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**8.315.5 ASSERTIVE COMMUNITY TREATMENT SERVICES**

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**TITLE 8 SOCIAL SERVICES**
**CHAPTER 315 OTHER LONG TERM CARE SERVICES**
**PART 5 ASSERTIVE COMMUNITY TREATMENT SERVICES**

**8.315.5.1 ISSUING AGENCY:** New Mexico Human Services Department.
[8.315.5.1 NMAC - N, 10-1-05]

**8.315.5.2 SCOPE:** The rule applies to the general public.
[8.315.5.2 NMAC - N, 10-1-05]

**8.315.5.3 STATUTORY AUTHORITY:** The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended and by state statute. See NMSA 1978, Sections 27-2-12 et seq. (2006).
[8.315.5.3 NMAC - N, 10-1-05; A, 7-1-08]

**8.315.5.4 DURATION:** Permanent
[8.315.5.4 NMAC - N, 10-1-05]

**8.315.5.5 EFFECTIVE DATE:** October 1, 2005, unless a later date is cited at the end of a section.
[8.315.5.5 NMAC - N, 10-1-05]

**8.315.5.6 OBJECTIVE:** The objective of these regulations is to provide policies for the service portion of the New Mexico medical assistance programs.
[8.315.5.6 NMAC - N, 10-1-05; A, 7-1-08]

**8.315.5.7 DEFINITIONS:** [RESERVED]

**8.315.5.8 MISSION STATEMENT:** The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of eligible recipients by furnishing payment for quality health services at levels comparable to private health plans.
[8.315.5.8 NMAC - N, 10-1-05; A, 7-1-08]

**8.315.5.9 ASSERTIVE COMMUNITY TREATMENT (ACT) SERVICES:** MAD pays for medically necessary health services furnished to eligible recipients. To help eligible recipients receive necessary services, MAD pays for covered professional and peer mental health services [42 CFR SS 440.40, 440.60(a) and 441.57].
8.315.5.9 NMAC - N, 10-1-05; A, 7-1-08]

**8.315.5.10 ELIGIBLE PROVIDERS:** Upon the approval of a New Mexico MAD provider participation agreement by MAD or its designee, a licensed practitioner, agency or facility that meets applicable requirements is eligible to be reimbursed for furnishing covered services to an eligible program recipient. A provider must be enrolled before submitting a claim for payment to the appropriate MAD claims processing contractor. MAD makes available on the HSD/MAD website, on other program-specific, or in hard copy format, information necessary to participate in health care programs administered by HSD or its authorized agents, including program rules, billing instructions, utilization review instructions, and other pertinent materials. Once enrolled, a provider receives instructions on how to access these documents. It is the provider's responsibility to access these instructions or ask for paper copies to be provided, to understand the information provided and to comply with the manuals, billing and utilization review instructions, and other pertinent materials and to obtain answers to questions on or not covered by these materials. To be eligible for reimbursement, a provider is bound by the provisions of the MAD provider participation agreement.

A. The provider must demonstrate compliance with administrative, financial, clinical, quality improvement and information services infrastructure standards established by MAD or its designee, including compliance and outcomes consistent with the ACT fidelity model. *(See New Mexico interagency behavioral health service requirement and utilization for more specific guidance*.)

B. ACT services must be provided by an agency that includes a team of ten to twelve individuals. Each team must have a designated team leader. Individuals on this team shall have sufficient individual competence, professional qualifications and experience to provide service coordination; crisis assessment and

intervention; symptom assessment and management; individual counseling and psychotherapy; prescription, administration, monitoring and documentation of medications; substance abuse treatment; work-related services; activities of daily living services; support services or direct assistance to ensure that individuals obtain the basic necessities of daily life; and education, support, and consultation to individuals' families and other major supports. The agency must coordinate their ACT services with local hospitals, local crises units, local law enforcement agencies, local behavioral health agencies and consider referrals from social service agencies.

C. Each team staff member must successfully be certified as trained according to standards for ACT as developed by HSD or its authorized agents. The approved training will focus on developing staff competencies for delivering ACT services according to the most recent ACT evidenced-based practices. Each ACT team shall have sufficient numbers of staff to provide treatment, rehabilitation, crisis and support services 24 hours a day, seven days per week.

D. Each ACT team shall have a staff-to-individual ratio in keeping with ACT evidence-based practice standards as approved by MAD or its designee.

E. Each ACT team shall include:

(1) at least one board-certified or board-eligible psychiatrist;
(2) two licensed nurses, one of whom shall be a registered nurse;
(3) at least one other independently licensed mental health professional;
(4) at least one licensed substance abuse professional;
(5) at least one employment specialist;
(6) at least one certified peer provider;
(7) one administrative staff person; and
(8) the eligible recipient shall be considered a part of the team for decisions impacting his/her services.

[8.315.5.10 NMAC - N, 10-1-05; A, 7-1-08]

**8.315.5.11 PROVIDER RESPONSIBILITIES:** A provider who furnishes services to a medicaid or other health care program eligible recipient agrees to comply with all federal and state laws and regulations relevant to the provision of services as specified in the MAD provider participation agreement. A provider also agrees to conform to MAD program regulations and instructions as specified in this manual, its appendices and program directions and billing instructions, as updated. A provider is also responsible for following coding manual guidelines and CMS correct coding initiatives, including not improperly unbundling or upcoding services.
[8.315.5.11 NMAC - N, 10-1-05; A, 7-1-08]

**8.315.5.12 ELIGIBLE RECIPIENTS:**

A. ACT services are provided to individuals aged 18 and older who have a diagnosis of severe mental illness (including schizophrenia, schizoaffective disorder, bipolar disorder or psychotic depression) who have severe problems completing activities of daily living, who have a significant history of involvement in behavioral health services, and who have experienced repeated hospitalizations or incarcerations due to mental illness.

B. A co-occuring diagnosis of substance abuse shall not exclude an individual from eligibility for the program.

[8.315.5.12 NMAC - N, 10-1-05; A, 7-1-08]

**8.315.5.13 COVERAGE CRITERIA:**

A. MAD covers medically necessary ACT services required by the condition of the eligible recipient.

B. This culturally sensitive service, delivered by an appropriately constituted team, provides therapeutic interventions that address the functional problems associated with the most complex or pervasive conditions of the identified population. These interventions are strength-based and focused on promoting symptom stability; increasing the eligible recipient's ability to cope and relate to others; and enhancing the highest level of functioning in the community, including learning, working and recreation, and making informed choices.

C. Interventions may address adaptive skill areas such as: housing; school, work and training opportunities; daily activities; health and safety; medication support; harm reduction; money management and entitlements; promotion of individual recovery processes; relapse prevention; and service planning and coordination.

D. All services must be furnished within the limits of MAD benefits, within the scope and practice of the eligible provider's respective profession as defined by state law, and in accordance with applicable federal, state, and local laws and regulations.

E. The ACT therapy model is based on empirical data and evidence-based interventions that target specific behaviors with an individualized treatment plan. Specialized therapeutic and rehabilitative interventions falling within the fidelity mode of ACT are used to address specific areas of need, such as experiences of repeated hospitalization or incarcerations, severe problems completing activities of daily living and who have a significant history of involvement in behavioral health services.

F. **Medical necessity:** All services must be provided in compliance with the MAD definition of medical necessity as found in current MAD regulations.

[8.315.5.13 NMAC - N, 10-1-05; A, 7-1-08]

**8.315.5.14 COVERED SERVICES:**

A. ACT is a voluntary medical, comprehensive case management and psychosocial intervention program provided on the basis of the following principles:

(1) the service is available 24 hours a day, seven days a week;

(2) the service is provided by an interdisciplinary ACT team that includes trained personnel as defined in Subsections D and E of 8.315.5.10 NMAC;

(3) an individualized treatment plan and supports are developed;

(4) at least 90% of services are delivered as community-based, non-office-based outreach services;

(5) an array of services are provided based on individual patient medical need;

(6) the service is consumer-directed;

(7) the service is recovery-oriented;

(8) the team maintains a low staff-to-patient ratio, following the ACT evidence-based model guidelines;

(9) mobilized crisis intervention is provided in various environments such as homes, schools, jails, homeless shelters, streets and other locations; and

(10) the team is not just a consortium of mental health specialists, but includes collaborative assessment and treatment planning for each service eligible recipient; cross-training of team members; daily team meetings; use of an open office format to promote team communication; and a team approach to each service eligible recipient's care and services; the team will assist the eligible recipient to access other appropriate services in the community that are not funded by MAD.

B. **Quality measurement:** Program success is evaluated based on outcomes which may include but are not limited to: improved engagement by eligible recipients in medical and social services; decreased rates of incarceration; decreased rates of hospitalization; decreased use of alcohol or illegal drugs; increased housing stability; increased relationships of eligible recipients with families; and increased employment; and increased attainment of goals self-identified by the service eligible recipient for his own life. Fidelity to the specific evidence-based ACT service model will also be measured to assure that ACT, rather than some other form of intensive case management, is being provided.

C. ACT services must be provided to the eligible recipient by the treatment team members.

[8.315.5.14 NMAC - N, 10-1-05; A, 7-1-08]

**8.315.5.15 NONCOVERED SERVICES:** ACT services are subject to the limitations and coverage restrictions that exist for other MAD services. See 8.301.3 NMAC, *General Noncovered Services*. No other psychiatric, mental health nursing, therapeutic, substance abuse or crisis services will be concurrently reimbursed for the ACT service eligible recipient except medically necessary medications and hospitalizations.

[8.315.5.15 NMAC - N, 10-1-05; A, 7-1-08]

**8.315.5.16 PRIOR AUTHORIZATION AND UTILIZATION REVIEW:** All MAD services may be subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See 8.302.5 NMAC, *Prior Authorization and Utilization Review*. Once enrolled, providers receive instructions and documentation forms necessary for prior authorization and claims processing.

A. **Prior authorization:** Services or procedures require prior authorization from MAD or its designee. Services may be reviewed retrospectively. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process. See Subsection A of 8.311.2.16 NMAC, *Covered Emergency Services* [MAD-721.71].

B. **Eligibility determination:** Prior authorization of services does not guarantee that individuals are eligible for medicaid. Providers must verify that individuals are eligible for a specific program at the time services are furnished and determine if the eligible recipient has other health insurance.

C. **Reconsideration:** Providers who disagree with prior authorization request denials or other review decisions can request a re-review and a reconsideration. See 8.350.2 NMAC, *Reconsideration of Utilization Review Decisions* [MAD-953].

[8.315.5.16 NMAC - N, 10-1-05; A, 7-1-08]

**8.315.5.17 REIMBURSEMENT:**

A. ACT service providers must submit claims for reimbursement on the HCFA/CMS claim form or its successor. See 8.302.2 NMAC, *Billing for Medicaid Services*. Once enrolled, providers receive instructions on documentation, billing, and claims processing.

B. Reimbursement to providers for covered services is made at the lesser of the following:

(1) the provider's billed charge; or

(2) the MAD fee schedule for the specific service or procedure for the provider, as established after considering cost data.

(a) The provider's billed charge must be their usual and customary charge for services.

(b) "Usual and customary charge" refers to the amount that the individual provider charges the general public in the majority of cases for a specific procedure or service.

[8.315.5.17 NMAC - N, 10-1-05; A, 7-1-08]

**HISTORY OF 8.315.5 NMAC:** [RESERVED]