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Memorandum

To: Rest-of-State Managed Care Behavioral Health Medical Directors

From: Thomas Smith, MD, Medical Director, NYSOMH Division of Managed Care

Date: July 7, 2016

Re: Rest-of-State MCO Behavioral Health Guidance re Utilization Management for ACT

Enclosed is guidance for Rest-of-State (non-NYC) Medicaid Mainstream Managed Care Organizations (MMCOs) and Health and Recovery Plans (HARPs) regarding utilization management for Assertive Community Treatment (ACT). NYS has issued prior guidance to NYC MMCOs and HARPs on ACT utilization management, but Rest-of-State plans should refer to these new guidelines which incorporate specific roles and responsibilities of local government units (LGUs) and Single Point of Access (SPOA) programs.

Please let us know if you have any questions.

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Guidelines for Rest of State 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 outside of New York City will assume management of this service in the adult Medicaid Managed Care Program beginning July 1, 2016.

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 April 2016 there are 83 licensed ACT teams serving over 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). 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 Utilization Management (UM) staff to facilitate communication and coordination with ACT teams and LGUs/SPOAs.

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) makes a SPOA referral and contacts MMCO/HARP to request an ACT level of service determination. The referring provider and MMCO/HARP care 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 LGU/SPOA that a level of care determination for ACT admission has been made. The MMCO/HARP must make the level of service determination within 24 hours.

2. If the MMCO/HARP does not approve ACT level of care, the MMCO/HARP notifies the LGU/SPOA so that the LGU/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.

3. If the MMCO/HARP approves the level of service determination for ACT level of care, the LGU/SPOA determines the availability of an ACT slot. The MMCO/HARP ensures that the referring provider and SPOA have up-to-date lists of in-network ACT teams.

4. If the LGU/SPOA disagrees with the MMCO/HARP approval of ACT level of care, the LGU/SPOA will contact the MMCO/HARP care manager, 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 authorization of ACT services will be final.

5. If the LGU/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.

6. When the member is assigned to a wait list, the LGU/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.

7. The LGU/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 LGU/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, the LGU/SPOA will assign to the next available ACT team.

8. If a recipient of ACT services is under a court order to receive Assisted Outpatient Treatment, 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 as 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/SPOA for discussion around a recommended change in level of care (and a modified the court order). In the event of a continued disagreement about appropriateness of ACT services for the individual, the decision of the

LGU/SPOA 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.

9. The accepting ACT team will contact the MMCO/HARP within 7 days prior to the date of admission to obtain the prior authorization and determine a timeframe for concurrent review.

10. It is the responsibility of the ACT team to notify the LGU/SPOA and the MMCO/HARP 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.

Most individuals who are appropriate for ACT level of care will need it for at least a year or 2, many will need it even longer than that. The general expectation is 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.

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 receipt of referral
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 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 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
• 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 pursuant 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 is completed within 30 days of admission, with specific objectives and planned services to achieve recovery goals.
- 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.
- 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 Guideline

- 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 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.
- The decision not to take medication is not a sufficient 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.

*****Prior authorization is required. MMCO/HARPs should follow prior 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.
**Individuals served by ACT are people who need the support and oversight of the ACT service.

ACT and Health Homes
Many individuals receiving ACT services are also eligible for Health Homes (HHs) and the benefits of HH enrollment should be fully explained to the individuals. HH enrollment is strongly encouraged and individuals should be given the opportunity for informed choice. The ACT bundled rate includes care coordination services and MMCOs/HARPs will not pay for Health Home Care Management while an ACT recipient is enrolled in a Health Home. Separate guidance will outline procedures for ACT teams and HHs.

ACT and HARP
All HARP enrollees must receive a Behavioral Health Home and Community Based Services (BH 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 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 (initial assessment) and annually thereafter. BH HCBS Eligibility Assessments are completed 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.

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 Community Mental Health Assessment (CMHA) will not be completed for as long as the individual is receiving ACT services. 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 providers are actively planning for an individual's discharge from ACT, the ACT Team will conduct an HCBS Eligibility Assessment to determine whether the individual will be eligible for BH HCBS post-discharge from ACT, and for which tier of BH HCBS the individual may qualify.

4. The ACT team will make BH HCBS referrals as appropriate. The ACT team will initiate the warm hand-off process by making a referral to a Health Home Care Manger (HHCM) and developing an initial plan of care (POC). The HHCM will complete the NYS CMHA and Adult BH HCBS Plan of Care (See Discharge Workflow for ACT Recipients Enrolled in HARP for more detail).

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 Standards of Care

ACT Billing Regulations

ACT Institute

Guidance for Providers regarding ACT:

- Joining Health Homes
- Providing Care Management