Vaya Health

Assertive Community Treatment Team Step Down (ACT-SD)

H0040 U5
H0040 TS Encounters

Service

ACT-SD service supports members whose symptom severity no longer merits the intensity of ACT interventions but cannot be adequately addressed with Outpatient Therapy alone. ACT-SD is a community based, person-centered and recovery-focused service designed to assist the member in maintaining stable functioning and wellness while providing support for continued recovery. ACT-SD includes psychiatric services, clinical case management, supportive housing (including tenancy supports), Wellness Management and Recovery (WMR) and 24/7 Crisis Services (provided by the ACT Team that is serving the member prior to step-down (the "home" ACT Team), not just the members of the identified ACT-SD team). ACT-SD includes "first responder" crisis response 24 hours a day/7 day a week/365 days a year. Individual staff who are members of the member's home ACT team also provide the ACT-SD services for the member once they transition to ACT-SD. The needs of ACT-SD members are reviewed in the home ACT Team meetings at least weekly. ACT-SD provides at minimum three face-to-face contacts per month, depending on the needs identified. For members receiving Tenancy Supports the provider will provide at minimum four face to face contacts per month, and then can taper as the member stabilizes. Most of these contacts are in the home or community. Given that ACT-SD is not an all-inclusive, comprehensive, bundled service, concurrent services deemed medically necessary can be provided including: Psychosocial Rehabilitation (PSR); Individual Placement and Support - Supported Employment (IPS-SE); Specialized Outpatient Therapy (e.g., Dialectical Behavior Therapy [DBT], Cognitive Behavioral Therapy [CBT] for Psychosis, Substance Abuse counseling); Opioid treatment; Detoxification Services, Facility-Based Crisis; Substance Use Disorder (SUD) residential or adult mental health residential programs. Only large and medium-size ACT teams that have full fidelity (3.7 or above on the TMACT) can provide ACT-SD and are considered the "home" ACT team for the member.

ACT-SD allows for a gradual transition to Outpatient Therapy for those members who maintain high levels of recovery with limited use of ACT services. Often, the anxiety about the prospect of transitioning out of ACT results in acute exacerbations in symptoms. The ACT-SD intervention provides enough support to minimize the likelihood of this occurring. ACT-SD Wellness Management and Recovery (WMR) services are the foundation of ACT-SD. The service goals and objectives are dependent upon the values and preferences of the member served, with emphasis on growth and recovery, including greater independence in self-care and functioning, which results in lower level of care needs.

Anticipated Outcomes

ACT-SD services will allow members to maintain symptom stabilization and remain in community-based settings while supporting recovery in life areas valued by the member, which include:

- Maintenance of current areas of functioning and wellness, as desired and valued by the member
- Increased use of wellness self-management and recovery tools, which includes independence around medication management
- Vocational/educational gains
- Increased length of stay in independent, community residence
- Increased functioning in activities of daily living, such as independence around money management and transportation

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- Increased use of natural supports and development of meaningful personal relationships
- Improved physical health

Concurrent Services

Up to two of the following services may be provided by non-ACT service providers concurrently with ACT-SD, provided that such services are medically necessary and otherwise comply with other applicable clinical coverage policies:

- Psychosocial Rehabilitation (PSR)
- Individual Placement and Support-Supported Employment (IPS-SE)
- Outpatient Therapy (e.g., DBT, CBT for psychosis, substance use counseling)
- Opioid Treatment
- Detoxification Services
- Facility-Based Crisis
- Substance Abuse Residential Treatment
- Adult mental health residential programs (for example, supervised living-low or -moderate; or group living-low, -moderate, or - high)
- Mobile Crisis Management
- A service that is in lieu of one of the above-identified services that can be provided concurrently with ACT-SD

Reviews of medical necessity for each of the concurrent services will consider services expected to be provided by ACT-SD and whether traditional NC Medicaid Clinical Coverage Policy No. ("CCP") 8A-1 Assertive Community Treatment Team services would better meet the needs of each member requesting the additional service.

Service Exclusion

Tailored Care Management may not be provided during the same authorization period as this is duplicative. The provider is expected to fulfill all TCM duties, including coordinating with physical health providers, with the exception of delivering interventions related to Healthy Opportunities and Prevention and Population Health Programs. A care coordinator may be assigned to member to ensure there are no gaps in member care.

A beneficiary can receive ACT services from only one ACT team at a time. A beneficiary's informed choice over needed services is made when the individual has agreed to be served by an ACT team

Service Frequency and Intensity

ACT Step-Down serves the needs of two distinct groups: (1) those in need of supports to meet the needs of a member with severe and persistent mental illness, but at a less intensive and comprehensive level than ACT Team and (2) those members with severe and persistent mental illness who need support to transition successfully to a lower level of care. ACT-SD provides ongoing support for those members who have achieved a level of stability that is within their satisfaction, but whose history indicates a high risk of decompensation. These members are often at risk of harm to self or others, hospitalizations, and/or homelessness if continual community-based support is not provided.

Psychiatric outreach and focused medication support provided through ACT-SD are critical to these members' continuing stabilization. ACT-SD is a graduated transition is for those members who have demonstrated more limited use of the breadth of ACT services, primarily due to improved functioning, but would benefit from time-limited support as services are titrated down and the member connects to a lower level of care. Such members may have attachments to the ACT

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Team staff, which could generate anxiety about the prospect of transition, resulting in acute exacerbations in symptoms.

ACT-SD services are provided primarily in the community and are available anytime throughout the week, as directed by the needs cited in the member's person-centered care plan. Evidenced-based "Wellness Management and Recovery" strategies are the foundation of ACT-SD, which help members assume greater responsibility and ownership for their own self-care.

Members who receive ACT-SD must have at least three face-to-face contacts with the ACT-SD team members each calendar month. At least one contact takes place in the member's residence. ACT-SD is billed on an event basis, also referred to as a "per diem." An ACT-SD event is a 15-minute face-to-face contact, defined as lasting at least eight minutes. A maximum of two events may be billed per month. All other contacts, activities, meetings, and travel time are accounted for in the event rate and are not directly billable. Only one event may be billed per member per day.

Provider Requirements

The provider delivering this service shall meet the following requirements:

1. Provider must meet qualification for participation in NC Medicaid and/or NC Health Choice program, as applicable, and be enrolled in NC Tracks.
2. Provider must be credentialed and enrolled as a network provider in Vaya Health's Closed Provider Network, in good standing, and contracted to deliver the service.
3. For any member requiring nursing level assistance, N.C. Board of Nursing regulations and requirements must be followed for tasks that present health and safety risks to the member.
4. Provider must verify employee/independent contractor qualifications at the time employee is hired/contracted. Providers must provide verification of staff qualifications on at least an annual basis.
5. Provider must comply with all terms and conditions of its contract with Vaya Health, other applicable written agreements, and all applicable federal, state, and local laws, rules, and regulations.

Staffing Requirements

ACT Step-Down is provided by identified ACT Team staff within the provider organization. The ACT-SD team consists of the following staff. (The staffing full-time equivalents provided below are applicable to large ACT Teams serving 75 to 120 beneficiaries. Lesser FTEs for the psychiatrist and QP may be approved by NC Medicaid for mid-size teams, which serve between 51 to 74 beneficiaries.)

- Psychiatric Care Provider (Psychiatrist, Psychiatric Nurse Practitioner or Physician Assistant) at 0.20 FTE (8 hours/week)
- A Qualified Professional/Clinical Case Manager at 1 FTE, who meets the qualifications of Qualified Professional (QP) as specified in 10A NCAC 27G .0104. Certification of the QP by the NC Peer Support Specialist Program (CPSS) is preferred.
- A registered ACT Nurse at 0.025 FTE (1 hour a week) to provide injections or medication monitoring as needed.

New ACT-SD teams with fewer than 20 members must be staffed as above, with the following exceptions to prescriber time based on the number of members enrolled in service.

- 1 - 6 members: 2 hours/week
- 7 - 13 members: 4 hours/week
- 14 - 20 members: 6 hours/week

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Most ACT-SD services are provided by the ACT-SD psychiatric care provider and the QP. The ACT-SD psychiatric care provider must also serve on the home ACT Team and cannot be exclusively assigned to ACT-SD members. To honor member choice, ACT Team staff may also assist with ACT-SD services, except for providing ongoing specialty services, such as substance use disorder treatment from the substance use specialist, vocational services from the vocational specialist, and nursing services, except for provision of injections by the registered nurse (RN).

To the extent not otherwise inconsistent with the staffing requirements set forth in this ACT-SD service definition, the staffing requirements set forth in NC Medicaid CCP 8A-1 shall apply.

Member Eligibility Requirements

To be eligible for ACT-Step Down, the member must have NC Medicaid based on residence in a county located within Vaya's region and be enrolled in the State of North Carolina MH/IDD/SAS Health Plan waiver authorized pursuant to section 1915(b) of the Social Security Act, and meet the following criteria:

- 18 years of age or older with severe and persistent mental illness (SPMI) who have been participating in ACT services for at least six consecutive months.
- Sections 2.0 and 3.2.1 and 3.2.2, including the eligibility and entrance criteria, set forth in NC Medicaid CCP 8A-1 shall apply.

Utilization Management

Utilization management of covered services is a part of the assurance of medically necessary service provision. Authorization, which is an aspect of utilization management, validates approval to provide a medically necessary covered service to eligible beneficiaries.

Prior Approval Requirements:
Services are based upon a finding of medical necessity, must be directly related to the beneficiary's diagnostic and clinical needs, and are expected to achieve the specific rehabilitative goals detailed in the beneficiary's PCP. Medical necessity is determined by North Carolina community practice standards, as verified by Vaya, which will evaluate the request to determine if medical necessity supports more or less intensive services. Medically necessary services are authorized in the most cost-effective mode, as long as the treatment that is made available is similarly efficacious as services requested by the beneficiary's physician, therapist, or other licensed practitioner. Typically, the medically necessary service must be generally recognized as an accepted method of medical practice or treatment.

An ACT-SD unit is an event. Prior Authorization for ACT-SD is required. Initial authorization for services may not exceed six months and are based on a finding of medical necessity documented on the comprehensive clinical assessment, service authorization request form, service order, and applicable supporting documentation.

Re-Authorization must be conducted at least every six months and requires the submission of a SAR and the ACTT Transition Readiness Tool (ATR) for each subsequent request.

Continued Stay Criteria:
The continued stay criteria set forth in the CCP 8A-1 definition shall apply.

Transition or Discharge Criteria:
The individual has made significant progress toward rehabilitation goals and discharge to a lower level of care is indicated OR Member requires a more intensive level of care or service such as ACT Team.

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This service shall be covered when the service is medically necessary and:

a. The procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the member's needs;
b. The procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide;
c. The procedure, product, or service is furnished in a manner not primarily intended for the convenience of the member, the member's caretaker, or the provider; and
d. The member meets and continues to meet the eligibility requirements for this service, and treatment goals have not yet been achieved. Services and interventions must be reviewed for effectiveness, and interventions should be modified, if necessary, so that the individual makes greater progress.

EPSDT SPECIAL PROVISION:

Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure:

- That is unsafe, ineffective, or experimental or investigational
- That is not medical in nature or not generally recognized as an accepted method of medical practice or treatment

EPSDT and Prior Approval Requirements

If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does NOT eliminate the requirement for prior approval.

Important additional information about EPSDT and prior approval is found in the NC Tracks Provider Claims and Billing Assistance Guide and on NC DHHS: Early Periodic Screening, Diagnostic and Treatment Medicaid Services for Children .

Service limitations on scope, amount, duration, frequency, location of service and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening or prevent the development of additional health problem.

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Documentation Requirements

The same documentation requirements that apply to ACT Team apply to ACT Step-Down. These services shall be properly and contemporaneously documented in accordance with this section and the DMH/DD/SAS Records Management and Documentation Manual 45-2 (RMDM) prior to seeking reimbursement from Vaya Health.

Regardless of the service type, significant events in an individual's life that require additional activities or interventions shall be documented over and above the minimum frequency requirements.

Providers shall make all documentation supporting claims for services reimbursed by Vaya Health available to Vaya Health, NCDHHS and CMS upon request.

Care Plan Each individual receiving ACT Step-Down services is required to have a care plan that is fully complete prior to or on the first date of service. The care plan must meet all the requirements, including an enhanced crisis plan, as outlined in the NC Person-Centered Plan Instruction Manual. The amount, duration, and frequency of the service must be included in the care plan.

Service Documentation A full service note that meets the requirements per APSM 45-2 is required for each contact or intervention (such as individual session, case management, crisis response) for each date of service. Each service note must include the following information:

- Member's name
- Service record number
- Medicaid identification number (as applicable)
- Name of service provided
- Full date of service
- Place of service
- Type of contact (face to face, telephone call, collateral, etc.)
- Purpose of contact as it relates to the goal(s) on the care plan
- Description of the interventions provided
- Time spent providing interventions (i.e., duration)
- Assessment of effectiveness of intervention and/or the member's progress towards the goal(s)
- Signature and credentials of the staff member(s) providing the service

Discharge Planning Beginning at the time of admission, all interventions/activities regarding discharge planning and transition with the member, family/caregiver, and care team will be documented. A documented discharge plan shall be discussed with the member and included in the service record.

Claims-Related Information

Providers shall comply with the NC Tracks Provider Claims and Billing Assistance Guide, applicable Medicaid bulletins issued by the NC Division of Health Benefits (DHB), applicable NC Medicaid Clinical Coverage Policies, this service definition, Vaya Health's fee schedule and other requirements and any other relevant documents for specific coverage and reimbursement for Medicaid and NC Health Choice.

- **Claim Type:** Professional (CMS-1500/837P transaction) billed through Vaya Health.
- **International Classification of Diseases, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS):**

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  - Provider(s) shall report the ICD-10-CM and Procedural Coding to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description.
  - A diagnosis of a severe and persistent mental illness must be present to bill for this service. (See 42 CFR § 435.110)
- **Codes and Modifiers:** Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description. If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.
- **Billing Units:** Providers bill this service on a unit basis. 1 unit=15-minute contact lasting at least eight minutes. Providers can only bill two units per month, although ACT-SD staff should be meeting with member at least three times per month face to face.
- **Place of Service:** Member's home/community
- **Prior Authorization:** Provider must have a prior authorization for the delivery of services to the member approved by Vaya Health prior to submission of claims for payment to Vaya Health.
- **NC Tracks Enrollment:** Providers must be enrolled through NC Tracks and ensure valid NPIs, taxonomies, sites, zip code (+4) and all other provider demographic information provided to Vaya Health matches the information in NC Tracks to bill Vaya Health and be reimbursed for this service.
- **Coordination of Benefits:** Providers must file with primary payor(s) prior to submission of claims for payment to Vaya Health, if applicable.
- **Reimbursement:** Vaya Health reimburses providers for clean claims for services rendered in accordance with this Service Definition.

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