AETNA BETTER HEALTH®

d/b/a Aetna Better Health of Louisiana

Policy

Policy Name:	Assertive Community Treatment (ACT) Services	Page:	1 of 22
Department:	Medical Management	Policy Number:	7100.35
Subsection:	Prior Authorization	Effective Date:	12/28/2020
Applies to:	■ Medicaid Health Plans		

PURPOSE:

The purpose of this policy is to define Aetna Better Health's ~~business standards~~**clinical requirements** for the prior authorization of Assertive Community Treatment (ACT) Services.

STATEMENT OF OBJECTIVE:

Objectives of the ACT prior authorization process are to:

- ~~Accurately document all ACT authorization requests~~ **Define ACT services**
- **Ensure the hierarchy of medical necessity criteria for ACT is utilized appropriately**
  ~~Verify that a member is eligible to receive ACT services at the time of the request and on each date of service~~
- **Establish procedures for reviewing and rendering determination for ACT prior authorization requests**
- ~~Assist providers in providing appropriate, timely, and cost-effective ACT services~~
- ~~Verify the practitioner's or provider's network participation~~
- ~~Define responsibilities of health professionals involved in the medical necessity decision making process~~
- ~~Evaluate and determine medical necessity and/or need for additional supporting documentation~~
- ~~Collaborate and communicate as appropriate for the coordination of members' care~~
- ~~Facilitate timely claims payment by issuing prior authorization numbers to practitioners or providers for submission with claims for approved services~~
- ~~Place appropriate limits on ACT on the basis of medical necessity or for the purposes of utilization management provided the services furnished can reasonably be expected to achieve their purpose in accordance with 42 CFR §438.210~~
- ~~Establish protocol for working with out-of-network ACT providers to facilitate SCA's as needed to secure appropriate treatment for members~~

DEFINITIONS:

MCG®	MCG, including Chronic Care Guidelines, are evidence-based clinical guidelines that are updated annually. They support prospective, concurrent, and retrospective reviews; proactive care management; discharge planning; patient education, and quality initiatives.

LEGAL/CONTRACT REFERENCE:

The ACT prior authorization process is governed by:

- ~~2020~~ **2023** Louisiana Medicaid Managed Care Organization Statement of Work~~, Section 8.0~~
- Applicable federal and state laws, regulations and directives~~, including the confidentiality of member information (e.g., Health Insurance Portability and Accountability Act [HIPAA])~~
- ~~National Committee for Quality Assurance (NCQA) Standards and Guidelines for the Accreditation of Health Plans 2021~~
- ~~Policy 7000.30 Process for Approving and Applying Medical Necessity Criteria~~
- Louisiana Department of Health (LDH) Behavioral Health Services Provider Manual, **Appendix E-1: Evidence Based Practices (EBPs) Assertive Community Treatment, 2023, Revised 10/02/23**~~revised 04/05/2022~~

FOCUS/DISPOSITION:

Assertive Community Treatment (ACT) services are community-based therapeutic interventions that address the functional problems of members who have the most complex and/or pervasive conditions associated with serious mental illness. These interventions are strength-based and focused on supporting recovery through the restoration of functional daily living skills, building strengths, increasing independence, developing social connections and leisure opportunities, and reducing the symptoms of their illness. Through these activities, the goal is to increase the member's ability to cope and relate to others while enhancing the member's highest level of functioning in the community.

Interventions may address adaptive and recovery skill areas. These include, but are not limited to, supportive interventions to help maintain housing and employment, daily activities, health and safety, medication support, harm reduction, money management, entitlements, service planning, and coordination[1].

~~***Aetna Better Health Responsibilities***~~

~~The chief medical officer (CMO) is responsible for directing and overseeing the Aetna Better Health prior authorization of ACT services function. The Prior Authorization department is principally responsible for carrying out the day-to-day operations (e.g., evaluating requests, documenting requests and decisions, and issuing authorization numbers for approved requests) under the supervision of a medical director or designated licensed clinical professional qualified by training, experience and certification/licensure to conduct the utilization management (UM) functions in accordance with state and federal regulations.[2] Other departments approved by the CMO (such as Care Management and Concurrent Review) may issue authorizations for specific services within their areas of responsibility per contractual requirements. Departments with authority to authorize services will maintain a postal address, direct telephone, fax number, or electronic interchange (if available) for receiving and responding to notifications and service authorization requests. Only a health care professional may make determinations regarding the medical necessity of health care services during the course of utilization review.~~

~~When initiating or returning calls regarding UM issues, Aetna Better Health requires UM staff to identify themselves by name, title, and organization name;[3] and upon request, verbally inform member, facility personnel, the attending physician and other ordering practitioners/providers of specific UM requirements and procedures. Aetna Better Health must triage incoming standard and expedited requests for services based upon the need for urgency due to the member's health condition. Aetna Better Health must identify the qualification of staff who will determine medical necessity.[4]~~

[1] LDH Behavioral Health Services Provider Manual, Appendix E: Evidence Based Practices (EBPs) Assertive Community Treatment, page 1
~~[2] NCQA HP 2021 UM4 A1~~
~~[3] NCQA HP 2021 UM3 A3~~
~~[4] 2020 Louisiana Medicaid Managed Care Organization Statement of Work, Section 8.1.13~~

~~Nonclinical staff is responsible for:~~[5]

- ~~Documenting incoming prior authorization requests and screening for member's enrollment, member eligibility, and practitioner/provider affiliation~~
- ~~Forwarding to clinical reviewers any requests that require a medical necessity review~~

~~Clinical reviewer's responsibilities include:~~[6]

- ~~Identifying service requests that may potentially be denied or reduced on the basis of medical necessity~~
- ~~Forwarding potential denials or reductions to the CMO or designated medical director for review~~
- ~~If services are to be denied or reduced:~~
  - ~~Providing written notification of denials/reductions to members~~
  - ~~Notifying the requesting practitioner/provider and member of the decision to deny, reduce or terminate reimbursement within the applicable time frame~~
  - ~~Documenting, or informing data entry staff to document the denial decision in the business application system prior authorization module~~

~~*Medical Director Reviewer Responsibilities*~~

~~Authorization requests that do not meet criteria for the requested service will be presented to the behavioral health medical director for review. The behavioral health medical director conducting the review must have clinical expertise in treating the member's condition or disease and be qualified by training, experience and certification/licensure to conduct the prior authorization functions in accordance with state and federal regulations. The behavioral health medical director will review the service request, the member's need, and the clinical information presented. Using the approved criteria and the behavioral health medical director's clinical judgment, a determination is made to approve, deny or reduce the service. Only the behavioral health medical director can reduce or deny a request for ACT services based on a medical necessity review.~~[7]

[5] ~~NCQA HP 2021 UM4 A2~~
[6] ~~NCQA HP 2021 UM4 A1-2~~
[7] ~~NCQA HP 2021 UM4 F1~~

~~If all applicable medical necessity criteria are not clear enough to make a determination or the requested service is not addressed by the standard criteria or Aetna Clinical Policy Bulletins (CPBs), the behavioral health medical director may submit a request for a position determination to the Aetna Clinical Policy Review Unit, using the Emerging Technology Review/Medical Review Request form. The Aetna Clinical Policy Review Unit will research literature applicable to the specific request and, when a determination is reached, will respond to the CMO/designated medical director.~~

~~When criteria are present but unclear in relation to the situation, the reviewing behavioral health medical director may contact the requester to discuss the case or may consult with a board-certified physician from an appropriate specialty area before making a determination of medical necessity.[8] Practitioners/providers are notified in the denial letter (i.e., Notice of Action [NOA]) that they may request a peer-to-peer consultation to discuss denied or reduced service authorizations with the behavioral health medical director reviewer by calling Aetna Better Health. All behavioral health medical director discussions and actions, including discussions between medical directors and treating practitioners/providers are to be documented in the Aetna Better Health authorization system.[9]~~

~~As part of Aetna Better Health's appeal procedures, Aetna Better Health will include an Informal Reconsideration process that allows the member (or provider/agent on behalf of a member with the member's written consent) a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing.[10]~~

Prior Authorization of ACT Services

Assertive Community Treatment (ACT) requires prior authorization and can authorized by Aetna Better Health UM clinicians for up to six (6) months. A comprehensive person-centered needs assessment must be completed within thirty (30) days of admission to the program. The assessment includes a complete history and ongoing assessment of:

~~[8] NCQA HP 2021 UM4 A2~~
~~[9] NCQA HP 2021 UM7 D~~
~~[10] 2020 Louisiana Medicaid Managed Care Organization Statement of Work, Section 8.5.4.1.3.1 and 8.5.4.1.3.2~~

- Psychiatric history, status and diagnosis,
- Level of Care Utilization System (LOCUS),
- Telesage Outcomes Measurement System, as appropriate,
- Psychiatric evaluation,
- Strength's assessment,
- Housing and living situation,
- Vocational, educational and social interests and capacities,
- Self-care abilities,
- Family and social relationships,
- Family education and support needs,
- Physical health,
- Alcohol and drug use,
- Legal situation, and
- Personal and environmental resources.

The[AD1][GK2] LOCUS and psychiatric evaluation will be updated at least every six (6) months or as
needed based on the needs of each member, with an additional LOCUS score being completed prior to discharge. For members participating in FACT, the assessment will include items related to court orders, identified within thirty (30) days of admission and updated every ninety (90) days or as new court orders are received. Utilizing the comprehensive person centered needs assessment, an initial vocational assessment (referred to as the "career profile") in addition to member interviews, shall be completed on all individuals participating in the ACT program within thirty (30) calendar days after program entry for members admitted on or after 10/01/2023, or within ninety (90) calendar days for existing members. The career profile typically occurs over 2-3 sessions by the IPS employment specialist. The career profile will be reviewed and updated at least every six (6) months, or more often as may be appropriate to the needs of each member. Refusals to participate in and complete the career profile assessment process shall be documented within the case notes, showing efforts to engage and clinically appropriate reasons for non-completion.

A treatment plan, responsive to the member's preferences and choices must be developed and in place at the time services are rendered. The treatment plan will include input from all staff involved in treatment of the member, as well as involvement of the member and collateral others of the member's choosing. In addition, the plan must contain the signature of the psychiatrist, the team leader involved in the treatment and the member's signature. Refusals must be documented. The treatment plan must integrate mental health and substance use services for members with cooccurring disorders. The treatment plan will be updated ~~at least~~ [AD3][GK4]every three~~six~~ (3~~6~~) [AD5][GK6]months or as needed based on the needs of each member. For members participating in FACT, the treatment plan will include items relevant for any specialized interventions, such as linkages with the forensic system for members involved in the judicial system. Treatment plan development will include an exploration of the member's employment interests and shall be documented in the progress notes. For those individuals interested in employment, their treatment plan will include at least one vocational goal pertaining to job search, job placement, job supports, career development, or career advancement. A[AD7][GK8] tracking system is expected of each ACT team for services and time rendered for or on behalf of any member. Each treatment plan must consist of the following:

- Plans to address all psychiatric conditions;
- The member's treatment goals and objectives (including target dates), preferred treatment approaches and related services;
- The member's educational, vocational, social, wellness management, residential or recreational goals, associated concrete and measurable objectives and related services;
- The member's goals and plans, and concrete and measurable objectives necessary for a person to get and keep their housing; and
- A crisis/relapse prevention plan, including an advance directive.

When psycho-pharmacological treatment is used, a specific treatment plan, including identification of target symptoms, medication, doses and strategies to monitor and promote commitment to medication must be used.

ACT services are comprehensive of all other services, with the exception of psychological

evaluation or assessment and medication management. These may be provided and billed separately for a member receiving ACT services. ACT shall not be billed in conjunction with the following services:

- Behavioral health (BH) services by licensed and unlicensed individuals, other than medication management and assessment or
- Residential services, including professional resource family care.

The ACT program provides three levels of interaction with the participating members, including:

1. Face-to-face encounter – ACT team must provide a minimum of six (6) clinically meaningful face-to-face encounters with the member monthly with the majority of encounters occurring outside of the office. Encounters shall address components of the member's treatment plan, involve active engagement with the member, and actively assess their functioning. Teams must document clinically appropriate reasons if this minimum number of encounters cannot be made monthly. Teams must also document reasons contacts are occurring within the office. Efforts shall be made to ensure services are provided throughout the month;

2. Collateral encounter – Collateral refers to members of the member's family or household or significant others (e.g., landlord or property manager, criminal justice staff and employer) who regularly interact with the member and are directly affected by, or have the capability of affecting, his or her condition and are identified in the treatment plan as having a role in treatment. A collateral contact does not include contacts with other mental health service providers or individuals who are providing a paid service that would ordinarily be provided by the ACT team (e.g., meeting with a shelter staff person who is assisting an ACT member in locating housing); and

3. Assertive outreach – Refers to the ACT team being 'assertive' about knowing what is going on with a member and acting quickly and decisively when action is called for, while increasing member independence. The team must closely monitor the relationships that the member has within the community and intervene early if difficulty arises. For those members transitioning from psychiatric or nursing facilities, ACT staff must

provide a minimum of four (4) encounters a week with the member during the first thirty (30) days post transition into the community. Encounters should be meaningful per the guidance outlined above. If this minimum number of encounters cannot be made, ACT staff must document clinically appropriate reasons for why this number of encounters cannot be achieved.

The teams will provide comprehensive, individualized services, in an integrated, continuous fashion, through a collaborative relationship with the member. The ACT program utilizes a treatment model that is non-confrontational, follows behavioral principles, considers interactions of mental illness and substance use and has gradual expectations for abstinence.

~~ACT~~[AD9] ~~teams must provide a minimum of six (6) clinically meaningful face to face (or via telehealth when appropriate and if allowed by the Centers for Medicare and Medicaid Services)~~ [AD10]~~encounters with the member monthly with the majority of encounters occurring outside of the office. Encounters should address components of the member's treatment plan, involve active engagement with the member, and actively assess their functioning. Teams must document clinically appropriate reasons if this minimum number of encounters cannot be made monthly.~~

ACT teams must meet national fidelity standards as outlined within [GK11]~~evidenced by~~ [AD12]the SAMHSA Assertive Community Treatment (ACT) Evidence-Based Practices (EBP) Toolkit. Teams shall adhere to the following:

1. ~~1.~~ New teams:

a. The ACT provider must notify the MCO in writing of its desire to create an additional team, including in this notification: justification for the creation of a new team and geographical location where the new team will operate.

i. The MCO will investigate the need for an ACT team in the proposed geographic location and will inform the ACT provider in writing of the MCO's decision to approve or deny. If the MCO gives the ACT provider the approval to establish a new team, the provider will be required to follow the standard contracting/credentialing process with the MCOs in order to render services.

b. The ACT provider must submit documentation to the MCO for contracting purposes including evidence of fidelity to the model including findings of self-evaluation using the DACTS/General Organizational Index (GOI) in addition to submitting the appropriate credentialing materials for vetting purposes and contact the MCO to ensure that all credentialing verification steps are met.

-i. The self-evaluation must reflect a minimum score of a 3.0 on the DACTS/GOI in order to be eligible to provide Medicaid funded services to members.

c. The provider must also adhere to the following related to newly established teams:

i. Submit monthly outcomes reporting to the MCOs via a template provided by the MCOs.

ii. Undergo a fidelity review using the DACTS/GOI and the Supported Employment Fidelity Scale by an MCO-identified third party within six (6) months of implementation:

1. This review must reflect a minimum score of 3.0 on the DACTS/GOI in order to maintain certification and the ability to accept new members, be eligible to provide Medicaid funded services to members, and increase staff-to-member ratios;

2. If the MCO identifies a potential Quality of Care concern based on the data from the monthly Outcome Measures report the team may be subject to corrective action. The team will implement an MCO approved corrective action plan immediately for any individual DACTS criterion that rates a one (1) or two (2). This plan should be implemented within thirty (30) days of findings or sooner as determined necessary by the MCO to mitigate health and safety issues for members; and

3. If the fidelity review findings does not reflect a minimum overall score of 3.0 on the DACTS/GOI, the provider will forfeit any new referrals until an overall score of 3.0 is achieved. The provider will be permitted to work with existing members as long as there are no health and safety violations with operations as determined by the MCO or LDH. The team shall implement a remediation plan and undergo another fidelity review within three (3) months by the fidelity monitor. This review will be at the cost of the provider. If the team achieves an overall score of 3.0 or greater on the DACTS/GOI in the subsequent review, the team can begin accepting new referrals;

4. The Supported Employment Fidelity Scale review must reflect continued improvement toward the desired score of 100 (good fidelity); and

5. The team will implement an MCO approved corrective action plan immediately for any individual Supported Employment Fidelity Scale criterion that rates below 100 (good fidelity). This plan must be implemented within thirty (30) days of findings or sooner as determined necessary by the MCO to mitigate health and safety issues for members. ~~New teams:~~ ~~[AD13]~~

- ~~Must submit documentation to Aetna Better Health for contracting purposes including evidence of fidelity to the model including findings of self-evaluation using the DACTS/General Organizational Index (GOI).~~
  - ~~The self-evaluation must reflect a minimum score of a 3.0 on the DACTS/GOI in order to be eligible to provide Medicaid funded services to members.~~
- ~~Must undergo a fidelity review using the DACTS/GOI by an Aetna Better Health-identified third party within six (6) months of implementation.~~
  - ~~This review must reflect a minimum score of 3.0 on the DACTS/GOI in order to maintain certification and the ability to accept new members.~~

- ~~The team will implement an Aetna Better Health **a health plan** approved corrective action plan immediately for any individual DACTS criterion that rates a one (1) or two (2). This plan should be implemented within thirty (30) days of findings or sooner as determined necessary by Aetna Better Health to mitigate health and safety issues for members.~~

Existing teams:

~~Existing teams:~~ a. Must submit monthly outcomes reporting to MCOs via a template provided by the MCOs;

b. Must participate in fidelity reviews using the DACTS/GOI conducted by the MCO or designee at least annually (every twelve (12) months) or more frequently as prescribed by the MCO;

c. The team will implement an MCO approved corrective action plan immediately for any individual DACTS criterion that rates a one (1) or two (2);

d. Must undergo a fidelity review using the Support Employment Fidelity Scale by an MCO-identified third party in conjunction with the DACTS/GOI fidelity review;

i. This review must reflect continued improvement toward the desired score of 100 (good fidelity);

ii. The team will implement an MCO approved corrective action plan immediately for any individual Supported Employment Fidelity Scale criterion that rates below 100 (good fidelity). This plan must be implemented within thirty (30) days of findings or sooner as determined necessary by the MCO to mitigate health and safety issues for members.

e. Must achieve a score of 3.0 and above on the DACTS/GOI in order to maintain certification and the ability to accept new clients;

f. If a score of 4.2 or higher on the DACTS/GOI is achieved, the team will be deemed as operating with "exceptional practice":

i. MCOs may grant extensions of eighteen (18) month intervals between fidelity reviews for teams operating with "exceptional practice".

e. Operating below acceptable fidelity thresholds:

i. Teams, which achieve less than a 3.0 on the DACTS/GOI, will forfeit the ability to accept new members though they can continue to work with existing members as long as there are no health and safety violations with operations as determined by the MCO or LDH;

ii. Teams shall implement a remediation plan and undergo another fidelity review within three (3) months by the MCO or designee. This review will be at the cost of the provider. If the team achieves an overall score of 3.0 or greater on the DACTS/GOI in the subsequent review, the team can begin accepting new referrals; and

iii. If the team achieves more than a 3.0 on the DACTS/GOI in subsequent review, the team can begin accepting new referrals.

- ~~Must participate in fidelity reviews using the DACTS/GOI conducted by Aetna Better Health or designee at least annually (every twelve (12) months) or more frequently as prescribed by Aetna Better Health.~~
    - ~~The team will implement an Aetna Better Health approved corrective action plan immediately for any individual DACTS criterion that rates a one (1) or two (2)~~
    - ~~Must achieve a score 3.0 and above on the DACTS/GOI in order to maintain certification and the ability to accept new clients~~
    - ~~If a 4.2 or higher on the DACTS/GOI is achieved, the team will be deemed as operating with "exceptional practice"~~
        - ~~Aetna Better Health may grant extensions of eighteen (18) month intervals between fidelity reviews for teams operating with "exceptional practice".~~

- ~~Operating~~ [AD14]~~below acceptable fidelity thresholds:~~
    - ~~Teams, which achieve less than a 3.0 on the DACTS/GOI, will forfeit the ability to accept new members though they can continue to work with existing members~~

~~as long as there are no health and safety violations with operations as determined by Aetna Better Health or LDH.~~

- ~~Teams shall implement a remediation plan and undergo another fidelity review within three (3) months by Aetna Better Health or designee~~
  - ~~If the team achieves more than a 3.0 on the DACTS/GOI in subsequent review, the team can begin accepting new referrals[11].~~

Medical Necessity Criteria

In addition to the LDH Behavioral Health Services Provider Manual, the primary medical necessity criteria used to authorize ACT services is 27~~5~~th Edition MCG Guideline Assertive Community Treatment ORG: B-808-T (BHG).

ACT serves members eighteen (18) years old or older who have a severe and persistent mental illness (SPMI) and members with co-occurring disorders listed in the diagnostic nomenclature (current diagnosis per DSM) that seriously impairs their functioning in the community.

The member must have one of the following diagnoses:

- Schizophrenia;
- Other psychotic disorder;
- Bipolar disorder; and/or
- Major depressive disorder.

These may also be accompanied by any of the following:

- Substance use disorder; or
- Developmental disability.

Include one or more of the following service needs:

- Two (2) or more acute psychiatric hospitalization and/or four (4) or more emergency room visits in the last six (6) months;

~~[11] LDH Behavioral Health Services Provider Manual, Appendix E: Evidence Based Practices (EBPs) Assertive Community Treatment, page 4-6, 13-15~~

- Persistent and severe symptoms of a psychiatric disability that interferes with the ability to function in daily life;
- Two (2) or more interactions with law enforcement in the past year for emergency services due to mental illness or substance use (this includes involuntary commitment);
- Currently residing in an inpatient bed, but clinically assessed to be able to live in a more independent situation if intensive services were provided;
- One or more incarcerations in the past year related to mental illness and/or substance use (Forensic Assertive Community Treatment (FACT));
- Psychiatric and judicial determination that FACT services are necessary to facilitate release from a forensic hospitalization or pre-trial to a lesser restrictive setting (FACT); or
- Recommendations by probation and parole, or a judge with a FACT screening interview, indicating services are necessary to prevent probation/parole violation (FACT).

Must have one (1) of the following:

• Inability to participate or remain engaged or respond to traditional community-based services;
• Inability to meet basic survival needs, or residing in substandard housing, homeless or at imminent risk of becoming homeless; or
• Services are necessary for diversion from forensic hospitalization, pretrial release or as a condition of probation to a lesser restrictive setting (FACT).[AD15][GK16]

Must have three (3) of the following:

- Evidence of co-existing mental illness and substance use disorder;
- Significant suicidal ideation, with a plan and ability to carry out within the last two (2) years;
- Suicide attempt in the last two (2) years;
- History of violence due to untreated mental illness/substance use within the last two (2) years;
- Lack of support systems;
- History of inadequate follow-through with treatment plan, resulting in psychiatric or medical instability;
- Threats of harm to others in the past two (2) years;
- History of significant psychotic symptomatology, such as command hallucinations

- ~~o~~ to harm others; or[AD17][GK18]
- Minimum LOCUS score of three (3) at admission[12].

~~All of the following criteria must also be met:~~

- ~~Recommended treatment is necessary and not appropriate for less intensive level of care (ie, patient requires assistance in accessing services; and documented behavior, symptoms, or risk is inappropriate for outpatient office care or traditional case management);~~
- ~~Current primary treatments (eg, pharmacotherapy) have been insufficient to meet care needs (or ACT is necessary to maintain adherence with recommended treatments);~~
- ~~Targeted symptoms, behaviors, and functional impairments related to underlying behavioral health disorder have been identified and are appropriate for ACT program;~~
- ~~Patient is expected to be able to adequately participate in and respond as planned to proposed treatment[13].~~

Exception criteria:

- The member does not meet medical necessity criteria above but is recommended as appropriate to receive ACT services by Aetna Better Health, the ACT team leader, clinical director and psychiatrist, in order to protect public safety and promote recovery from acute symptoms related to mental illness. Examples include:
  - Members discharging from institutions such as nursing facilities, prisons, and/or inpatient psychiatric hospitals,
  - Members with frequent incidence of emergency department (ED) presentations and/or involvement with crisis services,

~~o~~

  - Members identified as being part of the My Choice Louisiana Program target population who meet the following criteria, excluding those members with co-occurring SMI and dementia where dementia is the primary diagnosis:

[12] LDH Behavioral Health Services Provider Manual, Appendix E: Evidence Based Practices (EBPs) Assertive Community Treatment, pages 2-4

~~[13] 275th Edition MCG Guideline Assertive Community Treatment ORG: B-808-T (BHG).~~

- Medicaid-eligible members over age eighteen (18) with SMI currently residing in NF or
- Members over age eighteen (18) with SMI who are referred for a Pre-Admission Screening and Resident Review (PASRR) Level II evaluation of nursing facility placement on or after June 6, 2016.

Members whose functioning has improved to the point that they no longer require the level of services and supports typically rendered by an Assertive Community Treatment (ACT) team, should be transitioned into a lower level of care. When making this determination, considerations will be made regarding the member's ability to be served within the lower level of care available to them. The ACT team should begin implementing the discharge plan and preparing the member as functioning improves to the point that they no longer require the level of services and supports[14].[AD19]

ACT TEAMS MUST FORMALLY ASSESS MEMBER' NEEDS FOR ACT SERVICES AT LEAST ONCE EVERY SIX (6) MONTHS USING THE ACT TRANSITION ASSESSMENT SCALE, A TOOL THAT ESTABLISHES CRITERIA TO HELP DETERMINE WHETHER A CONSUMER MEMBER IS READY TO BE PLACED ON A GRADUATION TRACK TO TRANSITION TO A LESS INTENSIVE LEVEL OF CARE. AN INDIVIDUAL MAY BE PLACED WITHIN THE GRADUATION TRACK IF THEY ARE ASSESSED AT A ONE (1) OR TWO (2) ON ALL THE SCALED ITEMS. GRADUATIONS SHALL ALSO BE CONSIDERED FOR INDIVIDUALS ASSESSED AT A ONE (1) OR TWO (2) ON ALL SCALED ITEMS BUT ASSESSED AT A THREE (3) ON THE ACTIVITIES OF DAILY LIVING ITEM AND THREE (3) OR FOUR (4) ON THE COMMUNITY INTEGRATION ITEM. FURTHER, ASSESS THE MEMBER'S MOTIVATION TO GRADUATE OR TRANSITION FROM ACT, AGAIN CONSIDERING GRADUATIONS FOR INDIVIDUALS ASSESSED AT A THREE (3) OR FOUR (4) ON THIS ITEM. TEAMS ARE ENCOURAGED TO CONTINUALLY ASSESS THE SERVICE NEEDS OF PARTICIPANTS AS THE MEMBER'S NEEDS CHANGE. ~~***OPERATING PROTOCOL:***~~

~~***Systems***~~

~~The business application system has the capacity to electronically store and report all service authorization requests, decisions made by Aetna Better Health regarding the service requests, clinical data to support the decision, and timeframes for notification to practitioners/providers and members of decisions.~~

[14] LDH Behavioral Health Services Provider Manual, Appendix E: Evidence Based Practices (EBPs) Assertive Community Treatment, page 4, 8

~~Prior authorization requests, decisions and status are documented in the business application system prior authorization module.~~

~~Measurement~~

~~The Prior Authorization department measures:~~

- ~~Volume of requests received by telephone, facsimile, mail, and website, respectively~~
- ~~Service level~~
- ~~Timeliness of decisions and notifications~~
- ~~Process performance rates for the following, using established standards:~~
  - ~~Telephone abandonment rate: under five percent (5%)~~
  - ~~Average telephone answer time: within thirty (30) seconds~~
  - ~~Consistency in the use of criteria in the decision-making process among Prior Authorization staff measured by annual inter-rater reliability audits~~
  - ~~Consistency in documentation by department file audits at least quarterly~~
- ~~Percentage of prior authorization requests approved~~
- ~~Trend analysis of prior authorization requests approved~~
- ~~Percentage of prior authorization requests denied~~
- ~~Trend analysis of prior authorization requests denied~~

~~Reporting~~

- ~~Monthly report to the CMO of the following:~~
  - ~~Number of incoming calls~~
  - ~~Call abandonment rate~~
  - ~~Trend analysis of incoming calls~~
  - ~~Average telephone answer time~~
  - ~~Total authorization requests by source – mail, fax, phone, web~~
  - ~~Number of denials by type (administrative/medical necessity)~~
- ~~Utilization tracking and trending is reviewed by the CMO on a monthly basis and is reported at a minimum of quarterly to the QM/UM Committee~~
- ~~Annual report of inter-rater reliability assessment results~~

~~***INTER-/INTRA-DEPENDENCIES:***~~

~~***Internal***~~

- ~~Claims~~
- ~~Chief medical officer/medical directors~~
- ~~Finance~~
- ~~Information Technology~~
- ~~Medical Management~~
- ~~Member Services~~
- ~~Provider Services~~
- ~~Quality Management~~
- ~~Quality Management/Utilization Management Committee~~

~~***External***~~

- ~~Members~~
- ~~Practitioners and providers~~
- ~~Regulatory bodies~~

It is imperative that graduation be gradual, planned and individualized with assured continuity of care. More specifically, ACT teams shall employ the following strategies regarding graduations:

1. Introduce the idea of graduation from the very beginning of the member's enrollment (even during the engagement phase) and continue the discussion throughout their enrollment;

2. Frame graduation within the larger process of the member's recovery, enhanced well-being and independence in life;

3. Involve ACT team members in a discussion of the individual's potential for graduation and plans necessary to ensure successful transition to a less intensive level of care;

4. Involve the member in all plans related to his/her graduation;

5. Assess the member's motivation for transition to the graduation track and provide motivational interviewing interventions as appropriate to increase their comfort and interest in the graduation;

6. Be prepared with appropriate interventions should consumer the member temporarily experience an increase in symptoms or begin to "backslide" on treatment goals in response to graduation plans;

7. Involve the member's social network, including their family or support of choice, in developing and reviewing their graduation plan to the extent approved by the participant;

8. Coordinate several meetings with member, relevant ACT team members, and new service provider to introduce the new provider as well as review the participant's current status, progress in ACT and future goals;

9. Temporarily overlap ACT services with those of new provider for 30-60 days; and

10. Monitor the member's status following transition and assist the new provider, as needed, especially for the next 30-60 days.

Teams shall ensure member participation in discharge activities, as evidenced by the following documentation:

1. The reasons for discharge as stated by the member and ACT team;

2. The participant's biopsychosocial status at discharge;

3. A written final evaluation summary of the member's progress toward the goals set forth in the person-centered treatment plan;

4. A plan developed in conjunction with the member for follow-up treatment after discharge; and

5. The signature of the member, their primary practitioner, the team leader and the psychiatric prescriber.

When clinically necessary, the team will make provisions for the expedited re-entry of discharged members as rapidly as possible. If immediate re-admission to the ACT team is not possible because of a full census, the provider will prioritize members who have graduated but need readmission to ACT.

Aetna Better Health

~~Richard C. Born~~**Jess Hall**
Chief Executive Officer

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MD
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Policy

Policy Name:	Assertive Community Treatment (ACT) Services	Page:	22 of 22
Department:	Medical Management	Policy Number:	7100.35
Subsection:	Prior Authorization	Effective Date:	12/28/2020
Applies to:	■ Medicaid Health Plans		

Jared Wakeman, MD
Behavioral Health Medical Director

Review/Revision History	
12/28/2020	**New Policy**
11/2021	Updated NCQA references and MCG edition. Corrected name of MCG criterion. Added page numbers for LDH Behavioral Health Services manual reference.
03/2022	Added additional language from the LDH Behavioral Health Services manual regarding the minimum number of meaningful contacts. Added BH MD signatory line.
03/2023	**Removed unnecessary language: Aetna Better Health Responsibilities and Operating Protocol sections; Updated with 2023 Louisiana Medicaid Managed Care Organization Model Contract reference; Updated purpose, objectives, and references sections for clarity, Updated MCG, Removed MCG language for MNC**
11/2023	**Added language from the updated Louisiana Department of Health (LDH) Behavioral Health Services Provider Manual.**