ENCOMPASS FAMILY HEALTH HOME
Care Management
Policy & Procedure Manual

Care Management Policy #16 Discharge/Disenrollment

Effective Date: 07/29/14
Revised Date: 09/15/14, 5/1/16, 9/1/16, 11/1/16

Policy: Encompass Health Home will disenroll Participants who no longer require or meet the eligibility for Health Home services, and will strive to transition Participants to alternate services as appropriate.

Procedure:
Appropriateness/Eligibility and Utilization:

A. Encompass Health Home Care Managers, in cooperation with Participants, Families, Managed Care Plans (MCP) and community providers/supports will assess Participants/Family utilization, need and engagement in services as required.
   1. Care Managers providing services to Children will conduct a quarterly review on the Quarterly Review Form (**see attached**) of the continued need for Care Management services. This will include, but is not limited to:
      i. Condition and stability of the Child;
      ii. Continued Eligibility;
      iii. Progress made towards established goals in the Plan of Care.
   2. Care Managers will attach the form and document reviews in Netsmart, and plan for subsequent needs for discharge.

B. Care Managers will make Supervisors aware of any issues affecting the ability to provide Core Health Home services to a Participant/Family within a calendar month.

C. Supervisors will assist Care Managers with issues related to re-engaging Participants/Family into services.
   1. The Health Home/CMA will make every effort to locate/re-engage with Participants/Family.
      i. Supervisors will assist with making outreach phone calls to Participants/Families;
      ii. Providers/MCP's will be consulted for guidance;
      iii. Letters will be sent out to Participants/Families with whom contact has been lost.

D. When efforts to engage prove unsuccessful, or billing cannot occur for a 3 month period, disenrollment may be an option.

Discharge/Disenrollment

A. Discharge Planning will occur when one or more of the following is identified:
   1. The chronic condition that made the Participant eligible for Health Home is being self-managed and/or maintained;
   2. The Interdisciplinary Team and Participant/Family concurs that the Participant has met the goals identified on the Plan of Care and no longer requires Care Management;
   3. The Participant/Family has needs that are met by services, family and other supports, without the coordination of Health Home Care Management.

B. Other reasons that would prompt discharge/disenrollment include:
   1. Participant/Family is no longer eligible for Health Home and/or Medicaid;
   2. Choice: Participant/Family requests to opt out/dis-enroll;

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3. Participant/Family chooses to not collaborate with Health Home and/or providers;
4. Participant/Family requests transfer to another Health Home/Care Management Provider;
5. Participant/Family moves out of state/service area;
6. Contact lost despite efforts to connect;
7. Long term incarceration/institutionalization;
8. Death.

C. Participant/Family that has been identified as appropriate for disenrollment will be discussed with the Supervisor/CMA.
   1. Supervisor may recommend additional outreach efforts to re-engage the Participant/Family.
   2. Managed Care Plans will be notified of efforts and/or plans to disenroll.

D. Participant/Family that has been determined to be appropriate for disenrollment/discharge will be sent a letter notifying them of the decision.

E. Care Managers will begin the disenrollment/discharge process:
   1. A pre-discharge note will be written in Netsmart, including the date that the Participant/Family was determined to be lost to services if applicable;
      i. Health Home may begin a three month period of outreach and engagement for Participant/Family determined to be lost to services.
   2. All providers will be notified;
   3. Plan of Care will be updated, including efforts to transition and link Participant/Family to needed follow-up services;
   4. Participant/Family will be asked to sign DOH-5058 (Adult) Withdrawal of Consent form, or DOH-5202 (Children) Withdraw of Health Home Enrollment and Information Sharing Consent;
      i. Child Participant/Family will be asked to also sign the DOH-5204 Withdraw Release of Educational Records if appropriate;
   5. Signatures will be obtained as needed on all discharge documentation;
   6. Care Manager will add discharge note to Netsmart;
      i. Discharge note will include a brief explanation of why the Participant is being discharged (including relevant progress made and goals attained); all Comprehensive Transitional Care activities provided during the discharge process; and efforts to refer and connect to services to meet ongoing or unmet needs.
   7. DOH-5058/DOH-5202 (and DOH-5204) will be scanned and attached to the Plan of Care in Netsmart;
   8. Billing will be forwarded to the Health Home Administrative Coordinator (HHAC);
   9. Disenrollment will be reported through the MAPP.