

Clinical Policy: Assertive Community Treatment (ACT)

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[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

Assertive Community Treatment (ACT) services are community-based therapeutic interventions that address the functional problems of members/enrollees 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/enrollee's ability to cope and relate to others while enhancing the member/enrollee'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.

Employment services provided through ACT programming adhere to tenants of the Individual Placement and Support (IPS) model of supported employment. IPS is an evidence-based practice of supported employment for members/enrollees with mental illness designed to enhance the quality of employment services and overall employment outcomes for members/enrollees.

The primary goals of the ACT program and treatment regimen are:

- To lessen or eliminate the debilitating symptoms of mental illness or co-occurring addiction disorders the member/enrollee experiences and to minimize or prevent recurrent acute episodes of the illness;
- To meet basic needs and enhance quality of life;
- To improve functioning in adult social and employment roles and activities through the provision of evidence-based employment supports;
- To increase community tenure;
- To lessen the family's burden of providing care and support healthy family relationships;

The fundamental principles of this program are:

- The ACT team is the primary provider of services and, as such, functions as the fixed point of responsibility for the member/enrollee;
- Services are provided in the community;
- The services are person-centered and individualized to each member/enrollee;

Services

Service provision for ACT will be based on the assessment and a recovery-focused and strengths based treatment plan. The teams will provide the following supports and services to members/enrollees:

- Crisis assessment and intervention;
- Symptom management;
- Individual counseling;
- Medication administration, monitoring, education and documentation;
- Skills restoration to enable self-care and daily life management, including utilization of public transportation, maintenance of living environment, money management, meal preparation, nutrition, and health, locating and maintaining a home, skills in landlord/tenant negotiations, and renter's rights and responsibilities;
- Social and interpersonal skills rehabilitation necessary to participate in community based activities including but not limited to those necessary for functioning in a work, educational, leisure or other community environment;
- Peer support, supporting strategies for symptom/behavior management. This occurs through providing expertise about the recovery process, peer counseling to members/enrollees with their families, as well as other rehabilitation and support functions as coordinated within the context of a comprehensive treatment plan;
- Addiction treatment and education, including counseling, relapse prevention, overdose prevention, anger, and stress management;
- Referral and linkage or direct assistance to ensure that members/enrollees obtain the basic necessities of daily life, including primary and specialty medical care, social and financial supports;
- Education, support, and consultation to members/enrollees' families and other major supports;
- Monitoring and follow-up to help determine if services are being delivered as set forth in the treatment plan and if the services are adequate to address the member/enrollee's changing needs or status;
- Assist the member/enrollee in applying for benefits. At a minimum, this includes Social Security Income (SSI), Medicaid and Patient Assistance Program enrollment;
- For those members/enrollees with forensic involvement, the team will liaise with the forensic coordinators as appropriate, further providing advocacy, education, and linkage with the criminal justice system to ensure the member/enrollee's needs are met in regards to their judicial involvement, and that they are compliant with the court orders; and
- IPS services including ongoing exploration of employment interest, job search, job placement, job coaching, and follow-along supports.

Documentation shall be consistent with the Dartmouth Assertive Community Treatment Scale (DACTS), and the SAMHSA toolkit for ACT.

I. Policy/Criteria

- A. It is the policy of Louisiana Healthcare Connections that Assertive Community Treatment (ACT) is **medically necessary** for the following indications:

- a. ACT serves members/enrollees eighteen (18) years old or older who have a severe and persistent mental illness (SPMI) and members/enrollees with co-occurring disorders listed in the diagnostic nomenclature (current diagnosis per the diagnostic and Statistical Manual of Mental Disorders (DSM)) that seriously impairs their functioning in the community.
- b. The member/enrollee must have one of the following diagnoses:
 - i. Schizophrenia;
 - ii. Other psychotic disorder;
 - iii. Bipolar disorder; and/or
 - iv. Major depressive disorder.
- c. These may also be accompanied by any of the following:
 - i. Substance use disorder (SUD); or
 - ii. Developmental disability.
- d. Include one or more of the following service needs:
 - i. Two (2) or more acute psychiatric hospitalization and/or four (4) or more emergency room visits in the last six (6) months;
 - ii. Persistent and severe symptoms of a psychiatric disability that interferes with the ability to function in daily life;
 - iii. 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);
 - iv. Currently residing in an inpatient bed, but clinically assessed to be able to live in a more independent situation if intensive services were provided;
 - v. One or more incarcerations in the past
 - vi. Psychiatric and judicial determination that ACT services are necessary to facilitate release from a forensic hospitalization or pre-trial to a lesser restrictive setting; or
 - vii. Recommendations by probation and parole, or a judge, indicating services are necessary to prevent probation/parole violation.
- e. Must have one (1) of the following:
 - i. Inability to participate or remain engaged or respond to traditional community based services;
 - ii. Inability to meet basic survival needs, or residing in substandard housing, homeless or at imminent risk of becoming homeless; or
 - iii. Services are necessary for diversion from forensic hospitalization, pretrial release or as a condition of probation to a lesser restrictive setting.
- f. Must have three (3) of the following:
 - i. Evidence of co-existing mental illness and substance use disorder;
 - ii. Significant suicidal ideation, together with a plan and ability to carry out such a plan, within the last two (2) years;
 - iii. Suicide attempt in the prior two (2) years;
 - iv. History of violence due to untreated mental illness/substance use within the prior two (2) years;
 - v. Lack of support systems;
 - vi. History of inadequate follow-through with treatment plan, resulting in psychiatric or medical instability;

- vii. Threats of harm to others in the prior two (2) years;
- viii. History of significant psychotic symptomatology, such as command hallucinations to harm others; or
- ix. Minimum Level of Care Utilization System (LOCUS) score of three (3) at admission.

B. Exception criteria:

- a. The member/enrollee does not meet medical necessity criteria above but is recommended as appropriate to receive ACT services by the member/enrollee's health plan, 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:
 - i. Members/enrollees discharging from institutions such as nursing facilities, prisons, and/or inpatient psychiatric hospitals,
 - ii. Members on an Assisted Outpatient Treatment (AOT) order;
 - iii. Members/enrollees with frequent incidence of emergency department (ED) presentations and/or involvement with crisis services, and
 - iv. Members/enrollees identified as being part of the My Choice Louisiana Program target population who meet the following criteria, excluding those members/enrollees with co-occurring SMI and dementia where dementia is the primary diagnosis:
 - 1. Medicaid-eligible members/enrollees over age eighteen (18) with SMI currently residing in NF or
 - 2. Members/enrollees 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

II. Assessment

- A. An initial assessment must be completed prior to admission to the program. The assessment includes psychiatric history, mental status, and diagnosis to determine medical necessity and if the member meets eligibility criteria to receive ACT services.
- B. 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:
 - a. Updates to the initial assessment;
 - b. Level of Care Utilization System (LOCUS),
 - c.
 - d.
 - e. Strengths assessment,
 - f. Housing and living situation,
 - g. Educational and social interests and capacities,
 - h. Self-care abilities,
 - i. Family and social relationships,
 - j. Family education and support needs,
 - k. Physical health,
 - l. Alcohol and drug use,

- m. Legal situation, and
 - n. Personal and environmental resources.
- C. The sections of the person centered needs assessment shall be completed by ACT team members with subject matter expertise as indicated by their role within the program, though the entire assessment shall be reviewed and signed off on by the licensed mental health professional (LMHP).
- D. 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 30 calendar days for admission of new members. The career profile typically occurs over two-three sessions by the IPS employment specialist. The career profile will be reviewed and updated at least every six 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..
- E. The LOCUS and comprehensive person centered needs assessment will be updated at least every six months or as needed based on the needs of each member, with an additional LOCUS score being completed prior to discharge. For criminal justice involved members/enrollees, the comprehensive person centered needs assessment will include items related to court orders, identified within 30 days of admission and updated at least every 90 days or as new court orders are received.

III. Treatment Plan

- A. An individualized treatment plan, reflective of the member/enrollee’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/enrollee, as well as involvement of the member/enrollee and collateral others’ of the member/enrollee’s choosing. In addition, the plan must contain the signature of the prescriber ,the team leader involved in the treatment and the member/enrollee’s signature. Refusals must be documented. The treatment plan must integrate mental health and substance use services for members/enrollees with co-occurring disorders, define the specific issues and problems that the team will address in both the short-term (two-three months) and long-term (six months), and detail what specific interventions or services will be provided, by whom, when, for what duration, and where the service will be provided.. The treatment plan will be updated every three (3) months or more often as needed based on the needs of each member/enrollee.
- B. For criminal justice involved members/enrollees,, the treatment plan will include items relevant for any specialized interventions, such as linkages with the forensic system for members/enrollees involved in the judicial system.
- C. Treatment plan development will include an exploration of the member/enrollee’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, career advancement.
- D. A tracking system is expected of each ACT team for services and time rendered for or on behalf of any member/enrollee.

- E. Each treatment plan must be Specific, Measurable, Achievable, Relevant, and Time-Bound (SMART), individualized to the member, and consist of the following:
 - a. Plans to address all psychiatric conditions;
 - b. The member/enrollee's treatment goals and objectives (including target dates), preferred treatment approaches and related services;
 - c. The member/enrollee's educational, vocational, social, wellness management, residential or recreational goals, associated concrete and measurable objectives and related services;
 - d. The member/enrollee's goals and plans, and concrete and measurable objectives necessary for a person to get and keep their housing; and
 - e. A crisis/relapse prevention plan, including an advance directive.
- F. 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.

IV. Criteria for Discharge from Services:

- A. ACT teams must formally assess member's needs for ACT services at least once every six months using the ACT Transition Assessment Scale, a tool that establishes criteria to help determine whether a member is ready to be placed on a graduation track to transition to a less intensive level of care (LOC). An individual may be placed within the graduation track if they are assessed at a one or two on all the scaled items. Graduations shall also be considered for individuals assessed at a one or two on all scaled items but assessed at a three on the Activities of Daily Living (ADL) item and three or four 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 or four on this item. Teams are encouraged to continually assess the service needs of participants as the member's needs change. It is imperative that graduation be gradual, thoughtfully planned and individualized with assured continuity of care. More specifically, ACT teams should employ the following strategies regarding graduations:
 - a. Introduce the idea of graduation from the very beginning of the member/enrollee's enrollment (even during the engagement phase) and continue the discussion throughout their enrollment;
 - b. Frame graduation within the larger process of the member/enrollee's recovery, enhanced well-being, and independence in life;
 - c. Involve ACT team members/enrollees in a discussion of the individual's potential for graduation and plans necessary to ensure successful transition to a less intensive level of care;
 - d. Involve the member/enrollee in all plans related to his/her graduation;
 - e. Assess the member/enrollee's motivation for transition to the graduation track and provide motivational interviewing interventions as appropriate to increase their comfort and interest in the graduation;
 - f. Be prepared with appropriate interventions should consumer temporarily experience an increase in symptoms or begin to "backslide" on treatment goals in response to graduation plans;

- g. Involve the member/enrollee's social network, including their family of choice, in developing and reviewing their graduation plan to the extent approved by the participant;
 - h. Coordinate several meetings with member/enrollee, relevant ACT team members/enrollees, and new service provider to introduce the new provider as well as review the participant's current status, progress in ACT and future goals;
 - i. Temporarily overlap ACT services with those of new provider for 30-60 days; and
 - j. Monitor the member/enrollee's status following transition and assist the new provider, as needed, especially for the next 30-60 days.
- B. Teams shall ensure member/enrollee participation in discharge activities, as evidenced by the following documentation:
 - a. The reasons for discharge as stated by the member/enrollee and ACT team;
 - b. The participant's biopsychosocial status at discharge;
 - c. A written final evaluation summary of the member/enrollee's progress toward the goals set forth in the person-centered treatment plan;
 - d. A plan developed in conjunction with the member/enrollee for follow-up treatment after discharge; and
 - e. The signature of the member/enrollee, their primary practitioner, the team leader and the psychiatric prescriber.
- C. Members whose functioning has improved to the point that they no longer require the level of services and supports typically rendered by an ACT team, shall begin the process to transition into a lower LOC. When making this determination, considerations shall be made regarding the member's ability to be served within the lower LOC available to them. The ACT team shall 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.
- D. When clinically necessary, the team will make provisions for the expedited re-entry of discharged members/enrollees as rapidly as possible. If immediate re-admission to the ACT team is not possible because of a full census, LHCC will assist in locating a provider to meet the member/enrollee's needs.

V. Program Requirements:

- A. ACT services must be provided by an interdisciplinary team capable of providing the following:
 - a. Service coordination;
 - b. Crisis assessment and intervention;
 - c. Symptom assessment and management;
 - d. Individual counseling and psychotherapy;
 - e. Medication prescription, administration, monitoring and documentation;
 - f. Substance use treatment;
 - g. Rehabilitation services to restore capacity to manage activities of daily living (ADL);
 - h. Restoration of social, interpersonal relationship, and other skills needed to ensure the development of meaningful daily activities. This can occur through the provision of IPS services to supporting work and educational efforts in addition to linking to leisure activities; and

- i. Direct assistance to ensure that members/enrollees obtain supportive housing, as needed.
- B. ACT is a medical psychosocial intervention program provided on the basis of the following principles:
 - a. The service is available twenty-four (24) hours a day, seven (7) days a week;
 - b. An individualized treatment plan and supports are developed;
 - c. At least ninety (90) percent of services are delivered as community-based outreach services;
 - d. An array of services are provided based on the member/enrollee's medical need;
 - e. The service is member/enrollee-directed; and
 - f. The service is recovery-oriented.
- C. The ACT team must:
 - a. Operate a continuous after-hours on-call system with staff that is experienced in the program and skilled in crisis intervention (CI) procedures. The ACT team must have the capacity to respond rapidly to emergencies, both in person and by telephone
 - b. Provide mobilized CI in various environments, such as the member/enrollee's home, schools, jails, homeless shelters, streets and other locations;
 - c. Arrange or assist members/enrollees to make a housing application, meet their housing obligations and gain the skills necessary to maintain their home;
 - d. Be involved in psychiatric hospital admissions and discharges and actively collaborate with inpatient treatment staff;
 - e. Ensure provision of culturally competent services
 - f. Conduct ongoing monitoring and evaluation of program implementation through the collection of process and outcome measures, including the following:
 - i. Process measures related to ACT programming shall be obtained through utilization of the Dartmouth Assertive Community Treatment Scale (DACTS) and General Organizational Index (GOI);
 - ii. Concurrent to this process, fidelity to IPS programming shall be evaluated utilizing the Supported Employment Fidelity Scale found at <https://ipsworks.org/wp-content/uploads/2017/08/IPS-Fidelity-ScaleEngl.pdf>; and
 - iii. Outcome measures shall be collected via a standardized outcomes reporting instrument which is submitted to LHCC monthly.
- D. The ACT program provides three levels of interaction with the participating members/enrollees, including:
 - a. Face-to-face encounter – ACT teams are highly invested in their members and maintain frequent contact – to provide ongoing, responsive support as needed. Frequent contacts are associated with improved member outcomes and as such, high fidelity is considered for those programs that average four or more contacts a week per member. In order to bill beyond the first month of enrollment, the ACT team must provide a minimum of six clinically meaningful face-to-face encounters with the member for each full month of service. Clinically meaningful 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. This is demonstrated through robust documentation related to efforts to contact the member, non-face to face encounters with the member, communication with the member's support network, description of motivational interventions, assertive engagement attempts, and any other reason the minimum number of face to face encounters was neither clinically feasible nor appropriate. Provider shall obtain written approval from the MCO prior to submitting a claim for reimbursement in instances when a minimum of six encounters are not met. The MCO, based on a review of this information, can decide if reimbursement of services is still appropriate despite not achieving the minimum number of face to face encounters. The majority of encounters must occur within the community; in the event services are rendered within the office, teams must document reasons this has occurred. Efforts shall be made to ensure services are provided throughout the month using assertive engagement strategies. This includes having a plan for engagement while using well thought-out strategies, activating street outreach and legal mechanisms whenever appropriate;

- b. Collateral encounter – Program provides support and skills for member/enrollees informal support network (i.e., people not paid to support member, including family, landlord, shelter staff, employers, or other key person) as developing and maintain this community support further enhances members/enrollees integration and functioning. As such high fidelity on the frequency of Contact domain of the DACTS (S5) is considered for those programs that make four or more contacts per month, per member. Collateral refers to members/enrollees of the member/enrollee's family or household or significant others (e.g., landlord or property manager, criminal justice staff and employer) who regularly interact with the member/enrollee 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/enrollee in locating housing); and
- c. Assertive outreach and engagement – Refers to the ACT team being 'assertive' about engagement utilizing a variety of strategies to ensure program engagement while knowing what is going on with a member and acting quickly and decisively when action is called for, with the goal of increasing member independence. The team must closely monitor the relationships that the member has within the community and intervene early if difficulty arises. Members shall not be immediately discharged from the program due to failure to keep appointments. Retention of members is a high priority for ACT teams. Persistent, caring attempts to engage members in treatment help foster a trusting relationship between the member and the ACT team. Assertive outreach is considered a critical feature of the ACT team. As such, high fidelity on the Assertive Engagement Mechanisms domain of the

- DACTS (S3) is considered for programs demonstrating consistently well-thought out strategies, which may include street outreach, legal mechanisms, and care coordination, whenever appropriate.
- E. For those members/enrollees transitioning from psychiatric or nursing facilities, ACT staff must provide a minimum of four encounters a week with the member/enrollee during the first thirty (30) days post transition into the community. Encounters should be meaningful and, 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 per the guidance outlined above.
 - F. The teams will provide comprehensive, individualized services, in an integrated, continuous fashion, through a collaborative relationship with the member/enrollee. 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.
 - G. ACT teams will utilize IPS, an evidence-based supported employment model that is based upon eight basic principles that include the following:
 - a. Open to anyone who wants to work
 - b. Focus on competitive employment
 - c. Rapid job search
 - d. Targeted job development
 - e. Client preferences guide decisions
 - f. Individualized long-term supports
 - g. Integrated with treatment
 - h. Benefits counseling provided
 - H. Each IPS Specialist carries out all phases of employment services; including completion of career profile, job search plan, job placement, job coaching, and follow-along supports before step-down from IPS into ongoing follow along provided through the ACT team through traditional service provision. IPS Specialists provide only employment services. To achieve good fidelity, a minimum of 90 percent of IPS Specialists' time is dedicated to employment activities.
 - I. Members/enrollees are not asked to complete any vocational evaluations, i.e. paper and pencil vocational tests, interest inventories, work samples, or situational assessments, or other types of assessment in order to receive assistance obtaining a competitive job.
 - J. A career profile is typically completed during 2-3 sessions, and should include information about the member/enrollee's preferences, experiences, skills, strengths, personal contacts, etc. The career profile is reviewed and updated as needed with each new job experience and/or at least every six (6) months. The information may be provided by the member/enrollee, treatment team, medical records, and with the member/enrollee's permission, from family members/enrollees, and previous employers. For new admissions, the initial career profile should be completed within 30 days after admission to the ACT program.
 - K. For those individuals who have expressed an interest in employment, an individualized job search plan is developed with the member/enrollee, and is updated with information from the career profile, and new job experiences. IPS specialists will visit employers systematically, based upon the member/enrollee's preferences, to learn about the employer's needs and hiring preferences. Each IPS Specialist is to make at least six (6)

- face-to-face employer contacts per week, whether or not the member/enrollee is present. IPS Specialist are to use a weekly tracking form to document their employer contacts. The first face-to-face contact with an employer by the member/enrollee or the IPS Specialist should occur within 30 days of the member/enrollee entering the program.
- L. IPS Specialists are to have a face-to-face meeting with the member/enrollee within one (1) week before starting a job, within three (3) days after starting a job, weekly for the first month, and at least monthly for a year or more, on average, after working steadily, and desired by member/enrollees. At this time, members/enrollees are to be transitioned to step down job supports from a mental health worker following steady employment. If a need arises for more intense support by the IPS specialist, they will increase the number of interactions with the member/enrollee
 - M. IPS specialists contact members/enrollees within three (3) days of learning about the job loss. IPS specialists also provide employer support (e.g., educational information, job accommodations) at a member/enrollee's request.
 - N. IPS provides assistance to find another job, when one job has ended, regardless of the reason the job ended, or the number of jobs the member/enrollee has had. Each job is viewed as a learning experience and offers to help find a new job is based upon the lessons learned.
 - O. Job supports are individualized and continue for as long as the member/enrollee wants and needs the support. Members/enrollees receive different types of support based upon the job, member/enrollee preferences, work history, and needs. The IPS Specialist may also assist the member/enrollee to obtain the job accommodations necessary for the member/enrollee to perform the job efficiently and effectively.
 - P. IPS Specialists ensure that members/enrollees are offered comprehensive and personalized benefits planning, including information about how their work may affect their disability and government benefits, as both are based upon their income. These may include medical benefits, medication subsidies, housing subsidies, food stamps, spouse and dependent children benefits, past job retirement benefits, and other sources of income.
 - Q. Service termination is not based on missed appointments or fixed time limits.
 - R. Engagement and outreach attempts made by integrated ACT team members/enrollees are systematically documented, including multiple home/community visits, coordinated visits by IPS specialist with integrated ACT team member/enrollee, and contacts with family, when applicable. Once it is clear that the member/enrollee no longer wants to work or continue with IPS services, the IPS Specialist should review and update the career profile as needed every 6 months; employment should be screened every 3 months as the treatment plan is updated.

VI. Provider Qualifications and Responsibilities:

- A. ACT agencies must be licensed pursuant to La. R.S. 40:2151, et. seq. for behavioral health service providers and accredited by an LDH approved national accrediting body: Commission on Accreditation of Rehabilitation Facilities (CARF), Council on Accreditation (COA) or The Joint Commission (TJC). Denial, loss of, or any negative change in accreditation status must be reported in writing immediately upon notification

by the accrediting body of such denial, loss of, or any negative change in accreditation status to the managed care entities with which the ACT agency contracts or is reimbursed.

NOTE: Effective March 14, 2017, ACT agencies must apply for accreditation and pay accreditation fees prior to being contracted with or reimbursed by a Medicaid managed care entity, and must maintain proof of accreditation application and fee payment. ACT agencies must attain full accreditation within eighteen (18) months of the initial accreditation application date. ACT Agencies contracted with a managed care entity prior to March 14, 2017, must attain full accreditation by September 14, 2018, i.e., eighteen (18) months from the initial effective date of the requirement for ACT agencies.

- B. The provider agency must meet all qualifications as required for other outpatient and rehabilitation agencies and must maintain documentation and verification of licensure, accreditation, staff criminal background checks, TB testing, drug testing, evidence of fidelity to the model (via SAMHSA ACT EBP Toolkit) and required training for staff employed or contracted with the agency. This includes successful completion of an LDH-approved Person-Centered Planning training. New staff must complete the training within sixty (60) days of hire. Existing staff must complete the training by 6/30/24.
- C. ACT agencies must adhere to all requirements established in the LDH Provider Responsibilities section located in the Outpatient Services: Rehabilitation Services chapter of the manual. Please refer to that section for specific information on all provider responsibilities.
- D. ACT teams provide an integrated approach to mental health services, through which the range of treatment issues are addressed from a variety of perspectives. It is critical to maintain adequate staff size and disciplinary background to provide comprehensive, individualized services to each consumer. As such each ACT team shall have sufficient numbers of staff to provide treatment, rehabilitation, and support services twenty-four (24) hours a day, seven (7) days per week while consistently providing necessary staffing diversity coverage. Each ACT team shall have the capacity to provide the frequency and duration of staff-to-program member/enrollee contact required by each member/enrollee's treatment plan.
- E. Each ACT team shall have the capacity to increase and decrease contacts based upon daily knowledge of the member/enrollee's clinical need, with a goal of maximizing independence. The team shall have the capacity to provide multiple contacts to persons in high need and a rapid response to early signs of relapse. The nature and intensity of ACT services are adjusted through the process of daily team meetings. IPS specialists shall participate in these meetings at least weekly.
- F. While team sizes vary each ACT team shall have a staff-to-member/enrollee ratio that does not exceed 1:10. Teams serving fewer members must reflect an equivalent staff to member ratio, also ensuring each role identified below is reflected in the team composition and filled by staff qualified to fulfill the requirements of the position even if fulfilling multiple roles. As program sizes grow, it is expected the number of team members will increase proportionately to ensure staff to member ratios are not exceeded. Any ACT team vacancies that occur will be filled in a timely manner to ensure that these ratios are maintained. All professional staff must be currently and appropriately licensed by the applicable professional board. Prior to providing the service, each staff

member/enrollee receives training on the skills and competencies necessary to provide ACT services. Each staff member/enrollee must meet the required skills and competencies within six months of their employment on an ACT team. Successful completion of LDH-approved trainings can satisfy this requirement.

G. Each ACT team shall include at least:

- a. One (1) ACT team leader, who is a full time Licensed Mental Health Professional (LMHP,) who has must have both administrative and clinical skills, provides clinical supervision to other team members, and provides direct services at least 50 percent of the time;
- b. One (1) prescriber, who can be either a board-certified or board-eligible psychiatrist, a medical psychologist, or an advanced practice registered nurse (APRN) with specialty in adult mental health and meeting the medical director requirements of licensure for Behavioral Health Service (BHS) providers;

Note: In the event a medical psychologist or APRN are utilized, the team must be able to consult with psychiatrists.

- c. Two (2) nurses, at least one (1) of whom shall be a registered nurse (RN). Both nurses must have experience in carrying out medical functioning activities such as basic health and medical assessment, education and coordination of health care, psychiatric medical assessment and treatment, and administration of psychotropic medication;
- d. One other LMHP who is in good standing in the state of Louisiana to practice within the scope of all applicable state laws, practice acts, the practitioners license, and is credentialed as follows:
 - i. LMHPs who are licensed in the State of Louisiana to diagnose and treat mental illness or SUDs. An LMHP includes the following individuals who are licensed to practice independently:
 1. Medical psychologists;
 2. Licensed psychologists;
 3. Licensed clinical social workers (LCSWs);
 4. Licensed professional counselors (LPCs);
 5. Licensed marriage and family therapists (LMFTs);
 6. Licensed addiction counselors (LACs); and
 7. APRNs.
 - ii. Provisionally licensed professional counselors (PLPCs);
 - iii. Provisionally licensed marriage and family therapists (PLMFTs); or
 - iv. Licensed master social workers (LMSWs).
- e. One substance use specialist, who has a minimum of one (1) year specialized substance use training or supervised experience;
- f. One IPS specialist, who has successfully completed the OBH approved IPS training prior to providing IPS services; at least one (1) year of specialized training or supervised experience;
- g. One housing specialist, who has at least one (1) year of specialized training or supervised experience;

2. Undergo a fidelity review using the DACTS/GOI and the Supported Employment Fidelity Scale by an LHCC-identified third party within six (6) months of implementation:
 - a. 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/enrollees, be eligible to provide Medicaid funded services to members/enrollees, and increase staff-to-member/enrollee ratios; and
 - b. If LHCC 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 LHCC 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 LHCC to mitigate health and safety issues for members/enrollees; and
 - c. 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/enrollees as long as there are no health and safety violations with operations as determined by LHCC 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;
 - d. The Supported Employment Fidelity Scale review must reflect continued improvement toward the desired score of four on the rating scale (good fidelity); and
 - e. The team will implement an LHCC approved corrective action plan immediately for any individual Supported Employment Fidelity Scale criterion that rates below four on the rating scale (good fidelity). This plan must be implemented within thirty (30) days of findings or sooner as determined necessary by LHCC to mitigate health and safety issues for members/enrollees.
- b. Existing teams:
 - i. Must submit monthly outcomes reporting to LHCC via a template provided by LHCC;
 - ii. Must participate in fidelity reviews using the DACTS/GOI conducted by LHCC or designee at least annually (every twelve (12) months) or more frequently as prescribed by LHCC;

- iii. The team will implement an LHCC approved corrective action plan immediately for any individual DACTS criterion that rates a one (1) or two (2);
- iv. Must undergo a fidelity review using the Support Employment Fidelity Scale by an LHCC identified third party in conjunction with the DACTS/GOI fidelity review;
 - 1. This review must reflect continued improvement toward the desired score of four on the rating scale (good fidelity);
 - 2. The team will implement an LHCC approved corrective action plan immediately for any individual Supported Employment Fidelity Scale criterion that rates below four on the rating scale (good fidelity). This plan must be implemented within thirty (30) days of findings or sooner as determined necessary by LHCC to mitigate health and safety issues for members/enrollees.
- v. Must achieve a score 3.0 and above on the DACTS/GOI in order to maintain certification and the ability to accept new clients;
- vi. If a 4.2 or higher on the DACTS/GOI is achieved, the team will be deemed as operating with “exceptional practice”:
 - 1. LHCC may grant extensions of eighteen (18) month intervals between fidelity reviews for teams operating with “exceptional practice”.
- vii. Operating below acceptable fidelity thresholds:
 - 1. Teams, which achieve less than a 3.0 on the DACTS/GOI, will forfeit the ability to accept new members/enrollees though they can continue to work with existing members/enrollees as long as there are no health and safety violations with operations as determined by LHCC or LDH;
 - 2. Teams shall implement a remediation plan and undergo another fidelity review within three (3) months by LHCC 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
 - 3. If the team achieves more than a 3.0 on the DACTS/GOI in subsequent review, the team can begin accepting new referrals.

VII. Additional Exclusions

- A. 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/enrollee receiving ACT services.
- B. ACT shall not be billed in conjunction with the following services:
 - a. Behavioral health (BH) services by licensed and unlicensed individuals, other than medication management and assessment or
 - b. Residential services, including professional resource family care

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2024, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only and may not support medical necessity. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
H0039	Assertive Community Treatment

Reviews, Revisions, and Approvals	Revision Date	Approval Date	Effective Date
New Policy (was work process LA.UM.99)	11/21		
Annual review.	11/22		
Converted to Clinical Policy Template and added additional alphanumeric formatting.	2/23	5/2/23	
Changed formatting. Replaced “member” with “member/enrollee.” Updated Description section. Added section V. Program Requirements and VI. Provider Qualifications and Responsibilities. Added II(B), III(C), III(D), IV(B), IV(C), IV(D), and IV(E). References reviewed and updated.	6/23	10/19/23	
Annual Review. References Reviewed and updated.	08/24	11/20/24	12/21/24
Annual Review. Updates made according to updated LDH BHS Manual.	1/26	4/28/26	5/28/26

References

1. Louisiana Department of Health. Behavioral Health Services. Provider manual. Chapter Two of the Medicaid Services Manual Medicaid Program. Chapter 2: Behavioral Health Services. Appendix E-1: Evidence-based practices (EBPS) Assertive Community Treatment. <https://www.lamedicaid.com/provweb1/providermanuals/manuals/BHS/BHS.pdf>. Issued 12/17/25, Replaced 01/12/24.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. LHCC makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable LHCC administrative policies and procedures.

This clinical policy is effective as of the date determined by LHCC. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. LHCC retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom LHCC has no control or right of control. Providers are not agents or employees of LHCC.

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