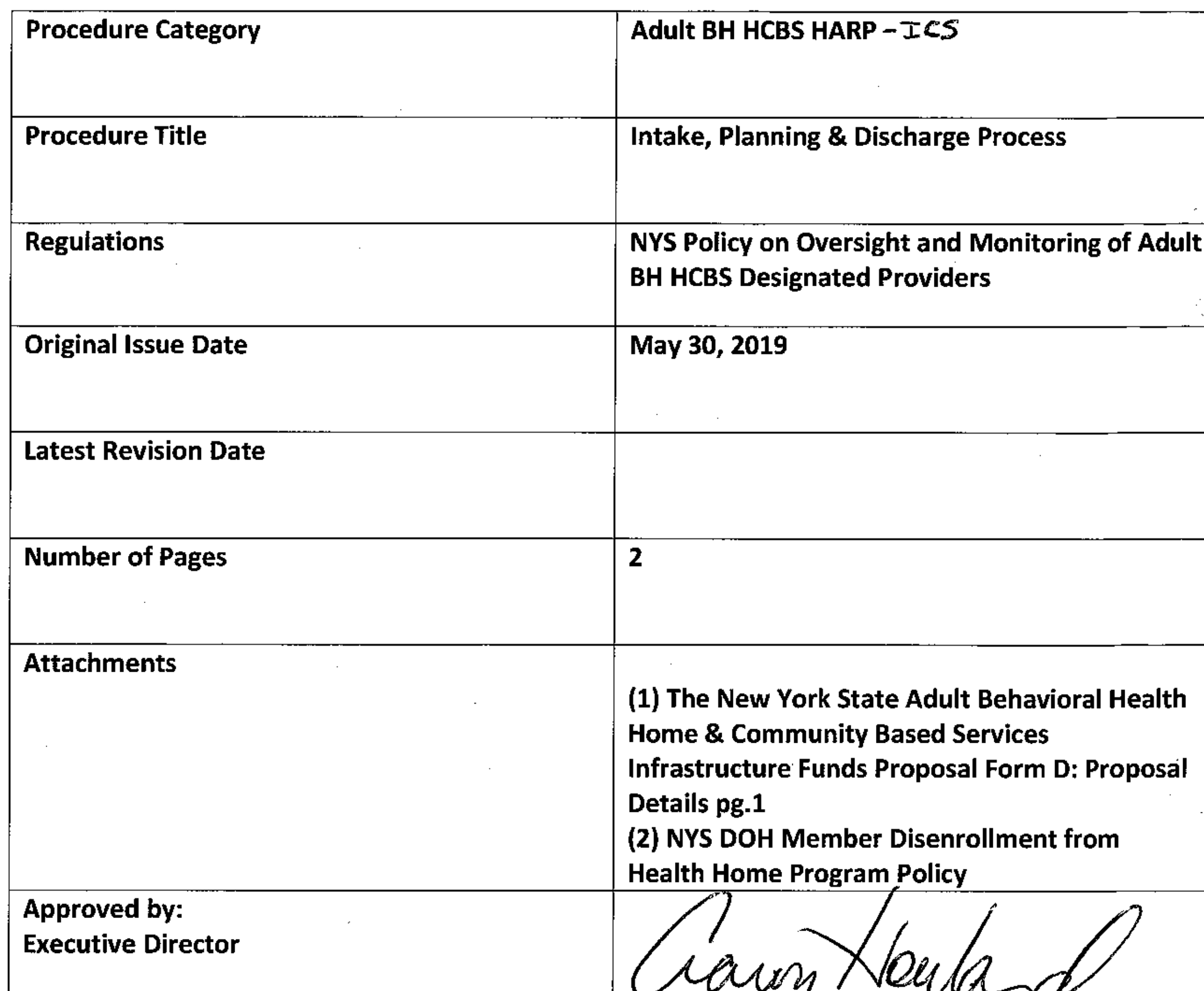
Catholic Charities Disabilities Services

Agency Procedure



Procedure Category	**Adult BH HCBS HARP – ICS**
Procedure Title	**Intake, Planning & Discharge Process**
Regulations	**NYS Policy on Oversight and Monitoring of Adult BH HCBS Designated Providers**
Original Issue Date	**May 30, 2019**
Latest Revision Date	
Number of Pages	**2**
Attachments	**(1) The New York State Adult Behavioral Health Home & Community Based Services Infrastructure Funds Proposal Form D: Proposal Details pg.1** **(2) NYS DOH Member Disenrollment from Health Home Program Policy**
Approved by: **Executive Director**	

Introduction: The following procedures relate to the intake, service planning and development, service documentation, communication and collaboration with Health Home Care Managers and/or Recovery Coordinators and the process for discharge.

Intake: HARP eligible members are agency contact information which consists of a HARP designated phone and email mode of commutation, from their care manager/recovery coordinator for referral for agency approve BH HCBS services to include the member's plan of care.

The HARP Coordinator will work with the member and their care manager/recovery coordinator on completing the Individualized Service Plan (ISP) to determine scope, frequency & duration of HCBS services through a person centered approach at the initial face to face meeting. Once ISP is developed the coordinator will send the ISP and plan of care to the members MCO for approval of services.

Once approval of services is received from MCO the coordinator will assign the member a HARP provider to schedule initial face to face meeting.

All time frames of intake actions and source of referrals will follow The New York State Adult Behavioral Health Home & Community Based Services Infrastructure Funds Proposal Form D: Proposal Details **(1).**

Crisis and Emergency Assistance: The agency operates a 24/7 community on call phone held by the Director of Individualized Community Service's or designee. Member will be provided with this phone number during the intake meeting to use when in crisis or an emergency for guidance and appropriate follow through.

Discharge- The agency will follow the NYS DOH Member Disenrollment from Health Home Program Policy **(2)** for discharges for HARP members receiving HCBS services from this agency in addition we will work closely with the member and their care manager to identify other provider's intra/inter agency to meet the continued or new need for services.

Office of Mental Health | Office of Alcoholism and Substance Abuse Services

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New York State Adult Behavioral Health Home & Community Based Services Infrastructure Funds Proposal

Form D: Proposal Details

Please refer to the Application Instructions for complete details on completion of each item.

Proposal Details

a. Proposal Funding Category (check all that apply)

☑ Access and Infrastructure Development

☐ Crisis Services Development

b. Proposal Narrative

The Catholic Charities Care Coordination Services (CCCCS) HARP Team has been in place for over two years and has demonstrated a high level of success completing assessments, working with MCO's and HCBS providers, and linking clients to services. CCCCS would assume the SDE/Assessment role for CDPHP. We propose the use of BH HCBS quality funds to add the dedicated resources of two HARP Assessors, serving Albany, Rensselaer, Columbia, Greene, Schenectady and Saratoga Counties. Our existing HARP Coordinator and HARP Assessor assigned to enroll CCCCS HARP clients will serve as "backups" if primary staff are unavailable for some reason.

The CCCCS HARP Assessor would collaborate with CDPHP care management staff on a weekly basis to identify HARP enrolled clients not currently enrolled in health homes. The Assessors would conduct minimally 10 HARP Eligibility Assessments weekly, including same day appointments completed in the clients choice of setting (home, office, hospital, etc); upon completion of assessments, the Assessors will refer to a health home (if client is agreeable) or notify CDPHP case management of health home refusal and subsequently follow through with the submission of LOSD and preliminary Plan of Care within 24 business hours of assessment. While awaiting CDPHP approval of preliminary Plan of Care, if the approval is not received within two business days, the Assessor will contact the member to maintain member engagement. Upon receipt of approval of the preliminary Plan of Care, CCCCS will contact the member with choice of providers. If the member is approved for CCDS authorized HCBS services, and is available on the list of choice providers the expedited process of service provision would be offered to the member. If CCDS is not the choice provider for the member, the Assessor will complete referral to choice provider within 1 business day.

Catholic Charities Disabilities Services (CCDS) is an authorized BH HCBS provider within Schenectady, Albany and Rensselaer Counties, but due to lack of referrals has been unable to successfully offer BH HCBS services. We propose the use of BH HCBS quality funds to support one HARP Coordinator and one FTE resource of HARP Support Professional(s). The CCDS HARP Coordinator will provide the CCCCS HARP Team a calendar of available appointments on a weekly basis. CCCCS HARP Assessors will utilize this dedicated calendar to use secured communication to schedule intake/assessment appointments for BH HCBS services to those members who choose CCDS as their BH HCBS provider while meeting with member and offering choice of provider. The appointment will be set for no less than 24 hours from the time of this meeting. For referrals whose source is SDE/HH's other than CCCCS, CCDS will receive these through a dedicated email box, fax or phone, and provide assessment appointment to the referring SDE/HH.

CCCCS and CCDS will partner in offering secured electronic calendar appointments and communication to expedite the assessment/intake appointment and further communication. CCDS HARP Coordinator will provide electronic confirmation of the calendar appointment sent by the CCCS Assessor, who will notify the member of the appointment confirmation. If the intake assessment appointment is more than 2 days from the time of the confirmation, due to whatever factors, including member availability, the Assessor will maintain member engagement by offering the member a reminder of the appointment 1-2 days before the appointment. Health Services Research found that text message reminders increase appointment attendance by 50%. CCDS Coordinator will complete intake/assessment and submit to CDPHP for approval. Concurrently CCDS will submit the intake/assessment to CCCS using secured electronic communication, so that the HARP Team can prepare for Plan of Care Development. While awaiting assessment approval, CCDS Coordinator will identify 1 or more HARP Support Professionals who would be a good match for the member and are already trained and qualified to provide BH HCBS services.

Upon receipt of assessment approval, the CCDS Coordinator will send the approved assessment to the CCCCS HARP Team. Within 7 business days of receipt of assessment approval, CCDS Coordinator will set an appointment for an initial service meeting to meet with the member and introduce the identified HARP Support Professional. This meeting allows for a "warm hand off" for the member and kicks off HCBS services. The identified HARP Support Professional will confirm the initial service meeting 1-2 days prior to the appointment, in an effort to foster and maintain member engagement.

CCCCS will complete the full Plan of Care within two business days of receiving the HCBS service approval and fax it to CDPHP. As needed CCDS will submit for additional services to CDPHP. CCCCS will develop care plan amendments as needed. We propose the added resources of a .25 FTE dedicated billing specialist to support billing and of the expedited assessment, enrollment and service delivery process.

The establishment of this partnership between CCCCS and CCDS will allow for expedited assessment, enrollment and service delivery to begin in as little as 7 business days from initial contact, as described below.

Day 1 - Identification of HARP eligible member and same day appointment with CCCCS. Submission of preliminary Plan of Care by CCCCS to CDPHP.
Day 3 - **estimated time based on historical response from CDPHP** Approval of preliminary Plan of Care received by CCCCS from CDPHP. CCCCS sets appointment with member.
Day 4 - CCCCS meets with member, offering choice of provider. Member selects CCDS. CCCS sends appointment for intake/assessment to CCDS. CCDS confirms appointment.
Day 5 - CCDS completes intake/assessment with member and submits to CDPHP for approval. CCDS also sends assessment to CCCCS. CCDS identifies qualified and trained HARP support professional to provide HCBS services, if approval is received.
Day 6 - **estimated time based on reported response from CDPHP** CCDS receives approval to delivery HCBS services. CCDS sends approval to CCCCS who then begins Plan of Care development. CCDS contacts member and sets up initial service meeting.
Day 7 - CCDS Coordinator and Support Professional meet with member and begin service delivery.

Policy Title: Member Disenrollment From the Health Home Program
Policy number: HH0007
Effective date: November 1, 2018
Last revised: March 1, 2019

Applicable to: This policy pertains to adults and children enrolled in the Health Home Program.

Purpose

The NYS Department of Health (The Department) is providing this policy guidance to Health Homes (HH) to address the requirements for managing the member disenrollment process.

Health Home 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.

Health Home Care Managers (HHCM) work with members to achieve a level of independence that allows for more active engagement in their healthcare and improves the ability to self-direct care so that a HHCM is no longer needed. 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.

In cases where a HHCM/Health Home Care Management Agency (CMA) is faced with the potential disenrollment of a member who has not reached their goals, the possibility of member *retention* must be evaluated, and additional steps taken to ensure a safe transition from HHCM services. Other considerations may be needed for members of special populations (such as HARP eligible/enrolled individuals, HIV SNP, etc.) to ensure their continued safety and engagement in other community services.

Discharge Planning for the disenrollment of a member should be a collective process consisting of the member, member's Medicaid Managed Care Plan (MMCP), member's care team and supports. Disenrollment must include steps to assure: member choice; member notification; provision of essential post disenrollment care and service information; protection of member Protected Health Information (PHI); following timelines and billing procedures; etc. Disenrollment activities should be monitored to include identification of high risk populations (e.g., HARP, HIV SNP, etc.) and the potential for member re-engagement following disenrollment, if necessary.

HH must have policies and procedures in place that outline the necessary steps to be taken by CMAs and HHCMs when disenrollment is indicated, and for ensuring safe and appropriate discharge planning. Procedures must include actions to be taken to minimize the potential for untimely member disenrollment whenever possible.

Through ongoing evaluation of their network outreach, enrollment, and retention rates, HHs are in a position to identify and address issues related to premature member disenrollment and must implement strategies for improvements that lead to better member engagement and enhance the overall performance of the HH network.

This policy replaces information previously provided in Medicaid updates and guidance webinars posted on the Department of Health's Health Home website related to this subject matter, as well as information specifically related to disenrollment in the following policy and procedures found in the Health Homes Provider Manual – Billing Policy and Guidance, Version 2014-1:

- **6.8** Health Home Member Disenrollment/Opt Out

NOTE: Although Section 6.8 includes guidance related to both Health Home Member Disenrollment *and* Opt Out, for the purpose of this policy, only information related to *Member Disenrollment* of an actively enrolled HH member will be replaced.

Opt Out refers to situations when an *eligible* individual is approached, provided with information about the Health Home program, and chooses *not to enroll*, thereby *opting out* of Health Home enrollment. The process and form used to Opt Out (DOH 5059) **must not be used** to disenroll actively enrolled HH members.

For more information regarding consent forms used to disenroll actively enrolled HH members (adults and children) please refer to the ***Related Policies and Procedures, Forms, Guidance, and Other Resources*** section of this policy.

Scope

When a member is being disenrolled from the Health Home program, the HHCM maintains responsibility for carrying out the discharge planning for disenrollment. The HHCM must include involvement of the member, the member's parent, guardian, or legally authorized representative (e.g. an adult with a legal guardian, or a child unable to self-consent). All members of the care team, including the CMA Supervisor, lead HH, and the member's MMCP must be included throughout the process to assure an appropriate disenrollment plan is developed and provided to the member. In addition, the HHCM must assure that access to/sharing of PHI ceases.

Related Policies and Procedures, Forms, Guidance, and Other Resources

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

DOH 5058 - Health Home Patient Information Sharing Withdrawal of Consent (Adult)

DOH 5202 - Health Home Withdrawal of Health Home Enrollment and

Information Sharing Consent Form For Use with Children and Adolescents Under 18 Years of Age (children)

DOH 5204 - Health Home Consent Withdrawal of Release of Educational Records (children), if DOH 5203 was completed and signed

DOH 5235 - Notice of Determination for Disenrollment in the NYS Health Home Program

DOH 5230 - Health Home Functional Assessment Consent utilized to enter member's information into the Uniform Assessment System (UAS). Bottom half of the form needs to be completed to withdraw this consent.

The HH website contains various resources referenced in this policy, as follows:

HH consent forms and instructions:

- Lead Health Home Resource Center https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/lead_hhc.htm - under *Forms and Templates*

- Health Home Serving Children (HHSC) https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_children/index.htm - under *HHSC Consent Forms and Templates*

Policies related to *disenrollment*:

- Health Home Quality Management Program policy #HH0003
- Health Home Notices of Determination and Fair Hearing policy #HH0004
- Continuity of Care and Re-engagement for Enrolled Health Home Members policy #HH0006
- Access to/Sharing of Personal Health Information (PHI) and the Use of Health Home Consents #HH0009 https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/index.htm - under *Policy and Standards*

Guidance documents:

Medicaid Analytics Performance Portal (MAPP) https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/mapp/index.htm -

Roles and responsibilities of HH/CMAs/CM/MMCPs in the transfer of HH enrolled members https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/index.htm - under *Health Home Standards and Requirements*

- *Health Home Standards and Requirements for Health Homes,*

Care Management Agencies, and Managed Care Organizations UPDATED November 2017
Re-engagement of members following disenrollment from the HH Program:
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/greater6.htm - Health Home Policy and Updates under *Outreach*

- *Modifications to Health Home Outreach: Guidance and Preliminary Timeline – October 2017*
- *Interim Guidance Addressing Outreach* Modifications – October 2017

Definitions
The following definition(s) is provided as guidance when conducting activities to disenroll members from the HH program.

Disenrollment: Disenrollment from the Health Home program occurs when the enrollment status of a Health Home member ends due to the member's choice to leave the Health Home Program or based on reasons of the HHCM/CMA or HH identified in the *Procedures* section of this policy.

Member: Whenever the term '*member*' is used in this policy, it refers to individuals (adults and children) 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.

Procedures
Enrollment in the Health Home Program is voluntary therefore, individuals have the right to exercise their independent choice to disenroll (e.g. the child/guardian/legally authorized representative and family are no longer interested in Health Home services). Member requests to disenroll from the Health Home Program must be honored and managed by the HHCM through a discharge planning process, whenever possible.

> **Note for Health Homes Serving Children (HHSC):** If an enrolled member is a child under the age of 18 and not able to self-consent, their parent/guardian/legally authorized representative has the responsibility to act on behalf of the child to authorize both enrollment in Health Home services and disenrollment from the Health Home program. Enrolled members 18 years of age and older, or under 18 but able to self-consent because s/he is a parent, pregnant, and or married, may exercise independent choice to enroll and disenroll in the Health Home Program.

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

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

2. member can successfully self-manage and monitor the chronic condition(s) that made her/him eligible for Health Home HHCM services, and no longer needs the intense level of HHCM services (e.g., no longer meets the appropriateness criteria for Health Homes);

   NOTE FOR HHSC: The HHCM can and should review if the member needs the intensive level of care management provided by a Health Home regardless of the acuity used to determine HH Per Member Per Month (PMPM) rate (High, Medium, Low).

3. member has service and support needs that can be met by family/guardian and service providers without the need for formal HHCM services;

4. member is no longer Medicaid eligible or, coverage type is not compatible with Health Homes.

   NOTE: This is **not** the same as when a member's Medicaid coverage has *lapsed*. When a lapse in coverage occurs, the HHCM should make every effort to assist the member in recertifying Medicaid to maintain coverage thereby avoiding an otherwise preventable disenrollment from the HH Program. 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).

5. 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 HHCM;

6. disengaged member is not located after HHCM/CMA conducts required search efforts (as described in *Continuity of Care and Enrolled Member Re-engagement* policy HH0006);

7. member submitted a withdrawal of consent form;

8. member has moved out of NYS;

9. search efforts locate the member 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 *Continuity of Care and Enrolled Member Re-engagement* policy HH0006);

10. member can no longer be served due to issues that affect the safety, health and welfare of the member or HHCM staff serving the member. In this case, the HHCM and 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, HH or CMA which can appropriately meet the member's needs. HHCM and Supervisor are required to involve the HH and MMCP in the process before a determination to disenroll is made; or,

11. member death.

When establishing appropriate activities for completing discharge planning, the reasons for the member's disenrollment must be taken into consideration. Some reasons may require a more comprehensive and integrated approach than others (e.g. the member is graduating versus when a member disenrolls without prior notification).

Note About Assisted Outpatient Treatment (AOT): Members who are on court-ordered AOT must *not* be disenrolled from the Health Home Program without approval from the Local Government Unit (LGU).

HHs must have policies and procedures in place to direct HHCM discharge planning activities through the process of disenrolling members from the HH Program, which must include but are not limited to the following *standard* procedures:

1. through 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.

   NOTE: The HHSC program requires that HHCMs verify each child's Health Home and Medicaid eligibility upon initial referral for Health Home services and monthly thereafter to determine appropriateness and the need for this level of care management services. Reviews should evaluate and consider condition/stability of the child and eligibility criteria for which they entered the Health Home program.

2. direct communication between HHCM/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;

3. support the member's right to make an informed decision related to program disenrollment;

4. document in the member's record reason(s) for member disenrollment, all communication with member related to the reason(s) for disenrollment and his/her response, and steps taken to complete the disenrollment process;

5. complete appropriate withdrawal of consent form(s) as listed in the *Reference* section of this policy. If member is not present to sign the withdrawal of consent, ensure form is provided to the member via appropriate method (e.g. drop off, mail, etc.). Member must be made aware that the date on the withdrawal of consent form(s) indicates the last day of enrollment and the date when all access to/sharing of PHI will cease;

6. notify HHCM Supervisor of any determination of disenrollment (refer to *The Role of the Care Management Agency Supervisor* section of this policy);

7. notify the member's care team including the member's MMCP and HH that the member will be disenrolled and the reason for disenrollment, and the date to end enrollment and cease access to/sharing of PHI;

8. hold a case review with member and care team to discuss disenrollment and establish a post disenrollment plan/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;

9. update member's plan of care to include member disposition, status of goals, discharge/safety plan, and any referrals made/needed, as appropriate;

10. issue written notification to the member on agency letterhead clearly describing the reason for and the date of disenrollment. The notification letter may be provided to the member directly, via mail, or through another method specifically requested by the member. 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:

    a. most recent plan of care including contact information for care and service providers (including contact information for the MMCP care manager who will be providing ongoing coordination of Behavioral Health Home and Community Based Services (BH HCBS) or Children's HCBS);
    b. discharge/safety plan;
    c. any referrals made by CMA/HHCM for new providers/services or the contact information for use by the member post discharge;
    d. a plan for ongoing coordination **if** member is receiving BH HCBS or Children's HCBS;

e. any other documents as appropriate.

NOTE: In the event the HHCM is unable to make contact with the member to discuss disenrollment, the CMA must send the notification letter to the member's 'last known address' (verify member's contact information with the MMCP). 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 in a-f above.

11. assure a warm handoff to the case manager and/or social worker at the PCMH/FQHC/clinic/primary care, etc. occurs for ongoing care coordination support, as applicable.

12. inform member of his/her Fair Hearing rights, as applicable (refer to the *Health Home Notice of Determination and Fair Hearing* Policy);

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

    NOTE: Specific *Billing* procedures apply in relation to the issuance of a Notice of Determination (e.g., aid continuing) and must be followed by HH and CMAs.

    - For more details, refer to: *Health Home Notice of Determination and Fair Hearing Policy. #HH0004*

14. update *Member Status in Medicaid Analytics Performance Portal Health Home Tracking System (MAPP HHTS)*: Upon a member's disenrollment from the Health Home Program, HHs and CMAs must evaluate each event and 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). The members' segment in MAPP HHTS is ended on the last day of the month in which the member is disenrolled from the HH program.

    - Refer to: *Medicaid Analytics Performance Portal (MAPP)* webpage on the Health Home website.

    NOTE: Specific procedures related to MAPP-HHTS must be followed by HH and CMAs in conjunction with the issuance of a Notice of Determination. For more details, refer to the *Health Home Notice of Determination and Fair Hearing Policy.*

HH policies and procedures must direct HHCMs to consider the need for additional steps beyond *standard* disenrollment procedures to include, but are not limited to the following:

1. ***Member Requests Disenrollment***

   If a member chooses to end enrollment in the HH program, the HHCM must also:

   a. ascertain from the member the reason(s) for requesting disenrollment (e.g., dissatisfaction with the HH program, HHCM/CMA; member feels s/he has met goals as per Plan of Care and does not have any new goals that require need for HHCM; member feels s/he is stable and able to self-manage care with family/guardian support, community services and providers without intensive level of HHCM; etc.);

   b. If reason is related to dissatisfaction, work with the member to address and resolve issues to regain member satisfaction and retention, if appropriate (for example: offer member option to change HH/CMA/HHCM and work with member to complete a timely transfer with warm handoff);

   c. hold a care team meeting (unless one has already been held) with the member to discuss and establish linkages to services, discharge/safety plan for post discharge care, if needed;

   d. ask the member to sign forms withdrawing consent (e.g., DOH 5058, **or** DOH 5202, DOH 5204, DOH 5230) identifying the date upon which sharing of PHI must cease, and provide a copy to the member and other party as designated by the member;

      NOTE: If a withdrawal of consent form needs to be sent to the member for signature (e.g. member notified HHCM via phone), the HHCM must document this activity and monitor for the form's return to complete the disenrollment process;

   e. provide option for member to contact HH or CMA in the future to request re-enrollment and provide contact information.

   Important Note: In the event a member refuses or is unable to sign withdrawal of consent to end enrollment and the sharing of PHI, the HHCM must document the details of the member's request to disenroll (e.g. date, means of communicating intent to disenroll, reasons provided, etc.) and refusal/inability to complete the required consent form(s) in the member's record, including all attempts made by the HHCMs to obtain completed and signed withdrawal of consent form(s).

   In addition, the HH/CMA must ensure that in the absence of a completed and signed withdrawal of consent, a copy of the DOH numbered withdrawal form(s) is provided to the member attached to written notification in the form of a letter on agency letterhead containing clear documentation of, at a minimum, the following components:

   - date and means (e.g. phone call, in person, written correspondence, etc.) the member notified CM/HHCMA of their decision to disenroll from the HH program;

- the reason for member's decision, if known;
- attempts made by HHCM to obtain member's signature, without success;
- member's right to request continued enrollment/re-enrollment in the HH program if s/he believes the information is incorrect, and the means for doing so (e.g. contact HHCM, CMA or HH, etc.)
- the right to request enrollment with a different HH, CMA or HHCM and process for doing so (e.g. contact current HH/CMA or MMCP the member is enrolled with);
- directions for member to contact CMA and/or CMA supervisor to discuss the disenrollment process and to request a copy of any pertinent documentation; and,
- thirty (30) day timeline from the date of the letter for the member to respond to prevent disenrollment from the HH program.

Letter must be sent to member's last known address, provided to the member directly or through another method previously established with the member for giving/receiving information.

2. *HH and/or HHCM Decision to Disenroll Member*

Due to reasons identified in the *Procedures* section of this policy, the HHCM or HH may initiate a member's disenrollment from the HH program.

HH policies and procedures must include additional steps HHCMs need to take beyond *standard* disenrollment procedures to include, but not limited to the following:

a. communicate information to the member that clearly defines the reason(s) disenrollment procedures were initiated by the HH or HHCM;

b. seek the member's input into the decision for disenrollment;

> **NOTE**: In the case where the decision to disenroll the member is made by the HH and/or HHCM, a *withdrawal of consent* form would not be obtained from the member.

c. hold a care team meeting with the member to discuss the disenrollment decision and establish a discharge/safety plan for post discharge care;

d. assure proper steps are taken to notify the HH regarding the issuance of the Notice of Determination to the member, according to the Health Home's policies and procedures.
    - Refer to: *Health Home Notice of Determination and Fair Hearing Process policy*

The Role of the Care Management Agency Supervisor
The role of the HHCM supervisor is to assure that HHCM activities support appropriate procedures to disenroll members from the HH program. The HHCM supervisor must:

1. discuss the determination and provide clinical and policy guidance to the HHCM related to the disenrollment process;
2. participate in case reviews and sign off, as appropriate;
3. 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; and,
4. assure notification was provided to the MCO and HH regarding the issuance the Notice of Determination to the member.

Training Requirements
HH and CMA staff must receive training on protocols related to discharge planning for disenrollment from the Health Home Program that includes ways to minimizing potentially preventable disenrollment from occurring, and how to effectively manage the process for member disenrollment including: identifying high risk members; the re-engagement of individuals post disenrollment; protections related to member privacy and sharing of PHI; HHCM Supervisor oversight of the CMAs disenrollment process; Billing requirements; issuance of the Notice of Determination (NOD); and so forth.

Quality Assurance
Through its Quality Management Program (QMP), 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.

HHs will review CMA activities surrounding disenrollment and if there is disproportionate number of disenrollments from a particular CMA or HHCM to include: member satisfaction; barriers in HHCM/CMA practices related to preventing disenrollment such as: capabilities of the HHCM in alignment with the member's needs/goals; if HHCM interventions were appropriate to keep members engaged; If the HHCM has the experience and skillset to work with high risk populations; if a cross-team approach was utilized to reinforce the member's willingness to stay engaged; etc. Additionally, HHs must include review of members who routinely move in and out of HH enrollment if it occurs within the same HH.

HH quality monitoring activities must include evaluation of data related to disenrollment to include but not limited to:

1. reason(s) that lead to member disenrollment;
2. identify patterns for disenrollment (e.g. by subpopulation such as HARP, HIV SNP, etc.);

3. appropriateness of steps taken by HHCM to complete the disenrollment process to include protection of member PHI and rights associated with ending enrollment with the Health Home program;
4. HHCM supervisory involvement;
5. completion of required documents (e.g., discharge and safety plan; withdrawal of consents, etc.);
6. management of member refusal/inability to participate in disenrollment activities;
7. notification to member's care team and outcome of case reviews;
8. member's plan of care was updated;
9. member status updates in MAPP;
10. appropriate billing activities;
11. timely notification to HH for issuance of NOD, as applicable;
12. QI plan including implementation timeline to address outcomes identified through quality monitoring activities; and,
13. appropriate training is provided to HH and CMA staff in response to outcomes identified through the HH's quality monitoring activities.

Post Disenrollment Reengagement

If a disenrolled member is later identified by the MMCP, HH, or CMA as eligible for re-engagement in HHCM services, and choses to re-enroll into the HH Program, continuity of care should be supported by connecting the member back to the HH in which s/he was last enrolled to be re-connected with the CMA and HHCM that last served the member, whenever possible.

If the member wishes to be enrolled with a different HH, CMA, or HHCM (e.g., the reason for the prior disenrollment was due to member dissatisfaction with the HH, CMA or HHCM and could not at that time be resolved), policies and procedures must be in place to assure a timely connection to the HH/CMA of choice. <u>A period of up to 3 business days</u> is allowed for such referrals to occur. HH/CMA must assure a direct and warm handoff of the member occurs to prevent any potential disengagement of the member, including the provision of any pertinent documents needed to appropriately serve the member within 14 business days to allow for scheduling a warm hand-off. 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. Ultimately, consideration must be given to member choice and to identify the most appropriate and direct pathway for re-engaging individuals back into HHCM services.

- Refer to: Health Home Standards and Requirements for Health Homes, Care Management Agencies, and Managed Care Organizations - UPDATED November 2017

The member's situation at the time of re-engagement must be evaluated to determine whether the need for new or updated, complete new assessments, establish a new plan of care, and so forth is needed, especially for high risk/high needs members that are more difficult to engage. When determining what is necessary, HHCMs must consider

what will help to remove any barriers to enrollment and minimize the potential for an otherwise avoidable or unnecessary future disenrollment. Therefore, it is important that HHCMs have the experience and skill level needed to manage varying populations to maintain member engagement and retention.

Protocols for carrying out activities related to re-engagement of members following HH Program disenrollment can be found in the following guidance documents:

- *Modifications to Health Home Outreach: Guidance and Preliminary Timeline – October 2017*
- *Interim Guidance Addressing Outreach* Modifications – October 2017