NEW YORK STATE OF OPPORTUNITY. Office of Mental Health

KATHY HOCHUL
Governor

ANN MARIE T. SULLIVAN, M.D.
Commissioner

MOIRA TASHJIAN, MPA
Executive Deputy Commissioner

Guidelines for New York State Medicaid Managed Care Organizations (MMCO) regarding Assertive Community Treatment (ACT) Utilization Management (UM)
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Assertive Community Treatment (ACT) is a specialty behavioral health services available in managed care. There are three models of the ACT program within New York State: Adult ACT, Young Adult ACT and Youth ACT[1]. This guidance applies to all MMCO product lines, including Health and Recovery Plans (HARP), Mainstream Plans, HIV Special Needs Plans (SNPs), and Medicaid Advantage Plus (MAP) Plans.

What is Assertive Community Treatment?
ACT teams deliver comprehensive services designed to engage adults with Serious Mental Illness (SMI) and children/youth with Serious Emotional Disorder (SED) whose needs have not been met by traditional service delivery approaches or are at risk of entering, or returning home from high intensity services, such as inpatient settings or residential services. ACT is an evidence-based practice that incorporates treatment, rehabilitation, case management, and support services delivered by a mobile, multi-disciplinary mental health team. ACT supports recovery through an individualized approach that provides people with the tools to obtain and maintain housing, employment, relationships and relief from symptoms and medication side effects. Youth ACT Team interventions are focused on enhancing family functioning to foster health and well-being, stability, and re-integration for the child/youth. Services are delivered using a family-driven, youth guided and developmentally appropriate approach that comprehensively addresses the needs of the child/youth within the family, educational, medical, behavioral, psychosocial, and community domains. The nature and intensity of ACT services are developed through a person-centered service planning process and adjusted as needed in daily ACT team meetings.

Individuals admitted to ACT teams may have a treatment history that has been characterized by frequent use of psychiatric hospitalization, crisis services and emergency rooms, involvement with the child welfare, juvenile justice or criminal justice systems, addiction disorder, and lack of engagement in traditional outpatient services. The ACT model is designed to serve a small subset of high-need individuals with SMI or SED who require complex multi-faceted care. For youth, the model also serves caregivers and family. Most individuals will not need the intensive services offered by ACT programs. Individuals who are eligible for ACT services are also at significantly higher risk for chronic medical problems that can result in increased utilization of acute medical services and result in significantly higher burdens of morbidity and early mortality. MMCOs have a critical role in helping members receiving ACT services access treatment for co-occurring medical problems.

The ACT program is an intensive service with limited capacity. ACT should be used appropriately as a specific service within the larger continuum of care. MMCOs should review how Adult Behavioral Health Home and Community Services (BH HCBS), Community Oriented

[1] Program guidance describes eligibility criteria for each program (including ages served), see “ACT Resources” at end of document for links.

Recovery and Empowerment Services (CORE), Health Home Plus, and other behavioral health services can help transition individuals off ACT teams, creating access for other individuals who need ACT services. The ACT Institute, in partnership with the State Office of Mental Health (OMH), provides supports and training to Adult ACT teams with emphasis on a transitional model of care.

For children, Youth ACT is targeted towards those returning from inpatient hospitalization, residential treatment, or a community residence to provide ample support for a successful transition home, or for those in the community and at risk of out of home care or placements due to significant functional deficits impeding their ability to remain in the community without intensive in-home services and supports. It is expected that children admitted to Youth ACT will continue to receive services until their complex needs are adequately met, are no longer at risk of out of home care, and can successfully transition to a lower level of service that will meet their needs. The Youth ACT Technical Assistance Center (YTAC) works closely with OMH to train Youth ACT teams on this intensive multidisciplinary approach provided to the child and their family in their home and community.

Referral to ACT
As of 2022, there are 108 licensed Adult ACT teams serving over 6,000 adults throughout NYS and two Young Adult ACT Teams. OMH has committed to expanding the number of ACT teams over the next year, including teams serving specialized populations. By the end of 2023, OMH anticipates there will be 20 Youth ACT Teams throughout the State, with the capacity to serve 852 youth.

Due to the limited availability for ACT services, OMH regulations require all referrals to ACT Services be reviewed and assigned by a county Single Point of Access (SPOA) entity under contract to the Local Government Unit (LGU). The SPOA process allows for ACT capacity to be accessed by managed care enrollees, fee-for-service Medicaid recipients, and individuals not eligible for Medicaid. Each county has a designated SPOA contact for both adults and children.

Individuals, including MMCO enrollees, should be referred for ACT services as follows:

- The referral source submits the application for ACT to the local SPOA. SPOA will:
    a. Confirm the individual is eligible for ACT; and
    b. Determine the urgency of the individual's need for ACT services relative to other applicants.
- If the SPOA determines that ACT level of care is indicated, SPOA will manage the process, from the point of receipt of a complete application, for placement on a referral list for ACT (if applicable) to assignment to an ACT team.
- When an individual is assigned to a referral list, the SPOA will communicate with the referral source and other service providers (e.g., Health Home care manager) as needed to ensure adequate care coordination while waiting for ACT services.
- If the individual is an MMCO enrollee, the SPOA will attempt to assign members to an in-network ACT team. If the first available appropriate ACT slot is with an out-of-network provider, the SPOA will assign to the available ACT team and the MMCO must reimburse the ACT provider on an out-of-network basis or pursuant to a single case agreement.

Utilization Management for ACT – Authorization and Concurrent Review
NYS issued an updated *Utilization Management (UM) Guidelines for New York State Medicaid Managed Care Organizations (MMCO) and Health and Recovery Plans (HARP) regarding Assertive Community Treatment (ACT)* to the MMCOs in August 2021. This March 2023 update

replaces the guidance issued in August 2021. Effective no later than June 20, 2023, Level of Service Determinations (LOSD) and prior authorization are no longer allowed. Additionally, concurrent review is no longer required. MMCO clinical staff are encouraged to communicate with ACT teams outside of the utilization review process to assist with care coordination, information exchange, and care planning.

MMCOs may conduct concurrent reviews for enrollees who have been enrolled in the ACT program for at least 12 months. If concurrent review is conducted, the minimum authorization must be for no less than six months of ACT.

(1) For enrollees who have been enrolled in ACT continuously for at least 12 months AND who meet specific clinical triggers, the MMCO may conduct concurrent review both to determine the medical necessity of ACT and to review if critical physical and behavioral health integration has been accomplished and the member's physical health needs are being addressed, including:
   - HIV/AIDS,
   - Hepatitis C,
   - Insulin-dependent diabetes, and
   - Four or more medical hospitalizations in the last 12 months.

(2) For enrollees who have been enrolled in ACT continuously for at least 36 months AND have not used any acute behavioral health services (CPEP, psychiatric ER, or psychiatric inpatient), the MMCO may conduct concurrent review to determine medical necessity of ACT and explore whether the member could step down to a less intensive service.

The concurrent review process shall be based on continued stay and discharge criteria as described in ACT Program Guidelines, found on the OMH Assertive Community Treatment website for Young Adults and Adults and in the Youth Act Guidance.

The ACT Program Guidelines outline requirements for assessments and service planning for all individuals enrolled in ACT. MMCOs may use this documentation and progress notes as part of concurrent reviews. UM should focus on the effectiveness of the service, progress towards goals, symptom stabilization and the development of skills to be more independent, and progress toward a discharge goal.

Most adults who are appropriate for ACT level of care will require services for a period of at least two-three years and many will require an even longer duration, while children in Youth ACT will likely require a minimum of 12 months, although children may also need a longer duration of care.

ACT must be reimbursed on a monthly basis using the full, partial, or inpatient State rate. These rates include required contacts, as outlined in 14 NYCCR Part 508 regulation.

> Unit of Service - Behavioral Health Billing Manual (pg. 7): *ACT services are billed once per month using one rate code for the month's services. There are three (3) types of monthly payments which are dependent on the number and type of contacts with the recipient or collaterals: full, partial, or inpatient. Claims are submitted using the last day of the month in which the services were rendered as the date of service.*

For individuals who have an AOT Court Order for ACT
If a recipient of ACT services is under a court order to receive Assisted Outpatient Treatment (AOT), the services included in the treatment plan developed by a psychiatrist and the LGU and approved by the court, should remain in place for the term of the AOT order unless a change is recommended by current treatment providers and agreed upon by the LGU (this will also require a material change through the court for change in service category). Individuals on an AOT order that includes ACT will receive admission priority with the local SPOA. MMCOs shall not conduct concurrent review for individuals receiving ACT services under an AOT order.

MMCO Care Management (CM)
MMCOs should identify an ACT liaison from their CM staff to facilitate communication and coordination with ACT teams. Even with the removal of LOSD and prior authorization, and the change in concurrent review, the expectation remains that ACT teams will continue to work with MMCOs and that MMCOs will continue to collaborate with ACT teams for clinical consultation, collaboration on care management needs, support of integrated care through member networks, including through transitions from inpatient hospitalization, and discharge from the ACT. MMCO CM and ACT teams should develop practices to review cases outside of the UM process, for reasons aforementioned. MMCOs with multiple members in the same ACT team are encouraged to establish quarterly meetings with the ACT team to monitor and collaborate on shared cases. Both the MMCO and the ACT team are expected to document in the member record any case discussion. ACT teams may proactively reach out the MMCO for a case review in preparation for discharge. MMCOs should help support realistic discharge planning that meets the individual's needs prior to transition. ACT team psychiatrists and psychiatric nurse practitioners may also seek consultation from the MMCO BH medical director for challenging clinical situations.

ACT Guidelines on Transition and Discharge
ACT Program Guidelines, found on the NYS OMH ACT website, shall be referenced for supporting the transition of individuals from ACT. OMH will support MMCO concurrent review efforts to identify individuals receiving ACT services who demonstrate, over time, an ability to function in major life roles and life domains, and who can be effectively served with less intensive services. The NYS Health Home program Specialty Mental Health Care Management (HH+), BH HCBS, PROS, Clinic, Certified Community Behavioral Health Clinic (CCBHC), and CORE, offer options for enhanced care management and supports to facilitate transition of individuals from ACT teams to other community-based services. This will help achieve an important system-wide goal to shorten ACT length of stay and improve access to ACT for high-need, high-risk individuals.

For children/youth ready for discharge and transition out of the Youth ACT program, teams will continue to collaborate with MMCO and local county SPOA to connect them to appropriate services and supports, such as Mental Health Outpatient Rehabilitative Treatment Services (MHOTRS), Children and Family Treatment Support Services (CFTSS) and Home and Community Based Services (HCBS) under the Children's Waiver. Additional details on discharge planning requirements can be found in the Youth ACT Guidance.

It is the expectation that the ACT team and MMCO work together when the individual is ready for transition off the team to determine available services for transition.

CPEP/ER/Inpatient Hospitalization
For individuals enrolled in ACT who go to CPEP, ERs, or inpatient hospitalization, MMCOs shall facilitate discharge planning between CPEPs/ERs/inpatient hospitals and ACT teams so ACT teams can provide intensive engagement at these critical transitions across levels of care.

ACT Service Combinations

- **Health Homes**
  HH+ services are available for adults with SMI who meet eligibility. ACT step down is an eligibility criterion to receive this level of intensive care management. Individuals transitioning off ACT to a lower level of service may benefit from the enhanced support of HH+ for up to 12 consecutive months. Details may be found on the NYS OMH Specialty Mental Health Care Management in Health Home (Adults) website.

  With the support of the local county SPOA, children stepping down from Youth ACT can be connected to Health Homes Serving Children. For many children, referral to High-Fidelity Wraparound (HFW), a higher-intensity family-centered evidence-based care management intervention currently delivered by 20+ Care Management Agencies, will be appropriate. OMH and DOH are currently expanding the High-Fidelity Wraparound (HFW) program statewide.

- **HARP**
  ACT Teams are responsible for comprehensive discharge planning for individuals receiving ACT services. If an individual is receiving ACT services when enrolled in a HARP, the ACT team will assume responsibility for the BH HCBS Eligibility Assessment process or the Licensed Practitioner of Healing Arts (LPHA) recommendation for CORE as described below:

  If the individual is interested in BH HCBS at the point that ACT teams are actively planning for an individual's discharge from ACT, the ACT Team will conduct a BH HCBS Eligibility Assessment to determine whether the individual will be eligible for BH HCBS post-discharge from ACT.
    - The ACT team will request the BH HCBS Level of Service Determination and make referrals for BH HCBS as appropriate. The ACT team will initiate the warm hand-off process by making a referral to a Health Home Care Manger (HHCM). The HHCM will complete the BH HCBS Plan of Care (See Discharge Workflow for ACT Recipients Enrolled in HARP for more detail).

  If the individual is interested in CORE services, the ACT team will complete the LPHA recommendation for services and make referrals directly to CORE providers.

- **Personalized Recovery Oriented Services (PROS)**
  PROS programs integrate treatment, support, and rehabilitation to facilitate individualized recovery. Many individuals may be able to transition from ACT to a PROS program as their community functioning and wellness management skills improve. To facilitate these transitions, NYS regulations allow for individuals receiving ACT services to simultaneously enroll in a PROS program with the following stipulations:
  - An individual receiving ACT services may enroll in a PROS program for no more than three months within any 12-month period;
  - Reimbursement for ACT services provided to individuals who are receiving both ACT and PROS services will be limited to the ACT partial step-down payment rate.

- **Youth ACT and HCBS Under the Children's Waiver**
  The Children's Waiver is available for children with SED who are at risk of hospitalization if not for receipt of supportive services available under HCBS, such as respite. For children stepping down from Youth ACT, the local county SPOA can help assist to connect the youth to HHSC/HFW and the Children's Waiver by conducting an HCBS Eligibility Determination.

ACT Resources

- **ACT Institute**
  The ACT Institute, part of the Center for Practice Innovations (CPI), provides training, support, and consultation to ACT providers across New York State. The training curriculum is based on national evidence-based practice consortium standards and modifications to these standards as developed by OMH. Training is delivered via in-person and distance- learning modalities.

- **Youth ACT Technical Assistance Center**
  The Youth ACT Technical Assistance Center (YTAC), part of the Community Technical Assistance Center of NY provides training and technical assistance to Youth ACT teams across New York State. YTAC utilizes a collaborative Learning Health System framework to support the Youth ACT model. The training curriculum is based on national evidence-based practice consortium standards and modifications to these standards as developed by OMH.

- NYS OMH Adult ACT Program Guidelines
- NYS OMH Youth ACT Program Guidance
- Adult ACT Standards of Care
- ACT Billing Regulations
- ACT Institute