

Utilization Management (UM) Guidelines for New York State Medicaid Managed Care Organizations (MMCO) and Health and Recovery Plans (HARP) regarding Assertive Community Treatment (ACT)

Assertive Community Treatment (ACT) is one of the specialty behavioral health services that has been incorporated into managed care. MMCOs and HARPs operating in New York State have assumed management of this service in the adult Medicaid Managed Care Program.

What is Assertive Community Treatment?

ACT teams deliver comprehensive services to individuals with Serious Mental Illness (SMI) whose needs have not been met by traditional service delivery approaches. 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 individual recovery through an individualized approach that provides individuals with the tools to obtain and maintain housing, employment, relationships and relief from symptoms and medication side effects. 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.

Typically, ACT individuals have a treatment history that has been characterized by frequent use of psychiatric hospitalization and emergency rooms, involvement with the criminal justice system, alcohol/substance abuse, and lack of engagement in traditional outpatient services. The ACT model is designed to serve a small subset of high-need individuals with SMI who require complex multi-faceted care. Most individuals will not need the intensive services offered by ACT programs.

The ACT program is an intensive service with limited capacity. ACT should be utilized appropriately as a specific service within the larger continuum of care. As HARPs begin to manage Behavioral Health Home and Community Based Services (BH HCBS), these and other behavioral health services will help transition individuals off of ACT teams, creating access for other individuals who need ACT services. The ACT Institute, in partnership with the State Office of Mental Health, provides supports and training to ACT teams with emphasis on a transitional model of care.

Referral to ACT

As of 2018 there are 108 licensed ACT teams serving over 6,000 individuals throughout NYS. Due to the limited availability for ACT services, OMH regulations require that all referrals be reviewed and assigned by a county Single Point of Access (SPOA) entity under contract to the Local Government Unit (LGU; Department of Health and Mental Hygiene in New York City). The SPOA process allows for ACT slots to be accessed by managed care enrollees and also by fee-for-service Medicaid recipients and individuals not eligible for Medicaid. Providers and MMCOs/HARPs must work with SPOA to facilitate referrals; MMCOs/HARPs should identify an ACT liaison from among their UM staff to facilitate communication and coordination with ACT teams.

MMCO/HARP members should be referred for ACT services as follows:

1. For New York City members only:

- The referring provider (e.g., hospital provider, Health Home care manager, or other behavioral health provider) contacts MMCO/HARP to request a Level of Service Determination (LOSD) for ACT. Provider and MMCO/HARP utilization management (UM)

staff review whether the member meets ACT level of care admission criteria. MMCO/HARP notifies the referring provider of LOSD within 24 hours.

- If the MMCO/HARP does not approve ACT level of care, MMCO/HARP works with the referring provider to develop an alternate service plan to meet the member's clinical, rehabilitation and recovery needs. The referring provider has appeal options as described in MMCO/HARP model contract.
- If the MMCO/HARP approves ACT level of care, the MMCO/HARP provides the referring provider with list of in-network ACT teams.
- The referring provider submits the SPOA application for ACT with notice of MMCO/HARP LOSD and list of in-network ACT teams to SPOA, which will:
 - a. Confirm the member is eligible for ACT; and
 - b. Determine the urgency of the member's need for ACT services relative to other applicants.
- For New York City members, skip to #3 below.

2. For Rest of State members only (For all communication between the MCO/HARP and SPOA, proper consent will be needed):

- The referring provider (e.g., hospital provider, Health Home care manager, or other behavioral health provider) makes a SPOA referral and contacts MMCO/HARP to request an ACT Level of Service Determination (LOSD). The referring provider and MMCO/HARP utilization manager review whether the member meets ACT level of care admission criteria. Simultaneously, SPOA reviews the referral and assesses for capacity/availability of ACT slot. The MMCO/HARP notifies the provider and SPOA that a LOSD for ACT admission has been made. The MMCO/HARP must make the Level of Service Determination within 24 hours.
- If the MMCO/HARP does not approve ACT level of care, the MMCO/HARP notifies the SPOA so that the SPOA can participate in discussions regarding plans to meet the member's needs. The MMCO/HARP must work with the referring provider and SPOA to develop an alternate service plan that meets the member's clinical, rehabilitation and recovery needs. The member and referring provider have appeal options as described in MMCO/HARP model contract.
- If the MMCO/HARP approves the LOSD for ACT level of care, the MMCO/HARP ensures that the referring provider and SPOA have up-to-date lists of in-network ACT teams.
- For Rest of State members, continue to #3 below.

3. For both New York City and Rest of State:

- If the SPOA disagrees with the MMCO/HARP approval of ACT level of care, the SPOA will contact the MMCO/HARP, UM staff, and include the referring provider, to review the application and arrive at a consensus. If a consensus cannot be reached, the MMCO/HARP's decision regarding LOSD of ACT services will be final.

- If the SPOA agrees that ACT level of care is indicated, SPOA will process a complete referral from the point of receipt of a complete application to the point of assignment to an ACT team or placement on a referral list for ACT.
- When the member is assigned to a referral list, the SPOA will communicate with the referring provider, MMCO/HARP, and other providers (e.g., Health Home care manager) as needed to ensure adequate care coordination while waiting for ACT services.
- The SPOA will attempt to assign members to an in-network ACT team on the list submitted with the application. 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/HARP must reimburse out-of-network ACT services with or without an executed out-of-network agreement.
- 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). MMCOs/HARPs are expected to conduct utilization review for individuals receiving ACT services under an AOT court order using the same processes for individuals not under an AOT order. Upon discerning the enrollee's needs no longer appear to meet medical necessity criteria for the services provided, the MMCO/HARP UM staff must consult directly with the ACT team psychiatrist and LGU for discussion around a recommended change in level of care (and possibility of a modified court order). In the event of a continued disagreement about appropriateness of ACT level of care for the individual, the decision of the LGU shall be final and the ACT level of care must remain a covered service as long as it remains in the treatment plan under the active court order.
- The accepting ACT team will contact the MMCO/HARP within seven (7) days prior to the date of admission to obtain the prior authorization and determine a timeframe for concurrent review.
- It is the responsibility of the ACT team to notify the SPOA and the MMCO/HARP when the individual is discharged from an ACT program.

Utilization Management for ACT – Authorization and Concurrent Review

NYS issued guidance to the MMCOs and HARPs regarding prior and concurrent review authorization for ambulatory services on May 14, 2015. As noted in the guidance, prior and concurrent review authorization is required for ACT.

1. Streamlining communication between MMCOs and ACT Teams for authorization requests. To ensure delivery of appropriate care that meets the members' needs, the following is recommended:

- a) MMCOs must identify and track members who are in ACT. MMCOs are expected to use Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) or other internal data systems (such as claims, UM/UR) at least monthly to update their internal records to ensure MMCO staff are aware of members in ACT (refer to [OMH guidance](#))

[memo "Using PSYCKES to identify members with Assisted Outpatient Treatment \(AOT\) orders and/or who receive Assertive Community Treatment \(ACT\) services", 12/9/2016](#)).

- b) MMCO UM staff who conduct prior authorization and concurrent reviews should have focused training in ACT principles. When possible, MMCOs should consider identifying specific UM primary staff, and a secondary staff, who will conduct all ACT prior authorization and concurrent reviews.
- c) ACT Teams should also have a primary point of contact, and a secondary contact, who is a clinician familiar with MMCO requirements, timelines and procedures around authorization requests.
- d) Scheduling reviews ahead of time is strongly recommended to ensure points of contact from MMCO and ACT are available and prepared for the review.
- e) MMCOs should develop and distribute to ACT Teams a list of required documentation that is routinely required for prior authorization/concurrent review. Additional clinical information may be required by the MMCOs on a case by case basis.
- f) ACT Teams should send required documentation as referenced above (e) or if requested, assessments, service plans and POCs to the MMCOs prior to scheduled meetings so they can review them.

2. Timeframes To Begin Concurrent Review Process are listed in the [Medicaid Managed Care Model Contract](#) (Appendix F). The parameters for Service Authorization Determinations listed in the Medicaid Managed Care Model Contract are made to maintain continuity of care for individuals, and continuity of payment for service providers. It is recommended that ACT providers and MMCOs put processes in place to identify members with expiring authorizations and begin the concurrent authorization request process no later than 14 days before the end of the current authorization period, to avoid lapses in payment and unnecessary expedited reviews.

3. Concurrent Review - OMH requires the following schedule of assessments and care planning for ACT recipients under the NYS Medicaid fee-for-service program:

- Immediate needs assessment is completed within 7 days of receipt of referral;
- Initial Comprehensive Assessment and Comprehensive Service Plan is completed within 30 days of admission;
- The Comprehensive Assessment is updated, and the Comprehensive Service Plan is reviewed at least every 6 months.

Aligning concurrent review with assessment and service plan dates (6-months) will allow MMCOs to have the most up-to-date documentation. However, this should not prevent MMCOs and ACT teams from communicating at any time to ensure provision of person-centered care. ACT documentation utilized for UM procedures may include any current documentation such as the Comprehensive Assessment, progress notes or the Comprehensive Service Plan.

Most individuals who are appropriate for ACT level of care will require services for a period of at least 2-3 years and many will require an even longer duration. It is expected that the intervals for UM should reflect the longer-term nature of the service. 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.

4. **Submitting Authorization Requests** - It is recommended that ACT providers and MMCOs put processes in place for ACT Teams faxing documentation, such as an ACT team calling or emailing the MMCO contact to verify that the MMCO received the fax and/or to let the MMCO know that the fax was sent.
5. **Unit of Service - Behavioral Health Billing Manual (pg7):** *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.*

ACT must therefore be reimbursed on a monthly basis using the full, partial or inpatient State rate. These rates include required contacts, as outlined in regulation. MCOs may not authorize "partial months" of ACT, or units of service defined by number of contacts within the month. ACT may only be authorized in months as each month is considered 1 unit of ACT service (1 unit = 1 month of ACT service).

If the MMCO/HARP and a provider want to negotiate an alternative reimbursable approach, they will need to come to the state for approval.

ACT Guidelines on Admission, Continuing Stay, and Discharge

The table below provides broad guidelines regarding ACT admission, continuing stay and discharge criteria. MMCOs and HARPs should consult these guidelines and incorporate a person-centered approach to develop specific ACT level of care criteria.

OMH will support MMCO/HARP concurrent review efforts to identify individuals receiving ACT services who demonstrate, over a period of time, an ability to function in major life roles and who can be effectively served with less intensive services. The NYS Health Home program and BH HCBS added to the HARP benefit package offer new 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.

Admission Guidelines
<ul style="list-style-type: none">• Severe and persistent mental illness listed in the diagnostic nomenclature (current diagnosis per DSM IV) that seriously impairs their functioning in the community. Priority is given to people with schizophrenia, other psychotic disorders (e.g., schizoaffective disorder), bipolar disorder and/or major or chronic depression, because these illnesses more often cause long-term psychiatric disability.• Priority is also given to individuals with continuous high service needs that are not being met in more traditional service settings.• AOT individuals with ACT in their order will get admission priority.• Recipients with serious functional impairments should demonstrate at least one of the following conditions:

- Inability to consistently perform practical daily living tasks required for basic adult functioning in the community without significant support or assistance from others such as friends, family or relatives.
- Inability to be consistently employed at a self-sustaining level or inability to consistently carry out the homemaker role.
- Inability to maintain a safe living situation (e.g., repeated evictions or loss of housing).
- Recipients with continuous high service needs should demonstrate one or more of the following conditions:
 - Inability to participate or succeed in traditional, office-based services or case management.
 - High use of acute psychiatric hospitals (two hospitalizations within one year, or one hospitalization of 60 days or more within one year).
 - High use of psychiatric emergency or crisis services.
 - Persistent severe major symptoms (e.g., affective, psychotic, suicidal or significant impulse control issues).
 - Co-existing substance abuse disorder (duration greater than 6 months).
 - Current high risk or recent history of criminal justice involvement.
 - Court ordered to participate in Assisted Outpatient Treatment.
 - Inability to meet basic survival needs or homeless or at imminent risk of becoming homeless.
 - Residing in an inpatient bed or in a supervised community residence, but clinically assessed to be able to live in a more independent setting if intensive community services are provided.
 - Currently living independently but clinically assessed to be at immediate risk of requiring a more restrictive living situation (e.g., community residence or psychiatric hospital) without intensive community services.
- Exclusion criteria: Individuals with a primary diagnosis of a personality disorder(s), substance abuse disorder or mental retardation are not appropriate for ACT.

Continuing Stay Guidelines

- Initial authorization criteria continue to be met.
- An immediate needs assessment and documentation of a plan to address these immediate needs is completed within 7 days of receipt of a referral.
- A Comprehensive Assessment and Comprehensive Service Plan is completed within 30 days of admission, with specific objectives and planned services to achieve recovery goals.
- The Comprehensive Assessment and Comprehensive Service Plan is reviewed and updated at least every 6 months which includes status of progress towards set goals, adjustment of goals and treatment plan if no progress is evident.
- There is evidence of coordination of care with other providers/stakeholders such as PCPs, specialty providers, inpatient treatment team, AOT, community supports, family, etc.
- When clinically indicated psychopharmacological intervention has been evaluated/instituted.

Discharge Guidelines

- ACT recipients meeting any of the following criteria may be discharged:
 - Individuals who demonstrate, over a period of time, an ability to function in major life roles (i.e., work, social, self-care) and can continue to succeed with less intensive service.
 - Individuals who move outside the geographic area of the ACT team's responsibility. The ACT team must arrange for transfer of mental health service responsibility to an appropriate provider and maintain contact with the recipient until the provider and the recipient are engaged in this new service arrangement.
 - Individuals who need a medical nursing home placement, as determined by a physician.

- Individuals who are hospitalized or locally incarcerated for three months or longer. However, an appropriate provision must be made for these individuals to return to the ACT program upon their release from the hospital or jail.
- Individuals who request discharge, despite the team's best, repeated efforts to engage them in service planning. Special care must be taken in this situation to arrange alternative treatment when the recipient has a history of suicide, assault or forensic involvement.
- Individuals who are lost to follow-up for a period of greater than 3 months after persistent efforts to locate them, including following all local policies and procedures related to reporting individuals as "missing persons."
- For all persons discharged from ACT to another service provider within the team's primary service area or county, there is a three-month transfer period during which recipients who do not adjust well to their new program may voluntarily return to the ACT program¹. During this period, the ACT team is expected to maintain contact with the new provider, to support the new provider's role in the recipient's recovery and illness management goals.
- The decision not to take medication is an insufficient reason for discharging an individual from an ACT program.
- If a recipient of ACT services is under a court order to receive Assisted Outpatient Treatment, any discharge must be planned in coordination with the County's AOT program administrator.

ACT and Health Homes

Individuals receiving ACT services may also be eligible for Health Home (HH). The ACT bundled rate includes care management services and MMCOs/HARPs will not pay additional for Health Home Care Management while an ACT recipient is enrolled in a Health Home. Separate guidance outlines processes for individuals enrolled in ACT and HH, and can be found [here](#).

HH+ services will be available for adults with SMI and who meet certain indicators for high need, such as risk for disengagement from care and/or poor outcomes (e.g., ACT stepdown). Individuals transitioning off ACT to a lower level of service may benefit from the enhanced support of HH+ for up to 12 consecutive months. Go to the following [link](#) for details.

ACT and HARP

All HARP enrollees must receive a BH HCBS Eligibility Assessment upon enrollment in the HARP and annually thereafter. 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 (irrespective of an individual's Health Home enrollment status) for as long as the individual is receiving ACT services as described below:

1. If an individual is receiving ACT services when he/she first enrolls in a HARP, the ACT team will assume the HH care management responsibilities. This means the ACT team will be responsible for completing the BH HCBS Eligibility Assessment, which must be completed for all HARP members upon enrollment and annually thereafter. BH HCBS Eligibility Assessments are completed because:
 - a. The assessment information should be used to support care planning; and

¹ Prior authorization is required for return to ACT level of care. MMCO/HARPs should follow OMH guidelines about this and should consult with NYS OMH and the LGU/SPOA prior to issuing a denial in this circumstance. If the review indicates the individual does not need ACT level of care, an alternative must be developed if the current alternative is not working.

- b. The assessment also elicits information required for the NYS MMCO/HARP performance measurement program.
2. If the BH HCBS Eligibility Assessment determines that the individual is eligible for BH HCBS and the individual will continue to receive ACT services, no further action is needed for as long as the individual is receiving ACT services. BH HCBS Eligibility Assessments are required annually for all HARP enrolled individuals. Individuals receiving ACT services are not eligible to receive most BH HCBS (ACT recipients can receive short-term crisis respite and intensive crisis respite services).
3. ACT Teams are responsible for comprehensive discharge planning for individuals receiving ACT services. At the point that ACT teams are actively planning for an individual's discharge from ACT, the ACT Team may use the current BH HCBS Eligibility Assessments (if completed within the year) or conduct a BH HCBS Eligibility Assessment to determine whether the individual will be eligible for BH HCBS post-discharge from ACT.
4. 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 Manager (HHCM). The HHCM will complete the BH HCBS Plan of Care (See [Discharge Workflow for ACT Recipients Enrolled in HARP](#) for more detail).

BH HCBS should be used as a transition resource.

ACT and Assisted Outpatient Treatment (AOT)

AOT individuals with ACT included in their court ordered treatment plan will receive admission priority with the local SPOA. Individuals on ACT Teams with active AOT court orders are not eligible for the Health Home Plus (HH+) billing rate as care management is included in the bundled rate for ACT services.

ACT and 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.

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 the Office of Mental Health (OMH). Training is delivered via in-person and distance- learning modalities. See "ACT Resources" below for more information.

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ACT Resources

Listed here are additional resources and recommended reading:

- [NYS OMH ACT Program Guidelines](#)
- [ACT Standards of Care](#)
- [ACT Billing Regulations](#)
- Guidance for Providers regarding ACT Joining [Health Homes](#)/Providing [Care Management](#):
- [ACT Institute](#)