ACT/FACT EBP Services Explanation Guide

The following service activities are included as part of the ACT/FACT EBP Medi-Cal Benefit, as defined in California's Medicaid State Plan:

- Assessment
- Crisis Intervention
- Employment and Education Support Services
- Medication Support Services
- Peer Support Services
- Psychosocial Rehabilitation
- Referral and Linkages
- Therapy
- Treatment Planning

Prior Authorization

Prior authorization is required for ACT/FACT. The ACT/FACT team should submit a prior authorization request to their BHP following clinical determination that the member is appropriate for ACT/FACT services.

SPOA Referrals:

- Upon referral to an ACT or FACT program, SPOA will also notify Optum UM Unit of the referral for the purpose of providing an initial ACT/FACT BHP Referral Authorization.
    - Program must open client to the program either in Requested Status or Enrolled Status within two (2) business days of receipt of SPOA referral.
    - Optum will enter the initial ACT/FACT BHP Referral Authorization which will cover the first 21 days of client enrollment.
        - This allows program to engage clients in services and complete intake and assessment process.
        - Services provided during this initial authorization period are able to be included in the monthly bundled rate.
- Programs should run the COSD Authorizations Report daily to verify that a valid authorization has been entered for referred client(s) to minimize risks of service errors for missing authorizations or recoupment of services due to missing authorizations.
- Programs will be required to submit the Prior Authorization request to Optum via Secure Fax, using the BHS approved ACT/FACT Authorization Request form by Day 14 (calendar days) from the date of receiving the SPOA referral.

- Programs should ensure that client meets eligibility criteria for ACT/FACT services and submit required clinical documentation.
- Authorization determination will be faxed back to the program within 5 business days of receipt of request.
- Programs can run the COSD Authorizations Report (My Office) to verify the authorization in SmartCare.
- The ACT/FACT Authorization covers all ACT/FACT services provided to the client for 6 months.

Internal ICM to ACT Transition/Step Up (within same program)

- When it is determined that an ICM client may require a "step up" to ACT level of services, the following actions will need to be completed:
  - the ACT program will place the client in Requested Status in the ACT program
  - Submit Prior Authorization Request to Optum UM
    - Select the checkbox indicating this is a "Step Up Request" for ACT level of service
    - Ensure Prior Authorization form is complete with required documentation to support medical necessity for ACT level of service (LOCUS, DLA-20 scores)
  - Client should remain in ICM and continue to receive services until confirmation of authorization approval for ACT level of services
    - Optum will provide approval or denial within 5 business days of receipt of faxed prior authorization request and enter the authorization in SmartCare
    - Initial authorization will be for a period of 6 months.
  - Programs can run the COSD Authorizations Report (My Office) to verify the authorization in SmartCare.
  - Upon confirmation of approved prior authorization, ACT program will place client in "Enrolled" status in ACT program and ICM program discharge client from ICM program.
  - ACT program will complete required intake and consents, complete program diagnosis document and update problem list, assessment and treatment plan(s) as required or clinically appropriate.

Monthly Bundled Rates:

- **Full monthly rate.** For Medi-Cal members that receive at least six contacts on six different days in a month, of which at least four are delivered face-to-face (in-person) to the member. Other contacts may be with a collateral (i.e., family member and/or significant support person) to support the member's recovery. If there are two or more contacts on a day, at least one of which is with the member and one of which is with a collateral, it may be counted as two separate days.
- **Partial monthly rate.** For Medi-Cal members that receive at least four contacts on four different days in a month, of which at least three are delivered face-to-face (in-person) to the member. Other contacts may be with a collateral (i.e., family member and/or significant support person) to support the member's recovery. If there are two or more contacts on a day, at least one of which is with the member and one of which is with a collateral, it may be counted as two separate days.

EBP Service (Abbrev.)	Code	Minimum No. of Total Units per Month for Partial Rate	Minimum No. of Face-to-Face Units per Month for Partial Rate	Minimum No. of Total Units per Month for Full Rate	Minimum No. of Face-to-Face Units per Month for Full Rate
ACT	H0040	4	3	6	4
FACT	H0039	4	3	6	4

Requirements for claiming monthly bundled rates:

- **Contact is defined as an encounter of at least 15 minutes in duration.**
    - Contacts under 15 minutes **cannot** be counted toward the 4-day or 6-day bundled rate thresholds,
    - And they **cannot** be selected as one of the 12 bundled services.
- A contact may be face-to-face (in-person) or using telehealth with the member, or with a collateral contact.
    - **Face-to-Face** is defined as ***in-person*** *with the member*.
- Only **one contact per day** may be counted, **except** when you have:
    - **One contact with the member AND one with a collateral on the same day**. This day may count as **two separate contact days** if both contacts meet the 15-minute requirement. (Same Day Duplication Rule)

- The **same day duplication rule** applies **only to contacts counted toward the monthly bundled rate**, which includes all selected contacts numbered **1 through 12.**

- **For the BHP to claim the full monthly bundled rate for ACT/FACT**, the member must receive a minimum of 6 encounters, and at least **four** of these encounters must be conducted face-to-face with the member.
    - A Face-to-face Client Contact and Collateral Contact may be provided on the same day and both may be counted towards the minimum 6 encounters to claim the bundled rate,
- **To claim the partial monthly bundled rate** for ACT/FACT, the member must receive a minimum of 4 encounters, and at least **three** of these encounters must be conducted face-to-face with the member.
    - A Face-to-face Client Contact and Collateral Contact may be provided on the same day and both may be counted towards the minimum 4 encounters to claim the bundled rate

- **If a member receives 13 or more ACT/FACT team contacts in a month**, the BHP may claim for appropriate, unbundled Medi-Cal covered outpatient behavioral health services in addition to the monthly bundled rate.

    - Unbundled Medi-Cal-covered outpatient behavioral health services delivered by the ACT team can only be claimed **after** the member reaches 12 contacts in a month.
        - Example: client receives 15 contacts in a month; program can bill the appropriate bundled rate for contacts 1-12 and claim the unbundled rate for the additional individual rendered services (13-15).
    - Bundled services **do NOT need to be the first 12 services chronologically.**
    - Programs may **include any 12 qualifying services** delivered within the month - **The "12 bundled services" are chosen during end-of-month review.**
    - **If a member receives fewer ACT/FACT team contacts than the minimum required for either the full or partial monthly bundled rate**, the BHP may claim for appropriate unbundled Medi-Cal-covered services.

- While ACT/FACT teams must deliver the minimum contacts required for the BHP to claim either the full or partial monthly bundled rate, ACT teams are expected to provide as many contacts as needed to support a member's recovery.

ACT/FACT in Residential Treatment Settings or Inpatient Settings

- Members who are in inpatient hospital or residential treatment settings may continue to receive ACT/FACT services from their ACT/FACT team which can be claimed for either the full or partial bundled rate as noted below.
    - Inpatient hospital settings include general acute care hospitals, acute care hospitals and psychiatric health facilities.
    - Payment is not available for ACT/FACT delivered to members while they reside in inpatient settings that are Institutions for Mental Diseases (IMDs), *unless* the IMD is participating in the BH-Connect IMD FFP Waiver.
        - Client stay must meet the IMD FFP waiver eligibility of 60 days or less in order for ACT/FACT services to be claimed.
        - Participating IMD settings: SDCPH, Sharp Mesa Vista, Alvarado Parkway Institute.
- BHPs may claim the full ACT/FACT rate during the month of a member's admission or discharge to the inpatient or residential treatment setting.
    - Services must meet all requirements for the full monthly rate
    - At least 3 of the 6 required contacts must be delivered before admission or after discharge from the inpatient or residential setting.
- If the member is in the inpatient or residential treatment setting for the entirety of a month, BHPs may only claim the partial rate.
    - Services must meet all requirements for the partial rate

ACT/FACT in Correctional Facilities or Jail Settings

- Services by ACT/FACT programs provided to individuals in correctional/jail/juvenile hall settings are **not** billable and cannot be claimed or included towards monthly bundled rates *(this includes Targeted Case Management services).*
    - Per DHCS, the primary Medi-Cal services available to individuals while incarcerated are the targeted pre-release services authorized under the CalAIM Justice-Involved Initiative (which can be provided in the 90 days prior to release by the Justice Involved (JI) programs). These include (but are not limited to) reentry care management services (TCM/ICC) and behavioral health clinical consultation services. Through these pre-release services, provided by the JI Behavioral Links programs, an individual could be assessed and linked to an ACT or FACT team for post-release care, but they could not receive ACT or FACT services while in jail or prison.

Billing for Clients with Medicare/Medi-Medi or Other Health Coverage (OHC)

- Medi-Cal is payer of last resort. Providers must submit claims to Medi-Cal or member's OHC for eligible services before claims can be submitted to Medi-Cal.
- Medicare reimbursable services provided by Medicare-recognized providers to clients who are enrolled in Medicare or Medi-Medi must be billed to Medicare first and the Medicare COB must be submitted to the MH Billing Unit whether the service(s) are bundled or unbundled.
    - Example: LCSW provides an assessment service to client (90791) – this would be billed to Medicare and COB submitted to MHBU before claim can be submitted to Medi-Cal. Unlicensed clinician provides assessment contribution service (H0031) – this would not be billable to Medicare, claim submitted directly to Medi-Cal.
    - Medicare-recognized providers: physician, physician assistant, nurse practitioner, clinical nurse specialist, LCSW, LMFT, LPCC
    - Medicare reimbursable services:

BH Connect Service	Service Component	Medicare Coverage
Assertive Community Treatment (ACT)/Forensic Assertive Community Treatment (FACT)	Assessment	Yes
	Crisis Intervention	Yes
	Employment and Education Support Services	No
	Medication Support Services	Yes
	Peer Support Services	No
	Psychosocial Rehabilitation	No
	Referral and Linkages	Yes

- Other Health Insurance (OHC) information must be included on the claim when submitting to Medi-Cal
    - If OHC does not respond within 90 days, provider may submit claim to Medi-Cal on the 91st day.

References:

BHIN-25-009-Coverage-of-BH-CONNECT-Evidence-Based-Practices.pdf

SMHS-Billing-Manual-SFY2026-27

EBP Policy Guide 5.1.25

Authorization for Services Process in SmartCare