NETWORK180 PROVIDER MANUAL
SECTION 1: SERVICE REQUIREMENTS

ASSERITIVE COMMUNITY TREATMENT (ACT)

Provider will be in compliance with regulations and requirements as outlined in the Michigan Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter, as well as the Lakeshore Regional Entity Contract Attachment A: Service Description for Assertive Community Treatment (ACT). In addition to these, Provider must adhere to the following specific requirements.

Services
1. Support the maximum level of self-determination desired by individuals through established procedures.
2. Work closely with referral sources to begin services as soon as possible following eligibility determination.
3. Provide psychotropic medications to individuals discharged from Inpatient or Crisis Residential Services. Network180 provides payment for psychotropic medications for the first 30 days after discharge when inpatient services are authorized by Network180 for persons not on Medicaid who have not met the monthly Medicaid spend down amount, or are without other insurance coverage.
4. Coordinate psychotropic medication for 30 days after discharge unless a subsequent service provider assumes this responsibility.
5. Advocate, refer, and coordinate within the Network180 system of care including but not limited to Supported Employment, Clubhouse, Residential, Peer-Delivered, Family Psychoeducation, and/or Housing Supports.
6. Case Managers are expected to provide clinical triage, crisis support, and face-to-face assessment during after-hours, weekends and holidays. Case Managers will respond within 10 minutes to an Access Center request for a return phone call. When the Access Center determines that a face-to-face intervention is required, Case Managers will respond to the request in person within one hour. Case Managers will notify the Access Center of the resolution of the intervention.
7. Provide assistance with acquisition and retention of public benefits, including Medicaid and Medicare insurance, Social Security, DHHS Home Help Services, food assistance, etc. It is the responsibility of the Case Manager to understand the funding source of the individual being served as well as the benefit available for services in order to coordinate care and work within the specified benefit.
8. Provide discretionary funds necessary to meet the individual’s treatment specific needs, including but not limited to the cost of medications for individuals with no insurance. Network180 does not reimburse for the cost of medications for Medicaid-insured or commercially insured individuals with prescription coverage. Provider can utilize multiple strategies to ensure medication access for individuals including, but not limited to: development of a formulary or adherence to the Network180 formulary, accessing free or reduced medications through pharmaceutical company patient assistance programs and referrals to community resources.
9. Coordinate intensive services. Complete assessment and admission for Psychiatric Inpatient Hospitalization, Partial Hospitalization, and Crisis Residential admissions. Request authorization for these services through the Network180 Access Center, as determined by the individual’s benefit.
   a. All step-down admissions from Inpatient to Crisis Residential or Partial Hospitalization must receive prior approval from the Network180 Utilization Management (UM) Department, as determined by the individual’s benefit.
10. Individuals must work within his/her benefit for acute psychiatric crisis services. This includes individuals with Medicare, Medicaid, and other private insurance policies. Network180 will fund
acute psychiatric crisis services for individuals with Medicaid and those without insurance. It is the responsibility of the Case Manager to understand the funding source of the individual being served as well as the benefit available for acute psychiatric crisis services in order to coordinate care and work within the specified benefit.

11. Participate in discharge planning for individuals during an Inpatient or Partial Hospitalization, SUD Intensive Stabilization or Crisis Residential admission.

12. Case Managers will make telephone contact with the program discharge planner within one business day following the date of admission for, or receipt of, a new authorization from the Network180 Access Center or UM Department.

13. Case Managers will make a minimum of one in-person visit to the program (programs in Kent County only) for the purpose of discharge planning with the individual and program staff within two business days following the date of admission for existing consumers, and within three business days for engagement and discharge planning with new referrals from the Access Center or UM Department.

14. Continue to make telephone contact with program discharge planners throughout the individual’s admission as appropriate to assist in discharge planning.

15. Participate in inpatient treatment team meetings in person, or by telephone if requested, and relay content of meetings to other care providers (e.g., agency psychiatrist). For individuals who are hospitalized in a facility outside of the community for more than ten days, it is expected that Case Managers will participate in more frequent treatment team meetings each week.

16. Provide follow-up after discharge from Inpatient, Partial Hospitalization, Crisis Residential, SUD Intensive Stabilization or the Jail:
   a. Conduct a face-to-face visit with the individual within seven business days of discharge. This follow-up visit can be conducted by the Case Manager, Nurse, or Supports Coordinator. During this visit, individuals will be assisted in adhering to their discharge plan and receive supports to prevent readmission.
   b. All individuals who discharge from a substance abuse detoxification unit must be seen for follow-up within seven days.

17. Provider is responsible for consistent collaboration with Professional Consulting Services (PCS) when the individual receiving services is associated with the Prisoner Reentry Mental Health Program.

   Professional Consulting Services
   Craig Judd
   Kathlene LaCour
   Phone: 269-929-1292
   Fax: 269-965-5267

**Utilization of Peers**

1. Provision of peer supports is highly encouraged as part of the ACT team.

2. Services must follow all applicable regulations and requirements set forth in the Additional Mental Health Services (B3s): Peer Specialist Services section of the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter of the Medicaid Provider Manual.

3. The intent of peer support services is for individuals employed in this capacity to function as an equal on the team, and from the unique perspective of having lived experience, in order to directly contribute to meeting the needs of individuals receiving ACT services through Network180’s system of care. Underlying all peer support activities is the intent to promote positive outcomes in independence, community inclusion, and productivity for the individual served, and ongoing recovery for the individual providing peer supports.

4. Provider shall ensure team members are educated regarding the value and potential contribution to the team and well-being of the individual served that can be provided by individuals with lived experience. Team members shall be encouraged to utilize the services of peers as appropriate.
5. Provider shall encourage individuals providing peer supports to obtain certified peer support specialist certification within the first two years of employment. Provider is encouraged to allow ongoing training and education for individuals providing peer supports.

6. Provider shall ensure supervisors have received education on supervision of individuals providing peer supports. Regular support and/or education may be beneficial in order to provide effective supervision and support of individuals with lived experience.

7. Provider shall provide regular 1:1 supervision of individuals providing peer supports.

8. Provider shall allow individuals providing peer supports, as part of their paid work day, to attend internal and/or external groups whose purpose is to provide support and a sense of community for individuals providing peer-delivered services.

9. Provider shall ensure guidelines are in place to effectively support individuals providing peer supports who are experiencing, or are at risk of experiencing, mental health crisis.

Payment
1. Report location of service delivery in progress/case notes and ensure place of service code is accurately reflected on all claims submissions.

2. Claims for face-to-face services provided in a correctional facility must be submitted using the QJ modifier and are billable for face-to-face services. The place of service code is “09”. Incarcerated individuals receiving ACT services who are sentenced to prison shall be terminated from services.

Access and Authorization
1. The Network180 Access Center or UM Department will determine eligibility for ACT services according to the Medical Necessity Criteria section of the Medicaid Provider Manual.

2. Following Network180 eligibility determination, Network180 staff will complete the referral process to Provider. In most cases the initial authorization will be performed through an in-person contact. An in-person contact may not be required in certain circumstances, including but not limited to the following:
   a. Transfer from Targeted Case Management
   b. State psychiatric facility discharges

3. Individuals must receive a face-to-face meeting with a professional within 14 calendar days of non-emergent request for services. In the time period between an initial referral from the Access Center or UM Department and the intake appointment with Provider, the Access Center is responsible for service. Provider assumes responsibility after the individual signs the agency’s consent for treatment.

4. If Provider does not open the case, Provider must send discharge information to the Access Center.

5. Provider will send all discharge summaries to the Access Center. The Access Center will enter discharge dates based on the date the summaries are received by the Access Center to maintain an accurate authorization database for the Network180 system.

Reauthorization
1. The Network180 UM Department will determine reauthorization for ACT services. The reauthorization determination will be based on whether the individual continues to meet medical necessity for services. Reauthorization episodes will not exceed 12 months, and will be supported by the current individual plan of service (IPOS) which documents medical necessity for continuation of scope, duration, and intensity of services.

2. The request for reauthorization must be submitted 14-30 days prior to the expiration of the current authorization.

3. A reauthorization request shall be submitted on the ACT Reauthorization Request Form. Additionally, Provider will verify and document the individual’s eligibility for Network180 services by providing updated demographic and financial status (including Ability to Pay) information to the Network180 Reimbursement Unit.
Referral Process
1. Provider will supply a standard schedule for ACT intakes to the Network180 Access Center via the SharePoint scheduling site.
2. The Access Center will schedule the intake appointment based on the intake schedule provided.
3. Access Center clinicians will provide the individual’s name, Network180 case number, and any comments associated with the referral on the schedule.
4. Intake appointments will be scheduled at least 48 hours after the individual has been authorized for services, unless otherwise specified by Provider.
5. Individuals referred will be given Provider’s contact information and the individual’s scheduled intake appointment time.
6. Provider will access all of the referred individual’s clinical records via the Network180 ECR.

Rapid Readmission
1. The rapid readmit procedure will be effective for any eligible individual up to 90 days after discharge from Provider. Provider will develop utilization procedures to ensure individuals who are in need of service and eligible for care are not prematurely discharged.
2. Provider discharge summary will indicate whether individuals are “eligible” for readmission to the agency. The discharge summary will be forwarded to the Access Center and included in the individual’s case record.
3. If an individual presents at the Access Center within 90 days after discharge meeting medical necessity for ACT services, a new authorization for ACT services will be created. A new authorization number will be faxed to Provider. The individual will be given an appointment per the Referral Process section. No other documentation is required.
4. If an individual contacts Provider within 90 days after discharge requesting readmission to ACT services, Provider will complete an in-person assessment to determine if the individual continues to be eligible. If Provider believes the individual meets medical necessity for ACT services, the individual will be readmitted immediately. Provider will inform the Access Center and a new authorization will be faxed to Provider. If Provider believes the individual is no longer eligible, the individual must be screened at the Access Center to determine the appropriate level of care.
5. If the individual contacts or presents to Provider after 90 days of discharge, the individual will be directed to the Access Center for screening and determination of eligibility.

Acute Readmission
1. For individuals who meet rapid readmission parameters and are in need of intensive services weekdays between 8:00 a.m. through 5:00 p.m., Provider will admit the individual and re-open the case immediately to provide discharge planning.
2. For individuals who meet the rapid readmission parameters and are in need of intensive services after 5:00 p.m. or on weekends, the Access Center will admit the individual. It is expected that Provider will assume the treatment, and discharge planning the next business day in the hospital.

Outcome Measures

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<thead>
<tr>
<th>Measure</th>
<th>How Measure is Calculated</th>
<th>Source of Data</th>
<th>Benchmark</th>
<th>Who Collects Data</th>
<th>How Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of ACT recipients living in an independent setting</td>
<td># of unduplicated recipients residing in an independent setting / total # of unduplicated ACT recipients</td>
<td>Provider</td>
<td>≥ 75%</td>
<td>Provider</td>
<td>Quarterly</td>
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<tr>
<td>Measure</td>
<td>How Measure is Calculated</td>
<td>Source of Data</td>
<td>Benchmark</td>
<td>Who Collects Data</td>
<td>How Often</td>
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<tr>
<td>% of work-eligible individuals who are competitively employed</td>
<td>% of unduplicated employed work-eligible individuals / total # of unduplicated ACT recipients</td>
<td>Provider</td>
<td>≥ 20%</td>
<td>Provider</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Average number of inpatient psychiatric hospital days per ACT recipient</td>
<td>Total # of inpatient psychiatric hospital days / Total # of unduplicated ACT consumers</td>
<td>Provider</td>
<td>11 days (decrease of 10% from FY 2014 of 12.2 days)</td>
<td>Provider</td>
<td>Annually</td>
</tr>
<tr>
<td>% of ACT recipients readmitted to an inpatient psychiatric hospital within 30 days of discharge</td>
<td># of episodes in which ACT recipients readmitted to inpatient psychiatric hospital within 30 days of discharge / Total # of inpatient episodes</td>
<td>Provider</td>
<td>≤ 15%</td>
<td>Provider</td>
<td>Quarterly</td>
</tr>
<tr>
<td>% of ACT recipients who are incarcerated</td>
<td># of unduplicated ACT recipients who are incarcerated / Total # of unduplicated ACT consumers</td>
<td>Provider</td>
<td>Establish baseline</td>
<td>Provider</td>
<td>Annually</td>
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