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Assertive Community Treatment (ACT) Providing Health Home Care Management Interim Instruction: February 19, 2014

Introduction

The Office of Mental Health (OMH) licensed and regulated Assertive Community Treatment Program (ACT) will join Health Home networks under an agreement to provide an integrated plan of care and care management as part of the Health Home continuum.

ACT will continue to provide all services to ACT participants with and without Medicaid eligibility. ACT Programs are the Health Home Care Management provider of record for ACT participants.

As ACT programs become part of Health Homes, the staffing requirements, core competencies, roles and qualifications will not change. The case ratio, required in regulation, will not change. ACT will continue to be a team model. By regulation, Single Point of Access (SPOA) will continue to be the single referral source for the ACT program.

In order to better coordinate members' care and effective immediately, both the OMH and the Department of Health (DOH) expect ACT Programs to join with Health Homes. This will allow ACT participants to enroll in Health Homes. Health Home enrollment will give ACT participants access to Health Home provider networks. The benefits for ACT participants include improved coordination, smooth reassignment to other care management resources when an individual's ACT enrollment ends, and preferred access to specialty health care providers in the Health Home network. The table at the end of this document, "Health Home Care Management Service Definitions," explains the similarities and differences between ACT's care management and care coordination activities and Health Home Care Management.

ACT is a mobile treatment and rehabilitation team providing integrated, evidence-based treatment, rehabilitation, case management, and support services. The ACT model's mobile, multi-disciplinary mental health treatment team delivers services to individuals with serious mental illness who require intensive services in order to remain in the community. ACT uses a person-centered planning process to determine the nature and intensity of services, and relies on daily team meetings to adjust services as needed. DOH-designated Health Homes provide a continuum of care management to Medicaid eligible individuals with complex health care needs. Health Home networks will focus on both behavioral and physical health care.

By engaging and serving individuals with serious mental illness who have not connected well with traditional place-based services, ACT is a valuable component of Health Home networks, as Health Homes are responsible for ensuring that their members receive all medically necessary primary, specialty, and behavioral health care. ACT is also a critically important recovery oriented resource for

individuals with serious mental illness. ACT Programs will continue to be licensed by OMH and governed by OMH guidance and regulations. The ACT Program will continue to provide all intensive community based services, including care management, to Medicaid-eligible and non-Medicaid eligible participants.

The successful use of the ACT Program will require close collaboration among the Health Home, the local governmental unit (LGUs/SPOA, managed care plans, the ACT Program, and the State. Together, these entities must coordinate movement along the continuum of care management within the Health Home by identifying and transitioning members into ACT who need it, and transitioning those members out of ACT whose needs allow them to move to a lower level of care.

OMH will not expand ACT resources under Health Homes. Because the ACT Program must be ready and available to those most in need at critical points in their care, Health Homes' quality and utilization management functions will support ACT participants moving more quickly through the program. ACT Programs, Health Home network partners, and the LGU / SPOA must collaborate to improve individual outcomes at critical transitions, such as from inpatient to outpatient, community re-entry from jail or prison, etc. ACT and Health Home network partners, including LGUs and individual service recipients, will establish clear guidelines to assess appropriate levels of service with individuals' needs by stepping service intensity up or down.

Action Steps for ACT Programs Providing Health Home Care Management

- ACT Programs must become part of one or more Health Home networks.
- ACT Programs and Health Homes must establish written agreements to stipulate that ACT Programs will provide care management for Medicaid eligible ACT participants (including those who are dually Medicaid / Medicare eligible), as part of the Health Home's care management continuum.
    - This involves completing the Data Exchange Agreement and Health Home Subcontractor Packet, and signing a Memorandum of Understanding with the Health Home.
    - In addition, in order to exchange protected health information about ACT participants with Health Home network partners, the ACT Program must also obtain a signed Health Home consent form from participants.
- ACT Programs will continue to bill eMedNY directly for ACT services. Health Homes will not bill for care management services for ACT participants. (See reimbursement section, below).

ACT Programs Becoming Part of Health Home Networks

Health Home Care Management

Medicaid Health Homes are designated by New York State. Their diverse partner networks are connected using health information technology and a single care management record. Heath Home networks partners may include the following:

- One or more hospital systems;
- Multiple ambulatory care sites (physical and behavioral health);
- Community Based Organizations (CBOs), including existing care management and housing providers;
- Managed care plans

Health Homes provide comprehensive care coordination and care management services to help people with chronic health conditions, including serious mental illness, to improve health outcomes, and reduce inappropriate use of inpatient and emergency room care. Health Homes are required to provide a

dedicated care manager to help eligible Medicaid members navigate complex medical, behavioral, and social service systems.

ACT Regulatory Requirements Are Unchanged

ACT Teams' OMH regulatory requirements are unchanged. ACT Programs must meet caseload size and all ACT billing requirements, including, for example, maintaining a team approach, providing a minimum number of face-to-face contacts per month with ACT enrollees, reporting data to OMH (currently, this is done in the CAIRS system), and using best practices such as assertive outreach and maintaining a policy of no refusal. ACT services and program requirements are defined in regulation and in the ACT Program Guidance. **ACT Programs' reimbursement standards and rate codes will not change**.

Sharing Information

Sharing information across the Health Home network is important for improving coordination and integration of medical and behavioral health care.

Establishing Agreements between ACT Programs and Health Homes

In order to exchange patient identifying and protected health information about ACT participants enrolled in Health Homes, ACT Programs must have or establish a Medicaid Data Exchange Application and Agreement (DEAA) and memorandum of understanding (also referred to as the Subcontractor Packet) with one or more Health Homes. Completing the Subcontractor Packet allows the Health Home to share limited data with network partners involved with the individual's care prior to obtaining member consent. Once the Subcontractor Packet/agreement is in place, ACT participants' information can be communicated to the Health Home.

Determining Whether an ACT Participant is in a Health Home

The Member Tracking System allows Health Homes and managed care organizations to access Health Home member information, such as enrollment status and dates of inpatient admission and discharge.

Currently, only Health Homes and managed care plans are able to access the Health Home member tracking file, located in the Health Commerce System in the Department of Health. ACT Programs or referring Single Point of Access / Accountability (SPOA) committees therefore must clarify with the Health Home whether the individual is enrolled in a Health Home.

ACT Assignments to a Health Home

ACT Programs are the Health Home care management provider of record for ACT participants.

For ACT participants who are not in a Health Home, ACT Programs will make assignments to Health Homes based the participant's current health care service relationships and needs. To make Health Home assignments, ACT Teams add participants to the Health Home Member Tracking System. ACT Programs should contact the Health Homes they are working with to determine how the Health Home would like the Member Tracking System information submitted.

If an ACT participant has already been assigned to a Health Home, the ACT Program should initially talk with the Health Home to inform them that an ACT participant is a member of their Health Home, that the ACT Program is the care management provider of record, and that the Health Home should not assign the individual to another care management entity. The ACT Program should indicate on the Health Home's member tracking form that the individual is in that Health Home. Exchanging information between the ACT Program and the Health Home requires an executed Subcontractor Packet agreement.

If an ACT participant has been assigned to another care management provider, the ACT program, Health Home and LGU / SPOA must discuss whether the person is better served in ACT or by the other care management provider.

Enrollment, Consent, Changing Health Homes

ACT Programs must work with participants to secure consent to participate in the Health Home program (Health Home Patient Information Sharing Consent Form, DOH-5055). The ACT Program is responsible for helping ACT participants understand and complete the form. The purpose of the Health Home Consent Form is to allow Health Home network partners listed on the consent form to share appropriate information to assist the member. Without a signed consent form, the ACT Program cannot share protected health information about the participant, and the participant will not benefit as much from the Health Home Member Plan of Care (also referred to as the Health Home *single plan of care*).

Because Health Home participation is not mandatory, ACT participants may opt out of the program. Signing the Opt-out form (DOH 5059) indicates they do not want to participate or receive Health Home services. The ACT Program will continue to provide ACT services to participants who opt out of the Health Home, and the ACT Program must ensure that no communication about the participant occurs between the ACT Program and the Health Home.

The ACT Program must serve participants who are reluctant to sign a Health Home consent form, or who opt out of Health Home participation. ACT should actively encourage them to participate in the Health Home. Participation in a Health Home will help ACT participants when they transition out of the program by ensuring continuity of care, and access to Health Home care management after ACT.

The ACT program will bill for all Medicaid active ACT participants, directly through the eMedNY system, whether or not they are part of Health Homes.

The Department of Health will monitor the percentage of Medicaid eligible ACT participants who opt out of the Health Home.

If an ACT participant chooses to be in a different Health Home, the ACT Team, both Health Homes and the LGU / SPOA must all ensure that all parties are notified immediately. The transfer to the new Health Home would be effective the first day of the next month. The involved Health Homes, the ACT Program and the LGU / SPOA will need to discuss the timing of the transfer. ACT Programs should have or enter into agreements with all Health Homes their members choose to join. In New York City, ACT programs should enter into agreements with a minimum of two Health Homes.

Additional information about consent, the Health Home Patient Information Sharing Consent Form (DOH-5055), the Health Home Patient Information Sharing Withdrawal of Consent (DOH-5058) and the Health Home Opt-out Form (DOH-5059) are located on the Department of Health's Medicaid Health Home website.

Health Home Record Keeping Requirements

ACT Programs' record keeping requirements, governed in regulation, will not change. The ACT record will still include care coordination as well as treatment.

In addition to their existing record keeping requirements, ACT Programs will use Health Homes' single care management record, using an electronic care management record platform chosen by the Health Home.

ACT Programs will continue to maintain an ACT clinical record, according to ACT guidelines. ACT Programs and Health Homes must decide together how ACT will provide Health Home care management records.

Reimbursement

Caseload size will remain the same and ACT Programs will continue to bill eMedNY directly for ACT services using rates codes 4508, 4509, and 4511. ACT Programs' Medicaid reimbursement standards will not change.

Since ACT Program services include a care management component, Medicaid claims for ACT services and Health Home services cannot be submitted for the same member in a given month.

To cover the administrative costs of both the ACT Program and the Health Home, new ACT rates became effective July 1, 2013 (July 2013 Dates of Service, claimed at the end of July). ACT Program rates have been increased by $50 per member per month for full, partial and inpatient rate codes. ACT Programs are required to send $30 per month per Health Home enrollee to the Health Home(s) to cover the incremental costs for additional Health Home enrollees. The ACT program will retain the $20 balance.

- DOH will readjudicate ACT claims to reflect the new rates, which became effective July 1, 2013.
- ACT Programs will retain the entire increase through the month that ACT adds the ACT participant information into the Health Home's tracking system.
- Beginning in the month that ACT adds a participant to the Health Home tracking system, the ACT Program must forward $30 per member per month to the Health Home.

Roles and Responsibilities Pre- and Post-Health Homes

What Are Health Homes?

Health Home services are defined in Section 1945(h)(4) of the Affordable Care Act (ACA) as "comprehensive and timely high quality services," including the following **six core health home services**:

- Comprehensive care management;
- Care coordination and health promotion;
- Comprehensive transitional care from inpatient to other settings, including appropriate follow-up;
- Individual and family support, which includes authorized representatives;
- Referral to community and social support services, if relevant; and
- The use of health information technology to link services, as feasible and appropriate.

Role of Single Point of Access / Local Governmental Unit

By regulation, a single Point of Access (SPOA) is the only entity that may refer to ACT. SPOA is managed by a local governmental unit (LGU). These referrals could include persons under a court order for Assisted Outpatient Treatment. Referral to the ACT Program will continue to follow ACT Guidelines. Because the LGU / SPOA process designates individuals as high priority candidates for an intensive level of service, ACT Programs, Health Homes may refer to the ACT Program through the LGU / SPOAs.

ACT Program / Health Home Care Management

As Health Home Care Management providers, ACT Programs must meet Health Home requirements. Most of these are consistent with the existing requirements of the ACT Program. In addition, ACT will

integrate participants' primary health care through the Health Home. This includes incorporating the ACT team's comprehensive assessment into the Health Home care record.

The following table provides definitions of Health Home Care Management (HHCM) services as defined in the State Plan Amendment, and compares Health Home service definitions with OMH ACT Model Guidance and evidence based practices (EBP) embedded in the ACT model. A small number of Health Home Care Management requirements are new requirements for the ACT program, and these are not expected to be burdensome.

Health Home Care Management Service Definitions (New York State Health Home State Plan Amendment)	**HHCM Requirements**	**ACT Prior to HH**
Comprehensive Care Management		
Requires comprehensive individualized patient centered care plan	**X**	**X**
Care plan developed based on the information obtained from a comprehensive health risk assessment that identifies the enrollee's physical, mental health, chemical dependency and social service needs.	**X**	**X**
Plan of care must include and integrate the individual's medical and behavioral health services, rehabilitative, long term care, social service needs, as applicable.	**X**	**X**
Plan of care clearly must identify the primary care physician/nurse practitioner, specialist(s), behavioral health care provider(s), care manager and other providers directly involved in the individual's care.	**X**	**-**
Plan of care must identify community networks and supports that will be utilized to address their needs.	**X**	**X**
Goals and timeframes for improving the patient's health, their overall health care status and the interventions that will produce this effect must be included in the plan of care.	**X**	**-**
Ensure the individual plays a central, active part in developing and executing their plan of care; that they are in agreement with the goals, interventions and timeframes in the plan. Family and other supports involved in the patient's care are identified and included in the plan of care.	**X**	**X**
The comprehensive care plan includes outreach and engagement activities to support engaging the patient in their own care and promote continuity of care. The individual's goals are clearly identified, reassessed periodically, and the plan of care identifies the individual's progress in meeting goals. Changes in the plan of care are based on the individual's needs.	**X**	**X**
Engage and retain enrollees in care, coordinate and arrange for service provision, support adherence to recommended treatment, monitor and evaluate individual's needs.	**X**	**X**

Health Home Care Management Service Definitions (New York State Health Home State Plan Amendment)	**HHCM Requirements**	**ACT Prior to HH**
Care Coordination		

The ACT Team is responsible for the individual's plan of care.[1] The individual's plan of care identifies all services needed to meet the enrollee's goals, such as prevention, wellness, medical treatment by specialists and behavioral health providers, transitions from provider to provider, and social and community supports where appropriate.	X	X
Coordinate and arrange for provision of services; support adherence to treatment recommendations; monitor and evaluate enrollees' needs.	X	X
Ensure communication between the dedicated care manager and treating clinicians to discuss as needed enrollee's care needs, conflicting treatments, change in condition, etc. which may necessitate treatment change (i.e., written orders and/or prescriptions).	X	X
Develop and maintain contractual and data sharing agreements, policies, procedures that support and define roles for effective collaboration with the Health Home and its local network (primary care, specialist, behavioral health providers).	X	-
Comprehensive Transitional Care		
Have policies and procedures that direct and incorporate successful collaboration through evidence-based referrals, follow-up consultations, & regular, scheduled case review meetings with all members of the interdisciplinary team. Can use technology conferencing tools to support care management, when appropriate security protocols & precautions are in place, such as audio, video and /or web solutions.	X	-
Develop and utilize a system to track and share patient information and care needs across providers, monitor patient outcomes, initiate changes in care to address patient need.	X	-
Complete patient tracking form on each Health Home enrollee to identify ACT Program participants to prevent Health Homes from enrolling ACT participants in another care management program.	X	-
Health Promotion		
Initiate health promotion for eligible health home enrollees with the commencement of outreach and engagement activities. Health promotion activities are built around the notion of linkages to care that address all of clinical and non-clinical care needs of an individual, and health promotion.	X	X
Actively seek to engage patients in care by phone, letter, health information technology and community "in reach" and outreach.	X	X
Support continuity of care and health promotion through developing a treatment relationship with the individual, and through the interdisciplinary team of providers.	X	X

Health Home Care Management Service Definitions (New York State Health Home State Plan Amendment)	**HHCM Requirements**	**ACT Prior to HH**
Health Promotion, cont.		
Promote evidence based wellness and prevention by linking health home	X	X

[1] The ACT Program is a team based model; the ACT Team is responsible for care management.

enrollees with resources for smoking cessation, diabetes, asthma, hypertension, self- help recovery resources, and other services based on individual needs and preferences.		
Promote patient education and self management of chronic condition(s).	**X**	**X**
Provide comprehensive transitional care to prevent avoidable readmission after discharge from an inpatient facility (hospital, rehabilitative, psychiatric, skilled nursing or treatment facility), and to ensure proper and timely follow up care. Develop and have a system in place with hospitals and residential/rehabilitation facilities in the Health Home network to promptly notify Health Home care management provider of an enrollee's admission and/or discharge to or from an emergency room, inpatient, or residential / rehabilitation setting.	**X**	**X**
Have in place policies and procedures with local practitioners, health facilities including emergency rooms, hospitals, and residential / rehabilitation settings, providers & community-based services to ensure coordinated, safe transition in care for its patients who require transfer to / from sites of care.	**X**	**-**
Be an active participant in all phases of care transition including discharge planning and follow-up to assure that enrollees received follow up care and services and re-engagement of patients who have become lost to care.	**X**	**X**
Individual and Family Support Services		
Develop and have in place systematic follow-up protocol in place to assure timely access to follow care post-discharge that provides, at minimum, for receipt of a summary care record from the discharging entity; medication reconciliation; a plan for timely scheduled appointments at recommended outpatient healthcare providers.	**X**	**X**
Individual's plan of care reflects and incorporates the individual's preferences, education and support for self-management; self help recovery; and other resources as appropriate.	**X**	**X**
Share and make accessible to the enrollee, their families or other caregivers (based on the individual's preferences), the individualized plan of care by presenting options for accessing the enrollee's clinical information.	**X**	**X**
Use peer supports to increase individual's and caregivers' knowledge of the individual's disease(s), promote engagement and self management abilities, and help the individual improve adherence to their prescribed treatment.	**X**	**X**
Provide information to and discuss with the individual, his/her family and care givers, and information on advance directives.	**X**	**X**
Referral to Community and Social Support Services		
Identify available community-based resources. Actively manage appropriate referrals, access to care, engagement with other community and social supports, coordinate services , and follow-up post engagement with services.	**X**	**X**
Health Home Care Management Service Definitions (New York State Health Home State Plan Amendment)	**HHCM Requirements**	**ACT Prior to HH**
Referral to Community and Social Support Services, cont.		
To accomplish this, develop policies, procedures and accountabilities (through contractual agreements) to support effective collaboration with community-based resources, that clearly define the roles and responsibilities of the participants.	**X**	**-**

Include in the plan of care community-based and other social support services, appropriate and ancillary healthcare services that address and respond to the individual's needs and preferences, and contribute to achieving the individual's goals.	**X**	**X**