

Assertive Community Treatment Meeting with OMH, DOHMH and The Coalition

Points for Discussion

October 3, 2003

1:00 -3:00

I. Conversion/Implementation Process

- Timetable for conversion and implementation is too aggressive and does not allow enough time for agencies to hire and train staff on activities related to ACT while also achieving a Medicaid enrollment roster and levels of service to reach revenue goals to maintain program viability. Rapid enrollment, high demands for billing, attracting/training staff all at the same time will impact service delivery.
- There is no written and clearly articulated schedule and plan for implementation which contains administrative rules, directives, and mandates. The lack of a written plan or schedule has been problematic in circumstances where the timing of certain mandates and directives did not represent coordinated agreement between State and local agencies. Conflicting and contradictory information from State and local agencies regarding fiscal viability potentially could have put providers at risk of not complying with programmatic requirements and/or could have seriously impacted the maintenance of programmatic and fiscal viability.
- ACT appears to be moving in a direction that is more program oriented and clinically based. The original model contemplated outreach to consumers who generally are known not to integrate well in clinical type settings and have habitually avoided such settings. Because of that, the ACT program permitted flexibility and this flexibility was tied to achieving better outcomes for the population receiving ACT services. As ACT converts to a MA system, OMH has added features to the ACT model that appear to deviate from the original ACT design. These features incorporate evidence based practices and clinical design/construction of treatment spaces which create an environment and treatment services that are more static in nature, more program oriented, and structured to operate more like a clinic than an outreach program. OMH appears to have created a “new model” that deviates from the original ACT model. This “new model” does not appear, therefore, to be the service model that was originally intended which is, namely, one that permits flexibility in program delivery to achieve the outcomes consistent with the original ACT design. What is the philosophy of the NY State ACT model? How can the model retain its flexible service delivery features? How is the renovation of space (or need to purchase new space), which is designed like a clinic under current guidelines, consistent with the outreach model generally associated with ACT?

II. Fiscal Concerns

- **Medicaid Eligibility:** The ACT program relies on only accepting those consumers who are Medicaid eligible. Current practice is to take clients regardless of Medicaid eligibility and, therefore, the program is expanding with a start up roster of consumers who may not be eligible for Medicaid. This can lead to a cash flow crisis that impacts program viability. The presumption that an agency always bill at a census of 48 will not always be the case and can present a real problem. How should agencies address expansion of ACT programs where the current roster of consumers are not Medicaid eligible and, therefore, providing continued services to such consumers do not result in reimbursements that will support the fiscal viability of the program?
- **Medicaid Billing:** NY State is designing ACT with a number of variants that are different from the original ACT model and a variant from ACT program fidelity. It has not been clearly articulated or defined whether such services are Medicaid reimbursable and what code sets should be used for billing purposes. Many agencies have never billed Medicaid and **need extensive training on Medicaid billing**. What communications has OMH had with DOH to support that DOH is in agreement with the billing practice advocated by OMH? What regulatory process has or is being implemented that evidences DOH's support of the proposed Medicaid billing methods and that the services mandated by OMH as a Medicaid reimbursable service will withstand a DOH audit? **If OMH is unable to support the Medicaid billing structure it advocates, agencies should be held harmless for the first year of program implementation.**
- **Transitional Funding:** There is a lack of coordination between the OMH and the DOHMH with regard to transitional funding information. It is often the case that the sources through which information is delivered to agencies have proven to be unreliable (the information is later found to be contradictory, proves to be incorrect, or misguided) and often is not accompanied with appropriate written confirmation from OMH and DOHMH. Providers need written clarification that reflects coordinated agreement between the OMH and DOHMH how this funding will be allocated and what categories of transitional expenses will be available for reimbursement. **Agencies need fiscal protection for programs that will not pull down Medicaid dollars quickly enough to maintain fiscal viability and, therefore, deficit financing should remain in place for one year or up to a point during the first year when Medicaid eligible enrollment supports the fiscal viability of the program.**
- **Regional Rates:** Personnel and rental rates costs in NYC are higher than the rest of New York State(ROS.) Travel costs need to be factored into the rate analysis not only for parking and garaging vehicles but also for the cost incurred in travel time of staff in moving around the City to deliver services. OMH needs to reexamine and reanalyze the actual cost to NYC

agencies and factor in the differentiation of costs to downstate providers against the costs to the ROS.

- **Fiscal Support for Agencies adhering to National ACT Model:** Some agencies have adhered to the national staffing model which appears to be more expansive to include regularly scheduled weekend and evening shifts. The fiscal model for NYC ACT should provide fiscal support to programs that maintain fidelity to the national model.

III. Programmatic Concerns

- **Staffing Issues:** Providers have expressed the following staffing concerns.
 - Staff recruitment/service delivery: Agencies are having difficulty recruiting professional staff such as psychiatrists for the required delivery of services. Nurse practitioners should be permitted to deliver some services under the supervision/direction of a psychiatrist as permitted in other certified outpatient programs.
 - Staff salaries: Salaries are too low to attract and retain qualified staff to work 24/7 with the ACT population. Agencies are experiencing high vacancy and turnover. Higher reimbursement (recognizing a regional differentiation for NYC) needs for NYC will permit an increase in salary levels which will also have a positive effect on service delivery.
 - Definition of Professional Staff: The professional staff definition needs to be flexible so that current staff with masters level education/experience can be considered professional to render certain services. Additionally, the professional staffing definitions should be reconsidered so that nursing functions can be performed by an LPN. An LPN is easier to recruit and retain (and can possibly be trained in other specialties at less cost to the provider).
 - Clinical and Administrative Demands on Team Leaders: Team leaders are required to spend 50% of their time delivering clinical services and 50% of their time performing administrative duties. This has been a difficult and taxing requirement that is creating early burnout for team leaders. This requirement needs to be modified so that team leaders can devote concentrated time to supervising clinical staff on service delivery matters or concentrate their time on administrative duties. Many team leaders are finding that they have to spend an exhaustive amount of time doing administrative work for which there is no reimbursement when their time could be maximized by delivering needed clinical services and/or supervising the delivery of clinical services.
 - Supervision: The change in the supervision requirement for ACT is problematic for both program administration and promoting strong and positive staff morale. The change to group supervision rather than individual supervision does not support or encourage individual growth and learning. It negatively impacts, undermines, and diminishes the employer-employee relationship which is based on privacy and confidentiality.

- Cultural Competency: Agencies are required to provide translation services to any and all non-English speaking clients. In NYC this can be very costly because of the variety of languages presented in NYC. Agencies are not receiving additional reimbursements for providing this service and it can be an additional hardship in circumstances where the revenue is insufficient to meet the service demands.

- Safety Demands: Many agencies in NYC are finding that the neighborhoods where staff must travel to reach consumers present serious safety concerns for staff. To address this concern, providers pair staff to ensure that no one is providing services to a consumer alone. This added protection is not without cost to the provider. It is an additional burden on staff and staff's time (the same number of contacts must be made by each staff person yet each individual's time to reach a consumer is reduced by having to balance safety considerations). For NYC ACT teams this safety demand needs to be considered and evaluated if OMH agrees to a NYC rate differential.

- **Documentation**: Information on documentation requirements needs to be clarified in writing and codified in regulations. OMH has produced an ACT manual containing information related to maintenance of client records e.g., progress notes. Some record maintenance is duplicative and may be unnecessary (e.g., logs which are gathered and reported on by a computerized charting system, multiple progress notes from each visit or multiple treatment plans for each specialty.) Moreover, documentation (although important for tracking and program evaluation) should be consistent with MA billing needs. That is one of the most important issues that will determine whether an agency's reimbursements will be disallowed upon a Medicaid audit. What documentation practice is OMH advocating for ACT programs in the circumstances where a DOH audit is at issue? What communications has OMH had with DOH to support that DOH is in agreement with the documentation practice advocated by OMH? What regulatory process has been or is being implemented that evidences DOH's support of the proposed documentation methods that will withstand a DOH audit? **If OMH is unable to support the documentation practice it advocates, agencies should be held harmless for the first year of program implementation or until OMH and DOH have reached agreement that the documentation practice is acceptable for Medicaid reimbursement purposes and will pass muster under a DOH audit.**

IV. Regulatory Concerns

- **ACT Regulations/Guidelines**: The ACT regulations do not address service delivery issues or identify rates of reimbursement tied to a specific service delivery. This is a problem because there are no rules that have the effect of law on the management of this program and providers have at times received unwritten, unsubstantiated, conflicting, and contradictory information with regard to the administration of the ACT program. The communications have been primarily verbal and the information from OMH and DOHMH have at times been

inconsistent and have caused major confusion for providers trying to ramp up for conversion to a Medicaid system (e.g., templates for content of treatment plans/progress notes; training; deadlines for conversion of certain practices before training and technical assistance is provided.) OMH and DOHMH need to strengthen their collaboration and coordination of the rules governing ACT in a Medicaid environment. These rules need to be codified in writing and clearly articulated to eliminate vagueness, inference and individual interpretation. **At a minimum agencies should be held harmless by OMH and DOHMH for the first year of program implementation from the date of the issuance of an operating certificate or until such time that OMH and DOH have reached agreement that the promulgated regulations and guidelines represent that which is acceptable for Medicaid reimbursement purposes and will pass muster under a DOH audit.**

- **Dual Enrollment:** Under the current ACT rules, individuals receiving ACT services may not be enrolled in other programs. As individuals from the ACT population are mainstreamed into community based services, ACT will have to provide support and coordination until the individual is compliant with a treatment regimen and is phased out of ACT. The ACT provider and the community-based provider can not bill Medicaid at the same time. This is a paradoxical and inequitable result – both the ACT provider and the community based provider are expected to provide a service but only one provider can be reimbursed. Another example of fiscal inequity in this regard is the requirement that ACT providers must accept AOT referrals (when the agency is under census) without regard to Medicaid eligibility. **Under these type of circumstances, agencies should receive a rate adjustment to account for the cost incurred in providing services which are not reimbursable so that service delivery is not impaired and staff deployment is not over burdened (or in the alternative provide a reasonable grace period that permits dual enrollment reimbursements in time frames consistent with the needs of the consumer and requirements of “best practice” program service delivery.**
- **Certification Standards:** It is expected that OMH will make a six (6) month post operating certificate visit to agencies to evaluate compliance with the ACT Certification Manual. OMH delayed circulation of the Certification Manual for two (2) months before making it available in May 2003. Because of this delay, agencies were at a major disadvantage in knowing what was required to be in compliance with certification mandates. Coupled with the various confusing and inconsistent communications concerning ACT implementation and the stringent certification standards now set forth in the Certification Manual that were not part of the Program Guidelines, agencies have had very little time to organize programs so that they can comply with the Certification Manual (e.g., the number of contacts required per client to bill at the Intensive

level has become a difficult standard to achieve). Given the lack of direction, training, assistance, written communication, funding support, and time necessary to prepare for this review, agencies are struggling with how to best prepare for this evaluation and meet certification standards.¹

To ensure compliance with the changes made from the Program Guidelines and efforts to meet the standards of the Certification Manual, agencies need to be held harmless for an additional six (6) months or until such time that OMH, DOH and DOHMH have reached agreement that the Guidelines and Certification Manual represent the full and final requirements for ACT programs in this transitioning and start up phase to a Medicaid reimbursable system.

V. Recommendation

OMH, DOHMH, Coalition representatives, and a representative number of agencies should form an ACT Task Force or Steering Committee to address the global programmatic and fiscal issues concerning providers of ACT services to ensure program and fiscal viability. This task force or steering committee should meet on a bi-monthly basis and incl

¹ Recently, an article in The Journal of Behavioral Health Services and Research, July/September 2003, entitled “Is It ACT Yet? Real World Examples of Evaluating the Degree of Implementation for Assertive Community Treatment” illustrates that ACT teams face particular challenges where state authorities do not provide explicit direction and there is a lack of targeted funding to support the implementation of services required for fidelity to the proposed ACT program.

