

**Policy Title:** Member Disenrollment From the Health Home Program

**Policy number:** HH0007

**Effective date:** November 1, 2018

**Last revised:**

**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 Uniformed Assessment System (UAS). Bottom half of the form needs to be complete 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](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](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](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](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](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](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).

**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 no less than quarterly, HHCM must actively review and document in the case record the child's eligibility, 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;
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. document any member refusals or inability to participate in the disenrollment process;
11. 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'

(verifying 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.

12. 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.
13. inform member of his/her Fair Hearing rights, as applicable (refer to the *Health Home Notice of Determination and Fair Hearing Policy*);
14. 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

15. 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).

- 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;
- e. provide option for member to contact HH or CMA in the future to request re-enrollment and provide contact 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 disenrollments 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 chooses 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. A period of up to 3 business days 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*

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