Bassett Healthcare Network
Community Health Navigation

Policy/Procedure:	HH Member Transfer & Disenrollment
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Approved by:	John Migliore III
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***Prior to this issue, Transfer & Disenrollment procedures were part of Bassett CHN Lost to Service, Transfer and Disenrollment Policy, which has been divided into two distinct policies.**

Policy:

Bassett Community Health Navigation will ensure that Members are engaged with appropriate Healthcare and Care Management Services as eligible, and that Members receive the appropriate care and services for their individual health needs and preferences. Bassett Community Health Navigation commits to promoting Member retention and engagement, facilitating transfers to other organizations and levels of care in a way which provides continuity of care and ensuring the Member's care needs continue to be met effectively. If a Member chooses or requires Disenrollment from Health Home Services, Care Management Agencies will take measures to ensure continuity of care, provide linkage to services which will continue to assist the Member with their needs, and ensure Members are made aware of their ability to re-enroll in Health Home services if eligible and appropriate for their needs.

Bassett CHN and CMA's must include involvement of the member, the members of the care team, including the CMA Supervisor/Team Lead, lead HH, and the member's MCO throughout the process to assure an appropriate disenrollment plan is developed and provided to the member. In addition, the CMA must assure that access to/sharing of PHI ceases by following the procedures included in this policy. The Bassett CHN discharge checklist can be used as a tool to help Supervisor's comply with this policy.

***CHN refers to Community Health Navigators & Partnering Health Home Care Managers**

Quality Management and Performance Improvement

To promote a culture of learning and continuous quality improvement, monitoring and oversight within the BASSETT CHN network, the following quality indicators with be monitored by BASSETT CHN and reported to the Quality Management and Performance Improvement Committee. Through ongoing evaluation of our network, BASSETT CHN will work to identify and address any issues related to premature member disenrollment and will implement strategies for improvements that lead to better member engagement and enhance overall performance of the HH network. CMA's should also have internal policy and procedure related to the oversight of the following performance indicators:

- Reasons that lead to member disenrollment
- Identify patterns for disenrollment
- Appropriateness of steps taken by CMA's to complete the disenrollment process to include protection of member PHI and rights associated with ending enrollment with the Health Home program
- CMA supervisory involvement
- Completion of required documents, including but not limited to (Bassett CHN Disenrollment Checklist & Discharge Summary)

- Management of member refusal/inability to participate in disenrollment activities
- Collaboration with member's care team and outcome of case reviews (prior & post discharge)
- Members plan of care was updated
- Member status updates in MAPP
- Appropriate billing activities
- Timely notification to HH for issuance of Notice of Determination DOH-5235, as applicable

Procedures:

A. Transfer to a New Care Manager Within the Same CMA

1. In the event of necessity or by the Member's preference, Members may be assigned to a new Navigator/Care Manager within the same CMA.
    a. CHN will document the reasons and preferences for transferring assignment to a new Navigator in the Member's Care Management Record Notes.
    b. CHN must notify Team Leader/Supervisor of transfer requests within 2 business days for review and approval before proceeding with transfer.
    c. Team Leader/Supervisor will notify CHN of decision within 2 business days.

2. If transfer is approved, CHN will arrange for a "warm hand-off" meeting, which should include the transferring Navigator, the Member, and the new Navigator, at minimum, as well as any other participants in the Member's Care Team, as the Member prefers.

3. CHN will complete the following in the Member's Care Management Record:
    a. A Non-Billable Note documenting transfer to the newly assigned staff and any details relevant to transfer of services.
    b. Update the new Staff Assignment in the Member's Care Management Record.

4. CHN will transfer any physical Care Management Record files to the newly assigned CHN.

B. Transfer between Partnering Care Management Agencies in the Bassett CHN Network

1. In the event of a Member moving, changing preferred providers due to care needs/capacity to serve, or upon member request, Members may be reassigned to another CMA in the Bassett CHN Health Home Network.
    a. CHN will document the reasons and preferences for transferring assignment to a new CMA in the Member's Care Management Record Notes.
    b. Transferring CMA must notify Bassett CHN Operations Manager of the request for transfer within 2 business days for review and approval.
    c. Bassett CHN Operations Manager will notify CMA of decision within 2 business days.

2. If transfer is approved, CHN will ensure a "warm hand-off" occurs, maintaining engagement with the Member during the transition process and facilitating direct linkage with services. At minimum, a face to face or phone meeting with the CHN, the Member, and the newly assigned Care Manager/CMA, (as well as any other participants in the Member's Care Team, as the Member prefers) should occur before transfer is completed.
    a. Transfer must be coordinated to ensure continuity of Health Home Care Management Services and minimize disruption/gap in service.

b. Transfers should be coordinated to occur at start of the next month. (Or in cases of immediate transfer, it must be determined which agency will bill for services during the month of transfer).

c. Transfers requested relating to dissatisfaction are addressed with the member to attempt to resolve issues and regain member satisfaction and retention (must be Supervisory documented within Netsmart), if appropriate (for example: offer member option to change providers in the following order:

   i. Change in Navigator with current CMA
   ii. Change in CMA within Network
   iii. Change in HH Network (if available and i. & ii. not member preference)

   Bassett CHN will require any Navigator/CMA/HH Network changes to complete a timely transfer with warm handoff);

3. CHN will document all contacts and information relevant to transfer in the Member's Care Management Record Notes, as per Bassett CHN Care Management Record Documentation Guide.

4. Upon successful hand-off/transfer of services, proceed with Bassett CHN Disenrollment Procedures.
   a. Transferring Agency must notify Bassett Lead Health Home Referral Coordinator and System Analyst when Transfer Discharges occur.
   b. Lead Health Home Referral Coordinator or System Analyst will update MAPP segments to reflect transfer between CMAs based on which agency is billing for each month.

C. Transfer to Other Lead Health Home Network

1. When a Member moves out of the Bassett Community Health Navigation Network Area, becomes ineligible for Medicaid Health Home Services or requires additional care needs which are not compatible with receiving Medicaid Health Home Services, Members may be transferred to another Lead Health Home or Healthcare Facility (Higher Level of Care).
   a. CHN will document the reason for member's need to disenroll from Bassett Community Health Navigation Services in the member's Care Management Record Notes.
   b. CHN must notify Bassett CHN Operations Manager within 2 business days of awareness of need/preference to transfer for review and approval before proceeding with Transfer.
   c. Bassett CHN Operations Manager will notify CMA of decision within 2 business days.

2. Once transfer is approved, CHN will make a referral to the new Lead Health Home.

3. CHN will ensure a "warm hand-off" occurs with the Member and the new Health Home services. At minimum, a face to face or phone meeting should occur with the CHN, the Member, and designated staff from the new Lead Health Home or Care Management Agency. The Member's providers and social supports may be included in the process as the Member prefers.

4. Transfers should be coordinated when possible to complete Disenrollment of Health Home services by the end of a Billable Month, so that the Member's new services are started on the 1st day of the next month.

5. CHN will document all contact and actions to facilitate transfer in the Member's Care Management Record Notes.

6. When all details of transfer have been approved and coordinated, and the Member is engaged with the new Health Home Provider, CHN will complete Bassett CHN Disenrollment Procedures.

D. Disenrollment from Bassett CHN Health Home Services

1. Members meeting any of the following conditions are to be Disenrolled from Health Home services:
    a. Member can successfully self-manage or has effective services and supports in place to manage their healthcare needs and no longer needs HH Care Management
    b. Member chooses to withdraw consent/disenroll from the program
    c. Member is being transferred to another Health Home
    d. Member no longer meets Medicaid Health Home eligibility and appropriateness requirements
    e. Member resides in an Excluded Setting (e.g., Inpatient or Residential Facility, Incarceration etc.) with an expected release date greater than 6 months
    f. Member remains "Lost to Service" after full completion of DSE/CSE process
    g. Member moved Out of State
    h. Member no longer has the appropriate type of Medicaid Coverage for Health Home*
    i. There are serious health, safety and/or welfare concerns for the Member or HH staff**
    j. Member is deceased

    * When a lapse in Medicaid coverage occurs, the CHN/CM should make every effort to assist the Member in recertifying Medicaid to maintain coverage thereby avoiding an otherwise preventable disenrollment.

    **For situations where disenrollment is due to the safety, health and welfare of the Member or Staff serving the Member, the CHN/CM and CMA Supervisor must work together to evaluate the circumstances and assure all options for addressing issues have been contemplated and exhausted, including the possibility of changing to another CM, CMA, or HH which can appropriately meet the Member's needs. HHCM and Supervisor are required to involve the HH and MCO in the process before a determination to disenroll is made.

    Members who are on court-ordered AOT must not be Disenrolled from the Health Home Program without approval from the Local Government Unit (LGU).

2. When a Member requests or meets the criteria for Disenrollment, CHN/CMs will notify their CMA Supervisor to review the circumstances of Disenrollment for approval and procedural guidance.
    a. The CMA Supervisor will:
        i. Participate in case reviews (include MCO and Care Team Providers) and approval of Disenrollment, as appropriate;
        ii. Provide clinical and policy guidance related to the Disenrollment process;
        iii. Consult Lead HH for additional guidance, as needed;
        iv. Ensure a safe and appropriate Discharge is arranged to support the Member's care and safety upon Disenrollment;
        v. Ensure notification is provided to the MCO and Lead Health Home when a DOH-5235 Notice of Determination is issued to the Member

3. CHN will complete the following, as applicable to the Member's circumstances:
    a. Communicate with the Member to discuss the purpose for Disenrollment,
    b. Address any dissatisfaction or concerns expressed by the Member (or others on Member's behalf) related to HH services, and assure adequate steps are taken to resolve issues;
    c. Discuss Disenrollment with the Member and Member's Care Team to:
        i. Evaluate the Member's ability to self-manage their Chronic Condition(s) and the need for intensive level of Care Management;
        ii. Establish a Disenrollment/Safety Plan, including any Referral(s) or contact information for new Provider(s) and/or Service(s) to support Member's care and safety post-discharge, as appropriate to the disenrollment reason;
    d. Ensure that the Member is referred and linked (by warm hand-off) with any needed services or resources prior to Disenrollment, as applicable.
    e. Complete a warm hand-off to the Case Manager/Social Worker at the Primary Care Clinic or Program/Facility that will be continuing care for the Member, as applicable.
    f. Inform member of his/her Fair Hearing rights (by phone or face to face), as applicable (refer to the Health Home Notice of Determination and Fair Hearing Policy); Mailing of Fair Hearing documents must only occur after informed discharge has been discussed and documented. Bassett CHN requires all CMA's to inform members (including explaining Fair Hearing Policy to members, based on their ability to understand this right).
    g. For situations where *transfer* is a safety concern, such as the health and welfare of the Member or Staff serving the Member, all options for addressing issues and creating stabilization need to have been exhausted, prior to the changing to another CM, CMA, or HH. Each HHCM and Supervisor are required to involve the HH, MCO (Case Reviews), and Care Team members in the process before a determination to transfer is made.

4. CHN will complete the following Disenrollment documents:*
    a. Bassett CHN Health Home Disenrollment Summary & Disenrollment Checklist
    b. Appropriate Disenrollment/Withdrawal of Consent Forms, as applicable
        i. For Members choosing to Disenroll (reasons 1a-c):
            a) DOH-5058: HH Patient Withdrawal of Consent with the Member
            b) DOH-5230: Withdrawal of Consent section (Only for HARP-enrolled Members who have previously provided consent on this form)
            c) HIXNY Withdrawal of Consent
        ii. For Members being withdrawn by CMA/HH (reasons 1d-i):
            a) DOH-5235: Notice of Determination for Disenrollment in NYS HH (Notice Date must be at least 10 days before actual Disenrollment occurs)

c. HH Member Disenrollment Letter on CMA Letterhead, which must include:
   i. Date of Disenrollment
   ii. Reason for Disenrollment
   iii. Information on how to re-enroll in HH services
   iv. The option to receive the following documents/information:
      a) Bassett CHN Disenrollment Summary
      b) Most recent Care Plan
      c) Contact information for Care and Service Providers (Includes MCO HARP Care Manager for HARP Members)
      d) A plan for ongoing coordination of HCBS (HARP Members Only)
      e) Any other documents as appropriate

*(If the Member is deceased, these documents are not required)

5. CHN will provide the Member with the following documents (in person, by mail, or through a method specifically requested by the Member):*
   a. If able to make contact with the Member during Disenrollment:
      i. HH Member Disenrollment Letter
      ii. Copy of completed DOH-5058 or DOH-5235, as applicable
   b. If unable to make contact with Member during Disenrollment, send the following document to the Member's verified "last known address" (or to jail/prison if incarcerated)
      i. HH Member Disenrollment Letter

6. CHN will notify the Member's Care Team (Providers & Social Supports), the Member's MCO, of the Member's Disenrollment, including the following details:*
   a. The Member was/will be Disenrolled
   b. The Reason for Disenrollment
   c. Date of Disenrollment

   *(HH Provider/Care Team Disenrollment Letter may be used to notify Providers)

7. Complete the following documentation in the Member's Care Management Record:
   a. A Non-billable Contact Note in the Member's Care Management Record which includes:
      i. The reason(s) for Member Disenrollment,
      ii. All communication with Member related to the reason(s) for Disenrollment and his/her response (if not already detailed in prior Notes)
      iii. The steps/documents completed during the Disenrollment process;
      iv. Any Member refusals or inability to participate in the Disenrollment process or complete required documents and procedures
   b. Upload all completed documents:
      i. Bassett CHN Health Home Disenrollment Summary
      ii. Completed DOH Withdrawal/Disenrollment Form: (DOH-5058 or DOH-5235)
      iii. Member Disenrollment Notification Letter
      iv. Provider/Care Team Notification Letter(s)

8. CHN will complete Discharge of the current episode in the Member's Care Management Record, entering the following information:
   a. Discharge/Disenrollment Date (Date DOH-5058 signed or DOH Effective Date)
   b. Discharged By (Staff Name)
   c. Reason for Discharge (Select the most applicable reason)

Related Forms & Documents:

- ◊ **Bassett CHN Care Management Record Documentation Guide**
- ◊ **DOH-5058 Health Home Patient Withdrawal of Consent**
- ◊ **DOH-5235 Notice of Determination for Disenrollment in the NYS Health Home Services**
- ◊ **HIXNY Withdrawal of Consent Form**
- ◊ **Bassett CHN Health Home Disenrollment Summary**
- ◊ **HH Member Disenrollment Letter Template**
- ◊ **HH Provider/Care Team Disenrollment Letter Template**
- ◊ **Bassett CHN Discharge Checklist**