

5160-27-04

Mental health assertive community treatment service.

- (A) For the purposes of medicaid reimbursement, assertive community treatment (ACT) refers to the evidence based model of delivering comprehensive community based behavioral health services to adults with certain serious and persistent mental illnesses who have not benefited from traditional outpatient treatment. The ACT model utilizes a multidisciplinary team of practitioners to deliver services to eligible individuals.
- (B) For the purposes of this rule, collateral contact occurs when the practitioner contacts individuals who play a significant role in a Medicaid recipient's life. The information gained from the collateral contact can provide insight into treatment or the basic psychoeducation provided to that collateral contact can assist with the treatment of the Medicaid recipient.
- (C) The ACT team is the sole provider to ACT recipients of outpatient behavioral health services, including level one outpatient services as defined by the american society of addiction medicine.
- (D) ACT services include but are not limited to the following:
- (1) Psychiatry and primary care as related to the mental health or substance use disorder diagnoses.
 - (2) Service coordination.
 - (3) Crisis assessment and intervention.
 - (4) Symptom assessment and management.
 - (5) Community based rehabilitative services.
 - (6) Education, support, and consultation to families, legal custodians, and significant others who are part of the recipient's support network.
- (E) The desired outcomes of ACT intervention for medicaid recipients include but are not limited to:
- (1) Achieving and maintaining a stable life in a community based setting.
 - (2) Reducing the need for inpatient hospital admission and emergency department visits.
 - (3) Improving mental and physical health status, and improving life satisfaction.

(F) A medicaid recipient may receive ACT services when determined by the ODM designated entity to have met all of the following:

- (1) The recipient has a diagnosis of schizophrenia spectrum, bipolar spectrum, or major depressive disorder with psychosis, and
- (2) The recipient has a supplemental security income or social security disability insurance determination or has a score of two or greater on at least one of the items in the "mental health needs" or "risk behaviors" sections or a score of three on at least one of the items in the "life domain function" section of the adult needs and strengths assessment (ANSA) administered by an individual with a bachelor's degree or higher and with training in the administration of the assessment, and
- (3) The recipient has one or more of the following:
 - (a) Two or more admissions to a psychiatric inpatient hospital setting during the past twelve months, or
 - (b) Two or more occasions of utilizing psychiatric emergency services during the past twelve months, or
 - (c) Significant difficulty meeting basic survival needs within the last twenty-four months, or
 - (d) History within the past two years of criminal justice involvement including but not limited to arrest, incarceration, or probation, and
- (4) The recipient experiences one or more of the following:
 - (a) Persistent or recurrent severe psychiatric symptoms, or
 - (b) Coexisting substance use disorder of more than six month in duration, or
 - (c) Residing in an inpatient or supervised residence, but clinically assessed to be able to live in a more independent living situation if intensive services are provided, or
 - (d) At risk of psychiatric hospitalization, institutional or supervised residential placement if more intensive services are not available or,
 - (e) Has been unsuccessful in using traditional office-based outpatient services; and

(5) The recipient is eighteen years of age or older at the time of ACT enrollment.

(G) Prior authorization of ACT services.

(1) The provider must submit a request for prior authorization and receive approval from the ODM designated entity before ACT services can be rendered. The request for prior authorization must be accompanied by the appropriate documentation which includes, but is not limited to, the ANSA results or the documentation that supports the social security determination. The maximum amount of ACT service which may be prior authorized at any one time is twelve months.

(2) At the conclusion of the previous ACT service period, the provider agency may request additional ACT service to be prior authorized by the ODM designated entity

(3) The provider may begin submitting claims for medicaid reimbursement of ACT services for dates of service within the subsequent calendar month following the date on which prior authorization is approved by the ODM designated entity.

(H) Disenrollment of a recipient from ACT. Upon planned or unplanned disenrollment of an ACT recipient, the ACT team shall document the circumstances regarding disenrollment in the recipient's medical record.

(1) A planned disenrollment from ACT occurs when a recipient, or recipient's guardian and ACT team members mutually agree to the termination of ACT services and transition of the recipient to a different care setting, provider, or benefit package. A planned disenrollment is appropriate when:

(a) The recipient has successfully reached established goals for disenrollment and the recipient and/or their guardian and ACT team members agree to the discharge from ACT, or

(b) The recipient moves outside the geographic area of the ACT team's responsibility. In such cases, the ACT team shall arrange to transfer mental health and substance use disorder service responsibility to another ACT program or other provider wherever the recipient is moving. The ACT team shall maintain contact with the recipient until the transfer is complete, or

(c) The recipient or their guardian requests a disenrollment, or

(d) The recipient is determined by the ODM designated entity to no longer meet the eligibility or medical necessity criteria for ACT.

- (2) As part of a planned disenrollment, the ACT team shall document that the recipient has actively participated in disenrollment activities by documenting in the recipient's medical record the following information:
- (a) The reason(s) for the recipient's disenrollment as stated by both the recipient and the ACT team.
 - (b) The recipient's progress toward the goals set forth in the treatment plan.
 - (c) Documentation that the recipient's behavioral health care is being linked and transferred to a provider other than the ACT team.
 - (d) The signature of the recipient or their guardian, the ACT team leader, and the psychiatric prescriber.
- (3) A recipient's disenrollment from ACT may be unplanned and due to circumstances facilitated by:
- (a) The inability of the ACT team to locate the recipient for more than forty-five days, or
 - (b) The recipient's incarceration, hospitalization or admission to a residential substance use disorder treatment facility. In these circumstances, the primary responsibility for the recipient's health care is transferred to the aforementioned setting.
 - (i) The ACT team is expected to maintain contact with the recipient to assist with transition between settings if the recipient is likely to be discharged and resume service from the ACT team within two months.
 - (ii) If the recipient's stay is predicted to be longer than two months, the recipient shall be disenrolled from the ACT team.
 - (iii) The recipient may be re-enrolled with the ACT team when discharged from the incarcerated, inpatient or residential setting. Any re-enrollment shall follow the eligibility determination criteria described in paragraph (F) of this rule.
- (4) Except for services found in paragraph (O) of this rule, a recipient may not obtain behavioral health services from a provider other than the ACT team unless the recipient is disenrolled from ACT services.

(5) The provider must inform the ODM designated entity of disenrollment within three business days of the discharge date. The ODM designated entity shall deactivate the authorization for the ACT service. Failure to timely dis-enroll the recipient from ACT may result in claim denial for other mental health or substance use disorder services.

(I) A provider furnishing ACT services must meet both of the following criteria:

- (1) Meets the eligibility requirements found in paragraphs (A)(1) or (A)(2) of rule 5160-27-01 of the Administrative Code; and
- (2) Employs one or more teams of mental health and substance use disorder practitioners who comprise the ACT treatment team.

(J) Each team must meet the following criteria:

(1) Completed an on-site fidelity review within the previous twelve months by an independent validation entity recognized by ODM. In year one of an ACT team's participation with Ohio Medicaid the team must achieve an average fidelity score of at least 3.0 on the dartmouth assertive community treatment scale (DACTS) as determined via an on-site fidelity review performed by an independent validation entity recognized by ODM. The DACTS fidelity scale and protocol can be found at www.medicaid.ohio.gov.

(a) Fidelity reviews of ACT teams must be repeated every twelve months from the report date of the previous fidelity review.

(b) In year three and subsequent years of ACT team participation with the Ohio medicaid program, each ACT team must achieve and maintain an average fidelity score of at least 4.0.

(c) An ACT team must have documented evidence of fidelity compliance prior to submitting any prior authorization requests for recipients of ACT services.

(2) Each team shall have a designated full-time team leader who may serve in that capacity with only one team.

(a) An ACT team leader shall have a national provider identification number and be actively enrolled as an Ohio medicaid provider.

(b) A team leader shall have psychiatric training and shall hold one of the following valid licenses from the appropriate Ohio professional licensure board or licensure equivalents for ACT teams located in other states:

- (i) Licensed independent social worker.
- (ii) Licensed independent marriage and family therapist.
- (iii) Licensed professional clinical counselor.
- (iv) Licensed psychologist.
- (v) Physician – medical doctor, psychiatrist, doctor of osteopathy.
- (vi) Clinical nurse specialist
- (vii) Certified nurse practitioner.
- (viii) Physician assistant.
- (ix) Registered nurse.

(c) Team leaders who are licensed in accordance with paragraph (A)(5) of rule 5160-27-01 of the Administrative Code but do not have independent licensure status from one of the boards referenced in paragraph (A)(5) of rule 5160-27-01 must receive approval from ODM before the ACT team to which they are assigned can begin billing Ohio medicaid.

(3) ACT teams that employ peer recovery supporters must ensure that they meet the criteria and requirements for the peer recovery support services set forth in rule 5160-43-09 of the Administrative Code.

(4) ACT teams must have a caseload no greater than one hundred and twenty and must maintain an average caseload ratio of one practitioner for every ten ACT recipients. Upon request from the ODM, the ACT team must provide to the ODM or its designated entity the ACT team caseload size and composition of medicaid and non-medicaid enrollees.

(K) ODM reserves the right to suspend or terminate the payment of ACT services and to require subsequent review of an ACT team's fidelity rating if ODM has reason to believe that the ACT team's fidelity to the DACTS model described in paragraph (J) (1) of this rule may be in question. ODM may, at its discretion, suspend payment of ACT medicaid claims from the provider agency employing the ACT team until such time as ODM receives documentation from its independent validation entity that the team does meet the fidelity criteria described in paragraph (J)(1) of this rule.

(L) A provider employing an ACT team may bill up to four ACT units per month per recipient when all clinical and billing requirements for each unit are met. The billing

of ACT units are subject to the following limits per provider category, per recipient, per month:

(1) Not more than one unit may be billed per medicaid recipient per month for services rendered by the ACT team medical prescriber including physician, clinical nurse specialist, certified nurse practitioner, or physician assistant operating within their respective scopes of practice.

(2) Not more than one unit per medicaid recipient per month may be billed for services rendered by any one of the following ACT team members: psychologist, licensed independent social worker, licensed social worker, licensed clinical social worker, licensed professional counselor, licensed professional clinical counselor, licensed independent clinical counselor, licensed independent marriage and family therapist, licensed marriage and family therapist, licensed practical nurse, registered nurse, licensed independent chemical dependency counselor, licensed chemical dependency counselor II or licensed chemical dependency counselor III.

(3) Not more than two units per medicaid recipient per month may be billed by an ACT team member not listed in paragraphs (L)(1) or (L)(2) of this rule. This unit category includes bachelor degree practitioners, and peer recovery practitioners.

(M) The medicaid payment rates for ACT are stated in the appendix to rule 5160-27-03 of the Administrative Code. Payment for services provided by authorized ACT teams is only available for dates of services on or after January 1, 2018.

(N) ACT teams shall maintain regular contact and deliver all medically necessary outpatient mental health and substance use disorder services and supports to ACT recipients enrolled with their team. However, only services and supports rendered in person, face-to-face, by an ACT team member are billable to Ohio Medicaid according to the requirements stated in section (L) of this rule. While ACT teams are encouraged to utilize the delivery of services and supports via telephone or secure video conference, these services and supports are not billable to the Ohio medicaid program.

(O) When a recipient is enrolled on an ACT team, no other medicaid community behavioral health services, as defined in Chapter 5160-27 of the Administrative Code, are eligible for reimbursement except:

(1) Supported employment as identified on a recipient's specialized recovery services program treatment plan if applicable, as described in rule 5160-43-01 of the Administrative Code.

(2) Substance use disorder services that are not considered part of the benefit package encompassed under level one of the American Society of Addiction Medicine (ASAM) as defined in rule 5160-27-09 of the Administrative Code. Prior authorization from the ODM designated entity is required.

(3) Crisis services furnished by a provider other than the billing provider agency employing the ACT team.

(P) Documentation requirements for ACT.

(1) Documentation in the recipient's medical record of the services provided by the ACT team must meet the requirements stated in this paragraph as well as those stated in rules 5160-1-27 and 5160-8-05 of the Administrative Code

(2) The ACT team must develop a specific treatment plan for each enrolled recipient. The treatment plan must, at a minimum, meet the requirements of rule 5160-8-05 of the Administrative Code plus the following additional requirements:

(a) The treatment plan shall be individualized based on the recipient's needs, strengths, and preferences and shall set measurable long-term and short-term goals and specify approaches and interventions necessary for the recipient to achieve the recipient goals. The treatment plan shall also identify who will carry out the approaches and interventions.

(b) The treatment plan shall address, at a minimum, the following key areas:

(i) Psychiatric illness or symptom reduction.

(ii) Stable, safe, and affordable housing.

(iii) Activities of daily living.

(iv) Daily structure and activities, including employment if appropriate.

(v) Family and social relationships.

(c) The treatment plan shall be reviewed and revised by a member of the ACT team with the recipient whenever a change is needed in the recipient's course of treatment or at least every six months. In conjunction with a treatment plan review, the ACT team member shall prepare a summary of the recipient's progress, goal attainment, effectiveness of the intervention and recipient's satisfaction with the ACT team interventions since enactment of the previous treatment plan.

(d) The treatment plan, and all subsequent revisions of it, shall be reviewed and signed by the recipient and the ACT team practitioner.

(O) The following activities performed by members of the ACT team are not eligible for reimbursement:

- (1) Time spent attending or participating in recreational activities.
- (2) Services provided to teach academic subjects or as a substitute for educational personnel, including but not limited to a teacher, teacher's aide, or an academic tutor.
- (3) Habilitative services for the recipient to acquire, retain, and improve the self-help, socialization, and adaptive skills necessary to reside successfully in community settings.
- (4) Child care services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision.
- (5) Respite care.
- (6) Transportation for the recipient or family.
- (7) Services provided to children, spouse, parents, or siblings of the eligible recipient under treatment or others in the eligible recipient's life to address problems not directly related to the eligible recipient's issues and not listed in the eligible recipient's ACT treatment plan.
- (8) Art, movement, dance, or drama therapies.
- (9) Services provided to collaterals of the recipient.
- (10) Contacts that are not medically necessary.
- (11) Any service outside the responsibility of the ACT team.
- (12) Vocational training and supported employment services, unless the recipient is enrolled in the specialized recovery services program as described in rule 5160-43-01 of the Administrative Code.
- (13) Crisis intervention provided by the provider agency employing the ACT team.

Effective:

Five Year Review (FYR) Dates:

Certification

Date

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