Bassett Healthcare Network
Community Health Navigation

Policy Title: Health Home Member Transfer Policy

Policy Number: BCHN003

Original Date: 9/30/2022 **Last Revised:** 12/13/2024 **Effective Date:** 1/1/2025

Approved By: Miranda Blakeslee

Applicable to: Health Homes Serving Adults (HHSA)

Purpose: To establish standards and clear guidance which will inform Health Homes (HH) and Care Management Agencies (CMA) of requirements for the transfer of enrolled members to a new HH, CMA, Waiver Service, and/or Care Manager.

Contents

Definitions

Administrative Transfer: The process followed by a Health Home and/or Care Management Agency to appropriately transfer Health Home enrolled members as a result of a closure/merger/acquisition.

Care Management Agency (CMA): an organization that has a fully executed contract with the Bassett Healthcare Network Health Home to provide Health Home outreach and/or care management services.

Care Manager (CM): Point of contact for all coordination of care related to a member enrolled in the Health Home.

Managed Care Organization (MCO): A member's insurance provider or insurance carrier managing a members Medicaid coverage.

Member: A person who meets the eligibility criteria for the Health Home and has agreed to enroll.

Member-Driven Transfer: The process followed when a Health Home enrolled member requests transfer to a new Health Home and/or Care Management Agency.

MAPP HHTS: Medicaid Analytics Performance Portal Health Home Tracking System is a performance management system that will provide tools to the Health Home network to support providing care management for the Health Home population.

Warm Handoff: A three-way communication that includes the current entity, new entity, and the member (family as appropriate) as a means to introduce the member and explain next steps in the transition process. Such communication can occur through phone call, telehealth, or in-person meeting to prevent any potential disengagement as the member is transitioning between entities. For example, current Health Home to new Health Home OR current Care Management Agency to new Care Management Agency.

Policy Statement

This document provides guidance to Care Management Agencies (CMA) regarding the required steps to take when transferring a Health Home (HH) enrolled member to a new HH, CMA, or waiver service.

Health Home care management integrates and coordinates healthcare providers (physical, behavioral, recovery service), community-based services and supports (such as housing, social services, etc.) with a focus on optimizing health outcomes and quality of life for enrolled members.

Member transfers will occur for various reasons:

- Health Home Enrollee or Health Home Candidate moves county of residence
- Member requests a change is service provider
- Member has cultural or linguistic needs that cannot be met by current provider
- CMA and/or HH are unable to serve the enrollee for various reasons

This document provides an outline to promote member retention and engagement by facilitating transfers to other organizations while providing continuity of care and assuring the members needs are being addresses during transition.

This document outlines the steps to be taken by the HH, CMA, and CM to ensure that:

- a warm handoff occurs for the member from the current entity to the receiving entity, and
- regular reviews of the status of each member involved in the transfer process,

To support a smooth, safe, and timely transfer it is imperative to have open communication and coordination between all entities. This includes:

- proper notification to the member about the reason for the transition and the member's selection, to include the member's choice not to transfer rather to disenroll from the Health Home (HH) program, if this is their desire.

Throughout a member transfer the Care Manager (CM) employed by the CMA where the member is enrolled will maintain responsibility as the single point of contact for coordinating and planning step related to a seamless member transfer. It is important to involve the member, supports, or legally authorized representative, the care team, CMA Supervisor, lead HH, and the member's MCO must be included throughout the process to ensure collaborative efforts are made to provide continuity of care through the transfer process. In addition, the CM must assure that access to/sharing of PHI ceases.

Procedure

When an **Administrative Transfer** is indicated, the Health Home Care Manager (HHCM) distributes to the member a letter written on Care Management Agency (CMA) agency letterhead clearly explaining the purpose for the transfer (e.g., Care Management Agency (CMA) closure, Health Home (HH) closure, merger, acquisition, or other reason(s), and include all available options depending on the nature of the situation, for example:

- Remain with current Health Home (HH), but change to another Care Management Agency (CMA)
- Remain with current Care Management Agency (CMA), but change to another Health Home (HH)
- Change to another Health Home (HH) and Care Management Agency (CMA)
- Disenroll from the Health Home (HH) Program (member choice to disenroll or member identified for graduation/step down)

  Note: For **Member-Driven Transfers,** the above letter would not be required by the Care Management Agency (CMA); however, the Health Home Care Manager (HHCM) must document every step of the transition process until successful completion, including warm hand off, has occurred.

For all transfers, the Health Home Care Manager (HHCM):

1. Assures the member is making an informed choice to transfer and obtains permission to contact the receiving Health Home (HH)/Care Management Agency (CMA)/Children to initiate and complete the transfer.

2. The current and receiving entities maintain ongoing communication throughout the process to include the member, Care Team members. All pertinent information to support the transfer is provided from the transferring entity(s) to the receiving entity(s).
3. Establishes a date for disenrollment or transfer via the Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS).
    a. Disenrollments occur on the last day of the month while transfer occurs on the first day of the month.
4. Informs and follows up with the member to ensure updates to their Health Home, as needed.
5. Informs and follows up with member regarding completion and signing of other documents needed.
6. Documents in the member's record all transfer activities that occurred throughout the transition process.
7. Ensures transfer of member's record, Plan of Care (POC), Assessments, Safety/Crisis Plan, etc. to receiving Health Home (HH)/Care Management Agency (CMA) are complete.

Depending on whether a member's Care Management Agency (CMA) remains the same or changes as a result of a transition, certain rules apply regarding transfer of the Health Home consent, Plan of Care, Assessments, Educational Records, Care Management documentation, and clinical documentation, as follows:

Guidance for Transferring Care to a New Care Manager in the Same Care Management Agency and Health Home

Ongoing communication is essential in ensuring continuity of care from Care Manager to Care Manager within the same CMA. The following tasks must be completed:

1. Current Care Manager must notify and receive transfer approval from a supervisor. Notification must include
    a. Reason for transfer
        i. If due to concerns with satisfaction, supervisor must follow-up with the member to understand reason for dissatisfaction prior to any transfer.
    b. Urgency of transfer
    c. Any member preferences
2. A Warm Handoff meeting to discuss and review the member's record for continuity of care.
3. Documentation of all communication surrounding the transfer.
4. Care Manager Assignment will be updated in the members record by a supervisor, once all required tasks are complete.

Guidance for Transferring Care to a New Care Management Agency in the Same Health Home

In an effort to maintain continuity of care it is important that entities involved in the transfer of member care from one CMA to another within the same HH maintain open communication. The current Care Manager maintains the role of the single point of contact throughout the transfer process, until enrollment begins with a new CMA.

1. Upon identifying a need for transfer to a new CMA, the CM must notify and receive transfer approval from a supervisor within 2 business days. The notification must include:
    a. Reason for transfer
        i. If concerns with satisfaction, supervisor must follow-up with the member to understand reason for dissatisfaction and see if resolution is an option prior to any transfer.
    b. Urgency of transfer
    c. Any member preferences
2. Current Care Manager must obtain consent for the new CMA (if known) on the DOH-5055.
    a. If unknown, move to step 3. The Health Home can assist with determining availability.
    b. If not obtained prior to sending the lead HH the transfer packet, it will be required once a CMA determination is made, prior to communication between current and new CMAs occurs.
3. Care Manager completes the Transfer Packet, and sends to a Supervisor for review.
4. Once approved, Supervisor will notify the Health Home. In addition to the required transfer packet and attachments, notification will include:
    a. If billing has occurred with the current CMA in the current month.
    b. If there is a need for immediate transfer
    c. If there is an agency preference
5. The HH will review the documents and information provided for completeness. Within 2 business days of receiving the notification the HH will inform the current CMA of approval or the need for additional information.
6. Once all information is gathered and the transfer is approved by the HH. A communication will be initiated by the HH to connect the current CMA, and receiving CMA. This communication will include:
    a. Transfer Packet with attachments
    b. Expected Transfer Date
    c. Contact information for the new CMA supervisor.
7. The receiving CMA will have two business days to confirm their ability to accept the transfer.
8. Upon acceptance of transfer the current CMA will coordinate a warm hand-off. The warm hand-off should be scheduled within 5 business day of the receiving CMA accepting the transfer.
9. Current CM will contact the member's care team to inform of the transfer and extend an invitation to the warm handoff meeting.
    a. At minimum, a face to face or phone meeting with the transferring CM, the Member, and the newly assigned CM/CMA, are required to meet via telephone, zoom, or in-person meeting for a transfer to be considered complete.
10. During the warm hand-off the following topics must be addressed and documented in the member's care management record:
    a. Plan of Care
        i. Annual due date
    b. Immediate needs

c. Care Team Members
    i. Social Supports
    ii. Review the DOH-5055
d. Assessments:
    i. Comprehensive
    ii. SDOH
    iii. Crisis Plan
    iv. Appropriateness Criteria
e. Date of Transfer

11. After review of the chart for task completeness, a supervisor will complete the disenrollment in the member's care management record.
    a. Once complete, Supervisor completing the disenrollment in the Care Management Record will notify the HH and receiving CM to ensure no gap in care occurs for the member.
    b. Disenrollment Reason selection will me "Transferred to another CMA"
12. The HH will process the transfer of CMA with the MAPP HHTS by updating the segment and completing a "My Member Upload" in Netsmart.
    a. Member will be entered as "Enrolled"
    b. HH will ensure "Attachments" in Netsmart include the Transfer Packet and associated attachments.

If, at any time, throughout the transfer process a member becomes disengaged and is unable to be contacted or found. The current CM should begin the DSE process. (Refer to: BCHN008: Continuity of Care and Re-Engagement of Enrolled Members)

Additional Guidance for Transfer of Documents Required

When a member is transferring HH's they may transfer to a new or remain in the same CMA. Identifying the correct type of transfer is important to assure proper steps are taken to maintain continuity of care. Certain rules apply according to which entities are changing for the member through a transfer.

Transferring to a New Health Home within the Same Care Management Agency

1. The currently signed HH consent (DOH-5055) will continue to be valid and used until the member's Plan of Care is due.
2. The Continued Eligibility for Services (CES) Tool does not transfer with the member.
    a. When a new segment is created with the new Health Home the CES Tool clock is restarted based on the date of transfer.
3. When the transfer function is used, the most current Initial Appropriateness determination transfers with the new segment.
    a. In all other instances when a new segment is started (e.g., when the Transfer Function is not used), a new Initial Appropriateness determination is to be submitted within twenty-eight (28) days.

Transferring to a New Care Management Agency within the Same Health Home

1. The currently signed HH consent remains valid for up to ninety (90) calendar days (or the equivalent of three (3) segment months) of the member's transition date in order for needed updates to be made in the CMA and any other providers. See BCHN009: Use of Health Home Consents and the Provision of Access and Sharing of Member's PHI, for outlined steps for completing changes to the HH consent.
    a. Members of the Care Team listed in the consent are made aware of the new Care Management Agency (CMA) and are offered and provided with a copy of the updated new consent.
2. The receiving CMA uses the member's current Plan of Care (POC) and Comprehensive Assessment (CA) due date to establish the timeline for the next review and update.

Transferring to a New Health Home and New Care Management Agency

1. A new consent is obtained by the receiving Health Home (HH) within ninety (90) calendar days (or the equivalent of three (3) segment months) of the member's transition date. This includes consents such as the DOH 5055, DOH 5201, DOH 5203, etc.
    a. See BCHN009: Use of Health Home Consents and the Provision of Access and Sharing of Member's PHI, for outlined steps for completing changes to the HH consent.
2. The receiving Health Home uses the member's current Plan of Care (POC), Children's Home and Comprehensive Assessment (CA) due dates to establish the timeline for the next review and update.
3. The Health Home monitors the transfer of information for all members involved in a transition including Health Home consent, current Comprehensive Assessment and other recent assessments, and the most current Plan of Care accessed through the Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS) transfer function.

Guidance for Transferring Care to a New Waiver Program

When a member/participant receiving care management services chooses to receive care management services from a different program, steps must be taken to ensure a timely transition with a warm handoff. Open communication and coordination between all parties involved is necessary for a smooth and successful transition to occur.

Throughout the transition process, if the member remains eligible for current services, enrollment should be maintained until such time the member is found eligible for the new program/waiver to ensure no gap in service occurs. Once eligibility and availability for the new program/waiver is confirmed, the transition to the new program/waiver can occur.

Upon request of a Waiver Service or Identification of a need for a Waiver Service, the follow must occur:

1. The current CM explains the various options, services, providers, and eligibility processes to the member to ensure an informed decision is made.

2. The current CM must obtain proper consent from the member while planning for transition to ensure that the current CM can share all the necessary information with the parties appropriate for obtaining the needed waiver services throughout the transition process.
3. The CM must ensure that a member/participant's eligibility status is reviewed in ePaces/eMedNY before proceeding with a transfer request.
    a. This is especially important in the event the member initiates transfer to another program without notifying their CM first.
    b. In the event an issue is identified that could affect the transfer, the member must be informed.
4. The current CM will continue to work with the member using the current care plan while transitional activities are occurring to guarantee no disruption in services occurs.
    a. The current CM will update the care plan to reflect the request of waiver services.
    b. The current CM will document all activities conducted to support the transition in the member's care management record, and also document eligibility and services in the member's care plan.
5. The current CM must notify Supervisor of transfer need within two business days of occurrence.
6. Supervisor must review and approve before proceeding with transfer.
    a. Supervisor and transferring CM must discuss the reason for the transfer in care and review that the appropriate documents and signatures have been obtained to begin communication with program or waiver service.
    b. Supervisor will approve the transfer.
    c. Supervisor must contact the lead HH to notify them of the transfer to a waiver program.
    d. Transferring CM will document the discussion with the Supervisor in the notes of the Care Management Electronic Record.
7. The current CM completes a referral and submits to the program/waiver service.
8. The current CM will gather appropriate information and notify the program/waiver service contact via Health Commerce System (HCS) secure file transfer that the member is interested in services under a specific Waiver of choice.
    a. This request must include the following:
        i. Member's name
        ii. Client Identification Number (CIN)
        iii. Date of Birth (DOB)
        iv. Reasons why the change is being pursued (e.g., member choice, no longer meets Health Home Program eligibility criteria, etc.).
9. The receiving Waiver program will provide information on available agencies and coordinate with the current CM to support the member's transition to the new Waiver. Once agency selection is made by the member the Waiver program will proceed with the process.
    a. The current CM will assist in gathering information needed to complete applications for the new Waiver program.
10. The Waiver program will review the application packet for completeness and confirm eligibility.
11. The CM will notify the member's care team of their choice to transition.

12. The current CM will document in the Care Management Record the choice of the waiver agency and other relevant information regarding the transfer decision and process.
13. The current CM coordinate a warm handoff with the waiver program contact. During the warm hand-off topics must be addressed:
    a. Care Plan to be reviewed and potential updates
    b. Social Supports
    c. Members of the Care Team
    d. Updates to Assessments
    e. Date of Transfer
    f. Signing of a new DOH-5055 with the new CMA.
14. The receiving waiver program will notify the current CM and the member and establish an effective transfer date.
    a. The effective date of the transfer must be a future date and must be the first of the month.
    b. The current CM will communicate the transfer date to the Supervisor and lead HH.
15. The lead HH will end the member's enrollment within their EHR/MAPP HHTS with appropriate transition date to allow for billing and payment by the receiving Waiver program.
16. The current CM must document all communications and actions in the Care Management Electronic Record.
17. The current CM should refer to the BCHN004: Health Home Disenrollment Policy for proper disenrollment procedures.

Requirement for transferring Members via Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS)

To support a successful transfer process, the transferring and receiving entity(s) establish arrangements outside the Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS) as outlined previously in this policy.

The Health Home (HH) that is transferring a member(s) obtains verbal agreement from the Health Home (HH) that has agreed to accept the member(s) from the transferring Health Home (HH), including any limitations on the number of members they can accept when conducting an administrative transfer.

The transferring Health Home (HH) moves the member(s) using the transfer functionality within the system. This process can be completed in bulk using files or one member at a time, on screen. The members eligible for transfer will require review and response from the receiving Health Home (HH) as to whether they accept or decline each member and communicate why. If a receiving Health Home (HH) does not accept members, the transferring Health Home (HH) maintains responsibility for these members and proceeds to locate another Health Home (HH) willing and able to accept these members, following the process outlined in the File Specifications documents.

As part of the transfer planning process, Health Homes (HH) and or Care Management Agencies (CMA) ensure that the members being transferred are still eligible and appropriate for Health Home Services, if applicable. This can be done through pre-existing processes Health Homes (HH) have in place or though completion of the CES Tool (as done by Health

Homes (HH) and Care Management Agencies (CMA) prior to release of this policy). If a member is not eligible and appropriate for continued enrollment, they should not be transferred rather should be moved through the discharge planning process.

Training

Health Homes (HH), Care Management Agencies (CMA)/Care Managers (CM) must receive training on protocols related to the requirements for the transfer of enrolled members to a new Health Home (HH) and/or Care Management Agency (CMA), including but not limited to:

1. reason(s) for transfer;
2. responsibilities of each entity involved in the transfer process;
3. notification to the member(s) and obtaining choice;
4. transfer of documentation and associated timelines;
5. communication and coordination between entities throughout transfer process, including warm handoff of members; and,
6. MAPP HHTS requirements

Quality Monitoring

As part of its structured transfer plan, Health Homes (HH) provide oversight and monitoring activities to ensure the transfer of its member(s) occurs in accordance with the requirements and timelines of this policy. Quality monitoring activities must include, but are not limited to:

1. type of transfer/purpose
2. member(s) involved in the transfer request
3. regular reviews of the status of each member involved (including identification of members disengaged from care, refusal to participate, eligible for disenrollment, etc.)
4. completion of required documents (e.g., HCBS Eligibility Determination) to support the member's transfer
5. access to required data and documents by receiving entity(s)
6. completing transfers in MAPP HHTS

Supporting Policies and Resources

- Medicaid Analytics Performance Portal (MAPP) website: Information related to transfer files can be found under the heading Tracking System Updates and File Formats.
    - Refer to the most updated version of the (Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System at the (Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS) Release Information table.
- Guidance for Use of the Continued Eligibility for Services (CES) Tool
- Appropriateness Codes and Criteria
- Health Home Transfer Packet
- BCHN004: Health Home Disenrollment Policy
- BCHN008: Continuity of Care and Re-Engagement of Enrolled Members
- BCHN009: Use of Health Home Consents and the Provision of Access and Sharing of Member's PHI