Good Morning:

Welcome to “IHBT and ACT Refresher and Lessons Learned” webinar scheduled from 8:30 to 11:00 am.

We will be recording the webinar. The recording and slides presented today will be posted to BH.Medicaid.Ohio.Gov under the “Provider” and “Medicaid Managed Care Plan” tabs.

Audio can be connected via your computer OR via telephone by selecting “Use Telephone” after joining the webinar.

Call in number: 1 (631) 992-3221
Access Code: 219-471-659
Audio PIN: Shown after joining the webinar

Behavioral Health Redesign
IHBT and ACT Refresher and Lessons Learned

For MCP Staff Performing Prior Authorization
Today’s Presenters:

**Intensive Home Based Treatment - CWRU Center for Innovative Practices**
- Bobbi L. Beale, PsyD
- Richard Shepler, PhD, PCC-S, Director

**Assertive Community Treatment - CWRU Center for Evidence Based Practice**
- Richard Kruszynski, MSSA, LISW, LICDC

**Prior Authorization Lessons Learned, Jan 1 – June 30, 2018**
- Chantal Hunt, PhD, RN, Program Director, KEPRO
- Mary Haller, Ohio Department of Medicaid
<table>
<thead>
<tr>
<th>Time</th>
<th>Agenda Item</th>
<th>Presenter(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:35</td>
<td>Welcome, Introductions, Housekeeping</td>
<td>Mary Haller</td>
</tr>
<tr>
<td>8:45</td>
<td>Review of IHBT: What it is, Who can render it, What is the client eligibility criteria</td>
<td>Bobbi Beale</td>
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<tr>
<td>9:00</td>
<td>Client scenarios of IHBT eligibility and discussion of what clinical documentation substantiates eligibility</td>
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<tr>
<td>9:15</td>
<td>Lessons Learned from first 6 months of IHBT</td>
<td>Bobbi Beale, Chantal Hunt, Mary Haller</td>
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<tr>
<td>9:30</td>
<td>Review of ACT – What it is, Who can Render it, What is the client eligibility criteria</td>
<td>Ric Kruszynski</td>
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<tr>
<td>9:45</td>
<td>Client scenarios of ACT eligibility and discussion of what clinical documentation substantiates eligibility</td>
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<tr>
<td>10:00</td>
<td>Lessons Learned from the first 6 months of ACT</td>
<td>Ric Kruszynski, Chantal Hunt, Mary Haller</td>
</tr>
<tr>
<td>10:15</td>
<td>Parting advice for the MCPs as they acquire this responsibility</td>
<td>Chantal Hunt, Mary Haller</td>
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<tr>
<td>10:30</td>
<td>Questions from the audience</td>
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</tr>
<tr>
<td>11:00</td>
<td>Adjourn</td>
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Welcome and Opening Remarks
Webinar Housekeeping

• Participants are Muted

• Questions can be typed into the chat box; we will try to respond to them at the end of each section and the end of the webinar

• Webinar is being recorded. It and the slides presented today will be posted to the BH.Medicaid.Ohio.Gov site at the end of the webinar.
Background on BH Redesign

- BH Redesign began Jan 1, 2018
- Behavioral Health Providers have historically billed Medicaid Fee For Service (except MyCare)
- Since 1/1/18, BH Providers have been submitting PA requests via MITS;
- PA requests have been reviewed by KEPRO, ODM Vendor
- MCPs will take over responsibility of Prior Authorization effective 7/1/2018; must follow ODM policy for 12 months

Carve in to Managed care is a BIG, challenging change for BH Providers, as is submitting PA requests via FAX to 6 Different Medicaid MCPs on 7/1/18. Keep Calm and Carry On!
Background on BH Redesign, cont

• Certain BH Services Require Prior Authorization at certain thresholds – see next slide
• Today’s focus is on Intensive Home Based Services (IHBT) and Assertive Community Treatment (ACT); Both services require PA PRIOR to treatment beginning
• Providers can still deliver BH services to consumers “ala carte” without PA; they have done this for many years. But ACT and IHBT rates are higher.

Today’s Focus:
# Prior Authorization Under BH Redesign

<table>
<thead>
<tr>
<th>Description and Code</th>
<th>Benefit Period</th>
<th>Authorization Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assertive Community Treatment (ACT) H0040</td>
<td>Based on prior authorization approval</td>
<td>ACT must be prior authorized and all SUD services must be prior authorized for ACT enrollees. See service description for additional information.</td>
</tr>
<tr>
<td>Intensive Home Based Treatment (IHBT) H2015</td>
<td>Based on prior authorization approval</td>
<td>IHBT must be prior authorized. See service description for additional information.</td>
</tr>
<tr>
<td>SUD Partial Hospitalization (20 or more hours per week)</td>
<td>Calendar year</td>
<td>Prior authorization is required for this level of care for adults and adolescents.</td>
</tr>
<tr>
<td>Psychiatric Diagnostic Evaluations 90791, 90792</td>
<td>Calendar year</td>
<td>1 encounter per person per calendar year per code per billing agency for 90791 and 90792. Prior authorization for any additional services within the calendar year.</td>
</tr>
<tr>
<td>Psychological Testing 96101, 96111, 96116, 96118</td>
<td>Calendar year</td>
<td>Up to 12 hours/encounters per patient per calendar year for 96101, 96111, and 96116, and 8 hours of 96118. Prior authorization for any additional services within the calendar year.</td>
</tr>
<tr>
<td>Screening Brief Intervention and Referral to Treatment (SBIRT) G0396, G0397</td>
<td>Calendar year</td>
<td>One of each code (G0396 and G0397), per billing agency, per patient, per year. Cannot be billed by provider type 95. Prior authorization for any additional services within the calendar year.</td>
</tr>
<tr>
<td>Alcohol or Drug Assessment H0001</td>
<td>Calendar year</td>
<td>2 hours per patient per calendar year per billing agency. Prior authorization for any additional services within the calendar year.</td>
</tr>
<tr>
<td>SUD Residential H2034, H2036</td>
<td>Calendar year</td>
<td>Up to 30 consecutive days without prior authorization. Prior authorization then must support the medical necessity of continued stay, if not, only the initial 30 consecutive days are reimbursed. Applies to first two stays; any stays after that would be subject to full prior authorization.</td>
</tr>
</tbody>
</table>

*Any service or ASAM level of care not listed in this table is not subject to prior authorization.*
Prior Authorization Calendar

Transition to new BH code set

Dec 2017

2018

Jan

Apr

Managed Care Carve-In

Jul

Oct

2019

Jan

Apr

Jul

Oct

Jan

2020

• KEPRO will begin accepting PA requests and documentation beginning 12/1
• No formal PA decisions will be issued until 1/1/18 when OAC is effective
• MyCare Ohio plans process new PAs in accordance with state policy for their members
• MCPs process new PAs in accordance with state policy & honor existing PAs until they expire
• MyCare Ohio plans set their own policies for new PAs and honor existing PAs until they expire
• KEPRO processes all other new PAs
• MCPs set their own policies for new PAs and honor existing PAs until they expire

• Plans will follow state benefit administration policies for one year.
• Medicaid benefit year is the calendar year (Jan-Dec).
• Any prior authorizations approved by Medicaid prior to carve-in will be honored by the plans, and the plans will assume the responsibility for the prior authorization process when authorizations under FFS expire.
Overview of Intensive Home Based Treatment

Dr. Bobbi Beale,
CWRU Center for Innovative Practice
INTENSIVE HOME BASED TREATMENT

MEDICAID OVERVIEW

FOR

PRIOR AUTHORIZATION

BOBBI BEALE, PSY.D. & RICK SHEPLER, PH.D, PCC-S

CENTER FOR INNOVATIVE PRACTICES

BEGUN CENTER FOR VIOLENCE PREVENTION
<table>
<thead>
<tr>
<th><strong>Intensive Home-Based Service Delivery Model</strong></th>
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<tbody>
<tr>
<td><strong>Location of Service</strong></td>
</tr>
</tbody>
</table>
| **Intensity** | Frequency: 2 to 5 sessions per week  
Duration: 4 to 8 hours per week |
| **Crisis response & availability** | 24/7 |
| **Active safety planning & monitoring** | Ongoing |
| **Small caseloads** | 4 to 6 families per FTE; no mixed caseloads (e.g. Outpatient & IHBT) |
| **Flexible scheduling** | Convenient to family |
| **Treatment duration** | 3 to 6 months |
| **Systemic engagement and community teaming** | Child and family teaming; skillful advocacy; family partnering; culturally mindful engagement |
| **Active clinical supervision & oversight** | 24/7 availability; field support; weekly team meetings |
| **Provider credentials** | Licensed Behavioral Health Professional: MA level preferred. |
| **Comprehensive service array: integrated and seamless; single point of clinical responsibility** | Crisis stabilization, safety planning, skill building, trauma-focused, family therapy, resiliency & support-building, cognitive interventions |
• The maximum amount of IHBT service which may be authorized is 72 hours within a 3 month authorization period.
  • Typical length of stay ranges between 3 and 6 months.
• The provider agency may request additional IHBT service to be authorized by the ODM designated entity up to an additional 72 hours of service per 3 month authorization.

• IHBT Fidelity Tool: IHBT treatment averages 3 to 6 months and exceeds 6-month length of stay in less than 10% of the cases served.
OMHAS ELIGIBILITY CRITERIA

• Is clinically determined to meet the "person with serious emotional disturbance" (SED) criteria in rule 5122-24-01 of the Administrative Code, and one of the following:
  • Is at risk for out-of-home placement due to his/her behavioral health/mental health condition;
    OR
  • Has returned within the previous thirty days from an out-of-home placement or is transitioning back to their home within thirty days; OR
  • Requires a high intensity of mental health interventions to safely remain in or return home.

• IHBT may also be provided to transitional age youth between the ages of eighteen and twenty-one who have had an onset of serious emotional and mental disorders at an age younger than eighteen.
MEDICAL NECESSITY AND ELIGIBILITY

• **Primary diagnosis**: diagnostic assessment that substantiates symptomatology that supports mental health diagnosis

• **Functional impairment**: documentation that behavioral health significantly impacts functioning (family, school, peers, community, etc.)
  - At risk of removal from school due to behavioral symptomatology
  - At risk of increased involvement in the juvenile justice system due to behavioral symptomatology

• **Risk and safety**: significant risk and/or safety issue related to youth’s behavioral health
  - At risk of hospitalization due to self harm, other harm
  - At risk of re-traumatization due to impulsive risk-taking behaviors

• **At-risk of out-of-home placement or returning home from placement**
### PRIMARY DIAGNOSIS CATEGORIES
(ODM RULE – IN APPROVAL PROCESS)

<table>
<thead>
<tr>
<th>Schizophrenia and associated disorders: rare in youth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bipolar and related disorders</td>
</tr>
<tr>
<td>Major depressive disorders</td>
</tr>
<tr>
<td>Disruptive mood dysregulation disorder</td>
</tr>
<tr>
<td>Conduct and oppositional disorders</td>
</tr>
<tr>
<td>Obsessive compulsive and related disorders</td>
</tr>
<tr>
<td>Eating disorders (Anorexia, Bulimia)</td>
</tr>
<tr>
<td>Post-traumatic stress and acute stress disorders</td>
</tr>
<tr>
<td>Anxiety disorders</td>
</tr>
<tr>
<td>Reactive attachment disorder</td>
</tr>
</tbody>
</table>
"Person with serious emotional disturbance" means a person less than eighteen years of age who meets criteria that is a combination of duration of impairment, intensity of impairment and diagnosis.

Criteria:
- (i) Under eighteen years of age;
- (ii) Marked to severe emotional/behavioral impairment;
- (iii) Impairment that seriously disrupts family or interpersonal relationships; and
- (iv) May require the services of other youth-serving systems (e.g., education, human services, juvenile court, health, mental health/mental retardation, youth services, and others).
PERSON WITH SERIOUS EMOTIONAL DISTURBANCE

- Marked-to-severe behavioral impairment is defined as impairment that is at or greater than the level implied by any of the following criteria in most social areas of functioning:
  - (i) Inability or unwillingness to cooperate or participate in self-care activities;
  - (ii) Suicidal preoccupation or rumination with or without lethal intent;
  - (iii) School refusal and other anxieties or more severe withdrawal and isolation;
  - (iv) Obsessive rituals, frequent anxiety attacks, or major conversion symptoms;
  - (v) Frequent episodes of aggressive or other antisocial behavior, either mild with some preservation in social relationships or more severe requiring considerable constant supervision; and
  - (vi) Impairment so severe as to preclude observation of social functioning or assessment of symptoms related to anxiety (e.g., severe depression or psychosis).
PERSON WITH SERIOUS EMOTIONAL DISTURBANCE

• An impairment that seriously disrupts family or interpersonal relationships is defined as one:
  • (i) Requiring assistance or intervention by police, courts, educational system, mental health system, social service, human services, and/or children's services;
  • (ii) Preventing participation in age-appropriate activities;
  • (iii) In which community (home, school, peers) is unable to tolerate behavior; or
  • (iv) In which behavior is life-threatening (e.g., suicidal, homicidal, or otherwise potentially able to cause serious injury to self or others.
In addition to the IHBT eligibility criteria listed in OhioMHAS and Medicaid rules, the child/adolescent must also meet certain scores on the following CANS Domains:

- Child Emotional/Behavioral Needs Domain
- Child Risk Behaviors Domain
- Life Functioning Domain
- 25 items total
CANS ITEM SCORING

- **0 – No Evidence of Need** – This rating indicates that there is no reason to believe that a particular need exists. Based on current assessment information there is no reason to assume this is a need.

- **1 - Watchful Waiting/Prevention** – This level of rating indicates that you need to keep an eye on this area or think about putting in place some preventive actions to make sure things do not get worse (e.g. a child/youth who has been suicidal in the past).

- **2 - Action Needed** – This level of rating implies that something must be done to address the identified need. The need is sufficiently problematic, that it is interfering in the child/youth’s or family’s life in a notable way.

- **3 - Immediate/Intensive Action Needed** – This level rating indicates a need that requires immediate or intensive effort to address. Dangerous or disabling levels of needs are rated with this level.
## CANS Scoring Eligibility for IHBT

<table>
<thead>
<tr>
<th>Behavioral &amp; Emotional Needs</th>
<th>Life Functioning</th>
<th>Risk Behaviors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rating of “2” or higher on any one of the following</td>
<td>Rating of “3” on <strong>one</strong> of the following; <strong>or</strong> rating of “2” on <strong>two</strong> of the following</td>
<td><strong>Suicide Risk</strong></td>
</tr>
<tr>
<td>Psychosis</td>
<td><strong>Family</strong></td>
<td><strong>Self-Mutilation</strong></td>
</tr>
<tr>
<td>Impulsive/ Hyperactivity</td>
<td><strong>Social</strong></td>
<td><strong>Other Self Harm</strong></td>
</tr>
<tr>
<td>Depression</td>
<td><strong>Legal</strong></td>
<td><strong>Danger to others</strong></td>
</tr>
<tr>
<td>Substance Abuse</td>
<td><strong>Living Situation</strong></td>
<td><strong>Sexual Aggression</strong></td>
</tr>
<tr>
<td>Anger Control</td>
<td><strong>School Behavior</strong></td>
<td><strong>Fire Setting</strong></td>
</tr>
<tr>
<td>Eating Disturbance</td>
<td><strong>School Attendance</strong></td>
<td><strong>Runaway</strong></td>
</tr>
<tr>
<td>Adjustment to Trauma</td>
<td></td>
<td><strong>Delinquency</strong></td>
</tr>
<tr>
<td>Anxiety</td>
<td></td>
<td><strong>Judgement</strong></td>
</tr>
<tr>
<td>Oppositional</td>
<td></td>
<td><strong>Social Behavior</strong></td>
</tr>
<tr>
<td>Conduct</td>
<td></td>
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</table>

**AND**

**OR**

Rating of “2” or higher on **one** of the following

**Rating of “3” on one of the following; or rating of “2” on two of the following**

**Rating of “2” or higher on one or more of the following**
IHBT TREATMENT PLAN

• Goals and desired outcomes are developed in conjunction with the recipient and/or legal custodian, including agreed upon strategies and services to be provided by the IHBT provider to assist the recipient in accomplishing the stated goals.

• The treatment plan shall be individualized based on the recipient's needs, strengths, and preferences and shall set measurable long-term and short-term goals and specify approaches and interventions necessary for the recipient to achieve the individual goals.

• The treatment plan shall also identify who will carry out the approaches and interventions.

• The treatment plan shall be reviewed and revised by the IHBT practitioner with the recipient and the recipient's family or legal custodian whenever there is a major decision point in the recipient's course of treatment or at least every six months.
THE TREATMENT PLAN SHALL ADDRESS, AT A MINIMUM, THE FOLLOWING KEY AREAS:

- (i) Behavioral health symptom reduction;
- (ii) Risk reduction and safety planning;
- (iii) Family and interpersonal relationships; and
- (iv) Functioning in relevant life domains.
CONTINUED STAY CRITERIA

• Youth continues to meet the eligibility criteria for IHBT; and
• Youth and/or family has insufficient or severely limited resources or skills necessary to cope with an immediate behavioral health crisis; or
• The desired outcome or level of functioning has not been restored, improved, or sustained; or
• The youth continues to be at risk for out-of-home placement; or
• Less intensive services would not be effective in managing the level of behavioral health symptoms.
LENGTH OF STAY

• Length of stay averages 4.5 months typically
• Fidelity range is between 3 and 6 months.
• Depends on breadth and depth of presenting concerns
• Can expect longer LOS for youth with:
  • Co-occurring disorders;
  • More complicated presentations;
  • Complex contextual and systemic issues; and
  • Higher number and severity of risk and safety issues (including trauma)
A recipient or their guardian may request to end receipt of IHBT services at their discretion.

Upon disenrollment of an IHBT recipient, the IHBT team shall document the circumstances regarding disenrollment in the recipient’s treatment plan.

The provider must inform the ODM designated entity of disenrollment within three business days of the discharge date.

Either the provider or the ODM designated entity shall deactivate the authorization for the IHBT service.

Disenrollment of a recipient from IHBT is necessary to assure that the recipient may obtain Medicaid reimbursed behavioral health services from a provider other than the IHBT team.
SERVICE EXCLUSIONS AND LIMITATIONS

- CPST
- Therapeutic Behavioral Service
- Psychosocial Rehabilitation
- Day treatment
- Psychotherapy; Group; Family therapy
- Other IHBT programs
- ACT
- Residential
- Intensive Outpatient

6/19/2018
SCENARIO 1

• Tamara (14) has been hospitalized for frequent episodes of self-injurious behaviors (cutting on her arms) and suicide ideation.
• She recently voiced suicidal thoughts to her outpatient therapist and was referred for IHBT.
• Her current symptoms are consistent with a diagnosis of Major Depression.
• Single working mom is concerned that she could lose her job due to Tamara’s need for supervision.
• More than one day a week she misses school due to her depression. She is falling behind significantly at school.
• Previous outpatient and CPST services have not been effective in stabilizing her symptoms.
TAMARA IS UP FOR REAUTHORIZATION

INITIAL CANS

- **Behavioral and Emotional Needs:**
  - Depression = 3
- **Life Functioning:**
  - School Attendance = 2
  - Family = 2
- **Risk Behaviors:**
  - Suicide Risk = 2
  - Self-mutilation = 3

CANS TIME 2

- **Behavioral and Emotional Needs:**
  - Depression = 2
- **Life Functioning:**
  - School Attendance = 2
  - Family = 1
- **Risk Behaviors:**
  - Suicide Risk = 1
  - Self-mutilation = 2

Tamara has made progress in treatment with a reduction in her suicidal ideation and self-mutilation. While progress had been made the therapist is requesting an additional authorization to solidify treatment gains and continue to decrease risk and safety issues.
SCENARIO 2

- 15 year old Tayshawn is currently on probation for domestic violence for engaging in a physical confrontation with his mother’s boyfriend.
- Tyshawn’s biological father was physically abusive with Tyshawn. Ever since he has vowed to protect himself and his mother by any means necessary.
- Diagnostic assessment supports a diagnosis of Conduct Disorder and PTSD
- He is on an IEP and is designated ED.
- Mother’s boyfriend has given mother an ultimatum that either Tyshawn goes or he goes.
TAYSHAWN IS UP FOR REAUTHORIZATION

• Tayshawn’s mother made the decision to move on in her relationship with her boyfriend.
• Since then family conflict has decreased and Tayshawn’s behavior has improved at home.
• Tayshawn is also doing better behaviorally at school.
• Based on this improvement the school is requesting that the IHBT program continue so until the end of the school year. Mother likes that he is doing better at school and conveys this request to the therapist.
• Reauthorization decision:
SCENARIO 3

- Alonzo is 11 years old and is fascinated with fire and frequently lights small fires to watch them burn. He recently set fire to the carpeting in his room.
- Mother reports that last year he deliberately harmed their family cat by throwing him by his tail down the stairs.
- Children’s Services was previously involved to investigate alleged sexual abuse which was unsubstantiated. The social worker recommended increased monitoring and supervision around potential safety issues in the home.
- Alonzo is quite impulsive and is diagnosed with ADHD.
- Alonzo is on a 504 Plan at school for to provide accommodations for his ADHD symptoms.
- Is Alonzo eligible for IHBT services?
SCENARIO 4

• Patrice was removed from her home earlier this year and placed in foster care. She has been in three foster homes this year.
• Patrice is not adjusting well to her most recent foster home and has runaway on two occasions in the past four weeks. When given consequences for her behaviors she began cutting on her arms.
• The foster home contacted CSB stating that they did not know how long they could maintain her in their home with these behaviors.
• In an effort to stabilize the foster placement and avoid more restrictive placement options, the CSB social worker refers Patrice for IHBT.

• What factors support an IHBT authorization?
• Health Care R Us chose not to authorize IHBT for Patrice. What possible reasons did they give for this decision?
SCENARIO 5

• Suzanne is a 12 year old female who presents with school phobia and a generalized anxiety disorder. She has already missed 20 days of school this year. The school called the mother with their concerns and stated that any further unexcused absences would result in truancy charges and possible court involvement.

• The school had a positive experience with another youth who had received IHBT and recommended the services to the mother. Mother follows through with the school’s suggestion.

• Suzanne has not had counseling previously.

• Based on this information what would be your decision? Why?
• What additional information would you need to consider IHBT authorization?
SCENARIO 6

• Martin is a 16 year old African American male who has Planned Permanent Living Arrangement (PPLA) status with Children Services. He has been living with the same foster home for the past 3 years and the parents are committed to keeping Martin until age 18.

• During the past year Martin had become more isolated and secretive about his whereabouts. Also this year the foster parents noticed a change in Martin’s peer group and suspected he was using marijuana on the weekends. Most recently, Martin came to the foster parent’s concerned he was hearing voices telling him to hurt himself. The foster parents are concerned for his safety.

• Health Care R Us denies referral for IHBT with the following rationale:

• Under what conditions would this referral be appropriate?
SCENARIO 7

- Jimmy (13) has been in residential treatment for the past year. The funding for his placement is running out. The residential treatment center communicates that he needs more time in their treatment center.
- Jimmy presented with suicidal and homicidal ideation. He threatened to kill his step-father during a physical altercation between them. When the police were called out to the home Jimmy stated being suicidal. He was taken to the hospital. At the time of discharge the psychiatrist recommended residential treatment for everyone's safety.
- Jimmy has the following diagnoses: Bipolar Disorder; ADHD; and PTSD.
- The family anticipates his return in the next 2 months and calls IHBT R Us for help.

- Under what conditions would you authorize IHBT?
- What other services would you recommend?
SCENARIO 8

• Jaden is diagnosed with Disruptive Mood Dysregulation Disorder and co-occurring Cannabis Use Disorder. He recently was adjudicated for a felony assault and was placed on probation. The magistrate ordered treatment in lieu of placement at ODYS. The probation officer recommended Multisystemic Therapy to the family because they are an evidence based practice for delinquent behaviors and substance use.
• The MST program submits the appropriate information for IHBT authorization.
• What other decision do you need?
• Your decision:
LESSONS LEARNED

Only need one of the following:

Is at risk for out-of-home placement due to his/her behavioral health/mental health condition; **or**

- Has returned within the previous thirty days from an out-of-home placement or is transitioning back to their home within thirty days; **or**
- Requires a high intensity of mental health interventions to safely remain in or return home.
RESOURCES

• BH Medicaid
• http://bh.medicaid.ohio.gov/manuals
• ODM IHBT rule
• http://bh.medicaid.ohio.gov/Portals/0/Providers/2017-1-31-BH-Redesign-Rule-Package.pdf?ver=2017-01-31-152824-760
• OhioMHAS rule
FOR MORE INFORMATION ON IHBT

Bobbi Beale:  bobbi.beale@case.edu

Rick Shepler:  richard.shepler@case.edu
Overview of Assertive Community Treatment

Richard Kruszynski, CWRU Center for Evidence Based Practice
Assertive Community Treatment

Ric Kruszynski, LISW-S, LICDC-CS

Ohio Department of Medicaid – Prior Authorization Vendor Training
June 13, 2017
CENTER FOR EVIDENCE-BASED PRACTICES

www.centerforebpbp.case.edu

A partnership between the Mandel School of Applied Social Sciences & Department of Psychiatry at the School of Medicine
A Technical-Assistance Center

Providing consultation, training, and evaluation for the implementation of integrated behavioral healthcare services
Service innovations for people with mental illness, substance use disorders

SAMI
- Substance Abuse & Mental Illness
- Strategies for co-occurring disorders
  - IDDT
    - Integrated Dual Disorder Treatment
    - The evidence-based practice
  - DDCAT
    - Dual Diagnosis Capability in Addiction Treatment
    - An organizational assessment & planning tool
  - DDCMHT
    - Dual Diagnosis Capability in Mental-Health Treatment
    - An organizational assessment & planning tool

ACT
- Assertive Community Treatment
- The evidence-based practice

SE/IPS
- Supported Employment/Individual Placement & Support
- The evidence-based practice

IPBH
- Integrated Primary & Behavioral Healthcare

MI
- Motivational Interviewing
- The evidence-based practice

TRAC
- Tobacco: Recovery across the Continuum
- A stage-based motivational model

www.centerforebhp.case.edu
History of ACT

• Developed early 1970’s at Mendota State Hospital in Madison, WI by Marx, Stein, and Test (1979)

• Brought intensive services to the community / where people live – to help them thrive in the community and stay out of the hospital
ACT Today...why?

- Overuse of expensive services (i.e., cost containment)
- Ongoing System fragmentation
- De-institutionalization
- Holistic service
- Reach individuals not currently served (well)
Fidelity
The research on EBPs tells us:

Effective intervention practices + Effective implementation practices

Good outcomes for consumers

No other combination of factors reliably produces desired outcomes for consumers
What is Fidelity?

**Fidelity** refers to the degree to which a practice model is delivered as intended.

Are the elements of the practice model present and recognizable?
Fidelity

Refers to the degree of implementation of an Evidence-Based Practice (EBP)

The ACT Literature reflects that a “high fidelity” team produces predictable and positive results
Dartmouth Assertive Community Treatment Scale (DACTS)

DACTS Subscales

• Human Resources
  o 11 items

• Organizational Boundaries
  o 7 items

• Nature of Services
  o 10 items
DACTS Subscales

Human Resources
- Small caseload
- Team approach
- Program meeting
- Practicing Team leader
- Continuity of staffing
- Staff capacity
- Psychiatrist
- Nurse
- SA specialist
- Vocational specialist
- Program Size

Organizational Boundaries
- Explicit admission criteria
- Intake rate
- Full responsibility for treatment services
- Responsibility for crisis services
- Responsibility for hospital admissions
- Responsibility for hospital discharge planning
- Time-unlimited services

Nature of Services
- Community-based services
- No dropout policy
- Assertive engagement mechanisms
- Intensity of service
- Frequency of contact
- Work with informal support system
- Individualized SA treatment
- Dual disorder treatment groups
- Dual disorder model
- Role of consumers on treatment team
DACTS: Item Response Categories

Each item is rated using anchors for scores of 1 through 5

1 = NOT IMPLEMENTED to 5 = FULLY IMPLEMENTED
Characteristics of an ACT program that would have a perfect score on the ACT Fidelity Scale

<table>
<thead>
<tr>
<th>Human resources, structure, team composition</th>
<th>Nurse on staff: A 100-consumer program has at least two full-time nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff-to-consumer ratio: 10 or fewer consumers per team member, excluding team psychiatrist and program assistant</td>
<td>Substance-abuse specialist: A 100-consumer program has at least two full-time substance abuse specialists with at least 1-year specialized training in substance abuse treatment or 1-year supervised experience</td>
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<td>Team approach: 90% or more of consumers have contact with more than one team member per week</td>
<td>Employment specialist: A 100-consumer program has at least 2 full-time employment specialists with at least 1 year specialized training or 1 year supervised experience</td>
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<tr>
<td>Practicing ACT leader: A full-time program supervisor (also called program leader) provides direct services at least 50% of the time</td>
<td>Program size: A total of at least 10 FTE staff</td>
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<tr>
<td>Continuity of staffing: Less than 20% turnover per year</td>
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<tr>
<td>Staff capacity: Program has operated at 95% or more at full staffing in the past 12 months</td>
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<tr>
<td>Psychiatrist on staff: A 100-consumer program has at least one full-time psychiatrist</td>
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<tr>
<td>Organizational boundaries</td>
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</table>
Nature of services

- **In vivo services**: At least 80% of total service time is spent in the community.

- **No drop-out policy**: 95% or more of consumers are retained over a 12-month period.

- **Assertive engagement mechanisms**: Program demonstrates consistently well thought out strategies, including street outreach.

- **Intensity of service**: Average of 2 hours per week or more per consumer.

- **Frequency of contact**: Average of four or more contacts per week per consumer.

- **Work with support system**: Each month, team members have four or more contacts in the community with members of the consumer’s support network.

- **Individualized substance abuse treatment**: Consumers with a substance-use disorder spend 24 minutes or more per week in substance-abuse treatment.

- **Dual disorders model**: Program is fully based in dual disorders treatment principles with treatment provided by team.

- **Role of consumers on treatment teams**: Consumers are employed as practitioners with full professional status.
# ACT Critical Ingredients

- Multidisciplinary staffing
- Integration of services
- Team approach
- Low patient-staff ratios
- Locus of contact in the community

- Medication management
- Focus on everyday problems in living
- Rapid access
- Assertive outreach
- Individualized services
- Time-unlimited svcs

ACT Critical Ingredients

Multidisciplinary Staffing
  Multiple challenges
  Multiple perspectives

Integration of Services and Holistic Approach
  System fragmentation (silos)
  Customer friendly

(Bond, 2001; Bond and Drake, 2015)
ACT Critical Ingredients

Team Approach
- Benefits to client
- Benefits to staff

Low Client to Staff Ratio
- ACT-appropriate population
- Required for ACT’s level of intensity
ACT Critical Ingredients

Services in the Community (In Vivo)
- Engaging
- Accurate
- Natural setting

Medication Management
- Medication education
- Teach, not police
ACT Critical Ingredients

Focus on “Every Day” Problems
ACT-appropriate population
Integration/Inclusion requires skill building
May be need for brief contacts and “check ins”

Rapid Access
24/7 on call
From the client’s perspective…
May reduce hospitalization, crisis, jail
ACT Critical Ingredients

Assertive Outreach
Creative and persistent
ACT-appropriate population

Individualized Services
More engaging
Recovery-focused
Other critical ingredients facilitate this
ACT Critical Ingredients

Long Term and Continuous Care

No *arbitrary* time limit to ACT services
Receive ACT as long as needed
New payers
ACT Team Staff Members

- Psychiatrist
- Team Leader
- Nurse
- Substance Abuse Team Member
- Vocational Team Member
- Case Manager
- Peer Support Team Member
- Counselor/Therapist
ACT Team Staff

Specialist-Generalist Concept

Specialist
  • Clinical expertise
  • Cross-train others

Generalist
  • Practical solutions, problem solver
  • “Case manager”
An ACT team is the single point of clinical responsibility/coordination of services
Structure of ACT services

• Services provided by team (not referred/brokered)
  o Self-management skill development
  o Medication management
  o Housing
  o Finances
  o Substance-related
  o Employment
  o Involvement of natural supports/family
  o Attention to/coordination of care for other medical needs
Who is appropriate for ACT?
Who should ACT teams serve?

Assertive community treatment is appropriate for individuals who experience the most intractable symptoms of severe mental illness and the greatest level of functional impairment.

These individuals are often heavy users of inpatient psychiatric services, and they frequently have the poorest quality of life (Drake et al, 2001)
ACT Consumer Outcomes

• Reduction use of institutional / high cost services
  • Inpatient (MH and/or AOD)
  • Emergency Department
  • Crisis
  • Criminal Justice

• Housing stability

• Improvement in quality of life
Who is appropriate/eligible for ACT?

People with:

- Severe and persistent mental health conditions
- High utilization of institutions
  - Inpatient psychiatric beds
  - Jail/prison
  - Crisis stabilization
- Are difficult to engage in community [services]
- Homelessness
- Significant difficulty doing the everyday things needed to live independently in the community
Who is *eligible* for **Ohio Medicaid ACT**?

OAC 5160-27-04: Mental Health Assertive Community Treatment Service.
ODM ACT Eligibility Criteria

(C) A Medicaid recipient is eligible to receive ACT when all of the following are met:

1. Diagnosis
2. ANSA
3. Institutional use / Functioning challenges
4. 18 or older
5. Determined eligible through prior authorization
(C)(1) Diagnosis

Combination of:

• Symptoms
• Duration of symptoms
• Impact on functioning in all life domains
• Not otherwise accounted for by medical condition or substance use
(C)(1) Diagnosis

- Schizophrenia spectrum
- Bipolar spectrum
- Major Depressive Disorder with Psychosis

Combinations of symptoms and episodes:
- Psychotic
- Manic / Hypomanic
- Depressive
(C)(2) Adult Needs and Strengths Assessment (ANSA)

- **Two or greater** on at least one of the items:
  - *Mental Health Needs* or
  - *Risk Behaviors*
- Or a score of **three** on at least one of the items in the *Life Domain Function* section
(C)(2) Adult Needs and Strengths Assessment (ANSA)

0 = no evidence
1 = history, watch/prevent
2 = moderate; causing problems; act
3 = severe; causing severe/dangerous problems; act immediately
(C)(2) Adult Needs and Strengths Assessment (ANSA)

1. At least one item:

<table>
<thead>
<tr>
<th>Subscale:</th>
<th>Minimum score of:</th>
</tr>
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<tbody>
<tr>
<td>Mental Health Needs</td>
<td>2</td>
</tr>
<tr>
<td>Risk Behaviors</td>
<td>2</td>
</tr>
<tr>
<td>Life Domain Function</td>
<td>3</td>
</tr>
</tbody>
</table>
(C)(3) Institutional use – 1 or more

a) Two or more admissions to a psychiatric inpatient hospital setting during the past twelve months or,

b) Two or more occasions of utilizing psychiatric emergency services during the past twelve months or,
(C)(3) Institutional use – 1 or more (cont.)

c) Significant difficulty meeting basic survival needs including residing in substandard housing, homelessness, imminent risk of homelessness or,

d) History within the past two years of criminal justice involvement including but not limited to arrest, incarceration, probation
(C)(3)(e) Other functional indicators – 1 or more

(i) Persistent or recurrent severe psychiatric symptoms including but not limited to affective, psychotic, suicidal or,

(ii) Coexisting substance use disorder of more than six month in duration or,

(iii) Residing in an inpatient or supervised residence, but clinically assessed to be able to live in a more independent living situation if intensive services are provided or,
(C)(3)(e) Other functional indicators – 1 or more (cont.)

(iv) At risk of psychiatric hospitalization, institutional, supervised residential placement if more intensive services are not available or,
(v) Has been unsuccessful in using traditional office-based outpatient services
ODM ACT Eligibility Criteria

(C) A medicaid recipient is eligible to receive ACT when all of the following are met:

1. Diagnosis
2. ANSA
3. Institutional use / Functioning challenges
4. 18 or older
5. Determined eligible through prior authorization
Prior Authorization for Ohio Medicaid for ACT

• Maximum authorization – 12 months
• At conclusion of previous 12-month authorization, provider may request additional ACT services to be PA
  – ACT is “time-unlimited”
  – Recovery timelines will vary by individual
  – Typically, no less than 12 months, may need ACT-level 7+ years
(E) Disenrollment from Ohio Medicaid ACT

• Since ACT is a “lock-out” service – may need to disenroll to receive other Medicaid services – Provider will send request to PA vendor

• (E)(1) and (2) Planned disenrollment

• (E)(3) Unplanned disenrollment

• Discussion point: what will be expected for reenrollment after disenrollment?
(E) Disenrollment from Ohio Medicaid ACT

(E)(1) Planned disenrollment
a) Achieved goals
b) Planned move/transfer to other services
c) Declines or refuses services (despite outreach/engagement attempts) and requests disenrollment
d) Determined to no longer meet eligibility criteria
(E) Disenrollment from Ohio Medicaid ACT

(E)(3) Unplanned disenrollment

a) Team unable to locate recipient (>45 days)

b) Incarceration, hospitalization or admission to residential SUD
   – If length of stay predicted to be longer than 2 months
   – May reenroll when discharged
Vignettes
David

- 38-year-old man diagnosed with Schizophrenia
- ANSA: MHN – 3/2/3/2/2/0/0/2/0/0
  - RB – 2/0/0/0/1/2/0/0
  - LDF – 1/0/0/2/1/0/0/3/3/0/2/3/3/1
- Very guarded with information – believes he is under surveillance by the DEA, FBI, and police
- Has been homeless living on the streets
- Won’t take meds, doesn’t have an illness – “if you were under intense surveillance with a transmitter implanted in you – wouldn’t you be suspicious and depressed?”
Rosalinda

- 25-year-old woman diagnosed with Schizoaffective d/o
- ANSA: MHN – 2/0/2/0/1/0/2/0/2/0
  - RB – 0/0/0/0/2/0/0
  - LDF – 2/1/0/2/1/0/0/2/0/0/0/2/1/1
- Has lived in the same group home for 1 year – really wants her own place.
- Moved into group home after a fire in her apartment: a pile of newspapers next to the stove caught fire
- Forgets to take meds, doesn’t want to get shots
Jamal

• 45-year-old man diagnosed with Bipolar I
• ANSA: MHN – 1/1/1/1/1/1/1/1/1/1
  – RB – 0/0/0/0/1/0/0
  – LDF – 2/2/0/0/0/2/3/0/0/2/1/1
• Has had 2 hospital admission in the last 12 months
• Has intermittent episodes of hearing voices (auditory hallucinations), but is able to ignore them
• No current use of alcohol or other drugs, except tobacco use
• Has been living with his mother in her house for the past 2 years
• Keeps most appointments at CMHC; has missed 2 in the past yr (missed the bus). Called his case manager to reschedule missed appointments
Ron

• 41-year-old man diagnosed with Schizophrenia
• ANSA: MHN – 3/2/3/2/2/0/0/2/0/0
  – RB – 2/0/0/0/1/2/0/0
  – LDF – 1/0/0/2/1/0/0/3/3/0/2/3/3/1
• Was released from the state hospital on November 10, 2016 – after 2 years hospitalized. He has been living in a supervised apartment since discharge.
• A team member comes twice a day to make sure he takes his meds and eats properly. He calls the team on-call number 3-5 times a week when the voices get overwhelming.
Contact Us

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Cleveland, Ohio 44106-7169

richard.kruszynski@case.edu
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216-368-0808

www.centerforebp.case.edu
Join Our Mailing List

create account | sign in

Get connected to ...  
- Training events  
- Educational resources  
- Consulting resources  
- Evaluation resources  
  (fidelity & outcomes)  
- Professional peer-networks

- Stories  
- Booklets  
- Posters  
- Audio  
- Manuals  
- Fidelity scales  
- More

www.centerforebp.case.edu
Stories

- News about us and our collaborators.
- Recovery stories told by consumers, family members, service providers, employers.
- Conversations with people who implement service innovations.
Our Mission

The Center for Evidence-Based Practices (CEBP) at Case Western Reserve University is a technical-assistance organization that promotes knowledge development and the implementation of evidence-based practices (EBPs) for the treatment and recovery of people diagnosed with mental illness or co-occurring mental illness and substance use disorders.

Our technical-assistance services include the following:
- Service-systems consultation
- Program consultation
- Clinical consultation
- Training and education
- Program evaluation (fidelity & outcomes)
- Professional peer-networks
- Research
Lessons Learned:
6 months of Prior Authorization Reviews for IHBT and ACT

Dr. Chantal Hunt, Kepro
Mary Haller, ODM
Current PA Review Process

KEPRO reviews Prior Authorization requests

• Verifies that they include the intake/referral information available at the time of the request
• Review specific required clinical documentation based on service requirements
Kepro Developed/ODM Approved Clinical Guidelines

http://ohmedicaid.kepro.com/providers/manuals-reference-materials/

MANUALS & REFERENCE MATERIALS

Ohio Department of Medicaid - Guidance Publications
Ohio Department of Medicaid - Hospital Transmission Letters
Ohio Administrative Code - 5160 Medicaid

Ohio Administrative Code (OAC)
- OAC 5160-2-40: Pre-certification Review
- OAC 5160-2-03: Conditions and Limitations
- OAC 5160-1-31: Prior authorization (except for services provided through medicaid contracting managed care plans (MCPs))

Behavioral Health Clinical Guidelines
- Ohio Medicaid UM - ACT Clinical Guidelines
- Ohio Medicaid UM - IHBT Clinical Guidelines
- Ohio Medicaid UM - SUD Partial Hospitalization LOC
- Ohio Medicaid UM - SUD Residential Treatment
Instructions for Providers Re: Documentation Needed

Do NOT send the entire record!
Usually only need the ANSA or SSI documentation and a recent (i.e., last six months) Diagnostic Assessment, or progress notes, signed/dated statement from member of treatment team with independent scope of practice, e.g., “I just had to skim through 74 pages on a previous case.”

When submitting hospital summaries - do not include the lab reports, vitals, meds, etc. Just send pages showing name, dates admitted and that it was a psych admission.

Only send medical admissions pertinent to the client’s need for ACT or IHBT services (e.g., individual not caring for complex medical problems due to psychiatric diagnosis, resulting in medical admissions).
PA Reviewer Suggestions

• A summary of history and current issues is most important. This is generally on the diagnostic assessment.

• Individualized Service Plans (ISPs) are not useful to document medical necessity. e.g. “Individual will decrease negative behaviors...” doesn’t give information about the recipient’s current situation.

• Better to send case notes that show recent treatment activity and problems. “The most helpful PA Requests contain a list of specific incidents that have occurred over the last year or two, such as hospitalizations, ER visits, calls to law enforcement, etc.”

• “For the cases that clearly don’t meet institutional requirements, provider should add an explanation specific to the patient (not boilerplate statements) of why they believe ACT services need to be continued.”

• Documentation MUST be Current “I’m reviewing notes from 2012 and older on some of these. Some agencies are not submitting anything current and seem to believe that because a person once qualified for ACT services that they always will.”
Institutional Use/Functioning Challenges: Examples of Source Documents - ACT

- State or psychiatric hospital or psychiatric unit admission and discharge dates & discharge summaries;
- Hospital emergency department/mobile crisis center/crisis residential unit stays/notes;
- Documentation that Home is dangerous or compromised:
  - drug trafficking/use house,
  - infested with pests,
  - lack of working utilities, plumbing, HVAC,
  - Located in area that compromises person’s safety;
  - Person is Homeless or at risk of homelessness (streets, park bench, under bridge, cardboard box, couch-surfing, shelters, lack of permanent residence/has moved more than twice in last 12 months
Institutional Use/Functioning Challenges: Examples of Source Documents – ACT, continued

Involvement with Law Enforcement:
Documentation of names of correctional facilities, dates of incarceration, charges, probation or parole dates;

ANSA rating sheet:
1 or higher on residential stability,
2 or higher on legal or medication compliance, or
3 or higher on Sexuality or Self-care, or
2 or higher on any item of Mental Health Needs, or
2 or higher on any item under Risk behaviors except Gambling.
Examples of Documenting Other Functional Indicators

• Present evidence that person is at risk of psychiatric hospitalization or other institutional placement if more intensive services are not available (e.g., current or recent acute/chronic psychosis, suicidal or homicidal ideation);

• Current or recent substance use has adversely impacted functioning, housing, community tenure, ability to care for needs, or has resulted in hospitalization, exacerbation of symptoms, or treatment engagement;

• Current or recent threatening behavior; vagrancy or loitering, or “nuisance to community”;

• Consumer has been unsuccessful in using traditional office-based outpatient services (e.g., terminated from services due to non-adherence, missing appointments, not engaging in treatment, being banned from premises for inappropriate behaviors, fired from previous providers, etc.)
Documentation for IHBT Requests

• Child and Adolescent Needs Survey (CANS) must meet the threshold criteria for the 3 domains of Life Functioning, Behavioral, and Risk Behaviors (See Ohio Administrative Code 5160-27-05)

• For initial reviews, the Comprehensive Assessment and CANS are required – the CANS does not take the place of the Comprehensive Assessment – also do not submit only a list of the CANS domain criteria with check boxes.

• Very important for providers to send information that documents a risk of out-of-home placement (placement stability risk for out-of-home placement, recent out-of-home placement, or need for high intensity MH interventions to stay in the home.) This cannot be inferred, but needs to be clear. **This is the information missing most often.**
Other General Guidance from KEPRO

• A phone call with the provider is worth the time spent. Even if on the phone for a long call with a provider, we often have better results when we verbally explain what is missing and what we need them to send.

• It has also been helpful to explain WHY we need specific information. Because PA is a new requirement, providers can get frustrated when they have to submit information, and then are asked to send even more information.

• Providers DO know their clients, and they know that they need services. Reviewers should explain that because we don’t know them, we need clear documentation showing that high-intensity services are needed and get a picture of what they know of the Individual.

• Often, the person submitting the PA is not the clinician; they are in the billing office. Explain to that person what is needed, but often you need to ask to speak directly to a clinician.
Kepro Contact Information

Telephone: 844-854-7281

Email: OHMedicaid@Kepro.com

Website: http://ohmedicaid.kepro.com/providers/manuals-reference-materials/
Lessons Learned – ODM perspective

• Anticipate large influx of PA requests, especially for SUD Partial Hospitalization and SUD Residential (reference the ASAM training given by Mercer on May 15.
  • We can schedule an additional webinar on ASAM if needed.

• Anticipate LOTS of back and forth negotiations and contacts via telephone and email from providers with questions about PAs. Consider how you want BH providers to contact MCP PA Staff.

• Anticipate complaints re: inconsistent review standards. Suggest closely following ODM rules and Kepro clinical guidance.

• Anticipate many requests for PA for retrospective dates.
  • ODM policy has been to approve very few cases; e.g. clients with retro Medicaid eligibility with services that started before
  • Possible topic for further discussion between ODM and MCPs

• Expect insufficient and old clinical documentation.
Questions for MCPs
(For possible further discussion with ODM)

• How do you want providers to communicate with you?
• How will you communicate back with providers?
• Do you have PA numbers or claim numbers to use as a reference for discussions with providers?
• Will you accept electronic uploads of clinical documentation vs faxed pages?
• How many times will you allow additional information to be submitted before rendering a decision?
• How long will you allow a PA request to remain open before rendering a decision. (Many requests for additional information go unanswered)
• What approval time thresholds (PA date span) will you allow for each service? (IHBT can vary depending on frequency of service; SUD PH and residential also variable)
BH Redesign Website
Behavioral Health Redesign Website

Go To: bh.medicaid.ohio.gov

Preparing for BH Redesign

Please utilize the ‘Preparing for BH Redesign’ section found on the home page of the BH Redesign website for latest updates as we approach 1/1/18 BH Redesign implementation.

- Manuals, Rates & Resources
- Training Opportunities
- MITS Bits Provider Information Releases
Questions?