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Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

ANN MARIE T. SULLIVAN, M.D.
Commissioner

To: Assertive Community Treatment (ACT) Teams & Health Homes

From: NYS Department of Health (DOH) and NYS Office of Mental Health (OMH)

Subject: **Assertive Community Treatment and Health Home Updated Instruction**

Date: June 25, 2019

In 2014, Assertive Community Treatment (ACT) programs joined Health Home networks under an agreement to provide care management as part of the Health Home continuum. For ACT recipients who chose to enroll in a Health Home, ACT teams served as the care management provider of record.

In efforts to enhance the relationship between ACT teams and Health Homes, the State hosted a stakeholder workgroup to collect feedback from both ACT Teams and Health Homes. Stakeholders concluded that Health Home enrollment for ACT recipients is most beneficial during the time of transition from ACT and post-discharge. Stakeholders also acknowledged that ACT teams do not operate in the same manner as Care Management Agencies (CMAs) under the Health Home since care management is only one component of the ACT model. The ACT teams operate based on ACT 508 regulations, ACT Program Guidelines, ACT Standards of Care and teams are licensed by the New York State Office of Mental Health (OMH).

In respect to this, the State has updated guidance in relation to the Assertive Community Treatment (ACT) Providing Health Home Care Management Interim Instruction dated February 19, 2014. Effective August 1st, 2019, ACT teams will no longer serve as downstream care management providers for Health Homes, and the following protocols will take effect:

- ACT recipients will no longer be enrolled in a Health Home. ACT recipients who are currently enrolled in a Health Home will be administratively disenrolled from the MAPP HHTS by the New York State Department of Health (DOH). The disenrollment process will be specific to ACT recipients only and will be different from standard Health Home discharge procedures as outlined in guidance.
- Where ACT is contracted as a Health Home downstream care management provider, the Health Home-ACT contractual relationship will be dissolved, and Health Homes will no longer provide oversight to contracted ACT teams.

This document will outline procedures to dissolve contracts for ACT as a downstream care management provider of the Health Home, including the-administrative disenrollment of ACT

recipients from the Health Home program. ACT recipients should not be enrolled in the Health Home or receive health home care management until time of transition from ACT.

As of July 31, 2019

Administrative Disenrollment

- All ACT recipients enrolled in Health Home, will be notified by the ACT team of the transition, including assurance that disenrollment does not change ACT services the recipient has been getting, ACT services will continue as they have with no change for the recipient.
- Individuals must be closed out in the Health Home's EHR system. The ACT team and Health Home will work together to determine who will be responsible to close out the episode of care.

MAPP HHTS

- The DOH will use a data feed from the OMH Child and Adult Integrated Reporting System (CAIRS) system to capture currently enrolled ACT recipients. ACT providers must ensure admission and discharge records in CAIRS are up to date.
- Segments in the MAPP-HHTS for ACT members will be ended by the DOH as of July 31, 2019.

Oversight

- HHs and ACT teams must work together to ensure a DOH 5058 He*alth Home Patient Information Sharing Withdrawal of Consent* form is completed for all identified ACT members with HH consent (DOH 5055) by July 31, 2019.
    - If the DOH 5058 is not completed, the administrative MAPP HHTS disenrollment will still occur.
- References to ACT contained in any DOH Health Home policies and/or other Health Home guidance documents are no longer applicable effective August 1st, 2019.
- HHs need to update their policies to remove ACT, ensuring that their network CMAs are notified to do the same.
- ACT teams will cease to provide reimbursement for administrative fees for ACT recipients.

Transition from ACT to Health Home Care Management

ACT teams are responsible for comprehensive discharge planning for ACT recipients. ACT teams will ensure that recipients have access to necessary medical and behavioral health services via referrals, screenings, communication with Managed Care Organizations, and providing ongoing transition support for recipients. As part of transition planning from the ACT program, **all** ACT recipients must be educated on the benefits of Health Home enrollment, and will be referred to Health Home Plus Care Management.

Effective May 1st, 2018, individuals stepping down from ACT services are eligible to receive HH+ services. For more information, please see Health Home Plus Program Guidance for High-Need Individuals with Serious Mental Illness(issued May 1, 2018). The ACT team will work with the Health Home(s) to identify available CMAs that serve HH+ SMI populations.

For individuals enrolled in HARP/HIV SNPs, Adult BH HCBS can offer effective step-down services needed for the transition from ACT. Health Home care managers play a key role in this transition. Please see the Discharge Workflow for ACT Recipients Enrolled in HARP.

The transition period for ACT recipients is a critical time in their recovery. Therefore, ACT Teams and HHs/CMAs must work together to ensure “warm hand-offs” occur for individuals transitioning between providers. At minimum, an introduction between the individual and HHCM prior to discharge/transition will allow the HHCM to participate in discharge planning and help orient the individual to HH+ services. The State will be monitoring this transition process.

The ACT team will provide the HHCM with discharge paperwork that includes the Child and Adult Integrated Reporting System (CAIRS) discharge summary. As services and supports are secured, ACT providers will ensure that the HHCM is involved in and informed of all referrals as they are secured for follow-up care.