ACT Step-Down Alternative (in lieu of) Service Proposal
Alliance Behavioral Healthcare

July 29, 2016

1. Service Name and Description:

Service Name: Assertive Community Treatment Step-Down (ACT-SD)

Procedure Code: License: H0040 TS

Description: ACT Step-Down (ACT-SD) will be the next lower level of care under ACT. The service will be provided by organizations that meet all of the provider requirements for Assertive Community Treatment (ACT) Team in DMA Clinical Policy 8A-1; ACT-SD will be provided by identified ACT team members within the provider organization. Only ACT Teams who have achieved full certification status, as measured by a rating of at least 3.7 on the Tool for Measurement of ACT (TMACT), will be permitted to offer ACT-SD services. An ACT Team is permitted to serve up to 20 individuals through their ACT-SD program.

ACT-SD is an intensive clinical case management model with a foundation in wellness management and recovery practices. Unlike ACT, where multiple services are bundled together in a single program thereby requiring a multidisciplinary team, ACT-SD staff will be limited to psychiatry, nursing, clinical case management, and peer supports. However, if an immediate need arises the specialists on the primary ACT team would be utilized as a first responder to help assess and stabilize. It would then be determined whether the consumer needs transition back to the full ACT service. Services provided through ACT-SD include:

- Psychiatric Services (MD/DO, completed psychiatric residency)
  - Psychiatric assessment, medication and symptom management, and brief supportive therapy;
  - Some coordination with other providers for both physical and psychiatric care needs;
  - Expectation is that ACT-SD service recipients are seen by the psychiatrist at least every three months.
- Nursing (RN or LPN)
  - Provision of injectable antipsychotic medications.
- Clinical Case Management (QP, preferably also a certified peer support specialist)
  - Person-centered planning and crisis planning;
  - Community-based service delivery and monitoring;
  - Benefits management;
  - Medication coordination and delivery;
  - Supportive therapy (more formal therapy may be delivered, conditioned on QP's training and license);
  - Family psycho-education;
  - Advocacy;
  - Supportive housing, which includes tenancy supports;

    - Peer supports;
    - Wellness management and recovery, which includes "manualized" curricula, such as Illness Management and Recovery (IMR); Wellness Management and Recovery (WMR); Wellness Recovery Action Plans (WRAP); Psychiatric Advance Directives (PADs).
- 24/7 Crisis Services: The Home ACT Team (i.e., not just identified ACT-SD team members) shall provide "first responder" crisis response 24 hours a day, 7 days a week, 365 days a year to beneficiaries experiencing a crisis.
    - Team members shall directly receive all crisis calls from beneficiaries without routine triaging by a third party.
    - Team members who are on-call shall have access to necessary information, such as all beneficiaries' crisis plans.
    - Many crisis calls will likely be handled on the phone directly with the beneficiary or by coordinating with other providers or natural supports (e.g., hospital staff, residential workers, housing provider, family members).
    - As needed, licensed team members shall be available to provide on-site assessment, de-escalation, and follow-up. Team members are not responsible for finding a disposition for a consumer once he or she is already in an ED or hospital setting.
    - Psychiatric coverage shall be available 24 hours per day. It is also necessary to arrange for and provide psychiatric back-up for all hours that the psychiatric care provider is not regularly scheduled to work.
    - First responder crisis response by the ACT Team is included in the ACT-SD per diem;
    - Mobile Crisis will be used as a back-up if the Home Act Team is not available.

ACT-SD will review all ACT-SD service recipients as part of the ACT daily team meeting at least weekly. ACT-SD services provided to the service recipient shall include a minimum of one contact per month in the individual's residence. ACT-SD service recipients are expected to receive at least three face-to-face contacts each month. It is expected, over the duration of the service, for more contacts to be community-based early-on, with a transition to more office-based services later in order to prepare the recipient for transition to traditional office-based services.

Concurrent Billing

As ACT-SD is not intended to be an all-inclusive, bundled service program (unlike ACT), some services are provided by the ACT-SD Team, and some may be provided by other non-ACT service providers given the limited scope of practice for the ACT-SD team. An ACT-SD recipient is limited to no more than two of these additional services (as it indicates a need for a higher level of care, such as ACT). The services that may be provided concurrently with ACT-SD if deemed medically necessary include:

- Psychosocial Rehabilitation (PSR);
- Supported Employment/Individual Placement and Support (IPS);
- Outpatient Therapy (e.g., DBT, CBT for psychosis, substance abuse counseling);
- Opioid Treatment;
- Detoxification Services;

- Facility Based Crisis;
- Substance Abuse Residential Treatment; or
- Adult mental health residential programs (for example, supervised living low or moderate; or group living low, moderate, or high);
- Mobile Crisis.

Determination of medical necessity for each of these services will take into account services expected to be provided by ACT-SD and whether or not traditional ACT would better meet the needs of each consumer requesting the additional service.

Transitioning from ACT to ACT-SD
Individuals identified for ACT-SD may continue with select ACT specialty services (e.g., receiving vocational or substance abuse services) during the initial transition phase, prior to the ACT-SD team being able to transition specialty services to other non-ACT providers.

2. Information About Population to be Served:

Population	Age Ranges	Projected Numbers	Characteristics
For initial entry into ACT-SD: individuals with severe and persistent mental illness who qualified for and received ACT services for at least six months, and ACT as a comprehensive, bundled service program is judged to be no longer medically necessary given the individual's	At least 18 years of age	A large ACT Team (serving a maximum (as yearly average) of 120 individuals) will have an additional 20 slots reserved for ACT-SD. Note that ACT-SD service recipients will not be considered as part of the enrollment roster of the home base ACT program.	Medicaid shall cover ACT-SD services for a beneficiary with a primary diagnosis of schizophrenia, other psychotic disorders (e.g., schizoaffective disorder), and bipolar disorder. Beneficiaries with other psychiatric illnesses are eligible dependent on their former enrollment in ACT services for at least six months. Individuals who had been receiving ACT services and who are now eligible for ACT-SD 1) no longer meet full ACT criteria reflecting high-service needs; and 2) are determined to not be appropriate for alternative programs or interventions within the LME-MCO at this time. Those eligible for ACT-SD do not meet any of the following ACT eligibility criteria: 1. High use of acute psychiatric hospital (2 or more admissions during the past 12 months) or psychiatric emergency services;

person-centered goals.			2. Coexisting mental health and active substance abuse/use disorders of significant duration (more than 6 months) and ongoing severity; 3. High risk or recent history (past six months) of criminal justice involvement (such as arrest, incarceration, probation); OR 4. Significant difficulty meeting basic survival needs, residing in substandard housing, homelessness, or imminent risk of homelessness. ACT-SD is determined to be the appropriate level of care compared to other available alternative interventions or programs within the LME-MCO service array. Such determination is based on the following: 1) The individual is judged to be in need of ongoing, community based outreach and supports, which involve psychiatric care provider outreach, to ensure stability and avoid significant negative consequences (e.g., death, victimization, hospitalization, homelessness, violence) that will compromise their recovery. Such judgment is based on a) service history, particularly during times of medication non-adherence and psychiatric decompensation; and b) and overall chronicity of their psychiatric illness (e.g., significant enduring paranoia or delusions, significant negative symptoms of schizophrenia). OR 2) The individual is judged to be in need of a more strategic and titrated transition to less intensive services to minimize risk of relapse and/or psychiatric decompensation and increase probability of a successful

			graduation to a lower level of care. Such judgment is based on a) individual's attachment to the team, and related anxiety about transition despite improvements in functioning; and/or b) a person-centered plan that indicates a time-limited continuation of psychiatric outreach and supports, while the individual, who is operating at a greater level of independence, continues to use limited ACT team specialty services.

3. Treatment Program Philosophy, Goals and Objectives:

ACT-SD will be person-centered and recovery focused, and with an aim of not only helping individuals maintain stability in areas of functioning and wellness valued by the person, but also helping individuals continue on their own path of recovery through person-centered planning and service delivery.

ACT-SD will serve the needs of two distinct groups: those in need of ongoing supports, but at a less intensive and comprehensive level than ACT and those who need prolonged transition period to ensure successful graduation to a lower level of care.

ACT-SD as a longer-term support will be used for those individuals who have achieved a level of stability that is within their satisfaction, but whose history indicates a high risk of decompensation, as indicated by risks to self or others, hospitalizations, and/or homelessness, if continual community-based support is not provided. Psychiatric outreach, which may include more focused medication supports, have shown to be critical to these individuals' stabilization.

ACT-SD as a graduated transition will be used for those individuals who have demonstrated more limited use of the breadth of ACT services, primarily due to improved functioning, but would benefit from time-limited psychiatric care provider outreach as the team titrates down services and connects to alternative lower level of care programs and services. Such individuals may have attachments to the ACT team that are generating anxiety about the prospect of transition, resulting in acute exacerbations in symptoms.

Services will include those directly provided by ACT-SD, as well as connecting service recipients to a larger array of community supports and resources, including paid and unpaid supports, in their community. The majority of services will be provided in the community, and will be provided anytime throughout the week, as directed by the needs cited in the person-centered plan. Wellness Management and Recovery (WMR) services will be the foundation of ACT-SD to help service recipients assume greater responsibility and ownership for their own self-care. Service goals and objectives are therefore attending to the

values and preferences of the individuals served, with an emphasis on growth and recovery, including greater independence in self-care and functioning, resulting in lower level of care needs.

4. Expected Outcomes:

Given the provision of ACT-SD services, it is expected that service recipients will demonstrate continued stabilization within the community (e.g., absence or very limited use of psychiatric inpatient services and no jail time) and growth in life areas valued by the service recipient, which includes:

a. Maintenance of current areas of functioning and wellness, as desired and valued by the service recipient;
b. Increased use of wellness self-management and recovery tools, which includes independence around medication management; and
c. Vocational/educational gains;
d. Increased length of stay in independent, community residence;
e. Increased functioning in activities of daily living, such as independence around money management and transportation;
f. Increased use of natural supports and development of meaningful personal relationships; and
g. Improved physical health

5. Staffing Qualifications, Credentialing Process, and Levels of Supervision (Administrative and Clinical) Required:

ACT-SD is provided by organizations that meet all of the requirements for ACT Team in DMA Clinical Policy 8A and are enrolled in the LME/MCO network.

The Home ACT team administering ACT-SD will meet minimal ACT staffing requirements as defined in DMA Clinical Policy 8A-1, ACT Team, "Staff Qualifications," and further augmented with additional staffing:

- Psychiatric Care Provider (Psychiatrist, Psychiatric Nurse Practitioner (PNP) or Physician Assistant (PA) at 0.20 FTE (8 hours/week); and
- 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 is preferred (CPSS).
- A RN or LPN ACT Nurse at 0.025 FTE (1 hour a week) will be available to provide injections or medication monitoring as ordered for the individuals. If the nursing is provided by a LPN, they are under the direct supervision of a home ACT RN and operating within the scope of NC Nursing Board Practice Guidelines.
- The ACT-SD Psychiatric Care Provider must also serve on the home ACT Team and cannot be exclusively assigned only to ACT-SD recipients.

The majority of ACT-SD services will be provided by the ACT-SD psychiatric care coordinator, QP. (In order to honor service recipient choice, ACT Team staff may also assist with ACT-SD services, with the exception of providing ongoing specialty services, such as substance abuse treatment by the substance abuse specialist, vocational services from the vocational specialist, and nursing services, excluding provision of injections, from the RN or LPN).

Staff time utilized for ACT-SD is accounted for through use of additional staff or splitting positions. ACT program team members cannot serve on both teams at the same time. Staff must be dedicated to either ACTT or ACT-SD during a single time span. This is accomplished by adding additional FTEs to the ACT program as described in the ACT-SD definition.

For example, an ACT program that provides ACTT (to 100 individuals) and ACT-SD (to 20 individuals) will be staffed as follows to account for the addition of ACT-SD:

- 1 psychiatric care provider FTE, minimum (.8 FTE for ACTT + .2 FTE for ACT-SD)
- 4 QP/AP FTEs, minimum (3 FTEs for ACTT + 1 FTE for ACT-SD)

3.025 RN FTEs, (3 FTEs for ACTT + .025 FTE for ACT-SD) or 2.0
RN FTE's, 1.0 LPN FTE's and .025 LPN under the direct supervision of one of the home ACT RNs, minimum. ACT program staff may serve on both ACTT and ACT-SD during different times of the day; for example, the same staff person may be scheduled to serve on ACTT from 8 a.m. to 4 p.m. and on ACT-SD from 4 p.m. to 6 p.m. as long as they are fully dedicated to the specific service at the scheduled time, and time to each service is documented.
The provider agrees to ensure that the ACTT staffing ratios will continue to be met or exceeded. In addition, the time that any staff spend providing services to ACT-SD consumers will be tracked and counted only toward fulfilling requirements for ACT-SD. This time will not be counted toward ACTT consumer contact and service requirements.

6. ACT Re-Entry

ACT-SD service recipients may be stepped back up to ACT services (thereby increasing intensity of services, as well as receipt of full breadth of services from the team) when the service is judged by the ACT-SD psychiatrist to be medically necessary given an acute exacerbation of illness or significant reduction in functional status that is not adequately addressed by ACT-SD within 4 weeks, and for which ACT is medically necessary to address. In such cases, the goal will be for ACT to stabilize the individual and return to ACT-SD, once determined medically appropriate.

7. Unit of Service:

The provider(s) shall report the appropriate code(s) used which determines the billing unit(s). 1 Unit = 1 event. ACT-SD service recipients will be limited to billing of two events per month.

ACT-SD per diems may only be billed on days when ACT-SD team has performed a face-to-face service with the beneficiary. Only one per diem may be billed per beneficiary per day. All other contacts, meetings, travel time, etc. are considered indirect costs and are accounted for in the buildup of the per diem rate. For the per diem rate to be generated, a 15 minute face-to-face contact that meets all requirements outlined in the NC Clinical Coverage Policy for ACT is required. A 15-minute contact is defined as lasting at least 8 minutes. Practitioners may not bill for services included in the ACT-SD per diem (H0040 TS) and also bill for that service outside of the per diem rate for beneficiaries enrolled in ACT Step Down.

8. Anticipated Units of Service per Person:

ACT-SD Service recipients are limited to billing of two service units per month. However, there is an expectation that individuals are seen (face-to-face with ACT-SD Team) at least three times per month.

9. Targeted Length of Service:

Continued need for ACT-Step Down will be monitored every 6 months, using a standardized tool (ACT Transition Readiness (ATR) to guide that review), with no specific arbitrary limitations on length of stay. The ATR will be pilot-tested to determine how it can be best used to identify readiness for ACT-SD.

10. Describe why this service is needed and is different than any State Plan or alternative service already defined. If implemented in other states, describe successful outcomes.

There is a significant service system gap between the level of care offered by Assertive Community Treatment (ACT) and what is conceivably the next lower level of care, Community Support Team (CST). For many ACT service recipients, they have demonstrated improvements in functioning and symptom stability, but moving to office based care and medication management is not sufficient, and they no longer qualify for the more restrictive eligibility criteria for CST. What is needed is an alternative level of care that can provide longer-term clinical case management supports with moderate intensity, and promotes continuity of care and ease of service access across ACT and ACT-SD, including the retention of their ACTT prescriber. Using the ACT-SD approach, it is hoped that transitions out of ACTT will be more successful as well as more efficient, and that recipients will experience less disturbance in their recovery. Use of ACTT-SD is expected to improve the success of a full transition to traditional office-based services for ACTT recipients.

ACT-SD will be carefully evaluated to clarify optimal eligibility criteria for ACT-SD, transition-readiness criteria (being discharged from ACT-SD to a lower level of care), as well as criteria indicating that ACT-SD is no longer sufficient, and ACT is once again recommended.

11. Cost-Benefit Analysis: Document the cost-effectiveness of this alternative service versus the State Plan services available.

Description of comparable State Plan Service Payment Arrangements (include type, amount, frequency, etc.)

Service	Procedure Code	Unit Definition	Units of Service	Cost of Service
ACTT	H0040	15 min face-to-face contact	4/month	$1295.92/mo.

Description of Alternative Service Payment Arrangements (include type, amount, frequency, etc.)

Service	Procedure Code	Unit Definition	Units of Service	Cost of Service
ACT-SD	H0040 TS	15 min face-to-face contact	2/month	$647.96/mo.

Cost Effectiveness Summary:
Based on our experience with ACT and the population it serves, and information shared from the UNC ACT Team who has implemented ACT-SD in the Cardinal LME-MCO, we believe that ACT-SD will be a cost effective alternative for a subset of the current ACT population based on the following assumptions:

- ACT consumers tend to be long-term. ACT Providers in the Alliance catchment project that over half of their consumers have been with them 3 years or more.
- Based on our providers' reported experience with ACT, at least 10% of individuals participating in ACT reach a point after at least six months where the comprehensive ACT service and staffing array are no longer needed and should be replaced with a less intensive model. However, there is no step-down or transitional service available, so these individuals must either continue participating in ACT to receive the support they need, or if discharged, risk relapse or decompensation. Many of these individuals will not meet the criteria for CST when they would qualify for ACT-SD. In addition, a gradual transition may be beneficial from ACT to ACT-SD and then to a lesser intense service if possible.
- Alliance concurs with the projection that the 10% who would access ACT-SD consist of two broad categories of need: Group 1) individuals judged to be in need of ongoing (long-term) community-based supports due to a high risk of decompensation (2/3 of the 10%); and, Group 2) individuals in need of graduated transition, who have largely

achieved their goals and need short-term support in transitioning to more independent functioning and a lower level of care (1/3 of the 10%).

- In calendar year 2015, Alliance paid an average of $8392.46 per individual or $10,402,642 for 1241 individuals. If 10% were able to take advantage of ACT-SD this would be an average savings of $520,013 across the year representing 124 individuals.

Alliance Behavioral Healthcare will monitor utilization of ACT-SD, plus concurrently billed services, on a pmpm basis and compare findings to what the pmpm cost would have been if individuals were to receive ACT Team instead.

Description of Process for Reporting Encounter Data (include record type, codes to be used, etc.)

ACT-SD encounters would be reported in the same manner as the State Plan ACTT service, i.e., the units per month billed would be reported. If required by the state, ACT teams can be required to track and report quarterly how many actual contacts occurred.

Description of Monitoring Activities :

*Evaluations of the Home ACT team using the Tool for Measurement of ACT (TMACT) will not consider ACT-SD service recipients as part of the ACT team roster. Staffing FTE associated with the ACT-SD will be considered and adjusted when reviewing the Home ACT team using the TMACT. That is, 0.20 FTE will be deducted from the total ACT psychiatry time. Similarly, CPSS-QP FTE will not count for both ACT and ACT-SD. Staff serving in both ACT and ACT-SD will have supporting documentation for their time in each separate service.