



## Supplemental Medicaid Managed Care Act Guidance

1. Guidance for MMCOs/HARPs and ACT Teams regarding enrollees referred for services and placed on the SPOA wait list **prior to 10/1/15**

There remains a wait list for ACT assignments in NYC managed by DOHMH SPOA. We are currently unsure how many of these individuals are covered by Managed Care, and are working with DOHMH to clarify this. It is the expectation that upon receipt of a referral from SPOA, the ACT Teams will contact the Medicaid Managed Care Organization (MMCO) or HARP to obtain Prior Authorization. As stated in the OMH guidance issued 8/6/15, 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, SPOA will assign to the available ACT team and the MMCO/HARP will execute an out-of-network agreement.

2. Level of Care Determination for Referrals to ACT **initiated after 10/1/15**

It has come to our attention that MMCOs/HARPs are experiencing systematic difficulties with issuing Level of Care determinations for new ACT referrals as required in the OMH guidance issued 8/6/15.

To ensure the smooth flow of referrals:

- Agencies making SPOA referrals for ACT are required to discuss the referral with the MMCO/HARP and receive approval for the ACT level of care.
- MMCOs/HARPs are required to document this approval in their system.
- MMCO/HARPs may develop and use an approval letter consistent with general notice requirements in the model contract, PHL and 42 CFR 438.
- MMCO/HARPs are expected to provide a list of In-Network ACT Teams to the referring agency.
- It is the expectation that MMCO/HARPs will collaborate with Health Homes and SPOA to ensure engagement in Care Coordination and appropriate treatment while individuals are on the wait list for ACT services.

**Inability to issue communication of approval should not delay submission of a SPOA application. If there are problems around this, please contact OMH immediately for assistance.**

MMCO/HARPs should identify an individual to be the point person for addressing problems with the flow of ACT authorization and notify Tom Smith, MD by Thursday, 10/22/15.

3. Prior Authorization requirements for MMCO/HARP enrollees with AOT orders

AOT-ordered ACT will require Level of Care and Prior Authorizations by MCOs. Authorizations are often the only way that MCOs know someone is getting a service and they need to enter authorizations into their system so that services are authorized, and claims paid. We expect MMCO/HARPs to comply with AOT orders, but an AOT order with ACT in it does not mean ACT is necessarily the appropriate treatment for the duration of the order. MMCO/HARP UM will work with ACT Teams and LGU AOT monitors to determine how long the person should stay in ACT and providers will work with local LGU AOT monitors to modify orders as needed to reflect changes in the AOT treatment plan.

4. Guidance regarding non-SPOA teams

There is one non-SPOA team in NYC – the Nathaniel ACT Team operated by CASES. This team does not accept referrals from SPOA. Since it functions as an Alternative to Incarceration, referrals to this team come via the court system. Staff from the Nathaniel ACT Team review potential recipients to ensure ACT criteria are met. If so, a plea is entered into where the sentence is deferred for the duration of treatment on an ACT Team, up to 24 months. Most recipients do not have Medicaid upon admission to the ACT Team, but the team helps with obtaining Medicaid and billing is initiated when Medicaid becomes active. The ACT team should request authorization from the MMCO/HARP immediately upon the individual's enrollment in the MMCO/HARP, even if the person has already been receiving ACT services. It is the expectation that MMCO/HARPs would authorize ACT services at the onset of treatment or Medicaid eligibility, and that the ACT Team will work with both the MMCO/HARP and the Court to determine duration of ACT services.



## **Guidelines for New York City Medicaid Managed Care Organizations and Health and Recovery Plans regarding utilization management for Assertive Community Treatment**

Assertive Community Treatment (ACT) is one of the specialty behavioral health services that will be carved into managed care. Mainstream Managed Care Organizations (MMCOs) and Health and Recovery Plans (HARPs) operating in New York City will assume management of this service in the adult Medicaid Managed Care Program beginning October 1, 2015. MMCOs and HARPs operating in other counties will begin managing specialty behavioral health services including ACT according to the previously established NYS timeline for integrated managed care.

### **What is Assertive Community Treatment?**

ACT teams deliver comprehensive services to individuals with serious mental illness 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 recipient recovery through an individualized approach that provides recipients 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 recipients have a serious and persistent psychiatric disorder and 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. ACT is especially beneficial for the high-need individuals who require complex multi-faceted care. The population served by ACT comprises a small subset of individuals with serious mental illness. Most people 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 Home and Community Based (HCBS) services, these and other behavioral health services will help move 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 June 2015 there are 80 licensed ACT teams serving approximately 5,000 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; DOHMH in NYC). 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. MMCO/HARP members should be referred for ACT services as follows:

1. The referring provider (e.g., hospital provider, Health Home care manager, or other behavioral health provider) contacts MMCO/HARP to request ACT referral. Provider and MMCO/HARP care manager review whether the member meets ACT level of care admission criteria. MMCO/HARP notifies the referring provider of level of care determination within 24 hours.

2. 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.
3. If the MMCO/HARP approves ACT level of care, the MMCO/HARP provides the referring provider with list of in-network ACT teams.
4. The referring provider submits ACT application with notice of MMCO/HARP level of care authorization 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.
5. If SPOA disagrees with the MMCO/HARP approval of ACT level of care, the SPOA care manager will contact the MMCO/HARP care manager to review the application and arrive at a consensus. If a consensus cannot be reached, the MMCO/HARP's decision regarding authorization of ACT services will be final. Individuals have the right to appeal such denials as per existing NYS Medicaid Managed Care Program regulations.
6. If 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 wait list for ACT. In NYC, this process will be completed within 1 business day.
7. When the member is assigned to a wait list, 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.
8. 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, SPOA will assign to the available ACT team and the MMCO/HARP will execute an out-of-network agreement. If an out-of-network ACT team refuses to contract with the MMCO/HARP, SPOA will assign to the next available ACT team.
9. The accepting ACT team will contact the MMCO/HARP within 7 days prior to the date of admission to confirm the prior authorization and determine a timeframe for concurrent review.
10. The MCO will notify the local SPOA when the individual is discharged from an ACT program.

### **Utilization Management for ACT**

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

1. Immediate needs assessment should be completed within 7 days of admission
2. Initial Comprehensive Service Plan should be completed within 30 days of admission
3. Comprehensive Service Plan reviewed and revised as indicated every 6 months

The table on the following page 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 Home and Community Based Services being 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.

**ACT Guidelines on Admission, Continuing Stay and Discharge**

Admission Guidelines	Continuing Stay Guidelines	Discharge Guidelines
<ul style="list-style-type: none"> <li>- 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.</li> <li>- Priority is also given to individuals with continuous high service needs that are not being met in more traditional service settings</li> <li>- AOT individuals with ACT in their order will get admission priority</li> <li>- Recipients with serious functional impairments should demonstrate at least one of the following conditions:             <ul style="list-style-type: none"> <li>o 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.</li> <li>o Inability to be consistently employed at a self-sustaining level or inability to consistently carry out the homemaker role.</li> <li>o Inability to maintain a safe living situation (e.g., repeated evictions or loss of housing).</li> </ul> </li> <li>- Recipients with continuous high service needs should demonstrate one or more of the following conditions:             <ul style="list-style-type: none"> <li>o Inability to participate or succeed in traditional, office-based services or case management.</li> <li>o High use of acute psychiatric hospitals (two hospitalizations within one year, or one hospitalization of 60 days or more within one year).</li> <li>o High use of psychiatric emergency or crisis services.</li> <li>o Persistent severe major symptoms (e.g., affective, psychotic, suicidal or significant impulse control issues).</li> <li>o Co-existing substance abuse disorder (duration greater than 6 months).</li> <li>o Current high risk or recent history of criminal justice involvement.</li> <li>o Court ordered pursuant to participate in Assisted Outpatient Treatment.</li> <li>o Inability to meet basic survival needs or homeless or at imminent risk of becoming homeless.</li> <li>o 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.</li> <li>o 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.</li> </ul> </li> <li>- Exclusion criteria: Individuals with a primary diagnosis of a personality disorder(s), substance abuse disorder or mental retardation are not appropriate for ACT</li> </ul>	<ul style="list-style-type: none"> <li>- Initial authorization criteria continue to be met.</li> <li>- An immediate needs assessment and documentation of a plan to address these immediate needs is completed within 7 days of receipt of a referral.</li> <li>- A Comprehensive Assessment is completed within 30 days of admission, with specific objectives and planned services to achieve recovery goals.</li> <li>- The 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.</li> <li>- There is evidence of coordination of care with other providers/stakeholders such as PCPs, specialty providers, inpatient treatment team, AOT, community supports, family, etc.</li> <li>- When clinically indicated psychopharmacological intervention has been evaluated/instituted.</li> </ul>	<ul style="list-style-type: none"> <li>- ACT recipients meeting any of the following criteria may be discharged:             <ul style="list-style-type: none"> <li>o 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.</li> <li>o 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.</li> <li>o Individuals who need a medical nursing home placement, as determined by a physician.</li> <li>o 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.</li> <li>o 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.</li> <li>o 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."</li> </ul> </li> <li>- 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 program. 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.</li> <li>- The decision not to take medication is not a sufficient reason for discharging an individual from an ACT program.</li> <li>- 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.</li> </ul>

### **ACT and Health Homes**

Many individuals receiving ACT services are also eligible for Health Homes (HHs) and HH enrollment is strongly encouraged. However, the ACT bundled rate includes care coordination services and MMCOs/HARPs will not pay for Health Home Care Coordination while an ACT recipient is enrolled in a Health Home. Separate guidance will outline procedures for ACT teams and HHs related to sharing care coordination payments.

All HARP enrollees must receive a Home and Community Based Services (HCBS) Eligibility Assessment upon enrollment in the HARP and annually thereafter. The HH care manager will complete these assessments for the majority of HARP enrollees. However, if an individual is receiving ACT services when enrolled in a HARP, the ACT team will assume responsibility for the HCBS Eligibility Assessment process 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 HCBS Eligibility Assessment, which must be completed for all HARP members upon enrollment in the HARP and at least annually thereafter.
2. If the Eligibility Assessment determines that the individual is eligible for HCBS, but the individual is going to continue to receive ACT services, the Full HCBS Assessment will not be completed for as long as the individual is receiving ACT services. Individuals receiving ACT services are not eligible to receive most HCBS (ACT recipients can receive short-term crisis respite, intensive crisis respite, and non-medical transportation services) but still must complete the initial and annual HCBS Eligibility Assessments because:
  - a. The assessment information should be used to support care planning; and
  - b. The assessment also elicits information required for the NYS MMCO/HARP performance measurement program.
3. When a HARP enrollee is being discharged from an ACT service, the ACT team care manager will review the latest HCBS Eligibility Assessment. If the individual's circumstances and/or clinical status have changed substantially, the ACT team care manager will repeat the HCBS Eligibility Assessment. Using either the new or prior HCBS Eligibility Assessment (which always must have been completed within the prior 12 months), the ACT care manager will determine whether the individual meets the HCBS eligibility criteria and if so, the ACT team care manager will complete the HCBS Full Assessment and develop an HCBS plan of care to supplement the ACT discharge plan.
4. Prior to discharge, the ACT team will ensure the individual is assigned a Health Home care manager or document a declination of service.
5. The HCBS plan of care along with the ACT discharge plan will be forwarded to the Health Home care manager as part of a "warm hand-off." The Health Home care manager will assume care management and HCBS plan of care responsibilities at that time.

### **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 coordination is included in the bundled rate for ACT services.

### **ACT and Personalize 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.

### **ACT resources**

Listed here are additional resources and recommended reading:

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