community Engagement Services are intended to engage a member in meaningful community involvement through activities such as volunteerism or community service.

Exclusions

Exclusions to the general AMHH program are outlined in [Section 2: Adult Mental Health Habilitation Program Overview](#). The following specific exclusions apply and are nonreimbursable or noncovered for AMHH Home- and Community-Based Habilitation and Support services:

- Job coaching
- Academic tutoring
- Services provided to professional caregivers

- Skill-building activities not identified in the IICP
- Activities billed under AMHH Supported Community Engagement Services, such as skills training and support related to community engagements (for example, obtaining or maintaining a meaningful purpose or role in the community)

HCPCS Codes

Table 2 shows the Healthcare Common Procedure Coding System (HCPCS) codes for Home- and Community-Based Habilitation and Support services. For a complete list of AMHH service codes and rates, see [Appendix H: AMHH Service Codes and Rates Table](#). Valid telehealth services can be found on *Telehealth and Virtual Services Codes*, accessible from the [Code Sets](#) webpage at [in.gov/medicaid/providers](https://www.in.gov/medicaid/providers).

Table 2 – HCPCS Codes for Home- and Community-Based Habilitation and Support Services

Code	Modifiers	Code Description	Limitations
H2014	UB	Skills training and development, per 15 minutes; adult mental health habilitation	Maximum is 6 hours (24 units) (1 unit = 15 minutes), every day
H2014	UB HR	Skills training and development, per 15 minutes; adult mental health; family/couple with client present	Maximum is 6 hours (24 units) (1 unit = 15 minutes), every day
H2014	UB HS	Skills training and development, per 15 minutes; adult mental health habilitation; family/couple without client	Maximum is 6 hours (24 units) (1 unit = 15 minutes), every day
H2014	UB U1	Skills training and development, per 15 minutes; adult mental health habilitation; group setting	Maximum is 6 hours (24 units) (1 unit = 15 minutes), every day
H2014	UB U1 HR	Skills training and development, per 15 minutes; adult mental health habilitation; group setting; family/couple with client	Maximum is 6 hours (24 units) (1 unit = 15 minutes), every day
H2014	UB U1 HS	Skills training and development, per 15 minutes; adult mental health habilitation; group setting; family/couple without client	Maximum is 6 hours (24 units) (1 unit = 15 minutes), every day

Service Unit Description and Limitations

The basic unit of service for AMHH Home- and Community-Based Habilitation and Support services is a 15-minute unit. Home- and Community-Based Habilitation and Support services, including all subtypes (individual or group setting, with or without family/couple or nonprofessional caregivers, with and without member present), may be provided for up to a total of six hours or 24 units per day, each day, throughout the eligibility period. See [Section 24: AMHH Program Billing](#) for additional information.

When delivering services via telehealth, the following service parameters satisfy the “face-to-face” contact required for this service:

- All clients being considered for telehealth services must be given the option of in-person services prior to telehealth being selected as modality.
- Client must indicate that telehealth is their preferred method for receiving services.

- Client must have documented acknowledgement of receipt of informed consent about risks/benefits of the telehealth modality.
- Within 30 days of the first telehealth session occurring, a licensed behavioral health practitioner, health service provider in psychology (HSPP) or overseeing psychiatric medical professional must document verification that telehealth is thought to be an effective modality for client based on symptoms, severity and access to services.
- Telehealth modality must be formally reviewed with client every 90 days and adjusted based on need/efficacy.
- If client is not progressing/stabilizing, evaluation of how treatment will be adjusted must be documented. This adjustment may include increasing in-person sessions.
- All habilitation and support sessions should have a clearly documented connection to diagnosis and/or treatment goals.
- At minimum, client must have an in-person session with a member of the treatment team every 90 days. This session may be in the home, community or office setting.
- The number of in-person visits and the percentage of time telehealth will be the delivery method of service will be based on what is clinically appropriate and in agreement with the consumer and/or legal guardian.
- The use of telehealth should protect against isolating participants by offering services that are in person and shall be invoked to prioritize and facilitate community integration.
- As required by *45 CFR 164.308 (a)(1)(ii)*, an accurate and thorough risk analysis shall be conducted for any functions using telehealth services to assess the potential risks and vulnerabilities to the confidentiality, integrity and availability of patient data.
- All telehealth services will be delivered in a way that respects privacy of the individual especially in instances of toileting, dressing and so on. Video cameras/monitors are not permitted in bedrooms and bathrooms. Participants are able to turn all telehealth-related devices on/off at their discretion to ensure privacy. The provider that is responsible for the treatment of the individual is responsible for training participants on the use of any telehealth-related devices both initially and ongoing.
- Telehealth services shall consider and respond to all accessibility needs, including whether hands-on or physical assistance is needed to render the service.
- Telehealth services must ensure the health and safety of the individual receiving services by adhering to all abuse, neglect and exploitation prevention practices that apply to in-person treatment, as well as by providing participants with resources on how to report incidences of abuse, neglect and exploitation.

Habilitation and support is not permissible via *audio-only* telehealth modalities. The IHCP reimburses for H2014 – *Skills training and development, per 15 minutes* (see [Table 2](#)) when the service is rendered through an *audiovisual* telehealth modality.

If behavioral health assistance needs to be rendered via *audio-only* telehealth modalities, the following procedure codes are reimbursable via audio-only telehealth per IHCP policy and may be used in place of habilitation and support:

- H0038 – *Self-help/peer service, per 15 minutes*
- H2011 – *Crisis intervention service, per 15 minutes*

For more information, see *Telehealth and Virtual Services Codes*, accessible from the [Code Sets](#) webpage at in.gov/medicaid/providers.

Section 18: Respite Care

Adult Mental Health Habilitation (AMHH) Respite Care services are provided to members who are unable to care for themselves and who are living with nonprofessional caregivers. The service is provided on a short-term basis because of the nonprofessional caregiver's absence or need for relief. This service is intended to provide support, supervision and services necessary to ensure members' health and safety if the member is not able to provide for themselves while the primary caregivers are unavailable for a short and defined period.

AMHH Respite Care services may be provided in any of the following locations:

- Member's home or place of residence
- Caregiver's home
- Nonprivate residential setting (such as a group home or adult foster care)

Provider Qualifications

Providers of AMHH Respite Care services, except for medication administration and medical support services provided as part of Respite Care, must have one of the following qualifications:

- Licensed professional, except for a licensed clinical addiction counselor
- Qualified behavioral health professional (QBHP)
- Other behavioral health professional (OBHP)

Medication administration and medical support services provided through the AMHH Respite Care service must be within the scope of practice, as defined by federal and state law, by an agency staff member who meets one of the following qualifications:

- A licensed physician
- A physician assistant
- A registered nurse
- A licensed practical nurse (LPN)

See [Section 3: AMHH Agency Staff Requirements](#) for additional information about qualifications for provider agency and staff members.

Program Standards

Program standards for AMHH Respite Care services include the following:

- The member must be living with a nonprofessional (unpaid) caregiver.
- The location where service is provided and the level of professional care are based on the needs of the member receiving the service and may include regular monitoring of medications or behavioral symptoms, as identified in the Individualized Integrated Care Plan (IICP).
- Services must be provided in the least-restrictive environment available and ensure the health and welfare of the member.

- Services must not be used as substitutes for regular care to allow the member's caregiver to:
 - Attend school
 - Hold a job
 - Engage in employment-related or employment-search-related activities
- Medication administration and medical support services provided with Respite Care must be provided within the scope of practice, as defined by federal and state law.
- Services must be provided by a DMHA-approved provider.
- Respite Care must not duplicate any other service being provided under the member's IICP.

Exclusions

General AMHH program exclusions are outlined in [Section 2: Adult Mental Health Habilitation Program Overview](#). The following specific exclusions apply and are nonreimbursable or noncovered as AMHH Respite Care services:

- Services provided to members living in Indiana Family and Social Services Administration (FSSA) Division of Mental Health and Addiction (DMHA)-certified residential facilities
- Services provided to members living in supportive housing
- Services provided to members who receive in-home support from professional caregivers, rather than nonpaid caregivers
- Respite Care provided by either of the following:
 - Any relative who is the primary caregiver of the member
 - Anyone living in the member's residence
- Services provided to members by family or friends (Respite Care services must be provided by DMHA-approved providers.)
- Any service that meets the definition of hospice services

HCPCS Codes

Table 3 shows the Healthcare Common Procedure Coding System (HCPCS) codes for Respite Care services. For a complete list of AMHH service codes and rates, see [Appendix H: AMHH Service Codes and Rates Table](#).

Table 3 – HCPCS Codes for Respite Care Services

Code	Modifier	Code Description	Limitations
S5150	UB	Unskilled respite care, not hospice; per 15 minutes; adult mental health habilitation	Maximum is 75 hours (28 units) (1 unit = 15 minutes), per 24-hour period, up to 300 units per eligibility period
S5151	UB	Unskilled respite care, not hospice; per diem; adult mental health habilitation	Maximum is 28 days (28 units) (1 unit = 1 day), per eligibility period, no more than 14 consecutive days

Service Unit Description and Limitations

There are two basic units of service for AMHH Respite Care services: hourly or daily. The available number of units per AMHH eligibility period depends on whether the Respite Care service is provided hourly or daily:

- *Hourly Respite Care:* The basic unit is a 15-minute unit, which applies to services provided up to seven hours, or 28 units, per day. Hourly Respite Care is available for a maximum of 75 hours (300 units) per the member's AMHH eligibility period.
- *Daily Respite Care:* The basic unit is a single-day unit, which applies to services provided between eight and 24 hours within the same calendar day. Daily Respite Care may be provided for up to 14 consecutive days for a maximum of 28 days per eligibility period.

<i>Note: Hourly and daily Respite Care may not be billed on the same calendar day.</i>
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Section 19: Therapy and Behavioral Support Services

Adult Mental Health Habilitation (AMHH) Therapy and Behavioral Support Services consist of a series of time-limited, structured, face-to-face or via telehealth, according to the *Indiana Administrative Code* (IAC), sessions that work toward the goals identified in the Individualized Integrated Care Plan (IICP).

AMHH Therapy and Behavioral Support Services may be provided to:

- Members individually in individual or group settings
- Family members or other nonprofessional caregivers in individual or group settings, with or without the member present

See [Appendix A: AMHH Acronyms and Definitions](#) for the definitions of individual and group settings as they apply to this service.

Provider Qualifications

Providers of Therapy and Behavioral Support Services must have one of the following qualifications:

- Licensed professional, except for a licensed clinical addiction counselor
- Qualified behavioral health professional (QBHP)

For additional information about qualifications for provider agency and staff members, see [Section 3: AMHH Agency Staff Requirements](#).

Program Standards

Program standards for AMHH Therapy and Behavioral Support Services include the following:

- Services may be provided face to face or with telehealth according to the IAC with the member or with family members or nonprofessional caregivers with or without the member present.
- The member must be the focus of the treatment, and documentation must support how the service benefits the member.
- Services must address one or more goals identified in the IICP, and these goals must be habilitative.
- Documentation must demonstrate progress toward and achievement of treatment goals.
- Therapy and Behavioral Support Services include, but are not limited to, the following:
 - Observing the member and environment to help develop the IICP
 - Developing a person-centered behavioral support plan and subsequent revisions, which may be a part of the IICP
 - Implementing the behavior support plan for staff, family members, roommates and other appropriate individuals
 - Training in assertiveness and/or relationship building
 - Addressing and managing behavioral health symptoms or impairment
 - Teaching stress-reduction techniques
 - Developing and retaining socially accepted behaviors

Exclusions

Exclusions to the general AMHH program are outlined in [Section 2: Adult Mental Health Habilitation Program Overview](#).

HCPCS Codes

Table 4 shows Healthcare Common Procedure Coding System (HCPCS) codes for Therapy and Behavioral Support Services. For a complete list of AMHH service codes and rates, see [Appendix H: AMHH Service Codes and Rates Table](#).

Table 4 – HCPCS Codes for Therapy and Behavioral Support Services*

Code	Modifiers	Code Description	Limitations
H0004	UB	Behavioral health counseling and therapy, per 15 minutes; adult mental health habilitation	Maximum is 75 hours (300 units) (1 unit = 15 minutes) per eligibility period in an individual setting
H0004	UB HR	Behavioral health counseling and therapy, per 15 minutes; adult mental health habilitation; family/couple with client present	Maximum is 75 hours (300 units) (1 unit = 15 minutes) per eligibility period in an individual setting
H0004	UB HS	Behavioral health counseling and therapy, per 15 minutes; adult mental health habilitation; family/couple without client present	Maximum is 75 hours (300 units) (1 unit = 15 minutes) per eligibility period in an individual setting
H0004	UB U1	Behavioral health counseling and therapy, per 15 minutes; adult mental health habilitation; group	Maximum is 75 hours (300 units) (1 unit = 15 minutes) per eligibility period in a group setting
H0004	UB U1 HR	Behavioral health counseling and therapy, per 15 minutes; adult mental health habilitation; group; family/couple with client present	Maximum is 75 hours (300 units) (1 unit = 15 minutes) per eligibility period in a group setting
H0004	UB U1 HS	Behavioral health counseling and therapy, per 15 minutes; adult mental health habilitation; group; family/couple without client present	Maximum is 75 hours (300 units) (1 unit = 15 minutes) per eligibility period in a group setting
<p><i>*Note: These services cannot be delivered via audio-only telehealth per IHCP policy, but they can be delivered via audiovisual telehealth. If a member has eligibility to receive these services in person through the IHCP, then they are eligible to receive these services via telehealth. For more information, see Telehealth and Virtual Services Codes, accessible from the Code Sets webpage at in.gov/medicaid/providers.</i></p>			

Service Unit Description and Limitations

The basic unit of service for AMHH Therapy and Behavioral Support Services is a 15-minute unit. The available number of units per AMHH eligibility period is determined according to the setting (individual or group) in which the service was provided:

- When provided in an individual setting, including a combination of all three subtypes (member only, family/couple or caregivers with and without the member present), the service may be provided for a maximum of 75 hours (300 units) per year.
- When provided in a group setting, including combination of all three subtypes (multiple members, family/couple or caregivers with and without the member present), the service may be provided for a maximum of 75 hours (300 units) per year.

Section 20: Addiction Counseling

Adult Mental Health Habilitation (AMHH) Addiction Counseling services consist of a series of planned and organized services delivered face to face or via telehealth (according to the *Indiana Administrative Code* [IAC]). Addiction professionals and other clinicians provide counseling interventions that work toward the member's recovery goals identified in the Individualized Integrated Care Plan (IICP) as they pertain to substance use-related disorders. Valid telehealth services can be found on *Telehealth and Virtual Services Codes*, accessible from the [Code Sets](https://www.in.gov/medicaid/providers) webpage at [in.gov/medicaid/providers](https://www.in.gov/medicaid/providers).

Addiction Counseling services may be provided for members with a substance use-related disorder with any of the following:

- Minimal or manageable medical conditions
- Minimal withdrawal risk
- Emotional, behavioral and cognitive conditions that do not prevent the member from benefitting from this service

AMHH Addiction Counseling services may be provided to:

- Members individually in individual or group settings
- Family members or other nonprofessional caregivers in individual or group settings, with or without the members present

See [Appendix A: AMHH Acronyms and Definitions](#) for definitions of individual and group settings as they apply to this service.

Provider Qualifications

AMHH Addiction Counseling services must be provided by qualified addiction professionals or other clinicians that have either of the following qualifications:

- Licensed professional, including a licensed clinical addiction counselor (LCAC)
- Qualified behavioral health professional (QBHP)

For additional information about qualifications for provider agency and staff members, see [Section 3: AMHH Agency Staff Requirements](#).

Program Standards

Program standards for AMHH Addiction Counseling services include:

- Services must be provided face-to-face or via telehealth, according to the IAC, with the member, family members or nonprofessional caregivers supporting the member.
- The member must always be the focus of Addiction Counseling.
- Addiction Counseling must consist of regularly scheduled sessions.
- Documentation must support how Addiction Counseling benefits the member and must demonstrate progress toward and achievement of goals identified in the IICP.
- Addiction Counseling services may include the following activities:
 - Education about substance use disorders (combined with other addiction-treatment activities)
 - Skills training in:
 - Communication

- Anger management
- Stress management
- Relapse prevention
- Referral to community recovery support programs, as available

Exclusions

Exclusions to the general AMHH program are outlined in [Section 2: Adult Mental Health Habilitation Program Overview](#). The following specific exclusions apply and are nonreimbursable or noncovered for AMHH Addiction Counseling services:

- Services provided to members with withdrawal risk or symptoms
- Services provided to members whose needs cannot be managed safely with AMHH services
- Services provided to members who require detoxification services
- Services provided to members who are determined to be at imminent risk of harm to the self or to others
- Addiction Counseling sessions that consist only of education services
- Services provided to professional caregivers

HCPCS Codes

Table 5 shows Healthcare Common Procedure Coding System (HCPCS) codes for Addiction Counseling services. For a complete list of AMHH service codes and rates, see [Appendix H: AMHH Service Codes and Rates Table](#).

Table 5 – HCPCS Codes for Addiction Counseling Services*

Code	Modifiers	Service Parameters	Limitations
H2035	UB	Addiction Counseling with Member (Individual Setting)	Maximum is 75 hours (75units) (1 unit = 1 hour) per eligibility period
H2035	UB	Addiction Counseling with Member (Individual Setting)	Maximum is 75 hours (75units) (1 unit = 1 hour) per eligibility period
H2035	UB HR	Addiction Counseling with Family and Member (Individual Setting)	Maximum is 32 hours (128 units) (1 unit = 1 hour) per eligibility period
H2035	UB HS	Addiction Counseling with Family without the Member Present (Individual Setting)	Maximum is 32 hours (128 units) (1 unit = 1 hour) per eligibility period
H2035	UB U1	Addiction Counseling with Member (Group Setting)	Maximum is 32 hours (128 units) (1 unit = 15 minutes) per eligibility period
H2035	UB U1 HR	Addiction Counseling with Family and Member (Group Setting)	Maximum is 32hours (128 units) (1 unit = 15 minutes) per eligibility period

Code	Modifiers	Service Parameters	Limitations
H2035	UB U1 HS	Addiction Counseling with Family Without the Member Present (Group Setting)	Maximum is 32 hours (128 units) (1 unit = 15 minutes) per eligibility period
<p><i>*Note: These services cannot be delivered via audio-only telehealth per IHCP policy, but they can be delivered via audiovisual telehealth. If a member has eligibility to receive these services in person through the IHCP, then they are eligible to receive these services via telehealth. For more information, see Telehealth and Virtual Services Codes, accessible from the Code Sets webpage at in.gov/medicaid/providers.</i></p>			

Service Unit Description and Limitations

The basic unit of service for AMHH Addiction Counseling, individual, is a one-hour unit. The service may be provided for a maximum of 75 hours (75 units) per eligibility period. All subtypes of Addiction Counseling services (group setting, family/couple with and without member present) may be provided for a maximum of 128 units (1 unit = 15 minutes), for a total of 32 hours per eligibility period.

Section 21: Supported Community Engagement Services

Adult Mental Health Habilitation (AMHH) Supported Community Engagement Services are face-to-face activities delivered on an individual basis and in a community setting. This service is designed to engage members in meaningful community involvement activities, such as volunteerism or community service. Services are habilitative in nature and are aimed at developing skills and opportunities that lead to the members' improved integration into the community through increasing community engagement. AMHH Supported Community Engagement Services may not, however, include explicit employment objectives.

Provider Qualifications

Staff providers of Supported Community Engagement Services must have one of the following qualifications:

- Licensed professional
- Qualified behavioral health professional (QBHP)
- Other behavioral health professional (OBHP)

For additional information about qualifications for provider agency and staff members, see [Section 3: AMHH Agency Staff Requirements](#).

Program Standards

Program standards for AMHH Supported Community Engagement Services include the following:

- The service requires face-to-face contact with the member in a community setting.
- The service is provided to members who may benefit from community engagement and are unlikely to achieve this level of community integration without the provision of support.
- The service includes helping the member develop a relationship with community organizations specific to that individual's interests and needs.
- The service involves collaboration with a community organization to develop an individualized plan that identifies specific supports required, organizational expectations, training strategies, time frames and responsibilities.
- Allowable activities are geared to achieving a generalized skill or behavior that may prepare the member for community engagement and may include (but not be limited to) teaching concepts such as:
 - Attendance
 - Task completion
 - Problem solving
 - Safety
- Services must be explicitly identified in the IICP and related to goals identified by the member, and may include activities such as:
 - How to use public transportation to get to and from the designated community setting
 - Work environment/modification analysis

- Work-task analysis – an activity intended to enhance the member’s functioning in a volunteer (community) setting and not an employment-related goal
- Use of assistive technology device/adaptive equipment

Note: Activities allowed under Supported Community Engagement Services are intended to engage members in meaningful community involvement through activities such as volunteerism or community service.

Activities allowed under Home- and Community-Based Habilitation and Support Services are intended to focus on the maintenance of basic skills needed to live in the community.

Exclusions

Exclusions to the general AMHH program are outlined in [Section 2: Adult Mental Health Habilitation Program Overview](#). The following specific exclusions apply and are nonreimbursable or noncovered for AMHH Supported Community Engagement Services:

- Reimbursement or compensation paid by the provider agency to the member for performing activities covered under the service. If a provider chooses to compensate a member 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
- Services provided to members 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
- Services that include explicit employment objectives

HCPSC Codes

Table 6 shows Healthcare Common Procedure Coding System (HCPSC) codes for Supported Community Engagement Services. For a complete list of AMHH service codes and rates, see [Appendix H: AMHH Service Codes and Rates Table](#).

Table 6 – HCPSC Codes for Supported Community Engagement Services

Code	Modifier	Code Description	Limitations
97537	UB	Community/work reintegration training (e.g., shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact by provider, each 15 minutes; adult mental health habilitation	Maximum is 18 hours (72 units) (1 unit = 15 minutes) per month

Service Unit Description and Limitations

The basic unit of service for AMHH Supported Community Engagement Services is a 15-minute unit. Supported Community Engagement Services may be provided up to a maximum of 18 hours (72 units) per month.

Section 22: Care Coordination

Adult Mental Health Habilitation (AMHH) Care Coordination services consist of activities that help a member access needed medical, social, educational and other services. These services include direct assistance in gaining access to services, coordination of care, oversight of the member's care in the AMHH program and linkage to appropriate services. AMHH Care Coordination services may be delivered face to face or via telehealth (according to the *Indiana Administrative Code* [IAC]). These services may be provided on behalf of a member, depending on the service.

AMHH Care Coordination includes the following activities:

- *Assessment to determine service needs:* Includes identifying the member's needs for medical, educational, social or other services. Activities necessary to form a complete needs assessment of the member may include the following:
 - Documenting the member's history
 - Identifying the individual's needs
 - Completing related documentation
 - Gathering information from other sources, such as family members and medical providers
- *Development of the IICP:* Includes the development of a written Individualized Integrated Care Plan (IICP) based on the information collected through the needs assessment. The IICP identifies the habilitative activities and assistance needed to accomplish the member's identified goals and objectives.
- *Referral and Linkage:* Includes activities that help link the member with programs and services that are capable of providing needed habilitative services that meet the member's needs, including but not limited to:
 - Medical providers
 - Social service providers
 - Educational providers
 - Community providers
 - Other providers
- *Monitoring and Follow-up:* Includes contacts and related activities necessary to ensure the IICP is effectively implemented and adequately addresses the member's needs. Such activities and contacts may include the following:
 - The member
 - Family members or individuals who have a significant relationship with the member
 - Nonprofessional caregivers
 - Providers
 - Other entities
- *Evaluation:* Includes face-to-face or via telehealth, according to the IAC, contact with the member at least every 90 days for the following reasons:
 - To determine if services are being furnished in accordance with the IICP
 - To assess the adequacy of the services in the IICP
 - To assess any changes in the member's needs or status
 - To make changes or adjustments to the IICP to meet the member's ongoing needs
 - To evaluate or reevaluate the member's progress toward achieving the IICP's objectives

Note: Time devoted to formal supervision of the case between the care coordinator and a licensed supervisor to review the member's care and treatment is considered an included Care Coordination activity. The supervision must be documented appropriately and billed under one provider only.

Provider Qualifications

Provider staff delivering AMHH Care Coordination must have one of the following qualifications:

- Licensed professional
- Qualified behavioral health professional (QBHP)
- Other behavioral health professional (OBHP)

For additional information about qualifications for provider agency and staff members, see [Section 3: AMHH Agency Staff Requirements](#).

Program Standards

Program standards for AMHH Care Coordination services include the following:

- Care Coordination includes:
 - Development of the IICP
 - Limited referrals to services
 - Activities or contacts necessary to ensure that the IICP is effectively implemented and adequately addresses the mental health or addiction needs, or both, of the member
- Care Coordination does not include direct delivery of medical, clinical or other direct services. It is provided on behalf of the member, not to the member.
- Care Coordination must provide direct assistance to the member in gaining access to necessary medical, social, educational and other services.
- The care coordinator must reevaluate the member's progress via face-to-face contact with the member at least every 90 days to:
 - Ensure that the IICP is effectively implemented and adequately addresses the needs of the member
 - Determine whether the services are consistent with the IICP
 - Make changes or adjustments to the IICP to meet the member's ongoing needs
 - Evaluate or reevaluate the member's progress toward achieving the IICP's objectives

Exclusions

Exclusions to the general AMHH program are outlined in [Section 2: Adult Mental Health Habilitation Program Overview](#). The following specific exclusions apply and are nonreimbursable or noncovered for AMHH Care Coordination services:

- Activities billed under behavioral health level of need redetermination (by a nonphysician)
- Services provided in a group setting
- Direct delivery of medical, clinical or other direct services, including but not limited to the following:
 - Training in daily living skills

- Training in work or social skills
- Grooming and other personal services
- Training in housekeeping, laundry or cooking
- Transportation services
- Individual, group or family therapy
- Crisis intervention services
- Services that go beyond assisting the member in gaining access to needed services, including but not limited to the following:
 - Paying bills and balancing the member's checkbook
 - Traveling to and from appointments with members

HCPCS Codes

Table 7 shows the Healthcare Common Procedure Coding System (HCPCS) codes for Care Coordination services. For a complete list of AMHH service codes and rates, see [Appendix H: AMHH Service Codes and Rates Table](#).

Table 7 – HCPCS Codes for Care Coordination Services

Code	Modifier	Code Description	Limitations
T1016	UB	Care Coordination, each 15 minutes; adult mental health habilitation	Maximum is 400 hours (1,600 units) (1 unit = 15 minutes) per eligibility period
<p><i>*Note: If a member has eligibility to receive these services in person through the IHCP, then they are eligible to receive these services via telehealth. For more information, see Telehealth and Virtual Services Codes, accessible from the Code Sets webpage at in.gov/medicaid/providers.</i></p>			

Service Unit Description and Limitations

The basic unit of service for AMHH Care Coordination services is a 15-minute unit. Care Coordination services may be provided for a maximum of 400 hours (1,600 units) per eligibility period.

Some members who receive AMHH Care Coordination services will also be enrolled in the Behavioral and Primary Healthcare Coordination (BPHC) Program. This program provides specialized case management to assist in the coordination, referral and linkage needs of a member with co-occurring mental and physical health concerns. For members approved for both AMHH and BPHC, the number of AMHH Care Coordination service units, or BPHC service units, will be adjusted as follows:

- For individuals who have active AMHH service package assignments at the time of BPHC application, the number of BPHC units is authorized based on the time left until the AMHH evaluation is due. If the AMHH end date is less than six months away, the BPHC end date is aligned with the AMHH end date. If the AMHH end date is more than six months away, the BPHC service is authorized for six months. In both scenarios, the active AMHH authorization period remains unchanged.
- If an individual applies for AMHH after they already have an active BPHC service package assignment, the number of authorized AMHH Care Coordination units (T1016 UB) is reduced to account for the BPHC service package assignment.

Section 23: Medication Training and Support

Adult Mental Health Habilitation (AMHH) Medication Training and Support services involve services delivered face-to-face or via telehealth, according to the *Indiana Administrative Code* (IAC). These services are provided to the member, in an individual or group setting, for the purpose of:

- Monitoring medication compliance
- Providing education and training about medications
- Monitoring medication side effects
- Providing other nursing or medical assessment

AMHH Medication Training and Support services may also include training family members and nonprofessional caregivers to assist with the member's medication management. When provided to family members or other nonprofessional caregivers (with or without the member present), the service:

- Must focus on and be on behalf of the member
- May include training family members or nonprofessional caregivers to:
 - Monitor the member's medication compliance
 - Assist with the administration of prescribed medications
 - Monitor side effects, including:
 - Weight
 - Blood glucose level
 - Blood pressure

AMHH Medication Training and Support services can be provided to:

- Members individually in individual or group settings
- Family members or other nonprofessional caregivers in individual or group settings, with or without the member present

For definitions of individual and group settings as they apply to this service, see [Appendix A: AMHH Acronyms and Definitions](#).

In addition to face-to-face services provided to a member or a member's family, some AMHH Medication Training and Support services are not required to be provided face to face. These services may be provided only in an individual setting and include:

- Transcribing medication orders of a physician or authorized healthcare professional (AHCP)
- Setting or filling medication boxes
- Consulting with the attending physician or AHCP regarding medication-related issues
- Ensuring that lab and other prescribed clinical orders are sent
- Ensuring that the member follows through and receives lab work and services pursuant to other clinical orders
- Follow-up reporting of lab and clinical test results to the member and physician

Provider Qualifications

Provider staff delivering AMHH Medication Training and Support services must be one of the following qualifications:

- Licensed physician
- Authorized healthcare professional (AHCP)
- Licensed registered nurse (RN)
- Licensed practical nurse (LPN)
- Medical assistant (MA) who has graduated from a two-year clinical program

For additional information about qualifications for provider agency and staff members, see [Section 3: AMHH Agency Staff Requirements](#).

Program Standards

Program standards for AMHH Medication Training and Support services include the following:

- Services must be provided within the scope of practice, as defined by federal and state law.
- Services provided that are not face-to-face or telehealth, according to the IAC, with the member must meet the following standards:
 - The member must be the focus of the service.
 - Documentation must support how the service benefits the member.
- When provided in a clinic setting, AMHH Medication Training and Support services may complement, but not duplicate, activities associated with medication management activities available as a Medicaid outpatient mental health service (as defined under 405 IAC 5-20-8).
- When provided in a residential treatment setting, AMHH Medication Training and Support services may include components of, but not duplicate, medication management services, as defined under the Medicaid outpatient mental health service (405 IAC 5-20-8).
- Services must be habilitative in nature and demonstrate movement toward and achievement of the member's treatment goals identified on the Individualized Integrated Care Plan (IICP).

Exclusions

Exclusions to the general AMHH program are outlined in [Section 2: Adult Mental Health Habilitation Program Overview](#). The following specific exclusions apply and are nonreimbursable or noncovered for AMHH Medication Training and Support services:

- If medication management, counseling or psychotherapy is provided through the Medicaid outpatient mental health benefit, and medication management is a component of the service, then AMHH Medication Training and Support services may not be billed separately for the same visit by the same provider.
- Coaching and instruction regarding member self-administration of medications is not reimbursable under AMHH Medication Training and Support but may be eligible for reimbursement under Home- and Community-Based Habilitation and Support services skills training and development.
- Services provided to paid, professional caregivers are excluded.

- When provided in a group setting, the following activities are not covered:
 - Transcribing physician or AHCP medication orders
 - Setting or filling medication boxes
 - Consulting with the attending physician or AHCP regarding medication-related issues
 - Ensuring that a lab or other prescribed clinical orders are sent
 - Ensuring that the member follows through and receives lab work and services pursuant to other clinical orders
 - Follow-up reporting of lab and clinical test results to the member and physician

HCPCS Codes

Table 8 shows the Healthcare Common Procedure Coding System (HCPCS) codes for Medication Training and Support services. For a complete list of AMHH service codes and rates, see [Appendix H: AMHH Service Codes and Rates Table](#).

Table 8 – HCPCS Codes for Medication Training and Support Services*

Code	Modifiers	Code Description	Limitations
H0034	UB	Medication training and support, per 15 minutes; adult mental health habilitation	Maximum is 182 hours (728 units) (1 unit = 15 minutes) per eligibility period
H0034	UB HR	Medication training and support, per 15 minutes; adult mental health habilitation; family/couple with the client present individual setting	Maximum is 182 hours (728 units) (1 unit = 15 minutes) per eligibility period
H0034	UB HS	Medication training and support, per 15 minutes; adult mental health habilitation; family couple without the client present individual setting	Maximum is 182 hours (728 units) (1 unit = 15 minutes) per eligibility period
H0034	UB U1	Medication training and support, per 15 minutes; adult mental health habilitation; group setting	Maximum is 182 hours (728 units) (1 unit = 15 minutes) per eligibility period
H0034	UB U1 HR	Medication training and support, per 15 minutes; adult mental health habilitation; group setting; family/couple with the client present	Maximum is 182 hours (728 units) (1 unit = 15 minutes) per eligibility period
H0034	UB U1 HS	Medication training and support, per 15 minutes; adult mental health habilitation; group setting; family/couple without the client present	Maximum is 182 hours (728 units) (1 unit = 15 minutes) per eligibility period

Note: These services cannot be delivered via **audio-only telehealth per IHCP policy, but they can be delivered via **audiovisual** telehealth. If a member has eligibility to receive these services in person through the IHCP, then they are eligible to receive these services via telehealth. For more information, see Telehealth and Virtual Services Codes, accessible from the [Code Sets](#) webpage at in.gov/medicaid/providers.*

Service Unit Description and Limitations

The basic unit of service for AMHH Medication Training and Support services is a 15-minute unit. AMHH Medication Training and Support services, including all subtypes (individual or group setting, family/couple, with and without member present), may be provided for a maximum of 182 hours (728 units) per AMHH eligibility period.

Section 24: AMHH Program Billing

This section outlines Adult Mental Health Habilitation (AMHH) billing guidelines, claim format and necessary billing-related information. Explanation of billing specifics, such as actual time spent conducting service versus time billed, modifiers and other helpful billing-related items, are included with examples. For more information about general billing, see *Indiana Administrative Code 405 IAC 1* and the provider reference modules on the [IHCP Provider Reference Modules](#) webpage at in.gov/medicaid/providers. Indiana Health Coverage Programs (IHCP) providers are responsible for reading and understanding applicable IAC and IHCP modules.

Note: The [IHCP Provider Healthcare Portal](#) (IHCP Portal), accessible from the homepage at in.gov/medicaid/providers, is an interactive web application that allows providers to submit claims and attachments, check eligibility, and check status of claims. The IHCP Portal is fast and free and does not require special software. Providers must register on the portal to use the portal to submit claims, verify member eligibility and maintain enrollment data. See the [Provider Healthcare Portal](#) module for more information.

Billing Standards

AMHH provider agencies that are enrolled IHCP providers must adhere to all IHCP rules, policies and processes required of IHCP-enrolled members.

In regard to AMHH services, the following applies:

- Physicians or health service providers in psychology (HSPPs) can enroll in the IHCP as rendering providers and receive IHCP Provider IDs. Rendering providers are linked to each service location where they render services for a group practice. Rendering providers are linked to the group's common taxpayer identification number (TIN) for billing.
- Reimbursement is 100% of the rate for all staff that meet provider qualifications for each service.
- Providers are responsible for internally tracking AMHH service utilization to ensure that service units are available. Providers can confirm service unit availability via the IHCP Portal, the state's recognized final reference for this information.
- Units of AMHH services, as displayed in the IHCP Portal, are decremented based on adjudicated claims. Failure to submit claims in a timely fashion may place the provider at risk for nonpayment.
- For an AMHH provider to receive reimbursement for the delivery of AMHH services, a member must have been deemed eligible for AMHH services and received an authorization notification confirming the AMHH services authorized on the Individualized Integrated Care Plan (IICP). The Indiana Family and Social Services Administration (FSSA) Division of Mental Health and Addiction (DMHA) state Evaluation Team (SET) retains final authority for determining AMHH eligibility and authorizing AMHH services.
- AMHH approval and authorization dates may be accessed by providers on the IHCP Portal.
- Providers of AMHH services are IHCP providers and, therefore, are responsible for complying with IHCP billing practices outlined in the provider reference modules on the [IHCP Provider Reference Modules](#) webpage at in.gov/medicaid/providers.

Electronic Visit Verification System Required for Personal Care Services

The *21st Century Cures Act* requires Medicaid providers of personal care services to use an electronic visit verification (EVV) system to document services rendered.

Affected providers may use an EVV system of their choice (either the state's EVV system [Sandata] or an alternate EVV system that can integrate with the Sandata system); however, providers are responsible for ensuring that the system selected complies with federal requirements, including documentation of the following information:

- Type of service performed
- Individual receiving the service
- Date of the service
- Location of service delivery
- Individual providing the service
- Time the service begins and ends

Effective for dates of service on or after Feb. 1, 2022, the IHCP does not require EVV records when certain services are performed in a 24-hour congregate setting. Providers are instructed to use the HQ modifier to indicate that services are being performed in a 24-hour congregate setting. To see which AMHH services are exempt when performed in a 24-hour congregate setting, see the *Service Codes That Require Electronic Visit Verification*, accessible from the [Code Sets](https://in.gov/medicaid/providers) webpage at in.gov/medicaid/providers.

Providers are required to use EVV to document all personal care services (procedure code and modifier combinations) indicated in *Service Codes That Require Electronic Visit Verification*, accessible from the [Code Sets](https://in.gov/medicaid/providers) webpage at in.gov/medicaid/providers. For more information, see the [Electronic Visit Verification](https://in.gov/medicaid/providers) webpage at in.gov/medicaid/providers.

Claim Submission Guidelines

Claims for AMHH services are billed on a professional claim (paper *CMS-1500* claim form, IHCP Portal professional claim or 837P electronic transaction). Paper copies of the *CMS-1500*, Version 02/12 form are available from the U.S. Government Bookstore or other online retailers. Instructions for completing the form are in the [Home- and Community-Based Services Billing Guidelines](https://in.gov/medicaid/providers) and [Claim Submission and Processing](https://in.gov/medicaid/providers) modules at in.gov/medicaid/providers.

Providers bill services based on an approved service authorization for the individual member, using an appropriate procedure code, modifier and the pricing method associated with the procedure code, such as per unit, per day or per month. Additional pricing information is available on the Professional Fee Schedule, accessible from the [IHCP Fee Schedules](https://in.gov/medicaid/providers) webpage at in.gov/medicaid/providers.

General billing guidelines include:

- Do not bill for services before they are provided.
- If a unit of service equals 15 minutes, a minimum of eight minutes must be provided to bill for one unit.
- Activities requiring less than eight minutes may be accrued to the end of that date of service.
- At the end of the day, partial units may be rounded up as follows: units totaling eight or more minutes may be rounded up and billed as one unit.
- Partial units totaling less than eight minutes may not be billed.

- Monthly units are billed at the end of the month.
- Daily units may be billed daily, weekly or monthly.

The following instructions must be followed for billing claims to the IHCP for AMHH services:

- The provider agency's group National Provider Identifier (NPI) must be entered in as the **billing provider NPI** (field 33a of the *CMS-1500* claim form).
- Each service detail of the claim must include the NPI of the rendering or supervising psychiatrist, physician, or HSPP as the **rendering provider NPI** for the service (field 24J of the *CMS-1500* claim form).

Note: Submit claims for reimbursement on a timely basis:

- *Units of AMHH services as displayed in the IHCP Portal are decremented based on adjudicated claims.*
- *Timely submission of claims ensures that the data accessible on the IHCP Portal accurately reflects remaining units of service for each member.*
- *Failure to submit claims timely may place the provider at risk for nonpayment.*

AMHH services may be billed with other IHCP-covered services on the same claim. Updated information is disseminated through IHCP provider bulletins posted on the [IHCP Bulletins](#) webpage at in.gov/medicaid/providers. Each provider is responsible for obtaining the information and implementing new or revised policies and procedures as outlined in these notices.

Facility Fees

No facility fees are paid for AMHH services.

AMHH and the Healthy Indiana Plan (HIP)

Individuals who are enrolled in the Healthy Indiana Plan (HIP) and who are determined to be medically frail have access to coverage established under the Indiana Medicaid State Plan. The Indiana Medicaid State Plan services include intensive behavioral health Medicaid programs such as Medicaid Rehabilitation Option (MRO) and Behavioral and Primary Healthcare Coordination (BPHC), as well as AMHH. The intensive community-based behavioral health service programs are carved out from the HIP benefit responsibilities of the managed care entities (MCEs) and are billed to the IHCP through the fee-for-service (FFS) claim payment system.

A member enrolled in *HIP Basic* who is determined medically frail is transferred to *HIP State Plan Basic* benefits, whereas a member enrolled in *HIP Plus* who is determined medically frail is transferred to *HIP State Plan Plus*. *HIP State Plan Basic* and *HIP State Plan Plus* are provided by the same MCEs and have the same cost-sharing structures as the standard *HIP Basic* and *HIP Plus* plans. In *HIP State Plan Basic*, the member is required to pay a \$4 copay for outpatient services, including many AMHH services. In *HIP State Plan Plus*, members are not subject to copays for most services, including all AMHH behavioral health services. [Table 9](#) identifies the AMHH service types that do not require copayment under *HIP State Plan Basic*. See the [Healthy Indiana Plan](#) provider reference module for more information.

Table 9 – AMHH Services That Do Not Require a Copayment under *HIP State Plan Basic*

Procedure Code	Modifiers	Code Description
H2014	UB HS	Skills training and development, per 15 minutes; adult mental health habilitation; family/couple without client present
H2014	UB U1 HS	Skills training and development, per 15 minutes; adult mental health habilitation; group setting; family/couple without client
H0004	UB HS	Behavioral health counseling and therapy, per 15 minutes; adult mental health habilitation; family/couple without client present
H0004	UB U1 HS	Behavioral health counseling and therapy, per 15 minutes; adult mental health habilitation; group; family/couple without client present
H2035	UB HS	Alcohol and/or other drug treatment program, per hour; adult mental health habilitation; family/couple w/o client present
H2035	UB U1 HS	Alcohol and/or other drug treatment program, per hour; adult mental health habilitation; group setting; family/couple without the client present
T1016	UB	Care Coordination, each 15 minutes; adult mental health habilitation
H0034	UB	Medication training and support, per 15 minutes; adult mental health habilitation
H0034	UB HR	Medication training and support, per 15 minutes; adult mental health habilitation; family/couple with the client present individual setting
H0034	UB HS	Medication training and support, per 15 minutes; adult mental health habilitation; family couple without the client present individual setting
H0034	UB U1	Medication training and support, per 15 minutes; adult mental health habilitation; group setting
H0034	UB U1 HR	Medication training and support, per 15 minutes; adult mental health habilitation; group setting; family/couple with the client present
H0034	UB U1 HS	Medication training and support, per 15 minutes; adult mental health habilitation; group setting; family/couple without the client present

For more information about the HIP program, see the [FSSA HIP website](https://www.in.gov/fssa/hip) at [in.gov/fssa/hip](https://www.in.gov/fssa/hip).

Time Documentation

Staff must document actual time spent delivering services in a given 24-hour period in the member's clinical record. For billing purposes, a provider agency must total the actual time spent delivering the same service on the same day by all provider types for each member. Minutes of service do not have to be consecutive to be billed together. When services are provided in group settings, it is appropriate to bill for each member in the group for the time spent in the group.

Figure 5 shows examples of time documentation.

Figure 5 – Examples of Time Documentation

Example A-1:

A member receives five minutes of Home- and Community-Based Habilitation and Support services from a staff member, four minutes of Home- and Community-Based Habilitation and Support services from a second staff member, and nine minutes of Home- and Community-Based Habilitation and Support services from a third staff member on the same day. The member's clinical record notes that three staff members provided Home- and Community-Based Habilitation and Support services on the same day and the amount of time each staff person spent with the member. For time documentation purposes, the total actual time spent is 18 minutes.

$$5 \text{ minutes} + 4 \text{ minutes} + 9 \text{ minutes} = 18 \text{ minutes of Home- and Community-Based Habilitation and Support services}$$

Example A-2:

A member receives 15 minutes of Therapy and Behavioral Support Services, individual, from a licensed clinical social worker (LCSW) and 25 minutes of Therapy and Behavioral Support Services, individual, from a master's level practitioner on the same day. The member's clinical record notes that two staff members provided Therapy and Behavioral Support Services, individual, on the same day and the amount of time each staff person spent with the member. For time documentation purposes, the total actual time spent is 40 minutes. Even though the two staff members have different provider qualifications, they must add their time spent with the member together.

$$15 \text{ minutes} + 25 \text{ minutes} = 40 \text{ Minutes of Therapy and Behavioral Support Services, individual}$$

Converting Time Spent for Service Delivery to Billing Units

Providers must determine the total actual time spent delivering a service in a given 24-hour period (see [Figure 6](#)). The total time spent is then converted into billing units for that service. Providers should refer to the Healthcare Common Procedure Coding System (HCPCS) code for each service for information on the unit increment that is used for each service. Providers should round the total actual time each day to the nearest whole unit when calculating reimbursement, described in the following sections.

15-Minute Unit

Services billed in 15-minute units include:

- Home- and Community-Based Habilitation and Support
- Therapy and Behavioral Support Services
- Supported Community Engagement Services
- Care Coordination
- Medication Training and Support
- Respite Care (may also be billed in single-day units, as described in the [Single-Day Units](#) section)

If staff delivers one of these services 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 (Figure 6). 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. The same rounding rules apply to portions of time remaining after one or more entire 15-minute units have been converted.

Figure 6 – Examples of 15-Minute Billing

Example B-1:

The member from the preceding Example A-1 (Figure 5) received 18 total minutes of Home- and Community-Based Habilitation and Support services from three different staff members in a 24-hour period, as reflected in the member's clinical record. Home- and Community-Based Habilitation and Support services are billed in 15-minute units; therefore, for billing purposes, only one unit of Home- and Community-Based Habilitation and Support services may be billed.

18 minutes of Home- and Community-Based Habilitation and Support services = One 15-minute unit of Home- and Community-Based Habilitation and Support services (one full 15-minute unit plus three additional minutes, which must be rounded down)

Example B-2:

The member (from the preceding Example A-2 in Figure 5) received 40 minutes of Therapy and Behavioral Support services, individual, from two different providers on the same day, as reflected in the member's clinical record. Therapy and Behavioral Support services are billed in 15-minute units; therefore, for billing purposes, three units of Therapy and Behavioral Support services may be billed.

40 Minutes of Therapy and Behavioral Support services = Three 15-minute units of Therapy and Behavioral Support services (Two full 15-minute units plus 10 additional minutes, which may be rounded up)

One-Hour (60-Minute) Unit

AMHH Addiction Counseling services are billed in one-hour (60-minute) units (Figure 7). If staff delivers Addiction Counseling for 45 or more minutes, or the total minutes of Addiction Counseling provided for the day add up to 45 or more minutes, the provider may bill for the appropriate number of units of Addiction Counseling. If staff delivers Addiction Counseling for 44 minutes or less, or the total minutes of Addiction Counseling provided for the day add up to 44 minutes or less, the provider rounds down to zero units and therefore, may not bill for this service. The same rounding rules apply to portions of time remaining, after one or more entire one-hour (60-minute) units have been converted.

Figure 7 – Example of 1-Hour Unit Billing

Example C-1:

A member receives 48 minutes of Addiction Counseling services, individual. For billing purposes, 48 minutes of service is greater than (>) the 44-minute threshold, and the provider may round up to one 1-hour unit.

48 minutes > 44-minute threshold = Provider may bill for one 1-hour unit of Addiction Counseling services.

Example C-2:

A member receives 25 minutes of Addiction Counseling services. For billing purposes, 25 minutes of service is less than (<) the 44-minute threshold. The provider must round down to zero (0) and may not bill for this service.

25 minutes < 44 minutes = provider may not bill for Addiction Counseling services rendered.

Example C-3:

A member receives 20 minutes of Addiction Counseling individual services from one staff member and 25 minutes of Addiction Counseling group services from a second staff member on the same day. The provider totals the actual time delivering the service to 45 minutes. For billing purposes, 45 minutes of service is greater than the 44-minute threshold, and the provider rounds up to one 1-hour unit.

20 minutes + 25 minutes = 45 minutes > 44 minutes threshold = Provider may bill for one 1-hour unit of Addiction Counseling services.

Example C-4:

A member receives 80 minutes of Addiction Counseling services, group. For billing purposes, 80 minutes is greater than the 44-minute threshold for one 1-hour unit of service but does not qualify for a second 1-hour unit of service.

80 minutes = 60 minutes (one 1-hour unit of service) + 20 minutes.

20 minutes < 44-minute threshold = Provider may bill for one 1-hour unit of Addiction Counseling services and may not bill the additional 20 minutes of services rendered.

Half-Day Units

AMHH Adult Day Services is the only AMHH service that is billed in half-day units, which consist of a minimum of three and maximum of five consecutive hours of the service (Figure 8). Up to 20 minutes in break time may occur within the minimum three-hour block of service time. If more than three consecutive hours are provided, up to a 60-minute break is allowed in addition to the 20-minute break. The 60-minute break may not be billed as a component of the service, however.

Adult Day Services allows for up to two half-day units of service to be billed in one day. The second half-day unit may be billed only if a previous half-day 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.

Figure 8 – Example of Half-Day Unit Billing

Example D-1:

A member receives 53 minutes of Adult Day Services followed by a 10-minute break, an additional 50 minutes of Adult Day Services followed by a 10-minute break, and finally, an additional 60 minutes of Adult Day Services. A total of 163 minutes of member contact was provided, and with the allowable 20 minutes of break time, a total of 183 minutes of Adult Day Services was delivered (183 minutes is greater than [$>$] the 180-minute unit).

183 minutes $>$ 180 minutes = Provider may bill for one half-day unit of Adult Day services.

Example D-2:

A member receives 30 minutes of Adult Day Services followed by a 10-minute break, then an additional 30 minutes of Adult Day Services, followed by a 10-minute break, and finally an additional 30 minutes of Adult Day Services. A total of 90 minutes of member contact was provided, and with the allowable 20 minutes of break time, a total of 110 minutes of Adult Day Services was delivered (110 minutes is less than [$<$] the 180-minute unit).

110 minutes $<$ 180 minutes = Provider may not bill for the Adult Day Services rendered.

Single-Day Units

AMHH Respite Care may be billed in two separate ways, depending on the length of time the service was provided during a 24-hour period (Figure 9). Respite Care is billed in 15-minute units when provided seven hours or less per day, and in single-day units when the service is provided for a minimum of eight hours, up to a maximum of 24 hours in a one-day period.

Note: Hourly Respite Care and Daily Respite Care may not be billed on the same date of service.

Figure 9 – Examples of Respite Care Billing

Example E-1:

A member receives 204 minutes of Respite Care in a calendar day, which equates to three hours and 24 minutes. Because this is less than seven hours, the provider may bill for total of fourteen 15-minute units of “hourly rate” Respite Care.

3 hours x 4 units/hour = 12 units, plus 24 minutes = one 15-minute unit plus 9 additional minutes, rounded up to another whole unit, totaling 14 units

Example E-2:

A member receives 14 hours of Respite Care services in a calendar day. Because this is more than seven hours, the provider may bill for one single-day unit of Respite Care.

Modifiers for AMHH Services

Providers must use the appropriate modifiers in Table 10 when submitting AMHH claims.

Table 10 – AMHH Service Modifiers

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

Modifiers that identify the qualifications of the practitioner rendering the service should **not** be used when submitting AMHH service claims. Using these modifiers results in denials of AMHH service claims.

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)
- 53 – Community mental health center (CMHC)

Mailing Address for Claims

AMHH paper claims are sent to the standard FFS medical claim address:

**Gainwell – CMS-1500 Claims
PO Box 50447
Indianapolis, IN 46250-0418**

Third-Party Liability (TPL) Requirements

The IHCP will not bill private insurance carriers through the third-party liability (TPL) or reclamation processes for claims containing any Home- and Community-Based Services (HCBS) benefit modifiers, including modifiers specific to AMHH services.

HCBS Audits

The state of Indiana employs a hybrid program integrity (PI) approach to overseeing HCBS programs, incorporating oversight and coordination by the FSSA Office of Medicaid Policy and Planning (OMPP) Program Integrity staff, as well as engaging the full array of technology and analytic tools available through the Fraud and Abuse Detection System (FADS) contractor arrangements. The FSSA has expanded its PI activities using a multifaceted approach that includes provider self-audits, desk audits and on-site audits. Program Integrity is required to complete an initial assessment of each provider type annually. Then, based on the assessment information and referrals, audits are completed as needed. The FADS team analyzes claims data, allowing them to identify providers and claims that indicate aberrant billing patterns and other risk factors.

The PI audit process uses data mining, research, identification of outliers, problematic billing patterns, aberrant providers, and issues that are referred by other divisions and state agencies. In 2011, the state of Indiana formed a Program Integrity Team, composed of key stakeholders that meet biweekly to review and approve audit plans and provider communications, and make policy and system recommendations to affected program areas. The OMPP Program Integrity staff also meets with all HCBS divisions on a quarterly basis, at a minimum, and receives referrals on an ongoing basis to maintain open lines of communication and understanding in specific areas of concern, such as policy clarification.

The Program Integrity staff is responsible for directly coordinating with the HCBS divisions. The Program Integrity staff also analyzes data to identify potential areas of risk and identify providers that appear to be outliers warranting review. Program Integrity may also perform desk or on-site audits and be directly involved in reviewing HCBS providers and programs.

Throughout the entire PI process, the FSSA maintains oversight. Although the FADS contractor may be incorporated in the audit process, no audit is performed without the authorization of the FSSA. The FSSA's oversight of the contractor's aggregate data is used to identify common problems to be audited, determine benchmarks and offer data to peer providers for educational purposes, when appropriate.

The Program Integrity staff offers education regarding key program initiatives and audit issues at waiver provider meetings to promote ongoing compliance with federal and state guidelines, including all IHCP and HCBS requirements.

FSSA Audit Oversight

The Audit Division of the FSSA reviews HCBS audit team schedules and findings to reduce redundancy and assure use of consistent methodology.

Medicaid Fraud Control Audit Overview

The Indiana Medicaid Fraud Control Unit (MFCU) is an investigative branch of the Attorney General's Office. MFCU conducts investigations in the following areas:

- Medicaid provider fraud
- Misuse of Medicaid members' funds
- Patient abuse or neglect in Medicaid facilities

When the MFCU identifies a provider that has violated regulations in one of these areas, the provider's case is presented to the state or federal prosecutors for appropriate action. Providers can access information about the MFCU from the [Medicaid Fraud & Patient Abuse](https://www.in.gov/attorneygeneral/medicaid-fraud-patient-abuse) webpage at [in.gov/attorneygeneral](https://www.in.gov/attorneygeneral).

Contact Information

Providers should direct questions about filing claims to Customer Assistance at 800-457-4584. The addresses and telephone numbers are also available on the [IHCP Quick Reference Guide](#) at [in.gov/medicaid/providers](https://www.in.gov/medicaid/providers).

Appendix A: AMHH Acronyms and Definitions

The acronyms and definitions in this appendix apply to Adult Mental Health Habilitation (AMHH) services and the policies and procedures outlined in this module.

837P electronic transaction allows providers to submit professional claims electronically to the Indiana Health Coverage Programs (IHCP). The 837P transaction can be used instead of the IHCP Provider Healthcare Portal (IHCP Portal) professional claim or the *CMS-1500* paper claim form.

Adult Mental Health Habilitation (AMHH) refers to medical or remedial services recommended by a licensed professional, as well as a qualified behavioral health professional (QBHP), within the scope of their practice, for the habilitation of a mental 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 substance use disorders. AMHH services include the following:

- Adult Day Services
- Home- and Community-Based Habilitation and Support
- Respite Care
- Therapy and Behavioral Support Services
- Addiction Counseling
- Supported Community Engagement Services
- Care Coordination
- Medication Training and Support

Adult Needs and Strengths Assessment (ANSA) is the approved Division of Mental Health and Addiction (DMHA) behavioral health assessment tool, administered by a qualified individual who is trained and DMHA-certified to administer the tool, to assist in determining the level of need and functional impairment of an applicant or member.

Applicant means an individual applying for AMHH services by inquiring about AMHH services or completing the AMHH application process.

Assistance means any kind of support given due to a behavioral health condition or disorder. This support includes but is not limited to the following:

- Mentoring
- Supervision
- Reminders
- Verbal cueing
- Hands-on assistance

Authorized healthcare professional (AHCP) means any of the following persons:

- 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 *Indiana Code IC 25-27.5-5*

- 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*

Behavioral and Primary Healthcare Coordination (BPHC) refers to coordination of healthcare services to manage the healthcare needs of the member, including direct assistance in gaining access to health services, coordination of care within and across systems, oversight of the entire case, and linkage to appropriate services.

Care coordinator means the DMHA-approved AMHH provider staff overseeing or managing the AMHH service member's case while the individual is enrolled in the AMHH program.

Centers for Medicare & Medicaid Services (CMS) is the federal agency that has authority over the 1915(i) State Plan Amendments in each state. The CMS must approve the state's requests to implement the federally funded State Plan Amendment and all subsequent program amendments and funding.

Certified Peer Support Professional (CPSP) is an individual who utilizes their lived experience combined with formal training to instill hope, inspire change and support other individuals through similar experiences, using personal connection, person-centered care and their shared understanding to navigate their life in recovery. To be certified as a CPSP, an individual must meet the following criteria:

- Meet one of both of the following:
 - Individual living in recovery with a mental health and/or substance use condition
 - Family member to another person living with a mental health and/or substance use condition
- Successfully complete DMHA CPSP training and receive a passing score on the certification exam

A CPSP is supervised by a certified peer supervisor, a licensed professional or qualified behavioral health professional (as defined in this section) and remains in good standing.

Rule changes are forthcoming to reflect updates to the certification. For more information, see the [Indiana Certified Peer Support Professionals](https://www.in.gov/fssa/dmha/certified-peer-support-professionals) webpage at [in.gov/fssa/dmha](https://www.in.gov/fssa/dmha).

Certified recovery specialist (CRS) and community health worker (CHW) are included under the CPSP certification.

Certified recovery specialist (CRS) refers to an individual who is certified to deliver services as defined at *Indiana Administrative Code 405 IAC 5-21.8-8(f)*. To be certified as a CRS, an individual must be maintaining healthy recovery from mental illness and must have completed the CRS DMHA state-approved training program and received a passing score on the certification exam. The CRS is supervised by a licensed professional or qualified behavioral health professional (as defined in this appendix) and remains in good standing. The CRS position includes the community health worker (CHW), which are now both included under one certification named certified peer support professional (CPSP).

CMS-1500 is the CMS-authorized professional claim form used to submit paper claims to the Medicaid fiscal contractor for reimbursement of rendered, DMHA-approved Home- and Community-Based Services (HCBS).

Community-based refers to AMHH services that are approved by the Centers for Medicare & Medicaid Services (CMS) to be provided within the individual's home (or place of residence) or at other locations based in the community (outside institutional settings). For more information regarding community-based settings, see [Section 4: AMHH Member Home- and Community-Based Settings Requirements](#).

Community Integration and Habilitation (CIH) Waiver provides services that enable individuals with developmental disabilities to remain in their homes or in community settings and assists people who transition from state-operated facilities or other institutions into community settings. This waiver is designed to provide supports for persons to gain and maintain optimum levels of self-determination and community integration while allowing flexibility in the provision of those supports.

Community mental health center (CMHC) is approved as such by the DMHA under 440 IAC 4.1-2-1. The centers offer communities access to a full continuum of behavioral health services.

Consumer Service Line is a toll-free line for consumers to share complaints, questions and concerns about services, treatments, procedures, rights and policies. The line is open Monday through Friday from 8:30 a.m. to 5 p.m. The DMHA contractor processes calls and informs the DMHA. The toll-free number is 800-901-1133. Deaf, hard-of-hearing or speech-impaired individuals can dial 711 to access the Consumer Service Line.

CoreMMIS is Indiana's Medicaid Management Information System (MMIS), or claim-processing system.

Data Assessment Registry Mental Health and Addiction (DARMHA) supports the use of information about the strengths and needs of individuals to help make decisions, to monitor progress and to improve quality. DARMHA is also the system by which the AMHH application is entered and submitted to the DMHA for review.

Detoxification services are services or activities that are provided to a member during their withdrawal from alcohol and other addictive drugs, while under the direct supervision of a physician or clinical nurse specialist.

Division of Disability and Rehabilitative Services (DDRS) is the division within the Indiana Family and Social Services Administration (FSSA) that oversees four 1915(c) Home- and Community-Based Services (HCBS) waiver programs: the Community Integration and Habilitation (CIH) Waiver, Family Supports Waiver (FSW), Health and Wellness (H&W) Waiver and the Traumatic Brain Injury (TBI) Waiver.

Division of Family Resources (DFR) is the division within the Indiana Family and Social Services Administration (FSSA) responsible for processing applications and approving eligibility for Medicaid, Temporary Aid for Needy Families (TANF, or cash assistance), childcare assistance, Supplemental Nutrition Assistance Program (SNAP, or food stamps), and employment and training services for low-income clients.

Division of Mental Health and Addiction (DMHA) refers to the division under the Indiana Family and Social Services Administration (FSSA) that oversees the implementation and ongoing monitoring of the AMHH program, which is provided by the DMHA's state-certified CMHCs.

Family Supports Waiver (FSW) provides limited, nonresidential supports to individuals with developmental disabilities who live with their families or in other settings with informal supports.

Gainwell Technologies is the Indiana Medicaid fiscal agent responsible for maintaining the Core Medicaid Management Information System (*CoreMMIS*) database of all Indiana Health Coverage Programs (IHCP) providers and members – including enrolled AMHH providers and approved AMHH participants, as well as their authorized AMHH services approved by the Division of Mental Health and Addiction (DMHA). Gainwell performs claim processing and reimbursement for eligible providers of AMHH and other fee-for-service (FFS), nonpharmacy Medicaid services. Gainwell assigns IHCP Provider IDs required for reimbursement of all IHCP claims. Gainwell also maintains the IHCP provider website and all provider reference modules.

Group setting means that the activity is meant to benefit more than one client and may include family members and nonprofessional caregivers of multiple clients, whether or not the clients are present during the activity. The benefit to the client must be in accordance with each client's individual treatment goals.

Example: The families of several clients meet for an orientation session to an upcoming AMHH skills development group, which will be attended by several AMHH clients. Because the group includes more than one client, the orientation is considered a group setting.

Habilitation services are activities that are designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in community settings.

Health means physical and behavioral well-being.

Health and Wellness (H&W) Waiver provides an alternative to nursing facility admission for Medicaid-eligible persons ages 59 and younger with a disability. The waiver is designed to provide services to complement and supplement informal supports for people who would require care in a nursing facility if waiver services or other supports were not available. The services available through this waiver are designed to help members remain in their own homes, as well as to help individuals residing in nursing facilities to return to community settings, such as their own homes, apartments, assisted living or adult family care.

Health Insurance Portability and Accountability Act of 1996 (HIPAA) refers to mandated requirements for the adoption of national standards for healthcare, including the protection of health information and standard unique identifiers for all healthcare providers, as well as coding healthcare services for approving, billing, reimbursing and tracking.

Health service provider in psychology (HSPP) as defined by *IC 25-33-1*.

Home- and Community-Based Services (HCBS) refers to services approved by the Centers for Medicare & Medicaid Services (CMS) to be provided within Medicaid member's home (or place of residence) or at other locations based in the community (outside the institutional setting). For Medicaid purposes, *HCBS* generally refers to Home- and Community-Based Services programs authorized by the CMS under Section 1915(c) of the *Social Security Act*.

Indiana Administrative Code (IAC) refers to the Indiana state policies and procedures.

Indiana Code (IC) consists of Indiana State statutes that govern the IAC.

Indiana Family and Social Services Administration (FSSA) is the Indiana state agency that includes the Division of Aging (DA), Division of Disability and Rehabilitation Services (DDRS), Division of Family Resources (DFR), Division of Mental Health and Addiction (DMHA), and Office of Medicaid Policy and Planning (OMPP).

Indiana Health Coverage Programs (IHCP) is Indiana's Medicaid program, collectively referred to as the Indiana Health Coverage Programs (IHCP). The IHCP provides a healthcare safety net for low-income children and adults, including those who are aged, disabled, blind, pregnant or meet other eligibility requirements. The IHCP receives federal and state funds to operate the program and reimburse providers for reasonable and necessary medical care for eligible members. Each state administers its own Medicaid program within the provisions of federal legislation and broad federal guidelines issued by the Centers for Medicare & Medicaid Services (CMS). The Indiana Family and Social Services Administration (FSSA) administers the IHCP. The IHCP includes the 590 Program, Healthy Indiana Plan (HIP), Hoosier Care Connect, Hoosier Healthwise (including Children's Health Insurance Program [CHIP]), Indiana PathWays for Aging (PathWays) and Traditional Medicaid.

Indiana Health Coverage Programs Provider Healthcare Portal (IHCP Portal) is a secure, web-based tool where AMHH authorization, claim and other information may be viewed by AMHH providers. Provider enrollment, provider profile updates and claims (including claims for DMHA-approved CMHW services rendered) may also be submitted via the IHCP Portal. The [IHCP Portal](#) is accessible from the homepage at in.gov/medicaid/providers. For more information about using the IHCP Portal, see the [Provider Healthcare Portal](#) module.

Indiana PathWays for Aging Waiver provides an alternative to nursing facility admission for people who are age 60 and older by providing supports to complement and supplement informal supports for persons who would require care in a nursing facility if waiver services or other supports were not available. The services available through this waiver are designed to help members remain in their own homes, as well as to help individuals residing in nursing facilities to return to community settings, such as their own homes, apartments, assisted living or adult family care.

Individual provider is a provider that practices privately and not under an agency.

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

- Integrates all components and aspects of care that are:
 - Deemed medically necessary
 - Needs-based
 - Clinically indicated
 - Provided in the most appropriate setting to achieve the member's goals
- Includes all indicated medical and support services needed by the member to:
 - Remain in the community
 - Function at the highest level of independence possible
 - Achieve goals identified in the IICP
- Is developed for each member
- Is developed with the member
- Reflects the member's desires and choices
- Identifies the individual's diagnosis, treatment goals, interventions, progress/outcomes, strengths, objectives

Integrated Health Technician (IHT) refers to an individual who is certified to deliver services as defined at 405 IAC 5-21.8-8(a). To be certified as an IHT, an individual must have completed the IHT DMHA and Indiana Department of Health state-approved training program and received a passing score on the certification exam. The IHT is supervised by a licensed professional or qualified behavioral health professional (as defined in this section) and remains in good standing.

Individual setting means the activity is meant to benefit one client, even though the activity may include family members and nonprofessional caregivers, and the client may or may not be present during the activity.

Example: An AMHH client, "John," attends a family counseling session with his siblings and mother. Since the session is intended to benefit only John, it is considered an individual setting, even though multiple people are present.

Level of need (LON) means a recommended intensity of behavioral health services based on a pattern of an individual's and family's needs, as determined by using the DMHA-approved behavioral health standardized assessment tool, the Adult Needs and Strengths Assessment (ANSA).

Licensed professional means any of the following persons:

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

Managed care entity (MCE) is an entity contracted to provide and manage benefits for members enrolled in a managed care program, such as the Healthy Indiana Plan (HIP), Hoosier Care Connect, Hoosier Healthwise or Indiana PathWays for Aging (PathWays). In a full-risk contract, the MCE agrees to provide all benefits on a per-member per-month basis, known as full capitation.

Medicaid Rehabilitation Option (MRO) services are any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of their practice under state

law, for maximum reduction of physical or mental disability and restoration of a member to their best possible level of functioning.

Member means an individual who has been approved by the DMHA State Evaluation Team (SET) to receive AMHH services and has Medicaid.

Member ID is the member identification number, also known as RID, used to identify individuals eligible for Indiana Health Coverage Programs (IHCP) services, including tracking and claim processing for eligible services.

Money Follows the Person (MFP) is a demonstration grant to help move individuals from institutional settings to home- and community-based settings.

Needs-based eligibility criteria are factors used to determine an applicant's requirement for AMHH service activities. The applicant meets the AMHH needs-based eligibility criteria when the following is demonstrated:

- Needs related to management of their health
- Impairment in self-management of health services
- A health need that requires assistance and support in coordinating health treatment
- A recommendation for intensive community-based care based on the uniform DMHA-approved behavioral health assessment tool, as indicated by a rating of four or higher

Nonprofessional caregiver means any individual who does not receive compensation for providing care or services to a Medicaid member.

National Provider Identifier (NPI) is the 1996 *Health Insurance Portability and Accountability Act* (HIPAA)-mandated standard unique identifier for all healthcare providers. Unique NPIs are assigned by application to the National Plan and Provider Enumeration System that collects identifying information on healthcare providers.

Note: An assigned NPI is not needed for AMHH service providers that do not perform healthcare services. HCBS providers may submit claims using their IHCP Provider ID.

Office of Medicaid Policy and Planning (OMPP) is the division within the Indiana Family and Social Services Administration (FSSA) that administers the Indiana Health Coverage Programs (IHCP) in accordance with federal and state requirements, which includes responsibility for financial oversight of the Home- and Community-Based Services (HCBS) program. The OMPP manages the Indiana PathWays for Aging (PathWays) Waiver and provides authority and oversight of the PathWays managed care program.

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

- An individual with an associate or bachelor's degree, or two years equivalent behavioral health experience, meeting minimum competency standards set forth by a behavioral health service provider and supervised by a licensed professional or a qualified behavioral health professional (QBHP)
- A licensed addiction counselor, as defined under *IC 25-23.6-10.5*, supervised by a licensed professional or a QBHP

Outpatient mental health services are services defined under *405 IAC 5-20-8*, formerly referred to as "Medicaid Clinic Option" services.

Participant refers to an individual who has been deemed eligible for Home- and Community-Based Services (HCBS) by the DMHA.

Professional caregiver means an individual who receives payment for providing services and supports to a Medicaid member.

Provider agency means any the DMHA state-certified community mental health center (CMHC) that meets required qualifications and criteria that can employ rendering providers to deliver the AMHH services.

Provider ID is a unique identifier, formerly referred to as the Legacy Provider Identifier (LPI), assigned to IHCP-enrolled providers, including service providers, for submission of all claims for IHCP reimbursement. This number is assigned by the Medicaid fiscal agent during the provider enrollment process.

Provider staff means any individual working under a DMHA-approved AMHH provider agency that meets the qualifications and requirements mandated by the AMHH service being provided.

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

- An individual who has had at least two 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:
 - Psychiatric or mental health nursing, plus a license as a registered nurse in Indiana
 - Pastoral counseling
 - Rehabilitation counseling
- An individual who is under the supervision of a licensed professional, is eligible for and working toward professional licensure, and has completed a master's or doctoral degree, or both, in any of the following disciplines from an accredited university:
 - Social work from a university accredited by the Council on Social Work Education
 - Psychology
 - Mental health counseling
 - Marital and family therapy
- A licensed independent practice school psychologist under the supervision of a licensed professional
- An authorized health care professional (AHCP) who is one of the following:
 - A physician assistant with the authority to prescribe, dispense and administer drugs and medical devices or services under an agreement with a supervising physician and subject to the requirements of *IC 25-27.5-5*
 - A nurse practitioner or 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*

Recreational means activities people do to relax or have fun (for example, activities done for enjoyment).

Residential Settings Screening Tool (RSST) is DMHA's Home- and Community-Based Services (HCBS) form used to screen for HCBS compliance in a member's current living situation.

Self-help means self-guided improvement in functioning through the use of supports and resources.

Serious mental illness (SMI) refers to persons (18 years of age or older) with serious and long-term mental disorders that impair their capacity for self-care, interpersonal relationships, work and schooling.

Significant means an assessed need for immediate or intensive action due to a serious or disabling need.

Skills training means services or activities to further the reinforcement, management, adaptation and retention of skills necessary for the individual to live successfully in the community.

State Evaluation Team (SET) means the DMHA independent evaluation team that reviews and assesses all evaluation information and supporting clinical documentation collected for AMHH applications and members, and is responsible for making final determinations regarding the following:

- Eligibility of applicants for AMHH services
- Authorization for AMHH services for eligible members
- Continued eligibility determination for AMHH members
- Appropriate service delivery to AMHH members, as a result of conducting quality improvement reviews of AMHH service provider agencies

Target-group eligibility criteria are factors used to determine an applicant's eligibility for the Adult Mental Health Habilitation (AMHH) service. To meet the AMHH target-group criteria, an applicant must be enrolled in an eligible Indiana Health Coverage Programs (IHCP) Medicaid program, be age 19 or older, and be diagnosed with an AMHH eligible primary mental health diagnosis.

Traumatic Brain Injury (TBI) Waiver provides services to Medicaid-eligible people of any age who have experienced an external event resulting in a traumatic brain injury and who require services ordinarily available only in a nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF/IID). Birth trauma-related injuries are not included.

Appendix B: AMHH-Eligible Primary Mental Health and Substance Use Disorder Diagnosis Codes

Adult Mental Health Habilitation (AMHH)-eligible members must have one or more AMHH-eligible primary mental health diagnoses, as outlined in [Section 5: AMHH Program Member Eligibility](#).

The AMHH-eligible primary mental health diagnosis codes (ICD-10) are available on the *Adult Mental Health Habilitation Codes*, accessible from the [Code Sets](#) webpage at in.gov/medicaid/providers.

Appendix C: AMHH Application Screen Shots

This appendix provides information about completing each page of the Adult Mental Health Habilitation (AMHH) application.

Page 1 – General

The first page of the AMHH application appears under the General tab. Figure 10 shows the top portion of the first page, Figure 11 shows the middle portion, and Figure 12 shows the bottom portion. The information required in each section follows each figure.

Figure 10 – AMHH Application – General (Top Portion)

AMHH Application View

General IICP Form Application Status History Logs

Data below is pulled from the DARMHA record provided. Errors need to be fixed in the DARMHA record.

IICP ID :
DARMHA ID :
Internal ID :
Applicant Last Name :
Applicant First Name :
Applicant Middle Name :
DOB : ***** Age : ✓
Qualifying Diagnosis : ✓
Diag_1 Diag_2 Diag_3 Diag_4 Diag_5
(n/a) (n/a) (n/a) (n/a) (n/a)
ANSA within 60 days : ✗
ANSA LON 3, 4 or 5 : 5 ✓
AMHH Algorithm : ✓
Medicaid ID : *****
Social Security No. : *****

Applicant Information

Home Address 1 : MUST be a physical mailing address
Address 2 : P.O. Box address, if applicable
City :
State :
Zip Code :
Email Address :
Phone : (xxx-xxx-xxxx) Ext. :
Medicaid enrolled : Yes No
Current MRO Service Package Level : NA
Current MRO Package End Date :
HCBS Address : ✗

Top left box: Information in the top left box is automatically imported from the applicant's record. All the imported information must be checked for accuracy and, if necessary, corrections made in the member's Data Assessment Registry Mental Health and Addiction (DARMHA) record before the application is submitted.

- A green check mark next to an item means the AMHH eligibility criteria is met for that item.
- A red X next to an item means the AMHH eligibility criteria is not met for that item.

Applicant Information: The current, physical home address must be entered in the Home Address 1 box. If there is a P.O. Box address, it can be entered in the Address 2 box. This address is the home mailing address to which the member's AMHH approval or denial notice is sent; therefore, it is critical that this information is accurate. Applicants must be asked where they prefer to receive AMHH notices. If the member is homeless or does not have or is unwilling to provide an address, the community mental health center (CMHC) address may be entered, if the member consents. The telephone number must be entered in the AMHH application (the member's email address is *not* required).

When “Yes” is selected for the Medicaid enrolled item, the Current Medicaid Rehabilitation Option (MRO) Service Package Level must be selected from the drop-down menu. The Current MRO Package End Date field is required if MRO Service Package Level 3, 4, 5 or 5A is chosen; a calendar box pops up to assist.

The Home- and Community-Based Services (HCBS) Address field allows for easier identification of whether the address provided in Home Address 1 has been identified by the CMHC as a residential setting in which the applicant resides. If a green check mark appears in this field, then the setting is identified by the CMHC. If the residential setting has not been identified by the CMHC, a red X will auto-populate.

HCBS Waivers: An AMHH applicant must be asked if they are participating in an HCBS waiver. As described in [Section 2: Adult Mental Health Habilitation Program Overview](#), AMHH service providers are responsible, in collaboration with waiver providers, for monitoring services of AMHH members also enrolled in a 1915(c) waiver program to prevent service duplication. Using the drop-down menu, the AMHH provider must select from the following options:

- Community Integration and Habilitation Waiver
- Family Supports Waiver
- Health and Wellness (H&W) Waiver
- Indiana PathWays for Aging Waiver
- Traumatic Brain Injury Waiver
- Money Follows the Person
- Unknown whether member (consumer) is on waiver

Note: This “unknown” option should be selected only if the question has been asked of the applicant, and they are uncertain. All AMHH applicants must be asked this question.

- Member (consumer) is on waiver, unsure which waiver
- Not on a waiver

Figure 11 – AMHH Application – General (Middle Portion)

Current Living Situation :

Community-based Settings:

- ☐ Homeless
- ☐ Private/Independent Home
- ☐ Non-POCO Residential Setting
- ☐ POCO Residential Setting
- ☐ Non-CMHC POCO Residential setting
- ☐ Potential Presumed Institutional setting

Institutional Settings:

- ☒ Nursing Home
- ☐ Hospital
- ☐ Institution for Mental Disease (IMD)
- ☐ ICF/IID
- ☐ Jail or Correctional Facility

Discharge Date:

Current Living Situation: Select the circle next to the applicable current living situation **as of the day the application is being completed**. For definitions of community-based and institutional settings, see [Section 4: AMHH Member Home- and Community-Based Settings Requirements](#) and [Section 7: Completing the HCBS Residential Setting Screening Tool](#) in this module.

For members who live in a community-based setting, provider agency staff completing the AMHH application must ensure that the setting selected on the DARMHA application is the same as the outcome from the completed HCBS Residential Setting Screening Tool (RSST). For members who live in an institutional setting, the provider must include a specific discharge date within 90 days of submitting the application. Applications for which the selected current living situation is not correct or is inconsistent will be pended for clarification. This section also links to the HCBS Address area to ensure consistency of identified provider owned, controlled or operated (POCO) residential setting throughout the assessment process.

Figure 12 – AMHH Application – General (Bottom Portion)

Eligible AMHH Mental Health Diagnosis :

Primary
Diagnosis:

List the mental health symptoms associated with the eligible AMHH diagnosis.

1.

[Insert New Row](#)

Physical Health Issue(s) :

List up to 5 of applicants current physical health issues.

1.

[Insert New Row](#)

Justification of Need for Program:

Describe how client has maximized rehabilitative interventions in the past and why client would benefit from current habilitative interventions.

Contact Person:

Edit	Case Manager
Edit	Alternate Provider Contact
Edit	Psychiatrist
Edit	Caregiver/Guardian

Eligible AMHH Mental Health Diagnosis: A drop-down menu will populate with the eligible AMHH diagnoses provided in the applicant's DARMHA record. A primary diagnosis must be selected from the drop-down menu and the mental health symptoms experienced by the client and associated with the selected diagnosis are the symptoms to be provided in list format.

Physical Health Issue(s): Current physical health issues experienced by the client are documented in list format. Consumers may have more than five physical health issues. The physical health issues are not required to be diagnosed by a doctor.

Justification of Need for Program: Description of the applicant's participation in any prior rehabilitative services and the outcomes from participation in those services must also be documented in this section of the application. Describe the reasons for difficulty achieving success in rehabilitative services and why client would benefit from habilitation services.

Example of Justification of Need for Program:

Jane is a 49-year-old female who resides with her parents. She has been living with her parents all her life. Her bicycle is her primary means of transportation. She needs to maintain safety by using her bicycle in a safe manner. Currently, she rides it in the middle of the street, even on busy streets. She needs to be educated about her medical and psychiatric diagnoses (Schizophrenia, Generalized Anxiety Disorder) and encouraged to take medications as prescribed. She needs assistance with managing her mental health symptoms and with managing her financial funds to prevent her from being exploited, as provider ABC serves as her payee. Due to her frequent infections, Jane would benefit from regular engagement with service providers who can monitor her physical and mental health, ensure access to a laundromat, and help her obtain supplies for arts and crafts to manage anxiety. Jane is trying to have her felonies expunged, which will assist with housing attainment. She needs to follow up with medical recommendations surrounding suspicious spots found on her lungs. Her family has a history of health problems, including cancer. She needs reminders to use her oxygen as prescribed. Her psychiatrist recommends addiction treatment and counseling for Jane, due to occasional cocaine use. Jane stated, “I would like to live on my own...instead of living in a group home.” She is optimistic about the future and has strong family support.

Contact Person: Primary and alternate case managers, as well as the attending psychiatrist, must be identified. The Caregiver/Guardian field must be completed, if applicable. Choose **Edit** next to each member role; enter name, telephone number and email; and then choose **Update** to save the information. The application may not be submitted until all required information is entered.

Page 2 – IICP Form

The second page of the AMHH application is the Individualized Integrated Care Plan (IICP) Form. It consists of three sections, which are accessed by clicking on the blue underlined “wizard” links on the left side of the application.

Figure 13 – IICP Form – Goals and Objectives

General **IICP Form** History Logs

IICP No. : **1050** Version # : **1** **Draft**

Date Created : 2/26/2020 2:08:40 PM By: XXXXXXXX, XXXXXX

[Needs](#)
[Services](#)
[Attestations](#)

Goals :
 Goals must be person-centered and address applicant's desired outcomes which promote stability and continued community integration. (May be in the applicant's own words but may require further provider clarification.)

Objectives :
 List the necessary steps needed to be taken for the client to accomplish their goals.

1.

[Insert New Row](#)

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Goal and Objectives narrative boxes: Goals and objectives for AMHH applicants and members must be habilitative. The goals and objectives are intended to 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. Goals are ideally presented in the member's own words, and must reflect the member's desires and choices. Staff clarification of goals should be added, when needed. Goals should be reflected in the objectives and AMHH services selected. Objectives are intended to support maintenance of previously learned skills and the preservation of the individual's current (best) level of functioning. Objectives should take into consideration the client/member goals and should align with the selected AMHH services.

Example of Goal and Objectives:

Goal: Jane states, “I want to live on my own, not with my parents. I still use cocaine, but I want to stop. My psychiatrist has recommended addiction treatment, but I don't know how to get started.”

Objectives:

- Jane will continue to meet with treatment team members at least five times per week for the nurse to help fill her medication planner and monitor medication compliance, to keep psychiatric symptoms and their impact on her behavioral functioning manageable as evidenced by staff and self-reports.
- Jane will remain abstinent from cocaine, as evidenced by self-report and random drug screenings. Jane will attend weekly Cocaine Anonymous groups until she feels ready for addiction counseling as reported by staff and self-reports.
- Jane will use care coordination to establish regular meetings with health professionals as required, including an oncologist; and her primary care provider to take preventative measures with other health concerns as they arise. This includes evaluation, monitoring and follow-up with medical and other services/social services for Jane as evidenced by staff and self-reports.
- Jane will use community support and engagement services to seek out meaningful and volunteer opportunities to enhance her positive engagement in her community. Her goal is to manage her critical auditory hallucinations and decrease her anxiety by being involved in activities and events that distract her from internal troubling voices and keep her calm, as evidenced by staff and self-reports.
- Jane will work with her parents and staff to develop and retain alternative options to help her stay safely in the community as evidenced by staff and self-reports.

Attestations

[Figure 14](#) shows the Attestation wizard. Seven required activities must be completed before the application is submitted. Included in the application is the required acknowledgement that the attestations have been fulfilled, signed by the appropriate individuals, and entered on the application:

AMHH provider agencies must maintain the actual documentation with signatures or verification that attestation was obtained via telehealth in the clinical record.

Figure 14 – IICP Form – Attestations

General **IICP Form** History Logs

IICP No. : **1050** Version # : **1** **Draft**


Date Created : 2/26/2020 2:08:40 PM By: XXXXXXXX, XXXXXX


[Needs](#)
[Services](#)
[Attestations](#)


Treatment Team Attestation :


- ☐ The applicant has been given choice of providers
- ☐ The applicant has been given choice of services
- ☐ The proposed IICP is individualized to meet the applicant's need
- ☐ The applicant and/or legal guardian has participated in the development of the IICP
- ☐ A copy of the IICP that was submitted with this application was offered to the applicant
- ☐ Program requirements, including financial requirements, have been reviewed with the applicant and/or legal guardian
- ☐ The HCBS Residential Setting Screening Tool has been completed with the applicant, a signed copy retained in the clinical record, and the HCBS Member Information Pamphlet was provided to the applicant

Date Attested

Applicant : 

Legal Guardian : 

Referring Care Coordinator : 


Super User : 

Why applicant did not sign (Please explain below) :

Psychiatrist/HSPP Attestation :

- ☐ The services requested and the IICP are deemed appropriate, clinically indicated and medically necessary, and are based on the identified needs of the applicant
- ☐ Without ongoing habilitation services the applicant will likely deteriorate and be at risk of institutionalization
- ☐ Applicant is not a danger to self or others at the time this application is submitted

Date Attested

Psychiatrist/HSPP : 

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Table 11 includes a description of each attestation, and who must sign for verification:

Table 11 – Required Attestations

Attestation	Individual Who Must Sign for Verification
The applicant has been given a choice of providers, which applies to choice in the provider agency and providers within an agency itself.	The applicant and/or legal guardian and the case manager/referring care coordinator
The applicant has been given choice of services to be provided.	The applicant and/or legal guardian and the case manager/referring care coordinator
The proposed IICP is individualized to meet the applicant's needs.	The applicant and/or legal guardian and the case manager/referring care coordinator
The applicant has participated in developing the IICP.	The applicant and/or legal guardian and the case manager/referring care coordinator
A copy of the IICP that was submitted with this application was offered to the applicant and/or legal guardian.	The applicant and/or legal guardian and the case manager/referring care coordinator
Program requirements, including financial requirements, have been reviewed with the applicant.	The applicant and/or legal guardian and the case manager/referring care coordinator
The HCBS Residential Setting Screening Tool (RSST) has been completed with the applicant, a signed copy retained in the clinical record, and the HCBS Member Information Pamphlet was provided to the applicant.	The applicant and/or legal guardian and the case manager/referring care coordinator
The services proposed on the IICP are deemed appropriate and medically necessary by the appropriate authority.	The psychiatrist or HSPP
The psychiatrist or HSPP attestation regarding the imminent likelihood that without ongoing habilitation services, the applicant will likely deteriorate and be at risk of institutionalization (for example, acute hospitalization, state hospital, nursing home or jail).	The psychiatrist or HSPP
The applicant is not a danger to self or others at the time this application is submitted.	The psychiatrist or HSPP
<i>Note: In addition to the preceding attestations, a signature from the ANSA SuperUser reviewing the ANSA must be documented. The date the SuperUser signs the attestation documenting their review must be entered in the application.</i>	

Hard-copy or electronic signatures from the applicant, staff, legal guardian (if applicable), reviewing ANSA SuperUser and the attending psychiatrist/HSPP must be kept in the member's clinical chart and made available for review by the State Evaluation Team (SET) upon request. The date of the signature on the attestation must be prior and within 60 days of the application submission date.

Prior Authorization

If additional service units are needed, the provider must request additional service units through a prior authorization (PA) (see [Figure 15](#)).

Figure 15 – IICP Form – Prior Authorization

IICP No. : New Application

[Needs](#)
[Services](#)
[Attestations](#)

Services Being Requested (Put narrative on each service selected) :

Describe how the requested service will help applicant attain specified goal(s) and objectives from IICP, as well as any other services that may be accessed by the applicant to meet the identified goal/objective (i.e., clinic option services, family/natural supports, etc.).

☐ Adult Day Services (S5101-UB)

☒ **HCB Habilitation and Support – Individual Setting (H2014-UB)**

Justification

Additional Units: Provider Name : **Oaklawn Psychiatric Center**

☐ HCB Habilitation and Support – Family/Couple with the Recipient Present (Individual Setting) (H2014-UB/HR)

☐ HCB Habilitation and Support – Family/Couple without the Recipient Present (Individual Setting) (H2014-UB/HS)

Transition to MRO

The Transition to MRO wizard (Figure 16) is visible only after a member's AMHH application is approved by the SET and processed by Gainwell Technologies. It is used if a member opts to transition to MRO services from AMHH services.

Figure 16 – IICP Form – Transition to MRO

Request transition to MRO:

Date of Attestation : 

[Clear Attestation Date](#)

☐ An ANSA has been completed in the past 60 days.

☐ Transition to MRO

Support Summary :

Provide information about the reason(s) consumer opted to transition back to MRO services.

An ANSA must be completed in DARMHA **no more than 60 days** prior to the transition date for MRO eligibility to be determined and an MRO package assigned. If it has been more than 60 days, Gainwell Technologies will not assess for MRO eligibility, and the member may lose *all* services.

The person completing the application must check the box attesting that an ANSA has been completed **and submitted in DARMHA** no more than 60 days before the request to transition to MRO. The person completing the application must also check the “Transition to MRO” box and enter the date the member requested to transition to MRO in the “Date of Attestation” field. Brief information about the reason for the transition must be included in the “Support Summary” narrative box. See [Section 13: Transitions During AMHH Eligibility Period](#) for additional information.

Note: The member’s attestation of their choice to transition to MRO must be captured via hard-copy or electronic signature.

Application Status

The Application Status tab allows the SET to perform various actions, including the following:

- Approve or deny the application and the requested services and, if necessary, decrement service hours.
- View the service package dates.
- Communicate among SET members (Internal Comments) and with the provider (External Comments).

History Logs

The History Logs tab displays the current status of the application with date and time stamps for each action. It is the responsibility of the provider to monitor the application status until the application shows *Gainwell Processed*. See [Table 12](#) for a description of each status.

Appendix D: CMHC Provider Application and Attestation to Provide AMHH Services

This appendix presents the provider agency requirements and expectations required to become an Adult Mental Health Habilitation (AMHH) service provider agency as well as the application and attestation form required.

Provider Agency Application

To become an AMHH service provider agency, the community mental health center (CMHC) must complete and submit a *CMHC Provider Agency Application and Attestation to Provide Adult Mental Health Habilitation Services* (see [Figure 17](#)), acknowledging that the agency will adhere to AMHH program policy and state requirements for all AMHH service providers. The completed provider application is submitted to the Division of Mental Health and Addiction (DMHA) director's office for review for approval or denial.

The DMHA documents approval or denial of the CMHC's application to become an AMHH provider agency. If the agency is approved as an AMHH provider agency, the DMHA notifies the Indiana Health Coverage Programs (IHCP) to add specialty 115 – *AMHH Service Provider* to the CMHC's existing provider profile.

Approvals are valid for three years. When possible, the DMHA aligns the AMHH provider agency renewal process with the routine CMHC certification timeline. CMHCs that are approved to provide AMHH services need to be sure to comply with rules and regulations noted on the [Home- and Community-Based Services \(HCBS\)](#) webpage at in.gov/fssa/dmha.

Provider Agency Requirements

All provider agencies must be approved by the DMHA, be an enrolled Medicaid provider, and meet the following AMHH provider agency criteria and standards:

- Be a DMHA-certified CMHC in good standing, including adherence to criteria required of all DMHA-certified CMHCs that offer the full continuum of care
- Have acquired and maintain a national accreditation by an entity approved by the DMHA
- Be an enrolled IHCP provider (see the [Provider Enrollment](#) module)
- Attest that they are willing and able to provide AMHH services, as described in the AMHH State Plan benefit, *Indiana Administrative Code 405 IAC 1-5-1* and *405 IAC 1-5-3*, and this provider module, including but not limited to:
 - Maintain documentation in accordance with IHCP requirements defined in *405 IAC 1-5-1* and *405 IAC 1-5-3*, and outlined in the provider modules for all IHCP providers.
 - Meet all AMHH provider agency criteria, as defined in the AMHH State Plan Amendment (SPA) and *405 IAC 5-21.6*.
 - Employ individual providers that are eligible to provide AMHH services. See the [Agency Staff Requirements](#) section for additional provider staff eligibility requirements.

Provider Agency Expectations

DMHA approval of an agency as an IHCP-enrolled AMHH provider agency is contingent on that agency complying with all IHCP and AMHH program rules and policies. In addition to meeting the requirements for IHCP-enrolled providers of AMHH services, all AMHH provider agencies must ensure that members are provided access to all the services and supports needed to meet members' individualized needs. AMHH provider agencies must:

- Provide information related to AMHH services, members and agency staff, as required or requested by the DMHA.
- Ensure that all direct care agency staff members providing AMHH services to members meet all standards and qualifications required for the AMHH service being provided. CMHCs are responsible for maintaining accurate and up-to-date files for each staff member, including but not limited to proof of training.
- Actively participate in the DMHA quality assurance program, ensuring compliance with all performance criteria set forth for the AMHH program. As required by the state, the agency must participate in any quality improvement initiatives as they relate to the AMHH program.
- Participate in AMHH provider agency meetings, trainings, conference calls and webinars provided or authorized by the DMHA.
- Comply with DMHA requirements regarding the reporting of critical incidents.
- Provide a system throughout its agency and network for handling individual complaints and appeals, including informing members of the availability of a toll-free number for reporting complaints to the state and the telephone number for the Indiana Protection and Advocacy Services Commission.
- Cooperate fully with the processing of any AMHH-related complaint or appeal, including any grievance plan or correction initiated by the state.
- Be compliant with all federal *Health Insurance Portability and Accountability Act (HIPAA)* and *Code of Federal Regulations 42 CFR Part 2* mandates and regulations in regard to client privacy and information sharing.
- Meet all clinical and operational standards and state requirements for a DMHA-certified CMHC, as found in *440 IAC 4.1*.
- Maintain written policies and procedures for timely intake, screening and comprehensive evaluation from the time a referral for AMHH services is received, to ensure that members have access to appropriate mental health and addiction treatment services in a timely manner.
- If a service or support required to meet the member's identified needs is not available or accessible by the member in a timely manner, the provider agency must provide or make provision for an alternative service or support to meet the member's identified needs until the requested service becomes available.
- Reapply for approval as an AMHH provider agency every three years from the date of initial approval as an AMHH provider agency, as determined by the DMHA.

Application and Attestation Form

The CMHC must complete and submit a *CMHC Provider Application and Attestation to Provide Adult Mental Health Habilitation Services* (see [Figure 17](#)) to the DMHA.

Figure 17 – CMHC Provider Application and Attestation
to Provide AMHH Services

<p style="text-align: center;">CMHC Provider Application and Attestation to Provide Adult Mental Health Habilitation Services</p> <p>I, _____, CEO of _____ CMHC, attest to the following:</p> <p>_____ CMHC is:</p> <ul style="list-style-type: none"> • A DMHA-certified community mental health center (CMHC) in good standing • Accredited by a national accreditation entity approved by the Division of Mental Health and Addiction (DMHA) • An enrolled Medicaid provider • Willing and able to provide AMHH services as described in the CMS approved 1915(i) State Plan Amendment (SPA) (TN19-013), AMHH Rule (405 IAC 5-21.6) and the AMHH module to meet the identified habilitation needs of each eligible recipient, including: <ul style="list-style-type: none"> ➤ Maintaining documentation in accordance with IHCP requirements ➤ Employing staff that are eligible to provide AMHH services • Committed to ensuring that recipients have access to the services and supports needed to meet his/her individual needs. <p>The signature below attests that _____ CMHC requests to become/maintain a DMHA-approved AMHH service provider in the state of Indiana. The above requirements and referenced documents have been read, are understood and will be implemented in accordance with the FSSA program standards.</p> <p>_____</p> <p>Date: _____</p> <p>Community Mental Health Center CEO</p>

Appendix E: AMHH Application Status Codes

The following table presents the codes regarding the status of the Adult Mental Health Habilitation (AMHH) application.

Table 12 – AMHH Application Status Codes

Status Code	Description
Discarded	The application was discarded by the provider or was in draft mode for more than 60 days and was discarded by the Division of Mental Health and Addiction (DMHA) State Evaluation Team (SET). Applications discarded for either reason have not been submitted for review by the DMHA SET.
Draft	A draft was saved by the provider. The application has not yet been submitted for review by the DMHA SET.
Submitted	The application was submitted by the provider and is undergoing DMHA SET review. The SET has 10 business days to review an application and render a decision.
DMHA Pending	The application was pended by DMHA SET for review and potential updates to be made by the provider (that is, the supporting documentation is inconsistent or insufficient for the DMHA SET to make a program and/or services eligibility determination). If the pended application is not resubmitted within seven calendar days from the date that the SET pended the application, the application will be subject to denial based on the original submission.
DMHA Approved	The applicant has been clinically approved for AMHH eligibility by the DMHA SET and all requested services were approved. The application will be forwarded to Gainwell Technologies (the Indiana Medicaid fiscal agent) for service package assignment.
DMHA Denied	The application has been denied by the DMHA SET. Therefore, the individual is not eligible for AMHH. The provider needs to review and reach out to the client for next steps.
Gainwell Data Sent	The applicant was clinically approved by the DMHA SET and the information has been sent to Gainwell for AMHH service package assignment.
Gainwell Error	An error occurs if the information sent from DARMHA does not match what Gainwell has in its system for that member identification (Member ID, last name, DOB, gender and so on), or if the format of the file was incorrect.
Gainwell Processed	The individual is fully approved for AMHH and a service package assignment has been generated by Gainwell. AMHH start and end dates and assigned units are viewable in the IHCP Provider Healthcare Portal (IHCP Portal).

Appendix F: AMHH Application Report

The Data Assessment Registry Mental Health and Addiction (DARMHA) system can generate a report indicating the status of all submitted Adult Mental Health Habilitation (AMHH) applications. To create a report:

1. Navigate to the main AMHH application search page by choosing AMHH from the main DARMHA menu. At the AMHH application search page, an empty box labeled Application Status has a drop-down menu showing all the available AMHH application status codes.
2. Select a status code to conduct a query of only the AMHH applications that have been assigned that particular status code. If no status code is chosen, all applications created will be listed.
3. Choose **Print Search Result** to generate a report that can be viewed onscreen.
4. To print the report, select the printer icon at the top of the page.
5. To export the report, select the desired file format from the drop-down menu at the top of the screen and select **Export**. Choose **Open** or **Save** from the dialog box.

To exit the report, choose **Close Report** to return to the AMHH main screen.

DARMHA also has the capability to generate a report that is useful in tracking the AMHH package end dates to identify members approaching the submission period to ensure timely submittal of renewal applications and a report that identifies applications that have ended with no AMHH renewal application submitted. The following steps indicate how to generate these reports:

1. Navigate to the main DARMHA screen.
2. Select **Reports** from the menu.
 - a. To identify AMHH applications that have expired and with no new application being submitted, select **AMHH Expired Application No Renewal**.
 - b. To identify current AMHH applications and their expiration dates, select **AMHH Expiring Applications**.

Appendix G: HCBS Residential Setting Screening Tool

The following figures show the pages of the current Home- and Community-Based Services (HCBS) Residential Setting Screening Tool (RSST) (as of July 1, 2024).

Figure 18 – HCBS Residential Setting Screening Tool (First Page) – as of July 1, 2024

HCBS Residential Setting Screening Tool <i>Effective July 1, 2024</i>			
<p>Members who receive services through the AMHH and/or BPHC program are required to live and receive HCBS services in settings that meet federal Medicaid guidelines for home and community-based services (HCBS). This tool is required to be completed (1) with every member applying for AMHH and/or BPHC during the development process for every application (initial, renewal, and modification), AND/OR (2) within 15 calendar days of any change in the member's living situation. A completed copy of this screening, with the member's and case manager's signatures in the appropriate section, must be kept with the member's clinical record. In addition, the "Current Living Situation" section on the DARMHA application should reflect the setting identified below.</p>			
Member Name: _____		Date of Screening: _____	
Member's address: _____			
DARMHA ID #: _____		Internal ID #: _____	
Benefit: AMHH/BPHC (circle one or both)			
<p>Please check the box that best described the member's living situation:</p> <div style="margin-top: 10px;"> <div style="display: flex; align-items: flex-start;"> <div style="width: 30px; text-align: center; margin-right: 10px;"> <input type="checkbox"/> </div> <div> <p><u>Identification for Homelessness</u></p> <p>Homeless is defined as: (1) lacking a fixed, regular, and adequate nighttime residence, and/or (2) the primary nighttime residence is: (a) a supervised publicly or privately operated shelter designed to provide temporary living accommodation of 3 or less months, or (b) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings (e.g., on the street, tent community?).</p> </div> </div> <div style="margin-top: 10px;"> <div style="display: flex; align-items: flex-start;"> <div style="width: 30px; text-align: center; margin-right: 10px;"> <input type="checkbox"/> </div> <div> <p><u>Identification for "Private/Independent Home" Setting</u></p> <p>An individual's private home (owned or leased), or a relative's home where the individual resides (owned or leased).</p> </div> </div> <div style="margin-top: 10px;"> <div style="display: flex; align-items: flex-start;"> <div style="width: 30px; text-align: center; margin-right: 10px;"> <input type="checkbox"/> </div> <div> <p><u>Identification of a CMHC Provider Owned, Controlled, or Operated (POCO) Residential Setting</u></p> <p>A provider CMHC owned, controlled, or operated (POCO) residential setting is a specific physical place that is owned, co-owned, and/or operated by a CMHC provider of HCBS.</p> </div> </div> <div style="margin-top: 10px;"> <div style="display: flex; align-items: flex-start;"> <div style="width: 30px; text-align: center; margin-right: 10px;"> <input type="checkbox"/> </div> <div> <p><u>Identification and Attestation for Non-POCO Residential Setting</u></p> <p>These are most often residential settings that provide some level of daily living support services, such as (this list is not all-inclusive):</p> <ul style="list-style-type: none"> Residential Care Facilities County homes Residential Care Assistance Program (RCAP) facilities Room and Board Assistance (RBA) facilities Cluster homes/cluster apartments owned by non-profit agencies </div> </div> <div style="margin-top: 10px;"> <div style="display: flex; align-items: flex-start;"> <div style="width: 30px; text-align: center; margin-right: 10px;"> <input type="checkbox"/> </div> <div> <p><u>Identification and Attestation for Non-CMHC POCO Residential Setting</u></p> <p>A provider of HCBS other than a CMHC may operate or be delivering services at that setting. The Indiana FSSA agencies Division of Aging (DA) and Division of Disability and Rehabilitative Services (DDRS) administer four other Medicaid HCBS programs, known as 1915(c) Home and Community-Based Waivers:</p> <ul style="list-style-type: none"> Traumatic Brain Injury (TBI; administered by DDRS) Health and Wellness waiver (administered by DDRS) Indiana PathWays for Aging (administered by OMPP) Community Integration and Habilitation (CIH; administered by DDRS) Family Supports (FS; administered by DDRS) </div> </div> </div> </div></div></div></div>			
Member Signature _____		Date _____	
Case Manager Signature _____		Date _____	
Member name (printed) _____		Case Manager name (printed) _____	
<p>***Individuals that reside in a private/independent home, please skip the questions below***</p>			

**Figure 19 – HCBS Residential Setting Screening Tool (Second Page) –
as of July 1, 2024**

RSST Ongoing Monitoring Plan	
Member Name: _____	Date of Screening: _____
Member's address: _____	
DARMHA ID #: _____	Internal ID #: _____
Benefit: AMHH/BPHC (circle one or both)	

For ONLY those members that reside in a POCO or non-POCO residential setting, please answer the following questions. If any responses to the following questions are "No," please email this RSST (2nd page) to bphc.services@fssa.in.gov.

1. The setting is integrated in, and supports residents' full access to, the greater community	
2. The setting is selected by the individual from among setting options	
3. Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint	
4. Enhances individual initiative, autonomy, and independence in making life choices	
5. Individuals have a choice regarding services and supports, and who provides them	
6. A lease or residency agreement is in place for each HCBS participant and includes protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law	
7. Each individual has privacy in their sleeping or living unit	
8. Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time	
9. Individuals are able to have visitors of their choosing at any time	
10. The setting is physically accessible to the individual	

By our signatures, we attest that the member's current living situation is selected correctly and the member answered the exploratory questions (when appropriate).

Member Signature	Date	Case Manager Signature	Date

Member name (printed)	Case Manager name (printed)

Appendix H: AMHH Service Codes and Rates Table

Table 13 shows the Adult Mental Health Habilitation (AMHH) service codes and reimbursement rates as of July 1, 2018.

Table 13 – AMHH Service Codes and Rates

AMHH Service	HCPCS Code	Modifiers	Unit/Rate
Adult Day Services	S5101	UB	\$28.80 per half-day unit
Home- and Community-Based Habilitation and Support with Member (Individual Setting)	H2014	UB	\$26.14 per 15-minute unit
Home- and Community-Based Habilitation and Support with Family and Member (Individual Setting)	H2014	UB HR	\$26.14 per 15-minute unit
Home- and Community-Based Habilitation and Support with Family without the Member Present (Individual Setting)	H2014	UB HS	\$26.14 per-15-minute unit
Home- and Community-Based Habilitation and Support with Member (Group Setting)	H2014	UB U1	\$4.71 per-15-minute unit
Home- and Community-Based Habilitation and Support with Family and Member (Group Setting)	H2014	UB U1 HR	\$4.71 per-15-minute unit
Home- and Community-Based Habilitation and Support Services with Family without the Member present (Group Setting)	H2014	UB U1 HS	\$4.71 per-15-minute unit
Respite Care (Hourly)	S5150	UB	\$3.50 per 15-minute unit
Respite Care (Daily)	S5151	UB	\$100.00 per 1-day unit
Therapy and Behavioral Support Services with Member (Individual Setting)	H0004	UB	\$28.65 per 15-minute unit
Therapy and Behavioral Support Services with Family and Member (Individual Setting)	H0004	UB HR	\$28.65 per 15-minute unit
Therapy and Behavioral Support Services without the Member Present (Individual Setting)	H0004	UB HS	\$28.65 per 15-minute unit
Therapy and Behavioral Support Services with Member (Group Setting)	H0004	UB U1	\$7.16 per 15-minute unit
Therapy and Behavioral Support Services with Family and Member (Group Setting)	H0004	UB U1 HR	\$7.16 per 15-minute unit
Therapy and Behavioral Support Services without the Member Present (Group Setting)	H0004	UB U1 HS	\$7.16 per 15-minute unit
Addiction Counseling with Member (Individual Setting)	H2035	UB	\$58.32 per 1-hour unit
Addiction Counseling with Family and Member (Individual Setting)	H2035	UB HR	\$58.32 per 1-hour unit
Addiction Counseling with Family without the Member Present (Individual Setting)	H2035	UB HS	\$58.32 per 1-hour unit

AMHH Service	HCPCS Code	Modifiers	Unit/Rate
Addiction Counseling with Member (Group Setting)	H2035	UB U1	\$14.58 per 1-hour unit
Addiction Counseling with Family and Member (Group Setting)	H2035	UB U1 HR	\$14.58 per 1-hour unit
Addiction Counseling with Family Without the Member Present (Group Setting)	H2035	UB U1 HS	\$14.58 per 1-hour unit
Supported Community Engagement Services	97537	UB	\$26.14 per 15-minute unit
Care Coordination	T1016	UB	\$14.53 per 15-minute unit
Medication Training and Support with Member (Individual Setting)	H0034	UB	\$18.62 per 15-minute unit
Medication Training and Support with Family and Member (Individual Setting)	H0034	UB HR	\$18.62 per 15-minute unit
Medication Training and Support with Family Without the Member Present (Individual Setting)	H0034	UB HS	\$18.62 per 15-minute unit
Medication Training and Support with Member (Group Setting)	H0034	UB U1	\$3.35 per 15-minute unit
Medication Training and Support with Family and Member (Group Setting)	H0034	UB U1 HR	\$3.35 per 15-minute unit
Medication Training and Support with Family Without the Member Present (Group Setting)	H0034	UB U1 HS	\$3.35 per 15-minute unit