GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

Office of the Senior Deputy Director and Medicaid Director **Transmittal 23-50 (rev.)**

TO: All District Assertive Community Treatment Providers

FROM: Melisa Byrd M.B.
Senior Deputy Director and Medicaid Director

DATE: **November 16, 2023**

SUBJECT: **Updated Assertive Community Treatment (ACT) Delivery and Billing Requirements**

Purpose

The purpose of this transmittal is to inform all Assertive Community Treatment (ACT) providers of changes the District Medicaid program is implementing to update billing, reimbursement, and service delivery requirements for ACT. Providers must meet the requirements outlined in the transmittal to receive reimbursement. This policy is effective for services delivered **September 1, 2023,** forward, and amends guidance previously communicated via **Transmittal 23-50 on September 29, 2023.**

Billing and Reimbursement

Effective September 1, 2023, the reimbursement methodology for ACT changed from the use of a fifteen (15) minute billing unit to a monthly rate.[1] To receive reimbursement, an ACT team must have at least eight contacts with the client enrolled in ACT during the month and must also meet the service delivery requirements outlined in Chapter 34 of Title 22-A DCMR. The new rates for ACT are in Table 1.

Table 1: ACT rates, effective September 1, 2023

Service	Procedure Code	Modifier	Rate
ACT	H0040	--	$2,375.43
ACT–Deaf/Hard of Hearing	H0040	HK	$3,206.83

Submitting Claims Under the New Reimbursement Methodology

Billing during September 2023 through February 2024:
DHCF and DBH understand that adjusting to the new reimbursement methodology and requirements will take time. In order to support providers and beneficiaries during the first six (6) months of implementation providers may receive half of the new reimbursement rate, upon submission of a claim to DHCF that meets the following requirements in Table 2, below.

[1] See DC Transmittal #23-50.

Table 2: Requirements for Partial Payment

	Servicing Provider	Procedure Code
Line 1	The NPI of one of the providers seeing the client must be reflected on the claim. The line must represent a single date of service (single contact) within the implementation month; the claim must be billed with only one line.	H0039 -X1

Once the requirements in Table 3 are met in a given month, the provider may submit a claim to DHCF using the process outlined in Table 4 to receive the other half of the new reimbursement rate. DHCF and DBH will audit and closely monitor claims to ensure providers are meeting requirements to receive the half payment from September 2023 to February 2024. Effective March 1, 2024, partial payments will no longer be available, and providers will be expected to meet full fidelity requirements to receive reimbursement for ACT.

Table 3: Second Half of Monthly Rate Payment

Time Period	Number of Contacts in a Month	Number of QPs seen in a month	Other Fidelity Requirements
September – October 2023	Eight (8) Contacts	Zero (0) Qualified Practitioners	Other requirements will be monitored
November – December 2023	Eight (8) Contacts	One (1) Qualified Practitioners	Other requirements will be monitored
January – February 2024	Eight (8) Contacts	Two (2) Qualified Practitioners	Other requirements will be monitored
March 2024: **Full Fidelity**	Eight (8) Contacts	Three (3) Qualified Practitioners	All requirements must be met

Full service period billing: ACT teams will submit a single claim that captures the entire month of services for each individual enrolled in ACT. Claims should only be submitted at the end of the month. The claim should be structured as outlined in Table 4.

Table 4: Full Service Period Billing

	Servicing Provider	Procedure Code
Line 1	The team MD/APRN will be listed as the servicing provider, include the total units and span bill for all dates of service on the claim.	H0040
Lines 2 - X	The individual provider performing the service will be listed as the servicing provider and should include their NPI number. Each line should represent a single contact.	H0039

Each claim must reflect the following information:

- Each contact and the respective servicing provider will be tracked on the claims using the procedure code H0039.
    - Up to two contacts may be provided in a single day.
    - The same provider may be listed as the servicing provider on more than one contact provided in a single day.
- At least eight (8) payable units of H0039 must be reflected on the claim to receive reimbursement.
- The date of service on each line must fall within the monthly service period.
- Any services that were provided beyond the minimum eight (8) contacts required for payment.

Service Delivery Requirements

In order to receive reimbursement, the eight (8) required contacts provided during the service period must meet the following requirements:

- A minimum of five (5) contacts must be face-to-face and in person;
- A maximum of three (3) contacts may be collateral contacts. Collateral contacts may be delivered via telehealth or in person; non-collateral contacts may be delivered via telehealth or in person;
- A minimum of three (3) contacts must be made by any of the qualified practitioners for ACT.
    - Qualified Practitioners: Psychiatrists, Psychologists, Licensed Independent Clinical Social Workers (LICSWs), Advanced Practice Nurse Practitioners (APRNs), Licensed Independent Social Workers (LISWs), Licensed Professional Counselors (LPCs), Registered Nurses (RNs), Licensed Marriage and Family Therapists (LMFTs), Licensed Graduate Social Workers (LGSWs), Licensed Graduate Professional Counselors (LGPCs), Psychology Associates, and Certified Addiction Counselors (CACs) I and II.
- Each consumer must have one (1) scheduled appointment with the Psychiatrist or APRN during the service period.
    - The Psychiatrist/APRN contact is the only face-to-face ACT contact that may be completed via telehealth.
- Up to two (2) contacts per day may count towards the eight (8) required contacts during the service period. A single provider may deliver more than one contact in a single day.

Although conditions of payment are outlined above for each member of the ACT Team, the broader expectations of each team member, throughout the course of treatment, should align with the ACT Model of care. All services must be delivered in accordance with requirements set forth in Chapter 34 of Title 22-A DCMR, and all contacts past the eight (8) required for payment should be documented and provided as medically necessary.

Prior Authorization
Providers must still obtain prior authorization for beneficiaries to be enrolled in ACT. Historically, DBH has been the agency responsible for prior authorization. They will remain responsible for ACT prior authorizations until further notice.

Effective Date and Provider Support
The policy changes outlined in this transmittal will become **effective for all services delivered on or after September 1, 2023.** All ACT providers will be expected to meet these requirements in order to receive reimbursement. DBH will continue to hold provider trainings to support implementation.

Throughout the first six (6) months of implementation, DHCF and DBH will continue to collect data to monitor the implementation of the new reimbursement methodology. Providers who do not consistently meet the phased in requirements will be issued a corrective action plan (CAP) with the expectation of correction prior to April 1, 2024.

Contact
If you have any questions, please contact Jennifer Joyce, Behavioral Health Coordinator, Health Care Delivery Management Administration, Department of Health Care Finance via email at Jennifer.joyce@dc.gov, or via telephone at (202) 478-2434.

Cc: DC Behavioral Health Association
DC Coalition of Disability Service Providers
DC Health Care Association
DC Home Health Association
DC Hospital Association
DC Medical Care Advisory Committee Stakeholders
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