ASSERTIVE COMMUNITY TREATMENT PROVIDER MANUAL TRAINING

May 2021

PROJECT BRAVO

VIRGINIA'S MEDICAID PROGRAM DMAS INNOVATION • QUALITY • VALUE

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About Today's Webinar

- The presentation portion of this webinar will be recorded and posted to the DMAS website along with the powerpoint presentation.
- The CHAT function has been disabled
- All participants are muted
- DMAS will not be answering questions during the presentation.
  - If time permits, DMAS will answer questions at the end of the presentation
  - Please use the Q&A function to type in your questions
  - If your question(s) is not answered you may email the DMAS Behavioral Health Division at enhancedbh@dmas.virginia.gov

Agenda Today

- Background and Context
  - Project BRAVO: Enhancement of BH Services
  - Purpose and Function of Assertive Community Treatment (ACT) in the Medicaid System
  - Provider Manual Overview
  - Question and Answer Session (recording will be off)

Agenda Today

- Provider Manual Overview
  - Assertive Community Treatment
    - Service Definition
    - Critical Features and Service Components
    - Provider Qualifications and Staff Requirements
    - Service Authorization
    - Medical Necessity Criteria
      - Admission Criteria: Diagnosis, Symptoms and Functional Impairment
      - Exclusion Criteria
      - Continued Stay Criteria
      - Discharge Criteria
      - Service Limitations
    - Billing Guidance

Enhanced Behavioral Health Services for Virginia
Project BRAVO

Behavioral Health Redesign for Access, Value and Outcomes

Vision Implement fully-integrated behavioral health services that provide a full continuum of care to Medicaid members. This comprehensive system will focus on access to services that are:

High Quality

Quality care from quality providers in community settings such as home, schools and primary care

Evidence-Based

Proven practices that are preventive and offered in the least restrictive environment

Trauma-Informed

Better outcomes from best-practice services that acknowledge and address the impact of trauma for individuals

Cost-Effective

Encourages use of services and delivery mechanism that have been shown to reduce cost of care for system

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The North Star
Behavioral Health Services Enhancement

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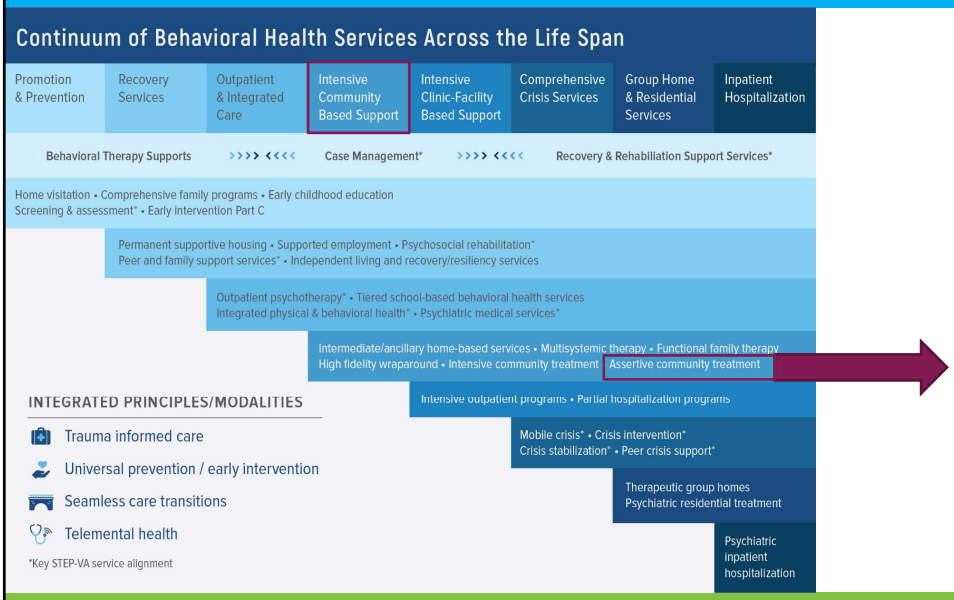

Assertive Community Treatment fall into the *"Intensive Community-Based Supports"* level of care

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Rationale for ACT Priority

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Alleviation of the Psychiatric Bed Crisis

- This service has existed for many years in Virginia and has previously been delivered through the "Intensive Community Treatment" or ICT Service in Medicaid. However, the rate for this service was not sufficient to support full fidelity to the Assertive Community Treatment model.
- The services provides both diversion and discharge options for the highest level of care: inpatient psychiatric hospitalization.
- Aligned with values of supporting members in the least restrictive environment (trauma informed) and research supports system utility (evidence-based)
- Program evaluation through DBHDS demonstrated that use of PACT reduced the number of days individuals participating in PACT spent in hospital stays by over half

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ICT to ACT Transition in Virginia

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Provider Resources and Communications

- DMAS Webinar on ICT-ACT Transition on 2/17/2021
- Individual team consultations with DBHDS & DMAS
- ACT Stakeholder Workgroup Meeting 3/25/21
- ACT 101 Trainings for Leadership 5/12-17-18/21
- EnhancedBH@dmas.Virginia.gov

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Where can I find the provider manuals?

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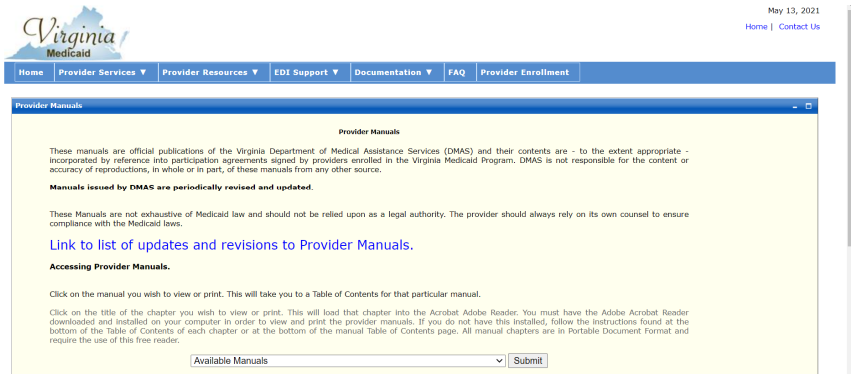
Direct Link: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual



- The BRAVO services are located in the newly named "Mental Health Manual"
- ACT is found within Appendix D

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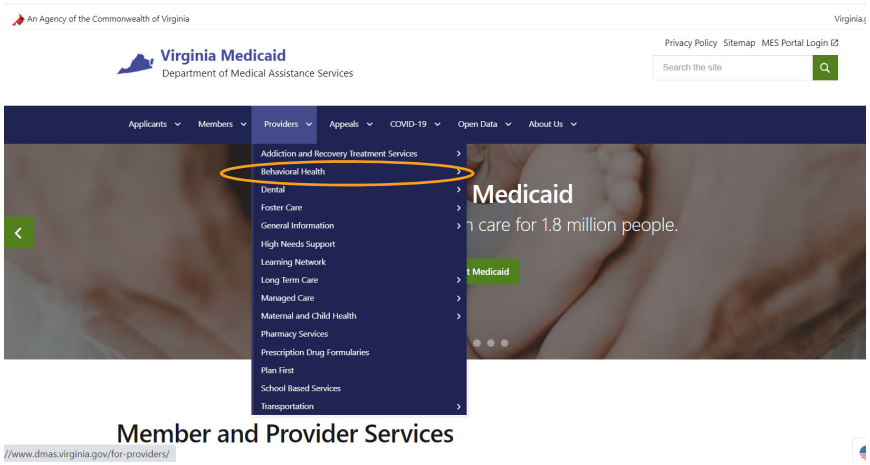
Where can I find the provider manuals?

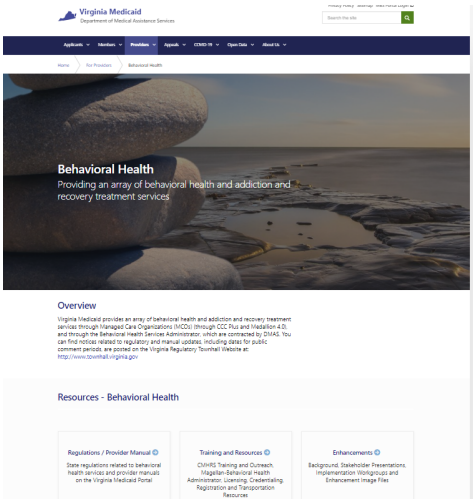
From our main website: www.dmas.Virginia.gov



- Under Providers Menu, select "Behavioral Health"

Where can I find the provider manuals?

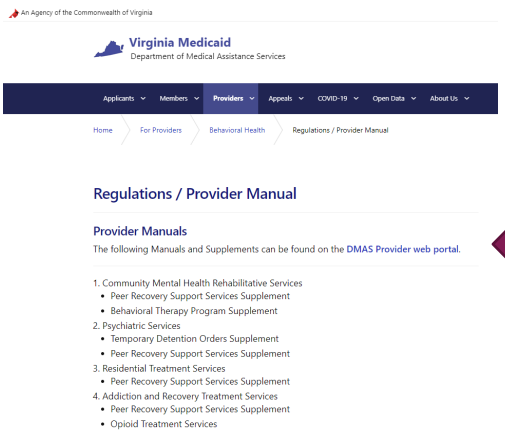
https://www.dmas.virginia.gov/for-providers/behavioral-health/



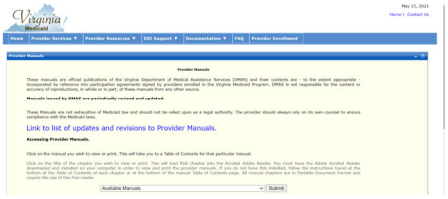
- Scroll down to Resources
- Select "Regulations/Provider Manual"

Where can I find the provider manuals?

https://www.dmas.virginia.gov/for-providers/behavioral-health/regulations-provider-manual/



- Click on link for Provider Web Portal



ASSERTIVE COMMUNITY TREATMENT

Provider Manual Overview

Assertive Community Treatment

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Service Definition

- *A highly coordinated set of services offered by a group of medical, behavioral health, peer recovery support providers and rehabilitation professionals in the community who work together as a team to meet the complex needs of individuals living with severe and persistent mental illness.*

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Service Definition

- Person-centered, oriented to the individual's goals
- First in line and generally sole provider of all services an individual needs
- Low individual to staff ratio
- Service levels are flexible and change over the duration of service

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Assertive Community Treatment

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Critical Features

- Recovery-Based Philosophy of Care
- Anticipates challenges to engagement and carries out thoughtfully planned assertive engagement techniques
- Shared decision making model
- *Promotion of self-determination, respect for the individual, hope that recovery and having meaningful roles and relationships in the community are possible*

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Critical Features

- ACT staff availability either directly or on-call 24-7-365;
- Crisis response and intervention that is available 24-7-365 including telephone and face-to face contact;
- Team is to be the first line (and generally sole provider) of all the services that individuals may need by providing individualized, intensive treatment/rehabilitation and support services in the community;
- Team develops and has access to each individual's individualized crisis plan and the team has the capacity to directly engage with each individual to help directly address emerging crisis incidents and to support stabilization;
- Team provides a higher frequency and intensity of community-based contacts with a staff-to-individual ratio no greater than 1:9; and
- Team provides services that are community based, flexible and appropriately adjusted based on the individuals evolving needs.

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Required Activities / Service Components

- Assessment and treatment planning
- Integrated dual disorders treatment for co-occurring substance use*
- Crisis assessment and treatment/intervention
- Health literacy counseling
- Medication management
- Skills restoration/development
  - Social Skills
  - Wellness self-management and prevention
  - Symptom management
  - Skills required for activities of daily and community living
- Mental health peer recovery support services;*
- Empirically supported therapeutic interventions & therapies;*
- ACT service coordination (care coordination) consisting of facilitating access to:
  - Employment and vocational services
  - Housing access & support
  - Other services based on client needs as identified in the Individualized Service Plan (ISP)

*As clinically indicated and supported by staff capacity and client engagement, these services components can be provided in an individual and/or group setting.

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Required Activities / Service Components

- LMHP, LMHP-R, LMHP-RP, LMHP-S, NP or PA conducts initial assessment consistent with components required by **Comprehensive Needs Assessment** (CNA, see Chapter 4)
  - If a PA or non-psychiatric NP conducts, the CNA only counts towards ACT
- **Individual Service Plan** required during the duration of services and should be current
  - Treatment planning should be collaborative but directed and authorized by LMHP, LMHP-R, LMHP-RP, LMHP-S, NP or PA

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Required Activities / Service Components

- **Medication prescription monitoring** must be provided by a psychiatrist or psychiatric nurse practitioner who completes an initial assessment on the day of admission and has contact with individuals on a quarterly basis.
- For individuals with a co-occurring substance use diagnosis, the ACT team will provide **individual and group modalities for dual disorders treatment based on the principles of Integrated Dual Disorder Treatment** and aligned with the individual's readiness/stage of change. In addition, the ACT team will provide active substance use counseling and relapse prevention, as well as substance use education.
- Registered* **peer recovery support** specialists shall be a part of the ACT team with services to include coaching, consulting, wellness management and recovery strategies to promote recovery and self-direction.
- Registered peer recovery support specialists may also model and provide education on recovery principles and strategies to fellow team members.

**Note: Registered means certified and then registered with the Board of Counseling*

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Let's Talk about Crisis

- Crisis System will be enhanced in December, so there will be changes to some of the terminology at that time
  - New crisis system aligned with the CRISIS NOW model
  - Integrated implementation with 988 and Marcus Alert legislation
  - Virginia will move towards single 988 crisis number as individual crisis lines are rolled in or phased out of the system infrastructure
  - New services to include: Mobile Crisis Intervention, Community Stabilization, Residential Crisis Stabilization, 23 hour bed
- Additional crisis services will become available, and this manual will be updated to reflect those services and their recommended interaction with ACT delivery

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Provider Qualifications

- **Licensed** by DBHDS as a provider of Assertive Community Treatment
  - *To bill ACT a provider must hold an ACT License*
  - *Providers cannot bill Medicaid for ICT services after 6/30/21*
- **Credentialed/Contracted** with the individual's Medicaid MCO for individuals enrolled in Medicaid managed care or the Fee for Service (FFS) contractor for individuals in FFS.

- ACT Team Fidelity Standards
  - ACT Teams are required to undergo the standardized rating process using the Tool for Management of Assertive Community Treatment (TMACT).

Department of Psychiatry UNC Center for Excellence in Community Mental Health

  - https://www.med.unc.edu/psych/cecmh/education-and-training/unc-institute-for-best-practices/assertive-community-treatment-act/tool-for-measurement-of-act-tmact/more-about-the-tmact/

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TMACT Fidelity Standards

- A new ACT team may be credentialed/contracted with the MCO/BHSA for ACT if their initial TMACT fidelity scores are in the *low fidelity range of 2.7-3.3*, but the team must rate at 3.4 or higher on the subsequent review to avoid being terminated from the Medicaid network.
- ACT teams may reach full ACT certification status if they obtain a TMACT score in the *base fidelity range of 3.4-3.9.*
- ACT providers scoring 4.0-5.0 are considered high fidelity (this category has two tiers:
  - 4.0-4.3 = high fidelity
  - 4.4-5.0 = exemplary fidelity

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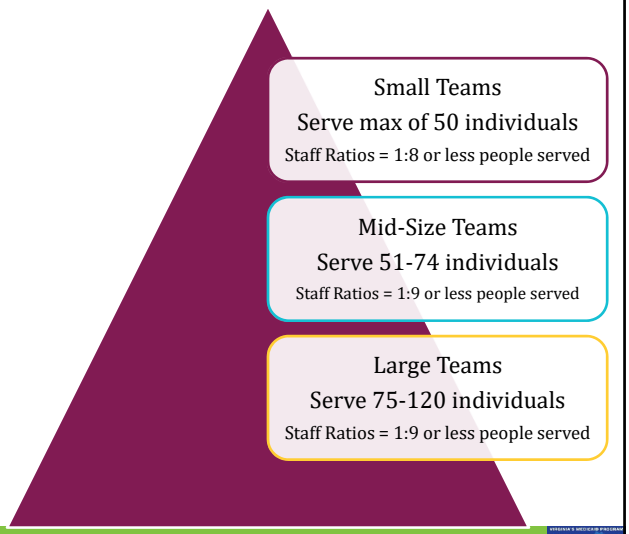
Staffing Requirements

- Urban locations = mid-size to large teams
- Rural locations = small or mid-size teams
- Operate from single home office
- New teams should titrate no more than 4 intakes per month, *former ICT teams transitioning to ACT can join network and provide services to existing caseloads as long as they meet staffing ratios*
- Annual averages should be 50 (small), 74 (medium), 120 (large)



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Staffing Requirements: Team Composition and Roles

- As required by DBHDS Emergency Regulations, a multidisciplinary ACT treatment team is comprised of the following professionals:
- *Team should also have at least one Generalist Clinical Staff Member*

- Team Leader
- Psychiatric Care Provider
- Nurse
- SUD/Co-Occurring Disorder Specialist
- Registered Peer Recovery Specialist
- Vocational Specialist (must be QMHP)
- Dedicated Office-Based Program Assistant

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Providers: Who is allowed to do what?

Service Component	Provider Type
Conduct an Initial Assessment consistent with the components required in the Comprehensive Needs Assessment documenting the individual's diagnosis/es and describing how service needs match the level of care criteria. Individual Service Plans (ISPs) shall be required during the entire duration of services and must be current.	LMHP, LMHP-R, LMHP-RP, LMHP-S, Nurse Practitioner or Physician
Individual, group, and family therapy	LMHP, LMHP-R, LMHP-RP, LMHP-S, or CATP.
Skills Restoration/Development, Crisis Treatment and Care Coordination	LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A or QMHP-E or QPPMH under supervision of at least a QMHP-A.
Health literacy counseling / psychoeducational interventions (medication management)	LMHP, LMHP-R, LMHP-RP, LMHP-S, Nurse Practitioner, Physician Assistant, CATP, CSAC*, CSAC Supervisee*, or a RN or LPN with at least one year of clinical experience.
Peer recovery support services	Registered Peer Recovery Specialist

**CSACs, CSAC Supervisees and CSAC-As may only provide services related to substance use disorder treatment per § 54.1-3507.1 and § 54.1-3507.2*

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Providers: Who is allowed to do what?

Service Component	Provider Type
Medication Prescription Monitoring	Psychiatrist or Psychiatric Nurse Practitioner who completes initial evaluation and has contact with individual at least quarterly
Medication Administration	Psychiatrist or Psychiatric Nurse Practitioner or appropriate licensed nursing professional based on ACT team size.
Crisis Intervention	LMHP, LMHP-R, LMHP-RP, LMHP-S
Crisis Treatment	LMHP, LMHP-R, LMHP-RP, LMHP-S, CATP, CSAC*, CSAC Supervisee*, CSAC-A*, QMHP-A or QMHP-E.
Care Coordination	LMHP, LMHP-R, LMHP-RP, LMHP-S, CATP, CSAC*, , CSAC Supervisee*, CSAC-A*, QMHP-A or QMHP-E or QPPMH under supervision of at least a QMHP-A.
Peer recovery support services	Registered Peer Recovery Specialist

**CSACs, CSAC Supervisees and CSAC-As may only provide services related to substance use disorder treatment per § 54.1-3507.1 and § 54.1-3507.2*

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Service Limitations

- An individual can participate in ACT services with only one ACT team at a time.
- Group therapy by licensed mental health professionals (LMHPs/CATPs) shall have a recommended maximum limit of 10 individuals in the group. *Group size may exceed this limit based on the determination of the LMHP/CATP.*
- If an individual is participating in ACT and has a concurrent admission to a Partial Hospitalization Program, the team should conduct close care coordination with those providers to assure alignment of the treatment plan (ISP) and avoid any duplication of services.

- **ACT may not be authorized concurrently with*:**
  - Individual, Group or Family Therapy
  - ARTS or MH IOP
  - Outpatient Medication Management,
  - Therapeutic Day Treatment
  - Intensive In Home Services
  - Crisis Stabilization
  - Mental Health Skill Building
  - Psychiatric Residential Treatment Facility (PRTF) and ARTS Level 3.3-3.7
  - Peer Recovery Support Services

*See authorization section for exceptions during 31 day transition to discharge

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Activities NOT authorized for reimbursement:

- Contacts that are not medically necessary.
- Time spent doing, attending, or participating in recreational activities.
- Services provided to teach academic subjects or as a substitute for educational personnel such as, but not limited to, a teacher, teacher's aide, or an academic tutor.
- Child Care services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision.
- Respite care.
- Transportation for the individual or family. Additional medical transportation for service needs which are not considered part of ACT Program Services may be covered by the transportation service through the Non-Emergency Medical Transportation Broker or MCO.
- Covered services that have not been rendered.
- Services rendered that are not in accordance with an approved authorization.
- Services provided without service authorization by the department or its designee.
- Services provided that are not within the provider's scope of practice.
- Any intervention or contact not documented or consistent with the approved treatment/recovery plan goals, objectives, and approved services.

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Activities NOT authorized for reimbursement:

- Services not identified on the individual's authorized ACT Treatment Plan.
- Services not in compliance with the ACT National Provider Standards and not in compliance with fidelity standards.
- Services provided to the individual's family or others involved in the individual's life to address problems not to the direct benefit of the individual in accordance with the individual's needs and treatment goals in the individual's plan of care. Anything not included in the approved ACT service description.
- Changes made to ACT that do not follow the requirements outlined in the provider contract, this appendix, or ACT fidelity standards.
- Any intervention or contact not documented or consistent with the approved treatment/recovery plan goals, objectives, and approved services.
- Time spent when the individual is employed and performing the tasks of their job.
  - Note: *ACT does include non-job specific vocational training, employment assessments, and ongoing support to maintain employment. ACT may provide the necessary medical services that enable the individual to function in the workplace, including ACT services such as a psychiatrist's or psychologist's treatment, rehabilitation planning, therapy, and counseling or crisis management that enable the individual to remain in and/or function in the workplace.*

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Service Authorization Requests

- The Managed Care Organizations (MCOs) and Fee for Service contractor will respond to the service authorization request in accordance to the guidelines defined by the National Committee for Quality Assurance.
- Providers shall submit service authorization requests within *one business day of admission* for initial service authorization requests and *by the requested start date* for continued stay requests.
- If submitted after the required time frame, the begin date of authorization will be based on the day of receipt.

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Initial Service Authorization Request Categories for 2021

Individual has open service authorization for ICT prior to 6/30/21

- As long as the provider transitions to ACT license and is accepted into MCO/BHSA network by 7/1/21, authorization will be extended through to the original end date of that prior authorization.
- At the continued stay request, provider will need to complete a NEW INITIAL ACT Comprehensive Needs Assessment and submit a new INITIAL ACT AUTHORIZATION

Individual has a service authorization that serendipitously ends on 6/30/21

- Providers will be asked to submit a NEW INITIAL ACT Comprehensive Needs Assessment and submit a NEW INITIAL ACT SERVICE AUTHORIZATION REQUEST

MCO has ended the service authorization as of 6/30/21 for a recent admission

- DMAS has asked MCOs to go back and extend those authorization for the "life of what the authorization would have been per MNC" to avoid clogging the authorization pipeline with a wave of these transitional authorizations
- At the continued stay request, provider will need to complete a NEW INITIAL ACT Comprehensive Needs Assessment and submit a new INITIAL ACT AUTHORIZATION

Individual has open service authorization for ICT prior to 6/30/21 but provider is not transitioning to ACT

- MCOs and DMAS will be monitoring open authorizations to problem solve these scenarios, which we hope will be limited in number as most ICT providers appear to be moving to ACT

Service Authorization (SA) Timelines

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Allowances across authorization milestones

Pre-Submission Period

- BHSA = Maximum of 30 days before start
- MCO = Maximum of 14 days before start

START DATE OF SERVICE

For BHSA or MCO:

- *Within one day of service* start for Initial Authorization
- *By requested start date* for continued stay request

OVERLAP IN OTHER SERVICES THAT WOULD OTHERWISE BE LIMITED

- 7 days on the front end of initial authorization
- 31 days on the back end of service to promote maintenance & recovery

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Service Authorization Forms

Initial Service Authorization

- ***NEW AND IMPROVED* Adobe Forms**
- Best efforts made to:
  - Make form fields more functional
  - Reduce duplication of information
  - Organize with clinical mindset and most logical way to tell the individual's story
  - Linking of content to corresponding elements in the Comprehensive Needs Assessment
- DMAS recommends making a provider template to save for efficiency
- Feedback welcomed and potential revision for December 1, 2021 update


THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

ASSERTIVE COMMUNITY TREATMENT (ACT: H0040)

INITIAL Service Authorization Request Form

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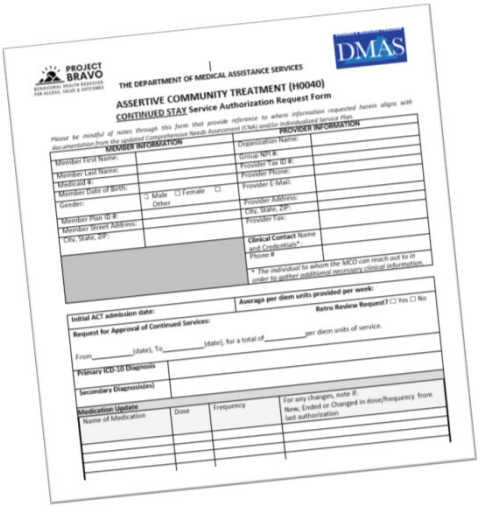
Service Authorization Forms

Continued Stay Service Authorization

- ***NEW AND IMPROVED* Adobe Forms**
- Best efforts made to:
  - Pair directly with updated Comprehensive Needs Assessment and ISP Information
  - Minimal form submission + most recent assessment and Individualized Service Plan
  - Any substantive changes in circumstances, goals or plan can be submitted with an additional progress note in provider's choice of format
- DMAS recommends making a provider template to save for efficiency
- Feedback welcomed and potential revision for December 1, 2021 update


THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

ASSERTIVE COMMUNITY TREATMENT (H0040)

CONTINUED STAY Service Authorization Request Form

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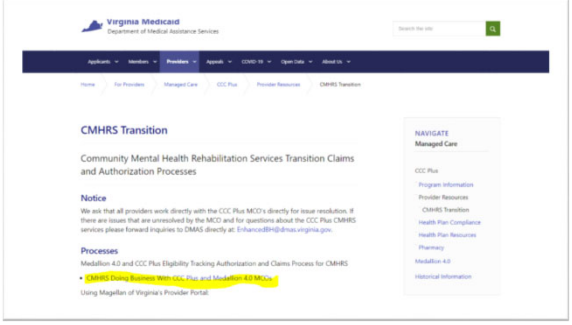
Service Authorization Processes

Fee for Service Vendor and Managed Care Organizations

- FFS: Magellan BHSA
- Forms
  - https://www.magellanofvirginia.com/for-providers/provider-tools/forms/
- Provider Portal
  - https://www.magellanprovider.com/MagellanProvider/do/LoadHome
- Managed Care Organizations
- https://www.dmas.virginia.gov/for-providers/managed-care/ccc-plus/provider-resources/cmhrs-transition/



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Service Authorization

- **One Unit = One day of service**
- **To bill a per diem unit, a qualified ACT team member must provide a face-to-face covered service with the individual or a face-to-face care coordination contact for a minimum of 15 minutes.**
- Individuals participating in ACT are expected to have challenges with engagement and this is understood, however:
  - *If the individual consistently deviates from the required services in the ISP, the provider should work with the MCO or the BHSA UM staff to reassess for another Level of Care or model to better meet the individual's needs*.

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Medical Necessity Criteria: Admission Criteria

- Individuals must meet all of the following criteria:

  - 18 years or older (as required by EPSDT, youth below age 18 may receive ACT if medically necessary);
  - Prior to the start of services, the following must occur:
    - Assessment inclusive of the components of the CNA is completed to document the individual's diagnosis(es) and describe how service needs match the level of care criteria;
    - This assessment must support a diagnosis from the current version of the Diagnostic and Statistical Manual (DSM) that is **consistent with a serious and persistent mental illness** (i.e. schizophrenia, other psychotic disorders (e.g., schizoaffective disorder), bipolar disorder).
    - *Individuals with psychiatric illnesses that fall outside the serious mental illness definition may be eligible depending on the level of associated long-term disability; in these cases, a Physician letter justifying this exception should accompany the service authorization request*

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Medical Necessity Criteria: Admission Criteria (continued)

- Individual has significant functional impairment as demonstrated by at least one of the following conditions:
  - Significant difficulty in *consistent performance of the range of routine tasks required for basic adult functioning in the community* (for example, caring for personal business affairs; obtaining medical, legal, and housing services; recognizing and avoiding common dangers or hazards to self and possessions; meeting nutritional needs; attending to personal hygiene) or persistent or recurrent difficulty *performing daily living tasks* except with significant support or assistance from others such as friends, family, or relatives;
  - Significant difficulty maintaining *consistent employment at a self-sustaining level* or *significant difficulty consistently carrying out the head-of-household responsibilities* (such as meal preparation, household tasks, budgeting, or child-care tasks and responsibilities); or
  - Significant difficulty *maintaining a safe living situation* (for example, repeated evictions or loss of housing or utilities);

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Medical Necessity Criteria: Admission Criteria (continued)

- Individual has *one or more of the following problems*, which are indicators of continuous high-service needs:
  - High use of acute psychiatric hospital (multiple admissions to or at least one recent long-term stay of 30 days or more in an acute psychiatric hospital inpatient setting within the last two years) or psychiatric emergency services (more than four interventions in the last 12 months);
  - Intractable (persistent or recurrent) severe psychiatric symptoms (affective, psychotic, suicidal, etc.);
  - Coexisting mental health and substance use disorders of significant duration (more than 6 months);
  - High risk or recent history of criminal justice involvement (such as arrest, incarceration, probation) as a result of the individual's mental health disorder symptoms;
  - Significant difficulty meeting basic survival needs, residing in substandard housing, homelessness, or imminent risk of homelessness as a result of the individual's mental health disorder symptoms;
  - Residing in an inpatient setting (e.g. state hospital or other psychiatric hospital) or supervised community residence, but clinically assessed to be able to live in a more independent living situation if intensive services are provided; or requiring a residential or institutional placement if more intensive services are not available; and/or
  - Difficulty in consistent participation in traditional office-based outpatient services;

Assertive Community Treatment

Exclusion Criteria

- The individual's functional impairment is solely a result of a substance use disorder, autism spectrum disorder, developmental disability, personality disorder or traumatic brain injury without a co-occurring psychiatric disorder;
- The individual is at imminent risk to harming self or others, or sufficient impairment exists that a more intensive level of service is required;
- The individual's psychiatric disorder can be effectively treated or recovery process safely maintained at a less intensive level of care;
- The individual or their authorized representative does not voluntarily consent to admission or treatment, and/or refuses or is unable to participate in all aspects of treatment;
- The individual requires a level of structure and supervision beyond the scope of the program;
- The individual has medical conditions or impairments that needs immediate attention;
- The individual's primary problem is social, custodial, economic (i.e. housing, family conflict, etc.), or one of physical health without a concurrent major psychiatric disorder meeting criteria for this level of care, or admission is being used as an alternative to incarceration.

Assertive Community Treatment

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Continued Stay Criteria

- ***Continuation of services may be service authorized at one year intervals based on written service-specific provider re-assessment and certification of need by an LMHP.***
- The individual continues to meet admission criteria;
- Another less intensive level of care would not be adequate to administer care;
- ACT participation remains necessary due to continued risk that without the service, the individual is at risk for the following:
  - Compromised engagement in or ability to manage medication in accordance to the treatment plan
  - Increased use of crisis services
  - Inpatient psychiatric hospitalization
  - Decompensation of social and recreational skills (e.g. communication and interpersonal skills, forming and maintaining relationships)
  - Decompensation in functioning related to activities of daily living
  - Fracture or loss in the individual's community supports due to individual's challenges with symptoms and functioning (Health, Legal, Transport, Housing, Finances, etc.)
  - Decompensation of vocational skills or vocational readiness
- The individualized treatment plan (ISP), updated monthly or as clinically appropriate, includes evidence suggesting that the identified problems are likely to benefit from continued ACT participation and the goals are consistent with the components of this service;
- The individual's natural supports, as appropriate, (e.g. individually identified-family/guardian/caregiver) are participating in treatment as clinically indicated and appropriate, or engagement efforts are underway; and include communication with potential future service providers, community partners, and related resources related to school, occupational or other community functioning.

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Assertive Community Treatment

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Discharge Criteria

The philosophy that guides the ACT model underscores that individuals participating in the service are expected to struggle with engagement given the severity of their mental illness. Individuals should therefore not be discharged from the service due to perceived "lack of compliance" with a treatment plan (ISP) or challenges integrating interventions into their lives towards recovery. Rather, discharge should be considered based on the criteria that follow.

- The individual meets discharge criteria if any of the following are met:
- The individual and team determine that ACT services are no longer needed based on the attainment of goals as identified in the ISP and a less intensive level of care would adequately address current goals;
- The individual no longer meets admission/continued stay criteria and/or meets criteria for another level of care, either more or less intensive, and that level of care is sufficiently available;
- Required consent for treatment is withdrawn or not obtained;
- Extenuating circumstances occur that prohibit participation including:
  - Change in the individual's residence to a location outside of the service area
  - The individual becomes incarcerated or hospitalized for a period of a year or more
  - The individual chooses to withdraw from services and documented attempts by the program to re-engage the individual with the service have not been successful.

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Assertive Community Treatment

Billing Codes

Billing Code	Unit	Description	Notes	Provider Qualifications
H0040 and modifier as appropriate	Per Diem	Assertive Community Treatment	ACT providers may bill only one per diem per individual per day. All other contacts, meetings, travel time, etc. are considered indirect costs and is accounted for in the buildup of the per diem rate.	Service components must be provided by a qualified provider (see Provider qualification and staff requirements section)
H0040 and modifier as appropriate	n/a	Comprehensive Needs Assessment		LMHP, LMHP-R, LMHP-RP, LMHP-S, Nurse Practitioner, Physician Assistant
90791	n/a	Psychiatric Diagnostic Evaluation	This code should be used when the provider conducts the comprehensive needs assessment with no medical services and determines that the individual does not meet MNC and will not enter the service.	LMHP, LMHP-R, LMHP-RP, LMHP-S, Nurse Practitioner, Physician Assistant
90792	n/a	Psychiatric Diagnostic Evaluation	This code should be used when the provider conducts the comprehensive needs assessment with medical services and determines that the individual does not meet MNC and will not enter the service.	Psychiatrists, Physician Assistants, and Nurse Practitioners

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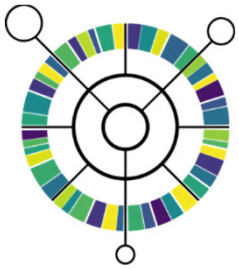
Assertive Community Treatment

Per diem rate

- A minimum of 15 minutes face-to-face service, including one of the service components, is required in order to bill the per diem.
- Licensed direct care staff shall provide services within the scope of practice for their license.
- Practitioners may not bill for services outside of the ACT per diem (H0040) rate while individuals are receiving ACT services.

- The Per Diem Rate includes any of the following service components provided by a qualified provider:
  - assessment
  - treatment planning
  - integrated dual disorders treatment for co-occurring substance use;
  - health literacy counseling / psychoeducation
  - therapy (individual, group and family)
  - skills restoration / development
  - crisis treatment/intervention
  - peer recovery support services;
  - care coordination;
  - ACT service coordination



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Assertive Community Treatment

Billing Codes Notes

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- In accordance with 42 CFR § 441.18, individuals must have free choice of case management providers and cannot be required to or prohibited from receiving case management as a condition of receiving a state plan service such as ACT.
- Mental health case management (MHCM) is a distinct service and may only be provided by a DBHDS licensed mental health case management provider (see Chapters II and IV of this manual for additional details).
- Should an individual choose to enroll in MHCM along with ACT, the providers of each of these services will need to clearly and substantially document the need for both and documentation must demonstrate that the two services are not being duplicated.

Assertive Community Treatment

Tiered Rate Structure Based on Fidelity Pairs with Modifiers

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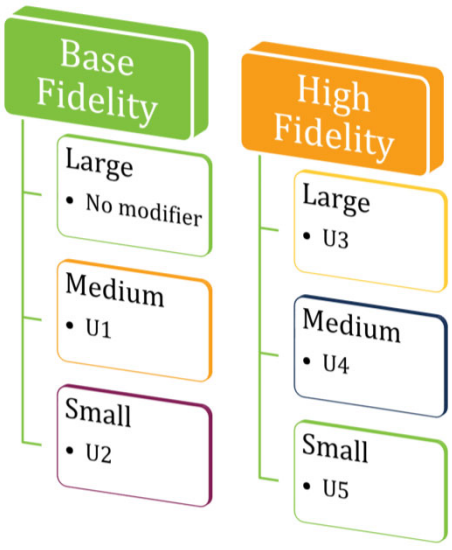
Category	Rate Active 7/1/21
Large team Base fidelity	$158.90
Medium team Base fidelity	$169.33
Small team Base fidelity	$195.20
Large team High fidelity	$190.08
Medium team High fidelity	$206.64
Small team High fidelity	$245.29



COVID-19 Flexibilities

- Service Authorization 14 day grace period
- Telehealth Allowances
  - Permanent Policy to be released soon
  - New telehealth manual for all services will be posted for public comment and state-wide webinars will be held to present new policies

Thank you for your partnership, support and participation.

Additional Questions?

Please contact EnhancedBH@dmas.Virginia.gov