Assertive Community Treatment in Ohio’s BH Redesign: Planning for the Future

March 25, 2017
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Douglas Day, Ohio Department of Mental Health and Addiction Services
Ohio Medicaid Behavioral Health Redesign Initiative

The Redesign Initiative is an integral component of Ohio’s comprehensive strategy to rebuild community behavioral health system capacity.

The Initiative is based on key Medicaid behavioral health reforms implemented in four steps:

- **Elevation**
  Financing of Medicaid behavioral health services moved from county administrators to the state.

- **Expansion**
  Ohio implemented Medicaid expansion to extend Medicaid coverage to more low-income Ohioans, including 500,000 residents with behavioral health needs.

- **Modernization**
  ODM and OhioMHAS are charged with modernizing the behavioral health benefit package to align with national standards and expand services to those most in need.

- **Integration**
  Post benefit modernization, the Medicaid behavioral health benefit will be fully integrated into Medicaid managed care.
Ohio Medicaid Behavioral Health Redesign Initiative
Where we are Today

Elevation – Completed as of July 1, 2012.

Expansion – Completed as of January 1, 2014.

Modernization – Underway, ODM and OhioMHAS are modernizing the community behavioral health benefit package to align with national standards and expand services to those most in need. Implementation on target for July 1, 2017.

Integration – Post benefit modernization, the community Medicaid behavioral health benefit will be fully integrated into Medicaid managed care. Implementation on target for January 1, 2018.
Behavioral Health Redesign Vision

OUTCOMES & VISION:

» All Providers: Follow NCCI & practice at the top of their scope of practice

» Integration of Behavioral Health & Physical Health services

» High intensity services available for those most in need

» Developing new services for individuals with high intensity service and support needs;

» Services & supports available for all Ohioans with needs: Services are sustainable within budgeted resources

» Implementation of value-based payment methodology

» Coordination of benefits across payers

» Improving health outcomes through better care coordination; and

» Recoding of all Medicaid behavioral health services to achieve alignment with national coding standards.
### Expanded Medicaid Behavioral Health Service Codes

#### *Current State of Behavioral Health*

- **8 service codes for MH & 10 service codes for SUD**
- Limited access to primary care services
- Payment rates based on provider reported costs; not parallel with other Medicaid rates
- MANY practitioners render each service, but rates are the same regardless of practitioner credentials
- No indication of which practitioner rendered the service
- Units can be billed in decimals
- No enforcement of billing Medicare or third party health insurer before billing Medicaid

*Currently, not aligned with national health care coding standards*

#### Future State of Behavioral Health

- Expanded CPT and HCPCS codes; all standardized with national coding standards
- SUD benefit aligned with ASAM criteria
- Services added to MH and SUD benefit package, including:
  - CLIA waived testing
  - Vaccines and administration
  - ACT
  - SUD residential
  - Buprenorphine administration (OTPs)
- Payment rates scaled to credentials of rendering practitioner
- Rendering practitioner on claims
- Third Party Liability enforced on all claims, assuring Medicaid is the last payer

**Added Medicaid Coverage for:**
- Assertive Community Treatment (adults)
- Intensive Home Based Treatment (youth)
- Buprenorphine administration (OTPs)
New Mental Health Benefit

July 1, 2017
BH Redesign Changes Support the Treatment of Mental Illness

Efforts

- Expanding MH Benefit package
- Adding family psychotherapy both with and without the patient
- Adding primary care services, labs & vaccines
- Adding coverage for psychotherapy, psychological testing
- Adding evidence based/state best practices:
  - Assertive Community Treatment - adults with SPMI
  - Intensive Home Based Treatment - youth at risk of out of home placement
- Expanding community based rehabilitation: Therapeutic Behavioral Services & Psychosocial Rehabilitation & maintaining coverage of CPST
- Maintaining prior authorization exemption for second generation antipsychotic medications when dispensed by physicians with a psychiatric specialty and in the standard tablet/capsule formulation
- Expanding eligibility for children’s respite care
# Medicaid Mental Health Benefit – July 1, 2017

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<thead>
<tr>
<th>Service Type</th>
<th>Description</th>
<th>Eligibility</th>
<th>Covered Codes</th>
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<tr>
<td>Psychotherapy CPT Codes</td>
<td>Individual, group, family and crisis</td>
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<td>Psychiatric Diagnostic Evaluation</td>
<td>Assessing treatment needs &amp; developing a plan for care</td>
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<td>Medical (Office/Home, E&amp;M, Nursing)</td>
<td>Medical practitioner services provided to MH patients</td>
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<td>Assertive Community Treatment (ACT)</td>
<td>Comprehensive team based care for adults with SPMI</td>
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<td>Intensive Home-Based Treatment (IHBT)</td>
<td>Comprehensive team based care for children/adolescents with SPMI</td>
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<td>Group Day Treatment</td>
<td>Teaching skills and providing supports to maintain community based care</td>
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<td>Crisis Services</td>
<td>Covered under crisis psychotherapy and other HCPCS codes</td>
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<td>Intensive Home-Based Treatment</td>
<td>Helping SED youth remain in their homes and the community</td>
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<td>CPST</td>
<td>Care Coordination</td>
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<td>Screening, Brief Intervention and Referral to Treatment (SBIRT)</td>
<td>Screening and brief interventions for substance use disorder(s)</td>
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<td>Therapeutic Behavioral Service (TBS)</td>
<td>Provided by paraprofessionals with Master’s, Bachelor’s or 3 years experience</td>
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<tr>
<td>Psychosocial Rehabilitation (PSR)</td>
<td>Provided by paraprofessionals with less than Bachelor’s or less than 3 years experience</td>
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<td>Respite for Children and their Families</td>
<td>Providing short term relief to caregivers</td>
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<td>Office Administered Medications</td>
<td>Long Acting Psychotropics</td>
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<tr>
<td>Psychological Testing</td>
<td>Neurobehavioral, developmental, and psychological</td>
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Substance Use Disorder (SUD) Benefit

July 1, 2017
ASAM Levels of Care

The green arrow represents the scope of Ohio’s Medicaid BH Redesign.
# Medicaid Substance Use Disorder Benefit – July 1, 2017

## Outpatient
**Adolescents:** Less than 6 hrs/wk  
**Adults:** Less than 9 hrs/wk
- Assessment
- Psychiatric Diagnostic Evaluation
- Counseling and Therapy  
  - Individual, Group, Family, and Crisis
- Medical
- Medications
- Buprenorphine and Methadone Administration
- Urine Drug Screening
- Peer Recovery Support
- Case Management
- Level 1 Withdrawal Management (billed as a combination of medical services)

## Intensive Outpatient
**Adolescents:** 6 to 19.9 hrs/wk  
**Adults:** 9 to 19.9 hrs/wk
- Assessment
- Psychiatric Diagnostic Evaluation
- Counseling and Therapy  
  - Individual, Group, Family, and Crisis
- Medical
- Medications
- Buprenorphine and Methadone Administration
- Urine Drug Screening
- Peer Recovery Support
- Case Management
- Level 1 Withdrawal Management (billed as a combination of medical services)
- Additional coding for longer duration group counseling/psychotherapy
- Level 2 Withdrawal Management (billed as a combination of medical services)

## Partial Hospitalization
**Adolescents:** 20 or more hrs/wk  
**Adults:** 20 or more hrs/wk
- Assessment
- Psychiatric Diagnostic Evaluation
- Counseling and Therapy  
  - Individual, Group, Family, and Crisis
- Medical
- Medications
- Buprenorphine and Methadone Administration
- Urine Drug Screening
- Peer Recovery Support
- Case Management
- Level 1 Withdrawal Management (billed as a combination of medical services)
- Additional coding for longer duration group counseling/psychotherapy
- Level 2 Withdrawal Management (billed as a combination of medical services)

## Residential
- Per Diems supporting all four residential levels of care including:
  - clinically managed
  - medically monitored
  - two residential levels of care for withdrawal management
  - Level 2 Withdrawal Management (billed as a combination of medical services OR 23 hour observation bed per diem)
- Medications
- Buprenorphine and Methadone Administration
- Medicaid is federally prohibited from covering room and board/housing
- Level 2 Withdrawal Management (billed as a combination of medical services OR 23 hour observation bed per diem)
Medicaid Funded
Assertive Community Treatment (ACT)
Beginning Jan 1, 2017, agencies employing ACT team(s) may begin requesting CWRU to perform Fidelity Review (DACTS Scale) for Medicaid enrollment.

Once an agency ACT team has met minimum fidelity, they may be enrolled in Ohio Medicaid and begin submitting prior authorization requests for consumers in their ACT caseload.

Medicaid billable ACT services begin July 1, 2017.
Why Initiate Medicaid Payment for ACT?

1. Investing in “what works” – an evidence-based practice
2. Improve health outcomes
3. Reduce use of emergency room and inpatient hospital admissions
4. Improve stability of community living & quality of life
5. Available to Medicaid enrollees with the most complex mental health conditions who meet eligibility criteria
6. Only ACT teams who meet and maintain minimum fidelity to the model may bill Medicaid for ACT intervention
Fidelity Measures to qualify for ACT billing methodology were built on recommendations and discussions from November 2015.
ACT Policy Update

1. ACT team fidelity measurement will be based on DACTS until carve in to managed care.
   - Team Fidelity must be measured by CWRU Center for Evidence Based Practice under contract with ODM.
   - TMACT fidelity measurement encouraged post carve in.

2. ACT payment rates set at the Medium caseload size regardless of the actual caseload size. Caseloads no larger than 120 / staffing capacity must have staff to client ratio of 1 to 10.

3. ACT enrollment and caseload:
   - All ACT enrollees must be prior authorized by ODM PA vendor regardless of previous ACT enrollment
   - Caseload may include both Medicaid and non-Medicaid enrollees; Teams must assure that total caseload size doesn’t exceed FTE capacity noted at time of Fidelity rating
   - Agencies may have more than one ACT Team

For additional reference on DACTS:
Dartmouth ACT Fidelity Scale Protocol (1/16/03)

For additional reference on TMACT:
Tool for Measurement of Assertive Community Treatment (TMACT) Summary Scale Version 1.0
ACT Policy Update Cont’d

Requirements for ACT Team Leaders:
• Must be dedicated to one team.
• Must be licensed (preferably licensed independent with a supervisory endorsement)
• Be enrolled in MITS as an active Medicaid provider.

No Medicaid payment for supported employment /vocational rehabilitation services unless the person is enrolled in SRS program.

ACT team members responsible for providing ASAM Level 1 services to enrollees as part of the ACT service.

For additional reference on DACTS:
Dartmouth ACT Fidelity Scale Protocol (1/16/03)

For additional reference on TMACT:
Tool for Measurement of Assertive Community Treatment (TMACT) Summary Scale Version 1.0
Role and Responsibilities of the ACT Team Leader

- Operate as the point of contact for ODM and their PA vendor

- Will be the “clinician of record” that links an ACT enrollee with an ACT team

- Be listed as the “Rendering” or “Supervising” practitioner on claims as appropriate

ODM requires that a team leader:
- Lead only one ACT team and
- Be licensed (preferably licensed independent with a supervisory endorsement)
ACT Team Monthly Billing Example – Physician Prescriber

**DACTS (w/ 2 BAs):**
- **Code - H0040**
- **Unit Rates**
  - MD/DO: $615.64
  - Master’s/RN/LPN: $251.91
  - Bachelor’s: $199.70
  - Total: $1,266.95

**DACTS (w/ 1 BA, 1 PRS):**
- **Code - H0040**
- **Unit Rates**
  - MD/DO: $615.64
  - Master’s/RN/LPN: $251.91
  - Bachelor’s: $199.70
  - Peer Recovery Supporter: $159.24
  - Total: $1,226.49

**DACTS (w/ 2 PRSs):**
- **Code - H0040**
- **Unit Rates**
  - MD/DO: $615.64
  - Master’s/RN/LPN: $251.91
  - Bachelor’s: $199.70
  - Peer Recovery Supporter: $159.24
  - Peer Recovery Supporter: $159.24
  - Total: $1,186.03

**ACT is a fully prior authorized service**
ACT Team Monthly Billing Example – APRN/PA Prescriber

**DACTS (w/ 2 BAs):** Code - H0040

- **APRN/PA**
  - Unit Rate: $352.75
- **Master’s/ RN/LPN**
  - Unit Rate: $251.91
- **Bachelor’s**
  - Unit Rate: $199.70
- **Total:** $1,004.06

**DACTS (w/ 1 BA, 1 PRS):** Code - H0040

- **APRN/PA**
  - Unit Rate: $352.75
- **Master’s/ RN/LPN**
  - Unit Rate: $251.91
- **Bachelor’s**
  - Unit Rate: $199.70
- **Peer Recovery Supporter**
  - Unit Rate: $159.24
- **Total:** $963.60

**DACTS (w/ 2 PRSs):** Code - H0040

- **APRN/PA**
  - Unit Rate: $352.75
- **Master’s/ RN/LPN**
  - Unit Rate: $251.91
- **Peer Recovery Supporter**
  - Unit Rate: $159.24
- **Peer Recovery Supporter**
  - Unit Rate: $159.24
- **Total:** $923.14

**ACT is a fully prior authorized service**
A 57-year-old client, Mary, is receiving services from an ACT team. She has Schizophrenia with a long history of multiple inpatient hospitalizations due to chronic paranoia, hallucinations, disorganized and delusional thinking. She has been able to maintain community living since initiating services with the ACT team 2 months ago. However, she continues to have poor medication compliance with her recently prescribed Clozapine, poor hygiene skills and overall poor ADLs and IADLs. She receives multiple services throughout the month to help her maintain in independent living and to reduce periods of decompensation.

- Mary has a monthly visit with her psychiatrist. At this visit, medications are reviewed to assure there are no needed adjustments/adverse interactions as well as providing psychotherapy as needed.
- Weekly, an RN medically monitors Mary by taking vitals and drawing blood. The RN educates Mary re: the importance of taking Clozapine as prescribed and the need for regular lab work to monitor blood levels and prevent possible side effects. The RN encourages Mary to take her daily medication to increase optimal thinking levels and to increase performance of ADLs and IADLs.
- Every evening and twice a day on weekends, an unlicensed BA staff member (acting as a medication monitor) goes to Mary’s home to prompt and monitor her self-administration of medication. The BA staff member reminds Mary about the importance of medication compliance.
- Weekly, an LPN provides verbal direction and supervision when Mary fills her weekly medication box. The LPN educates Mary about the side effects of Clozapine and how medication compliance can reduce and stabilize her Schizophrenia, as well as helping her to maintain independent living in her own apartment.
- Weekly, a peer recovery supporter works with Mary overcome her disorganized thinking by helping her at her home and in other community settings with money management and healthy nutrition. The peer recovery supporter redirects Mary and keeps her focused on ADLS and IADLs as reflected on her care plan.

Scenario is for illustrative purposes only
# ACT Services/Billing Events: November 2016

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# ACT Policy Summary

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<tr>
<td>ACT Fidelity Review &amp; Technical Assistance</td>
<td>ACT Prior Authorization and Eligibility</td>
<td>ACT is a “Lock In” BH Benefit</td>
<td>ACT Billable Events</td>
<td>ACT Services to Hospitalized Enrollees</td>
</tr>
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</table>

1. ACT Fidelity Review & Technical Assistance
2. ACT Prior Authorization and Eligibility
3. ACT is a “Lock In” BH Benefit
4. ACT Billable Events
5. ACT Services to Hospitalized Enrollees
• The Ohio Department of Medicaid has contracted with Case Western Reserve University to perform fidelity reviews for Medicaid payment
• To qualify for Medicaid payment, ACT Teams must achieve a minimum average score of 3 on the DACTS fidelity scale. Once an ACT Team has met minimum fidelity, they will be authorized to begin using the ACT billing model (see slide 18).
• Teams who fail to achieve a minimum fidelity score of 3 are not penalized
  • These teams may seek technical assistance from Case Western under the OhioMHAS funded component of CWRU CEBP*
• Annual ACT team fidelity review.
• ODM reserves the right to have additional fidelity reviews conducted as necessary

*see next slide for further detail
ACT Technical Assistance

Technical Assistance Guidance

- Free technical assistance is available for provider agencies interested in or providing ACT (but not yet ready for Medicaid fidelity review) from CWRU via OhioMHAS financing
ACT Prior Authorization and Eligibility

- Medicaid recipients may only be enrolled with ACT teams after they have been prior authorized by the ODM designated PA entity.
- ACT teams must submit clinical documentation of each potential Medicaid enrollee’s eligibility for ACT.

Draft ACT Eligibility Criteria (Draft OAC 5160-27-04):

- Age 18 or over
- Diagnosis of schizophrenia spectrum, bipolar spectrum, or major depressive disorder with psychosis
- Functional limitation(s) measured by the Adult Needs and Strengths Assessment (ANSA)
  - Teams will need competency to administer ANSA
- One of the following risk factors:
  - At risk of psych inpatient psych hospitalization
  - One or more previous inpatient psych admissions
When a person is enrolled on an ACT team, no other Medicaid BH services will be paid except recovery management through the SRS program or SUD services that are prior authorized.

- BH medications will be covered outside of ACT; this includes physician administered medications and methadone/buprenorphine administration by OTPs.

ACT enrollees may receive other non-BH Medicaid services like:

- Hospital services including inpatient and emergency room visits
- Physician services (e.g. OBGYN, cardiac, and other specialties)
- Prescription and over the counter (OTC) medications
ACT Billable Events

All ACT billable events must be rendered “face to face”
• ACT services rendered via telephone or video conference are allowable, but they do not qualify as a billing event
• See slides 18 – 22 for more detail on billable ACT events
ACT teams are expected to maintain contact with their enrollees if they are hospitalized

• ACT teams should assist with admission and discharge planning
  • However, these are not billable events
• Depending on length of stay, the ACT team may want to consider the clinical appropriateness of maintaining the individual on the case load until they are discharged
Disenrollment from ACT

**Planned Disenrollment**
- ACT teams must develop a transition plan in partnership with the consumer for disenrollment

**Unplanned Disenrollment**
- ACT enrollees may lose touch with the team for some period of time
- It is recommended ACT teams disenroll the consumer after a month of no communication
- This will allow the consumer to receive BH services outside the ACT team
- The ACT team may pursue expedited re-enrollment once the consumer is found
ACT CHECKLIST

TO DO

- Prescriber must be enrolled in Ohio Medicaid as either a ORP or a billing provider

- Team leader must be enrolled in Ohio Medicaid

- Team should have a member competent in conducting the ANSA

- Agency must have an IT system that supports medical documentation plus clinical and billing nuances

- Attend training on use of the MITS PA functionality

- Team must prepare to submit PA requests for potential ACT enrollees, including documentation of their eligibility for ACT
• ODM assumes that Assertive Community Treatment is not a service covered by Medicare or commercial insurers.

• Therefore, H0040 “billable events” may be submitted directly to Medicaid without first submitting to Medicare or commercial plans to obtain a denial code.
Additional Resources for ACT Teams

1. Updated July 1, 2017 BH Redesign Manual – Posted to bh.medicaid.ohio.gov website
   - Shorter
   - More user friendly
   - Coordinates with OAC Rules

2. DRAFT OAC rules defining ACT – Posted to bh.medicaid.ohio.gov website
   - Service definition
   - Consumer eligibility
   - Provider eligibility and team composition
   - Fidelity rating requirements
   - Documentation standards
   - Billing guidance

3. ODM: Informal comment period on ODM rule was open through COB Monday Feb 20th. Rule review continues via the CSIO and JCARR public process.

OhioMHAS: Comments on OhioMHAS rule continues via JCARR public hearing process.
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Questions?