Keystone First
VIP Choice

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Assertive Community Treatment

Clinical Policy ID: CCP.1480

Recent review date: 3/2022

Next review date: 6/2023

Policy contains: Assertive Community Treatment; bipolar disorder; major depressive disorder; Program of Assertive Community Treatment; schizophrenia; substance use disorder.

Keystone First VIP Choice has developed clinical policies to assist with making coverage determinations. Keystone First VIP Choice's clinical policies are based on guidelines from established industry sources, such as the Centers for Medicare & Medicaid Services (CMS), state regulatory agencies, the American Medical Association (AMA), medical specialty professional societies, and peer-reviewed professional literature. These clinical policies along with other sources, such as plan benefits and state and federal laws and regulatory requirements, including any state- or plan-specific definition of "medically necessary," and the specific facts of the particular situation are considered by Keystone First VIP Choice when making coverage determinations. In the event of conflict between this clinical policy and plan benefits and/or state or federal laws and/or regulatory requirements, the plan benefits and/or state and federal laws and/or regulatory requirements shall control. Keystone First VIP Choice's clinical policies are for informational purposes only and not intended as medical advice or to direct treatment. Physicians and other health care providers are solely responsible for the treatment decisions for their patients. Keystone First VIP Choice's clinical policies are reflective of evidence-based medicine at the time of review. As medical science evolves, Keystone First VIP Choice will update its clinical policies as necessary. Keystone First VIP Choice's clinical policies are not guarantees of payment.

Coverage policy

Assertive Community Treatment is clinically proven and, therefore, medically necessary for adult members who have a severe and persistent mental illness that seriously impairs their functioning in the community, when provided in accordance with the following criteria for admission, continued review, and discharge of services:

Admission criteria:
Must have one or more of the following (Substance Abuse and Mental Health Services Administration, 2008):

- A *Diagnostic and Statistical Manual of Mental Disorders — Fifth Edition* diagnosis consistent with a serious and persistent mental illness, which includes schizophrenia, bipolar disorder, major depressive disorder, and other psychotic disorders (American Psychiatric Association, 2013).
- Substance use disorders, developmental disorders, organic brain syndromes, or social conditions are excluded, unless they occur with a diagnosable serious mental illness.
- Significant functional impairments, to include at least one of the following:
    - Consistent inability to perform practical daily tasks needed to function in the community.
    - Inability to maintain personal hygiene.
    - Difficulty meeting nutritional needs.
    - Problems with caring for personal business affairs.
    - Difficulty obtaining medical, legal, and housing services.
    - Inability to recognize and avoid common dangers or hazards to one's self and one's possessions.

- Persistent or recurrent failure to perform daily living tasks, except with significant support or help from others, such as friends, family, or relatives.
- Consistent inability to be employed at a self-sustaining level or to carry out homemaker roles.
- Inability to maintain a safe living situation (e.g., repeated evictions or loss of housing).

Must have at least one indicator of continuous high-service needs, including:

- High use of acute psychiatric hospitalization (e.g., two or more admissions per year) or psychiatric emergency services.
- Intractable (i.e., persistent or recurrent) severe major symptoms (e.g., affective, psychotic, suicidal).
- Coexisting substance use disorder of significant duration (e.g., greater than six months).
- High risk or a recent history of being involved in the criminal justice system.
- In substandard housing, homeless, or at imminent risk of becoming homeless.
- Living in an inpatient bed or in a supervised community residence, but clinically assessed to be able to live more independently if intensive services are provided.
- Inability to participate in traditional office-based services.

Continued review criteria:
While continued coverage of Assertive Community Treatment varies by member, criteria should include: severity of illness and resulting impairment; treatment planning; appropriateness of mode, intensity, and frequency of services; progress towards goals is observed or adjustments made to address lack of progress; and the individual and family participate to the extent possible.

Discharge criteria:
Any decision to transfer members out of an Assertive Community Treatment program should include all of the following:

- Should be made on a case-by-case basis, carefully considering individual clinical needs.
- Should ensure continuity of care before and after the discharge.
- Should be a gradual discharge with overlapping services.
- Should allow members to readily transfer back to the program if needed.

The Substance Abuse and Mental Health Services Administration suggests that members are ability to function independently in all major roles (e.g., work, social, and self-care) for two years as an element of discharge criteria for Assertive Community Treatment programs.

Limitations
Assertive Community Treatment services are comprehensive of all other services and shall not be billed in conjunction with the following services:

- Behavioral health services by licensed and unlicensed individuals, other than medication management and assessment.
- Residential services, including professional resource family care.

Alternative covered services
Intensive case management.

Background

Serious mental illness is a persistent mental, behavioral, or emotional disorder resulting in serious functional impairment that substantially interferes with or limits one or more major life activities. In 2019, there were an estimated 13.1 million adults age 18 or older in the United States with serious mental illness, representing 5.2% of all U.S. adults (National Alliance on Mental Illness, 2021).

Examples of serious mental illness include major depressive disorder, schizophrenia, and bipolar disorder. Addiction disorder and/or a developmental disability may accompany serious mental illness. Individuals may experience frequent acute psychiatric episodes resulting in hospitalization or emergency room visits, interactions with law enforcement or imprisonment, suicidal ideation or attempts, or a history of violence related to their mental illness.

In the 1970s, researchers in Wisconsin recognized that, for patients with serious mental illness, the progress made in the inpatient setting was often lost when they moved back into the community (National Alliance on Mental Illness Minnesota, 2017). Researchers developed Assertive Community Treatment to address this need. Assertive Community Treatment is a service delivery model centered in a multidisciplinary, team-based approach that provides individualized, proactive behavioral health care services in the home or other community settings. The primary goals of the model are to lessen or eliminate the debilitating symptoms of mental illness, reduce recurrent acute episodes (hospital admissions), and to enhance quality of life and functioning.

An adaptation of the federal Substance Abuse and Mental Health Services Administration (1993) definition provides more detailed eligibility criteria:

- Age 18 years or older.
- A diagnosable mental, behavioral, or emotional disorder that meets the sufficient duration to meet the criteria specified in the *Diagnostic and Statistical Manual of Mental Disorders — Fifth Edition* (American Psychiatric Association, 2013).
    - Substance use disorders, developmental disorders, and organic brain syndromes are excluded, unless they occur with a diagnosable serious mental illness.
- The mental illness has resulted in impairment that significantly interferes with or limits one or more of the following major life activities:
    - Activities of daily living.
    - Interpersonal functioning.
    - Concentration, persistence, and pace.
    - Adaptation to change.

Multidisciplinary teams employed in Assertive Community Treatment often include 10 – 12 staff members. The types of disciplines included can vary, but typically includes a leader/psychiatrist; two psychiatric nurses; two employment specialists; two substance abuse specialists; a mental health consumer; a program assistant; and possibly other mental health professionals with training in social work, nursing, rehabilitation counseling, psychology, or occupational therapy (Substance Abuse and Mental Health Services Administration, 2008).

Unlike case management, the Assertive Community Treatment team provides a comprehensive array of treatment, rehabilitative, and support services directly rather than through referrals. As a higher-intensity model of service delivery than case management, Assertive Community Treatment is associated with a lower average caseload. Services are provided 24 hours a day, seven days a week, in the community setting, and with no time limitation. As a result, the Assertive Community Treatment team is often positioned to anticipate and avoid crises.

Assertive Community Treatment is also known as Program of Assertive Community Treatment, Community Support Programs, or Mobile Treatment Teams (National Alliance on Mental Illness Minnesota, 2017). Assertive Community Treatment services are designed for individuals with severe and persistent mental illness and the greatest level of functional impairment, and whose needs have not been adequately met by traditional approaches. Assertive Community Treatment is generally long-term and can form a basis for integrated programs.

A 2018 survey found 33 state Medicaid agencies covered Assertive Community Treatment, 13 agencies did not, and five did not respond to the survey (Kaiser Family Foundation, 2018).

Findings

For this policy, we included nine systematic reviews (Dieterich, 2017; Hopkin, 2018; Hunt, 2019; McDonagh, 2017; Penzenstadler, 2019; Ponka, 2020; Randall, 2015; Vanderlip, 2017; Vijverberg, 2017), two individual studies (Monroe-DeVita, 2018; Valenstein, 2013), and two guidelines (National Alliance on Mental Illness Minnesota, 2017; Substance Abuse and Mental Health Services Administration, 2008). The evidence from moderate-to-high-quality studies establishes Assertive Community Treatment as a cost-effective, community-based model of delivering treatment, rehabilitation, and supportive mental health services to adults living with serious mental illness or dual diagnoses, significant functional impairment, and complex needs (National Alliance on Mental Illness Minnesota, 2017; Substance Abuse and Mental Health Services Administration, 2008). From a societal perspective, the cost-effectiveness of Assertive Community Treatment lies primarily in its ability to improve housing stability and reduce inpatient and emergency mental health use, as its targeted population is often a heavy user of inpatient services and experiences the poorest quality of life (Ponka, 2020).

Assertive Community Treatment compares favorably to less-intensive case management services with respect to patient and family satisfaction, reduction in hospitalization, housing stability, medication adherence, and management of substance abuse (Hunt, 2019; McDonagh, 2017; Randall, 2015; Valenstein, 2013). Its impact on incarceration avoidance is inconclusive (Hopkin, 2018). Its effectiveness in other cohorts (children and adolescents with severe mental illness or those with only substance use disorder) or when integrated with curriculum-based programs or primary care programs is not established (Monroe-DeVita, 2018; Penzenstadler, 2019; Vanderlip, 2017; Vijverberg, 2017). Based on the evidence review, an expansion of the patient selection criteria to non-adult populations or populations without a diagnosis of a serious mental illness is not supported.

The effectiveness of community-based interventions is related both to model intensity and the team's ability to address and advocate for the comprehensive needs of the participants. Secondary analyses stress the importance of reporting fidelity to the Assertive Community Treatment model in the research, as programs that adhere to the program components are more effective in reducing hospital use than programs with lower adherence (Dieterich, 2017; Penzenstadler, 2019; Ponka, 2020; Substance Abuse and Mental Health Services Administration, 2008). Standardized examination of critical program elements ensures consistent good practice standards, may explain the variance in effectiveness across programs, and allows more accurate comparison of interventions.

A comparison of patients (n = 2,034) receiving community mental health services with versus without flexible Assertive Community Treatment found those in the treatment group had more outpatient contacts but fewer admissions. There were no significant differences in total inpatient days, use of coercion, episodes of self-harm, or deaths (Nielsen, 2021).

A cost-effectiveness analysis randomized 950 homeless individuals with serious mental illness to scattered-site housing with Assertive Community Treatment or treatment as usual, followed to 24 months. Most (69%) of the costs of the intervention were offset by savings in other costs (Latimer, 2020).

A seven-year follow-up of 527 persons in the same program showed those with high needs in the Assertive Community Treatment group had 34% and 36% reductions in visits to primary care and non-primary care practitioners, versus treatment as usual (Mejia-Lancheros, 2021). Assertive Community Treatment for those in the program with high needs reduced hospital days and emergency visits by 68% and 43%, respectively; no differences exist for those with medium needs (Lachaud, 2021).

References

On November 11, 2021, we searched PubMed and the databases of the Cochrane Library, the U.K. National Health Services Centre for Reviews and Dissemination, the Agency for Healthcare Research and Quality, and the Centers for Medicare & Medicaid Services. Search terms were “assertive community treatment,” “intensive case management,” and “serious mental illness.” We included the best available evidence according to established evidence hierarchies (typically systematic reviews, meta-analyses, and full economic analyses, where available) and professional guidelines based on such evidence and clinical expertise.

American Psychiatric Association. *Diagnostic and statistical manual of mental disorders (5th ed.)* 2013, https://doi.org/10.1176/appi.books.9780890425596.

Dieterich M, Irving CB, Bergman H, et al. Intensive case management for severe mental illness. *Cochrane Database Syst Rev.* 2017;1(1):Cd007906. Doi: 10.1002/14651858.CD007906.pub3.

Hopkin G, Evans-Lacko S, Forrester A, Shaw J, Thornicroft G. Interventions at the transition from prison to the community for prisoners with mental illness: A systematic review. *Adm Policy Ment Health.* 2018;45(4):623-634. Doi: 10.1007/s10488-018-0848-z.

Hunt GE, Siegfried N, Morley K, Brooke-Sumner C, Cleary M. Psychosocial interventions for people with both severe mental illness and substance misuse. *Cochrane Database Syst Rev.* 2019;12(12):Cd001088. Doi: 10.1002/14651858.CD001088.pub4.

Kaiser Family Foundation. State Health Facts: Behavioral Health Services. Assertive Community Treatment. Medicaid Behavioral Health Services: Assertive Community Treatment. https://www.kff.org/medicaid/state-indicator/medicaid-behavioral-health-services-assertive-community-treatment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D. Published 2018.

Lachaud J, Majia-Lancheros C, Durbin A, et al. The effect of a Housing First intervention on acute health care utilization among homeless adults with mental illness: Long-term outcomes of the at home/Chez-Soi randomized pragmatic trial. *J Urban Health*. 2021;98(4):505-515. Doi: 10.1007/s11524-021-00550-1.

Latimer EA, Rabouin D, Cao Z, et al. Cost-effectiveness of housing first with assertive community treatment: Results from the Canadian at home/Chez Soi trial. *Psychiatr Serv*. 2020;71(10):1020-1030. Doi: 10.1176/appi.ps.202000029.

McDonagh MS, Dana T, Selph S, et al. AHRQ comparative effectiveness reviews. *Treatments for schizophrenia in adults: A systematic review*. Rockville (MD): Agency for Healthcare Research and Quality (US). https://www.ncbi.nlm.nih.gov/books/NBK487628/. Published October 2017.

Mejia-Lancheros C, Lachaud J, To MJ, et al. The long-term effects of a Housing First intervention on primary care and non-primary care physician visits among homeless adults with mental illness: A 7-year RCT follow-up. *J Prim Care Community Health*. 2021;12:21501327211027102. Doi: 10.1177/21501327211027102.

Monroe-DeVita M, Morse G, Mueser KT, et al. Implementing illness management and recovery within assertive community treatment: A pilot trial of feasibility and effectiveness. *Psychiatr Serv.* 2018;69(5):562-571. Doi: 10.1176/appi.ps.201700124.

National Alliance on Mental Illness. Mental Health by the Numbers. https://www.nami.org/mhstats. Published March 2021.

National Alliance on Mental Illness Minnesota. Assertive Community Treatment (ACT). https://namimn.org/wp-content/uploads/sites/188/2018/05/Assertive-Community-Treatment_TreatmentOptions_2018.pdf. Published 2013. Updated March 2017.

Nielsen CM, Hjorthoj C, Killaspy H, Nordentoft M. The effect of flexible assertive community treatment in Denmark: A quasi-experimental controlled study. *Lancet Psychiatry*. 2021;8(1):27-35. Doi: 10.1016/S2215-0366(20)30424-7.

Penzenstadler L, Soares C, Anci E, Molodynski A, Khazaal Y. Effect of assertive community treatment for patients with substance use disorder: A systematic review. *Eur Addict Res.* 2019;25(2):56-67. Doi: 10.1159/000496742.

Ponka D, Agbata E, Kendall C, et al. The effectiveness of case management interventions for the homeless, vulnerably housed and persons with lived experience: A systematic review. *PLoS One.* 2020;15(4):e0230896. Doi: 10.1371/journal.pone.0230896.

Randall JR, Vokey S, Loewen H, et al. A systematic review of the effect of early interventions for psychosis on the usage of inpatient services. *Schizophr Bull*. 2015;41(6):1379-86. Doi: 10.1093/schbul/sbv016.

Substance Abuse and Mental Health Services Administration. Assertive community treatment: The evidence. DHHS pub. No. Sma-08-4344, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. https://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4344. Published 2008.

Substance Abuse and Mental Health Services Administration. Center for Mental Health Services. Final notice. *Federal Register*. May 20, 1993;58(96). www.samhsa.gov/sites/default/files/federal-register-notice-58-96-definitions.pdf.

Valenstein M, McCarthy JF, Ganoczy D, et al. Assertive community treatment in Veterans Affairs settings: Impact on adherence to antipsychotic medication. *Psychiatr Serv.* 2013;64(5):445-451, 451.e441. Doi: 10.1176/appi.ps.201100543.

Vanderlip ER, Henwood BF, Hrouda DR, et al. Systematic literature review of general health care interventions within programs of assertive community treatment. *Psychiatr Serv.* 2017;68(3):218-224. Doi: 10.1176/appi.ps.201600100.

Vijverberg R, Ferdinand R, Beekman A, van Meijel B. The effect of youth assertive community treatment: A systematic PRISMA review. *BMC Psychiatry.* 2017;17(1):284. Doi: 10.1186/s12888-017-1446-4.

Policy updates

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