Bassett Healthcare Network
Community Health Navigation

Policy Title: **Health Home Member Disenrollment Policy**	**DOH Policy Name: Member Disenrollment From the HH Program** **DOH Reference Number: HH0007** **Effective Date: May 1, 2022**
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A. POLICY STATEMENT

The Bassett Community Health Navigation Health Home (BCHNHH) is providing this policy guidance to Care Management Agencies (CMA) to address the requirements for managing the member disenrollment process. Care management integrates and coordinates healthcare providers (such as primary, acute, and behavioral health (mental and substance abuse) and 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.

Bassett Community Health Navigation Health Home 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. Graduation and/or step down from the Health Home Program begins at program enrollment and is continually evaluated throughout enrollment.

Disenrolling members should be made aware that if they again have difficulties with self-directing their own care or connecting to health care providers, HH care management is available to them to re-enroll if they continue to meet eligibility and appropriateness requirements.

HHs must ensure that CMAs have policies and procedures in place that outline the necessary steps to be taken to identify members for disenrollment including those eligible for graduation or step down, and for ensuring safe and appropriate discharge planning procedures are implemented and monitored. Through ongoing evaluation of their network performance related to enrollment and retention rates, HHs must identify and address issues related to member disenrollment and must implement strategies for improvements that enhance the overall performance of the HH network.

B. SCOPE

When a member is being disenrolled from the Health Home program, the Care Manager (CM) maintains responsibility for carrying out the discharge planning for disenrollment. The CM must include involvement of the member, the member's parent, guardian, or legally authorized representative (e.g. an adult with a legal guardian). All members of the care team, including the CMA Supervisor, HH, and the member's Managed Care Organization (MCO) must be included throughout the process to ensure an appropriate transition plan is in place and monitored to support the member's disenrollment and post disenrollment plan. In addition, the CM must assure that access to/sharing of PHI ceases.

In addition to member choice, a member's enrollment may be ended due to circumstances identified by the HH or CMA/CM to include, but are not limited to:

1. Member no longer meets eligibility criteria required for continued enrollment (such as: need for CM services, risk factors, etc.)

2. Member can successfully self-manage their chronic condition(s) and no longer meets the appropriateness criteria for HH services.
    a. CMAs/CMs must have a plan in place for monitoring member activity to identify whether members are eligible for graduation.

3. Member's care management needs can be managed through a less intensive level of Care Management.
    a. From the point of enrollment CMs must discuss with members the eligibility and appropriateness criteria and the process to evaluate for continued enrollment in the HH program.
    b. CMAs/CMs must have a plan in place for monitoring member activity to identify whether members are eligible for step down to a lower intensity of care management services (e.g. PCMH, MMCP, etc.); in need of continued HHCM services.

4. Care Management activities do not support continued enrollment.
    a. For example: a monthly check-in with the member without the provision of a CM core service is not sufficient activity to warrant continued enrollment.
    b. Or, a member who does not access CM services despite attempts by the CM to address and improve the situation.

5. Member is no longer Medicaid eligible or, coverage type is not compatible with HH services;
    a. This is not the same as when a member's Medicaid coverage has lapsed. When a lapse in coverage occurs, the CM must make every effort to assist the member in recertifying Medicaid to maintain coverage thereby avoiding an otherwise preventable disenrollment from the HH Program.
    b. Billing can only occur for the period of time Medicaid is in effect. Therefore, the HH may retroactively bill for services provided during the months in which Medicaid coverage was not in place only if appropriate Medicaid coverage has been reinstated and back-dated to include those months (no longer than 90 days).

6. Member's care team concurs with the member that all goals have been met and there are no new goals identified that require the support of a CM.

7. Disengaged member is not located after CM/CMA conducts required search efforts (as described in *BCHN008: Continuity of Care and Enrolled Member Re-engagement policy*).

8. Member has moved out of the service area.

9. Member is in an excluded setting (e.g., inpatient, hospitalization, institution or residential facility; incarceration; nursing home, etc.) and the length of stay is anticipated to be longer than six months (as described in *BCHN008: Continuity of Care and Enrolled Member Re-engagement policy*).

10. Member can no longer be served due to issues that affect the safety, health and welfare of the member or CM staff serving the member.
    a. In this case, the CM and Supervisor must work together to evaluate the circumstances and assure all options for addressing issues have been exhausted, including the possibility of changing to another CM, HH, or CMA which can appropriately meet the member's needs.

b. CM and Supervisor are required to involve the HH and MCO in the process before a determination to disenroll is made.

11. Member death.

C. OBJECTIVES

- Effective implementation of the processes necessary to meet the Health Home Program standards and requirements as stipulated by the NYS DOH, federal regulations, and best practices.
- Provide CMA and CM with a clear understanding of requirements related to the transfer of a member between CM, CMA, HH, and Waiver Services.
- Provide resources and forms to assist with a smoother transition of care.
- Ensure CM is point of contact to conduct all activities of disenrollment.
- Provide clear understanding of roles and responsibilities involved in the disenrollment process.

D. DEFINITIONS

Disenrollment: When enrollment in the Health Home program ends due to member choice or based on reasons of the CM/CMA or HH identified in the procedures section of this policy.

Graduate: The member has achieved goals that supported Health Home enrollment and is ready and able to self-manage any post disenrollment care and services needed.

Member: Individuals that are actively enrolled in the HH program and/or the individual's family/supports (such as: parent, guardian, legally authorized representative) or other person(s) designated by the member to act on behalf of member.

Step Down: The process through which members, identified as no longer needing the level and intensity of CM services, are prepared for disenrollment to ensure a warm handoff to care and services needed post disenrollment.

Managed Care Organization (MCO): A health care company or a health plan that is focused on managed care as a model to limit costs, while keeping quality of care high.

E. ROLES AND RESPONSIBILITIES

Health Home Administration Responsibilities:

- Update MAPP billing segment to ensure:
    - The HH will determine what the most appropriate Segment End Reason is to end the member's assignment within the MAPP HHTS. Each situation is different and must be handled accordingly (e.g., a member who has moved out of NYS is different from a disengaged member who could not be located through required search efforts, or a member who has graduated versus stepped down, etc.)

- The HH will ensure the member's segment in MAPP HHTS is ended to show the last day of the month in which the member is disenrolled from the HH program.
  - Must have a system in place to track disenrollment reason codes for all members disenrolled from their network.

- Complete Quality Assurance checks to ensure procedures are being followed.

Care Management Agency Supervisor:

The role of the CM supervisor is to assure that CM activities support appropriate procedures to disenroll members from the HH program. The CM supervisor must:

- Discuss the determination and provide clinical and policy guidance to the CM related to the disenrollment process.
- Participate in case reviews and sign off, as appropriate.
- Ensure a safe and appropriate discharge has been put into place to support the member's care and safety upon disenrollment from the HH program.
- Ensure policy and procedure is in place that address criteria for identifying members appropriate for step down planning and establishing an appropriate plan.
- Ensure notification was provided to the MCO and HH regarding the issuance of the Notice of Determination to the member.
- Required to approve and ensure all transfer procedures and requirements are complete.
- Reassign to a new CM when person transferred within own CMA.
- Member Disenrollment
- Provide Health Home Notifications

CM Responsibilities:

- Point of contact for all disenrollment activities.
- Ensures completion of all CM tasks for appropriate discharge.

F. PROCEDURES

Enrollment in the Health Home Program is voluntary; therefore, individuals have the right to exercise their independent choice to disenroll (e.g. the member, guardian, legally authorized representative are no longer interested in HH services). Member requests to disenroll from the HH Program must be honored and managed by the CM through a discharge planning process, whenever possible. The goal of the HH Program is to prepare members by building on their needs and abilities to facilitate a post disenrollment plan that supports the coordination and continuation of healthcare services.

Member Disenrollment General

This section indicates the disenrollment procedures that need to occur in every disenrollment situation.

1. CM must discuss with their Supervisor the reason for discharge. The Supervisor must monitor the discharge process and ensure appropriate documentation is occurring in the Member Care Management Record file.

a. CM must document in the Member Care Management Record file reason(s) for member disenrollment, all communication with member related to the reason(s) for disenrollment and response, and steps taken to complete the disenrollment process.

b. Thorough discussion with the member and Care Team. Discharge planning should be part of the Plan of Care process to include ongoing evaluation of the member's ability to self-manage their chronic condition(s) and the need for intensive level of care management.

2. Direct communication between CM/CMA and member will occur to discuss the purpose for disenrollment, and address any dissatisfaction or concerns expressed by the member or others on behalf of the member related to HH services, and assure adequate steps were taken to resolve issues.

    a. Member's disenrolling due to dissatisfaction with services must be offered a transfer option, if a member decides to transfer services CM should refer to the *BCHN003; Health Home Member Transfer Policy.*

3. Support the member's right to make an informed decision related to program disenrollment and possible step down to a lower level of care.

    a. The step down plan supports the disenrollment process by helping members prepare in advance, building on their needs and abilities to facilitate a post disenrollment plan that supports the coordination and continuation of healthcare and services.
    b. Step down occurs over a period of time, determined by the member's needs and preferences and includes assessment of the member's ability and strategies for managing their own care and services. The approach must be member-focused, developed collaboratively between the CM, member, MCO, member's care team and supports.
    c. A timeline for completing transition activities must be specific to each member's needs and preferences and may require adjustment throughout the step down period.
    d. Step down must be member focused and developed collaboratively with the member care team including the MCO, PCP, and other identified supports.

4. Notify the member's Care Team including the member's MCO and HH that the member will be disenrolled, the reason for disenrollment, and the date to end enrollment and cease access to/sharing of PHI;

    a. Hold a case review with member and care team including MCO to discuss disenrollment as appropriate for disenrollment reason and establish:
        i. a post disenrollment plan;
        ii. safety plan/safety post discharge;
        iii. Referral(s) or contact information for new provider(s) and/or service(s) to support member's care.
    b. If care team is unable to attend a case review, written notification should be sent to each participant of care team to cease PHI sharing.

5. CM must update member's plan of care to include:

    a. Member goals being dispositioned;
    b. Update status of goals;
    c. Discharge/safety plan;

d. Any referrals made/needed.

6. CM will issue written notification to the member and members Care Team on agency letterhead clearly describing the reason for and the date of disenrollment, the letter will include (each CMA must have a Member Disenrollment Letter and a Care Team Disenrollment Notification Letter that meets the requirements below):
    a. Means for notification to CM/CMA by member (Parent, Guardian, Legally Authorized Representative, etc.).
    b. The date all sharing of PHI and other information will cease.
    c. How member may request consideration for re-enrollment at a later time, if desired.
    d. The notification letter may be provided to the member directly, via mail, or through another method specifically requested by the member.
    e. The member must be offered the option of receiving a copy of any pertinent documentation (including the method through which they wish to receive it) as appropriate, such as:
        i. Most recent Plan of Care including contact information for care and service providers (including contact information for the MCO care manager who will be providing ongoing coordination of Behavioral Health Home and Community Based Services (BH HCBS) or;
        ii. Discharge/safety plan;
        iii. Any referrals made by CMA/CM for new providers/services or the contact information for use by the member post discharge;
        iv. A plan for ongoing coordination if member is receiving BH HCBS.
            1. If the CM is unsuccessful in attempting to contact the member to discuss disenrollment, the CMA must send the notification letter to the member's last known address. Additional documents will not be sent with the notification letter. However, the letter must contain directions for the member to contact the CMA to discuss the reasons and process for disenrollment, and the option to request a copy of pertinent documentation listed above.

7. CM will inform member of Fair Hearing rights, as applicable.
    a. Refer to *BCHN010: Health Home Notice of Determination Fair Hearing Policy*

8. CM will assure appropriate billing practices are met. Billing must cease on the first of the month immediately following the month in which the member was disenrolled.

9. CM must complete:
    a. BHCNHH Disenrollment Summary
    b. HIXNY Withdrawal of Consent

10. Lead HH will update Member Status in Medicaid Analytics Performance Portal Health Home Tracking System (MAPP HHTS).
    a. CMA Supervisor must evaluate member disenrollment and notify the lead HH of the disenrollment reason.
    b. The Systems Analyst will determine what the most appropriate Segment End Reason is to end the member's assignment within the MAPP HHTS. Each situation is different and must be handled accordingly (e.g., a member who has moved out of NYS is different from a disengaged member who could not be located through required search efforts, or a member who has graduated versus stepped down, etc.)
    c. The Systems Analyst will ensure the member's segment in MAPP HHTS is ended to show the last day of the month in which the member is disenrolled from the HH program.

i. Must have a system in place to track disenrollment reason codes for all members disenrolled from their network.

11. CMA Supervisor must:
    a. Discuss the disenrollment determination in each situation with the CM and provide guidance on the disenrollment process.
    b. Participate or review completion of Care Team meeting, or at minimum the attempt to complete the Care Team Meeting.
        i. In cases the Care Team was unable to meet, a review that all required written notifications were sent, uploaded and noted in the Members Care Management Record appropriately.
    c. Note in the members Care Management Record the completion of a safe and appropriate disenrollment. Supervisor must indicate their review and completion of all documents.

Member Requests Disenrollment

If a member chooses to end enrollment in the HH program, HH policies and procedures must include additional steps CMs need to take beyond standard disenrollment procedures to include, but not limited to the following:

1. CM must discuss with the member their reason(s) for requesting disenrollment.
    a. CM must clearly document a note in the Member Care Management Record file.

2. If reason is related to dissatisfaction, work with the member to address and resolve issues to regain member satisfaction and retention.
    a. If member would like to remain enrolled and would like to transfer to another agency or health home please refer to the *BCHN003: Health Home Member Transfer Policy.*

3. CM will update the care plan as indicated in **Member Disenrollment General,** step 5.

4. CM will hold a care team meeting (including MCO) as indicated in **Member Disenrollment General**, step 4.
    a. CM will ensure member is provided with contact information for resources they may need post disenrollment.
    b. CM will ensure member has re-enrollment information for the HH program if needs arise.
        i. If unable to conduct a care team meeting the CM must:
            1. Document a note in the Member Care Management Record the attempt to schedule a team meeting and the reason why the team is unable to meet.
            2. Issue written notification as indicated in **Member Disenrollment General**, step 6.

HH and/or CM Decision to Disenroll Member

The CM or HH may initiate a member's disenrollment from the HH program.

1. CM will communicate information to the member that clearly defines the reason(s) disenrollment procedures were initiated by the HH or CMA/CM.
    a. If member is unable to be reached and DSE procedures have been completed, CM will issue a letter to the member with this information.
    b. CM will allow member 10 business days to respond to the notification.

2. CM will seek the member's input into the decision for disenrollment:
    a. CM must attempt contact with the member to receive feedback.
    b. CM must clearly document attempts and/or conversation in the Member Care Management Record file.

3. CM will hold a care team meeting with the member and care team to discuss the disenrollment decision and establish a discharge/safety plan for post discharge care.
    a. CM must clearly document meeting participants and discussion in the Members Care Management Record file.
        i. Discussion must include:
            1. Updates to the Care Plan:
                a. Member goals being dispositioned
                b. Update status of goals
                c. Discharge/safety plan
                d. Any referrals made/needed
            2. Resources available in the community and within the Care Team to provide a safe disenrollment.
            3. Resources to re-engage in HH services in the future.
    c. If member and/or Care Team are unable to attend meeting written notification to the member and/or care team is required by the CM as indicated in **Member Disenrollment General**, step 6.
        ii. CM will document these notifications in the Members Care Management Record file:
            1. Upload copy of issued letter.
            2. Document a non-billable note indicating letter issuance.
    d. CM must notify the HH regarding the issuance of a DOH 5235 Notice of Determination to the member, according to the Health Home's policies and procedures. Refer to: *BCHN010: Health Home Notice of Determination Fair Hearing Policy.*
    b. CM must clearly document a note of the HH notification in the Members Care Management Record file.
    c. Upload a copy of the DOH 5235 to the Members Care Management Record.
    d. Effective Date of Disenrollment, is 10 days after Notice is sent to the Member.
        i. If no response is received from the member, CM will proceed with disenrollment in the member's Care Management Record.
        ii. Refer to **Member Disenrollment General** section to complete disenrollment.

Disenrollment of Deceased Member

Upon discovery of a deceased member a CM must meet all requirements indicated in the **Member Disenrollment General** section. There are areas that cannot be completed by the CM due to the member being deceased and a CM will ensure at minimum the following are completed:

1. Notify CMA Supervisor of event.

2. Upload verifying documentation of the event.

3. Provide written notification to the Care Team as indicated in **Member Disenrollment General**, step 6.

4. Complete a note in the Member's Care Management Record indicating:
    a. Event discovery.

b. Communication with Supervisor.
c. Written notification of completion to Care Team to end enrollment.

5. Supervisor will notify BCHNHH Systems Analyst and Operation Manager per **Member Disenrollment General,** step 10.

6. Supervisor will verify procedures are completed in full and complete member disenrollment from services.

Disenrollment Post Diligent Search Efforts (DSE) Status

Upon completion of DSE procedures found in *BCHN008 Continuity of Care and Re-Engagement of Enrollment Policy* a CM must meet all requirements outlined in the **Member Disenrollment General** section.

CM must follow procedures found under **HH and/or CM Decision to Disenroll Member.**

Disenrollment for Members Found in Excluded Setting During Diligent Search Efforts (DSE) Status

When member is in an excluded setting (e.g., inpatient, hospitalization, institution or residential facility; incarceration; nursing home, etc.) and the length of stay is anticipated to be longer than six months the CM must meet all requirements outlined in the **Member Disenrollment General** section.

Prior to disenrolling the member will complete the following:

1. CM will connect with member in the excluded setting (if possible).
2. Obtain member consent to communicate with the entity/care providers in the Excluded Setting.

These steps will allow for the CM to complete procedures outlined in the **HH and/or CM Decision to Disenroll Member** section for disenrollment completion.

Within this procedure the Excluded Setting entity or care providers added to the DOH 5055 consent become a member of the members care team.

Post Disenrollment Re-engagement

1. If a disenrolled member is later identified by the MCO, HH, or CMA as eligible for re-engagement in HH services, and chooses to re-enroll into the HH Program, continuity of care should be supported by connecting the member back to the HH.
    a. If able member should be assigned to the CMA/CM last enrolled to be re-connected with the CMA/CM that last served the member, whenever possible.
    b. If the member wishes to be enrolled with a different CMA, or CM (e.g., the reason for the prior disenrollment was due to member dissatisfaction with the CMA or CM and could not at that time be resolved).
        i. Policies and procedures must be in place to assure a timely connection to the HH/CMA of choice.
        ii. A period of up to 3 business days is allowed for such referrals to occur.
    c. CMA receiving new assignment should work with the member to add their previous CMA to the DOH 5055 consent.

i. If member consents, CMA should schedule a warm handoff with the member and previous CMA to prevent any potential disengagement of the member.
ii. If available previous CMA should provide any pertinent documents needed to appropriately serve the member within 14 business days to allow for scheduling a warm hand-off.

d. A warm hand-off can be in the form of a call or face to face meeting between the member, past HH or CMA and the new HH or CMA, or in the form of a Team Meeting with involved providers.
e. Ultimately, consideration must be given to member choice and to identify the most appropriate and direct pathway for re-engaging individuals back into CM services.

f. The member's situation at the time of re-engagement must be evaluated.
i. Once a member has been disenrolled from the health home program and has been re-referred for HH services the CMA/CM should refer to the *BCHN002: Health Home Referral, Eligibility, Assignment & Outreach Policy.*
g. CM must consider what will help to remove any barriers to enrollment and minimize the potential for an otherwise avoidable or unnecessary future disenrollment.

G. COMMUNICATION/TRAINING/IMPLEMENTATION

HH and CMA staff must receive training on protocols related to discharge planning for disenrollment from the Health Home Program including, but not limited to:

- identifying members that no longer require or desire to receive continued CM services;
- determining members appropriate for transitional care and the process to create and manage a transition plan;
- establishing post disenrollment and safety plans including reengagement of disenrolled members;
- protections related to member privacy and sharing of PHI;
- conducting oversight of the CMAs disenrollment process;
- billing requirements related to member disenrollment;
- Use of HH consent(s) and issuance of the Notice of Determination (NOD) during disenrollment process.
- Quarterly Trainings will be provided by BCHNHH to review policy and procedure, and related resources.
- Attestations will be signed after distribution and review of new and updated policy and procedure.

H. Quality Management & Performance Improvement

QMP Committee:

- Will review and update policy and procedure, at minimum, annually.
- HHs must evaluate patterns related to member disenrollment within its own network and establish quality monitoring activities to evaluate practices and address issues identified.
  - HHs must work with their network CMAs to assure a method is in place for accessing information needed to conduct quality monitoring activities.

Quality Assurance:

- HHs will review CMA activities surrounding disenrollment.
- HHs must include review of members who routinely move in and out of HH enrollment if it occurs within the same HH.
- Quality Reviews will be conducted by BCHNHH to ensure the following:
  - reason(s) that led to member disenrollment, for example:
    - CM services are no longer desired or utilized by the member;
    - Member no longer meets HH eligibility or appropriateness criteria;
    - Lack of appropriate CM activities to support core HHCM services;
    - Member requires alternate level or type of services.
  - Identify patterns for disenrollment;
  - Appropriateness of steps taken by CM to complete the disenrollment process to include protection of member PHI and rights associated with ending enrollment with the Health Home program;
  - CM supervisory involvement.
  - Use of transitional planning to help member prepare for disenrollment;
  - Completion of required documents;
  - Management of member refusal/inability to participate in disenrollment activities;
  - Notification to member's care team and outcome of case reviews;
  - Member's plan of care was updated;
  - Member status updates in MAPP HHTS;
  - Appropriate billing activities;
  - Timely notification to HH for issuance of NOD, as applicable;
  - QA plan including implementation timeline to address outcomes identified through quality monitoring activities;
  - Appropriate training is provided to HH and CMA staff in response to outcomes identified through the HH's quality monitoring activities.
- Concerns within the policy will be discussed at the QMP Committee meeting. The QMP Committee will work together to come to an agreement about the best way to proceed with a change.
- The lead HH is required to draft and finalize all policy and procedure.

I. RELATED FORMS

The following DOH Health Home Consent forms are used for disenrollment from the HH program:

- *DOH 5235 Notice of Determination for Disenrollment in the NYS Health Home Program*
- *HIXNY Withdrawal of Consent Form*
- *BCHNHH Disenrollment Summary*
- *BCHNHH Provider-Care Team Disenrollment Notification Letter Template*
- *BCHNHH Inter-Agency Transfer Disenrollment Letter Template*
- *BCHNHH Member Disenrollment Letter Template*