ST. JOSEPH'S HEALTH A Member of Trinity Health ST PETER'S HEALTH PARTNERS A Member of Trinity Health	**Effective Date:** March 1, 2026

Category: **C. Care Coordination**

Title: **6. Case Closure and Re-engagement**

Applies to:

☐ St. Peter's Health Partners (SPHP)

☐ All SPHP Component Corporations **OR** ☐ Only the following Component Corporations: (Click here for a list)
☐ _____

☐ All SPHP Affiliates **OR** only the following Affiliates: (Click here for a list)
☒ **All Community Health Connections Care Management Agencies**

☐ St. Peter's Health Partners Medical Associates (SPHPMA)

Contents

PURPOSE

This policy seeks to clarify when enrolled Members are ready for discharge from Health Home services and when Members are disengaged from Health Home services. The policy also outlines the activities that are required leading up to and at time of case closure.

POLICY STATEMENTS

It is the policy of Community Health Connections that Member cases be closed when the Health Home Member is ready for discharge and has achieved all of his or her care coordination-related goals, the Member is no longer meaningfully engaged in services or the Member is disengaged in Health Home services. This policy seeks to define each situation and outline the steps that must be taken in each situation. Care Management Agencies may have policies that are more specific in place related to case closure; however, these policies must be followed at a minimum.

SCOPE OF AUTHORITY / COMPETENCY

All Care Management Agencies that comprise the Community Health Connections Health Home program.

DEFINITIONS

CES Tool: NYS-required screening for enrolled Members to ensure continued eligibility for the Health Home program

Diligent Search Efforts: Activities undertaken by the Care Management Agency for three months once it is determined that a Member is disengaged from Health Home services

Disengaged: When a Member is not available to a direct contact within the calendar month and this lack of direct contact is out of character for the Member; Any Member who has not had direct contact with the Care Coordinator (or other CMA staff) for two calendar months is considered disengaged

Disenrollment: When enrollment in the Health Home program ends due to Member choice or reasons identified by the CMA (lost to contact, no longer eligible, not meaningfully engaged, etc.)

DOH 5055**:** Health Home Patient Information Sharing Consent Form; the State produced form for capturing consent for other providers as well as natural supports

DOH 5235: Notification of Disenrollment in the Health Home Program; the State developed form that must be completed and sent to a Member prior to his or her case closing due to Health Home ineligibility or inappropriateness, or the Member being lost to contact

Excluded Setting: A sub-status of enrollment in which the Member is in a facility or institution such as a hospital or jail for more than one month but less than six months and will not receive Health Home service during that time and no billing occurs

Graduation: Occurs when a Member achieves his/her goals that supported Health Home enrollment and the Member is ready to self-manage any post-disenrollment care and services needed.

Health Home Candidate: An individual who is in active Client Search (Outreach) status, but who has not yet been enrolled in Health Home services

Health Home Member: An individual who is enrolled in Health Home services

Initial Appropriateness Screening: NYS-required screening to ensure Members meet at least one appropriateness criteria at the time of enrollment or re-engagement from DSE or Excluded Setting

Not Meaningfully Engaged Members: Those who are participating in Health Home services, but are not making progress on Plan of Care Objectives and Interventions and are not benefitting from the Health Home program; these Members may need to be considered for closure

NYSDOH: New York State Department of Health; the regulating State entity for Health Homes

Step-down: The process though which Members, identified as no longer needing the level of intensity of Health Home services, are prepared for disenrollment with a warm handoff to a lower level of care, such as Managed Care Organization services

PROCEDURE

A. Case Closure and Re-engagement during Outreach

1. CareManager is designed to automatically close the charts of Health Home Candidates from Client Search status (Outreach) after two (2) consecutive months of Client Search Status in CareManager, putting them into an “Opt Out” status.

2. There may be times in which a Candidate is outreached with no success and closed; however, the Candidate is re-referred, or contact is made after the case is closed. If the Candidate is re-referred or reaches out in the same month as the opt out, or the month immediately following, the discharge in CareManager may be voided so that the contacts fall under the same Episode of Care. If the Candidate is re-referred or contact is made after the month following opt out, a new Episode of Care must be started. For example, if a Candidate is opted out in January 2020 but is re-referred or contact is made in January or February 2020, the opt out may be voided. If the Candidate is re-referred in March 2020, a new Episode of Care must be started in CareManager.

B. Identifying Members Ready for Disenrollment

1. A Member should be disenrolled from the Health Home program when one of the following occurs.
   a. The Care Coordinator and Member have discussed the current Plan of Care and determined that the articulated goals, objectives, and interventions have been achieved to the extent they can be under Health Home services and there are no additional goals to pursue related to the Member's overall wellness. Care Coordinators and Supervisors may use the Graduation Readiness Questionnaire to help determine if a Member is ready for discharge. (See Attachment A: Discharge Readiness Questionnaire)
   b. The Member refuses to accept services from the Health Home because he or she believes that the goals, objectives, and interventions of the Plan of Care have been met or the Member is no longer meaningfully engaged with Health Home Services.
   c. The Member is no longer eligible to receive Health Home services. (See Policy B2. Outreach and Engagement: Medicaid and Health Home Eligibility)
   d. The Member continually refuses to sign the DOH 5055 Consent, which prohibits care coordination from occurring.[1]

2. Members who refuse to accept services or who are no longer meaningfully engaged with Health Home Services as described in 1b above are those who are not making progress on Plan of Care goals and who are no longer benefiting from Health Home services. The decision to close a Member's case because he or she is not meaningfully engaged should be done on a case-by-case basis. Some questions to consider when deciding to close a case may include the following.
   a. Will the Member be at significant risk in terms of medical, mental health or substance abuse needs if the case is closed?
   b. Although he or she is not making significant progress on Plan of Care goals, is the Member still benefiting from Health Home services?
   c. Are the objectives in the current Plan of Care the objectives that the Member is ready to work towards achieving?

C. Excluded Setting: Hospitalizations and Incarcerations

1. Members who are admitted for an inpatient hospital or rehabilitation program stay or who are incarcerated with an expected discharge/release within six months may continue to be enrolled in Health Homes.

[1] The only exception to the requirement to sign the DOH 5055 is AOT Members who are court-ordered to receive Care Coordination services. For more information, see Policy B4. Outreach and Engagement: Health Home Consent and Policy F2. Special Programs: Assisted Outpatient Treatment (AOT).

2. If the admission / incarceration is expected to last for more than one full calendar month, the Member must be moved to Excluded Setting status while inpatient.

3. To determine if an admission/incarceration is expected to last at least one full month or more than six months, the Care Coordinator must attempt to contact the Member or discharge planning staff to confirm the Member's admission/incarceration date and anticipated length of stay and to collaborate on discharge planning.

4. The six-month timeframe is calculated based on the date of admission or incarceration.

5. Except for the month of admission and the month of discharge, the Member's segment in MAPP must be pended and no billing may occur while the Member is admitted / incarcerated. To pend the segment, the Member's case must be placed in Excluded Setting status in CareManager via a Contact Note. When the Member is ready to resume standard Care Coordination services through the Health Home, a Contact Note must be written to move the Member back to Enrolled Status, which will un-pend the MAPP segment and allow the CMA to bill for services.

6. While the Member is in Excluded Setting status, the Care Coordinator (or other staff) must document all communications with the Member and discharge-planning staff made throughout the Member's admission / incarceration, or until the Member is discharged from Health Home.

7. The Care Coordinator must establish a plan for re-engagement in Health Home services once discharged / released or a plan for discharge from Health Home services and inform the Member's consented care team of the plans, including the MCO.

8. When a Member is re-engaging back in Health Home services and is removed from Excluded Setting status in CareManager, the Initial Appropriateness Screening must be completed at the time the Member is moved back to enrolled status.

9. The CMA is permitted to bill at the enrolled rate for the month the Member enters the setting and the month in which the Member is discharged only if a Core Service, in accordance with Policy C1. Care Coordination: Health Home Services, is provided in each month. This is to support care transitions as outlined in C5 above.

   For Members who are incarcerated, billing during the month of admission will only occur if the Core Services was provided BEFORE the date of incarceration.

   For Members who are incarcerated, billing may occur if the Care Coordinator provided a Core Service to support discharge planning in the 30 days prior to release.

10. If the Member's inpatient stay is longer than six months, the Member must be discharged from the Health Home program, in accordance with this policy. Upon discharge from the inpatient facility/criminal justice setting, the Member may be re-enrolled in the Health Home.

For information on billing for Health Home Core Services provided during hospitalizations and inpatient rehabilitation stays, please see Policy E1. Billing and Payment: Billable Services and Billing.

D. Member Disengagement

1. During supervision, Supervisors should review cases with staff to help them determine which Members are disengaged from services.

2. A Member is considered disengaged from Health Home services when the Care Coordinator has not had direct contact with the Member during the calendar month despite multiple attempts to reach the Member, and this lack of engagement is out of character for the Member.

3. Before determining someone is disengaged, the following should be considered on a case-by-case basis.
   a. Past patterns of inconsistent attendance with scheduled appointments despite reminders provided
   b. Living situation that is unstable and changes frequently
   c. Lack of consistent access to a phone or numbers change frequently

4. A Member must be considered disengaged from Health Home services when the Care Coordinator has not had direct contact with the Member throughout two (2) calendar months despite multiple attempts to reach the Member.

5. If the Member presenting as disengaged is new to Health Home services, meaning he or she was enrolled within the last two (2) months, the Care Management Agency may make the decision to place the Member in DSE or simply close the Member's case in accordance with Section G of this policy. This decision must be made with a supervisor and factors such as level of engagement during past successful contacts and information obtained on the Member to date should be considered (contact information, risk factors, etc.).

6. For Members enrolled for longer than two (2) months who present as disengaged, the CMA may make an informed, Member-specific decision to either move the Member to Diligent Search Efforts (DSE) status or complete a CES Tool indicating lack of Member engagement.

a. Moving Members to DSE will allow the CMA to bill at the enrolled rate for up to three months while diligent efforts are executed to locate and re-engage the Member.
b. Completing a CES Tool will allow the CMA to move to discharge shortly after the tool completion, anywhere from ten (10) days to 60 days post-tool completion and Recommended Disenrollment outcome.

7. When determining if DSE will be pursued or the CES Tool completed, staff and supervisors should take the following into account.
   a. Past patterns of disengagement (if frequent, CES Tool may be the appropriate path)
   b. Member acuity and risk factors (if the Member is high risk or staff are concerned about the Members safety, DSE may be the appropriate path)

8. Once a decision is made to move a Member to DSE, a Contact Note must be written in the Member's chart in CareManager, indicating a status change to Diligent Search Efforts. This will pend the Member's MAPP segment with the reason type of "Pended due to Diligent Search Efforts" however billing will be able to occur as long as the requirements in Section E of this policy are satisfied. This should be done on or around the first business day of the month following the one (1) to two (2) months of disengagement despite attempts.

9. Once a decision is made to complete a CES Tool and move to discharge, the case closure requirements in Section G of this policy must be followed, including sending the Member the DOH 5235 at least ten (10) days prior to closure and within five (5) days of the determination of disenrollment.

10. As described in Section C of this policy, Members who are inpatient at a facility such as a hospital, institution or nursing home or are incarcerated, are not considered dis-engaged and the Diligent Search procedures in Section E of this policy do not need to be followed for those Members.

E. Diligent Search Efforts

1. After a Member is moved into Diligent Search Efforts status (DSE), DSE must commence and last for up to three (3) consecutive months, or until the Member is located and a discussion results in he or she dis-enrolling from the program, or re-engaging with Health Home services.

2. While Diligent Search Efforts are ongoing, Care Management Agencies may bill for the Member at the Member's enrolled rate if and only if, three (3) of the Diligent Search activities listed on the Plan are conducted each month. Activities must be progressive in nature and vary to assure all opportunities to locate the Member are exhausted. The following provides some suggestions of what might DSE activities

might be pursued, however activities must be specified to the Member and what is appropriate for them.

a. The Lead Health Home and Member's MCO are notified of the Member's disengagement and the commencement of Diligent Search Efforts (***must be completed during Month 1 of Diligent Search***). See Attachment C for a list of MCO contacts. *If the Member did not sign consent for the MCO, the required information (as indicated in Attachment C) must be submitted to the Lead Health Home for MCO notification.*
b. An attempt is made to locate the Member face-to-face at his or her last known address.
c. Phone contact is made with the Member's Care Team/Service Providers to obtain information on the Member's whereabouts.
d. The Local Government Unit (LGU) or Single Point of Access (SPOA) is contacted to determine if the Member has been brought to their attention.
e. Other collaterals, family members, emergency contacts, social supports, etc. are contacted to obtain information on the Member's whereabouts.
f. The Member's Parole or Probation officer is contacted to obtain information, if applicable.
g. Online database or resources such as WebCrim or NYS Find an Inmate are utilized to determine if the Member has been incarcerated.
h. Other know locations the Member may frequent are contacted, such as schools, methadone clinics, etc.
i. Other activities or contacts that would help the Care Coordinator to get in direct contact with the Member.

3. During Month One (1) of DSE the Care Coordinator – or other CMA staff – must notify the Member's MCO that the Member has been identified as disengaged and Diligent Search Efforts are commencing. Each MCO has its own requirements for reporting that a Member is in DSE status. The requirements for each MCO can be found on the Health Home website site under "MCO Contacts."

4. This required MCO notification means that the Member's MCO must be on the DOH 5055. If the Member refuses give consent to the MCO this refusal must be documented in the Member's chart in CareManager (See Policy B4. Outreach and Engagement: Health Home Consent). In these instances, the Lead Health Home must be notified so that the MCO can be alerted. The required information (as found on MCO Contacts document on the website) must be submitted to the Lead Health Home for MCO notification. This MCO notification will count as a billable DSE effort during Month One (1) of DSE.

5. Diligent Search Efforts must be progressive in nature and vary to ensure that all opportunities to locate the Member are exhausted. Once it is determined that all opportunities to locate and re-engage the Member are exhausted, the Member's

case will be closed in accordance with this policy. This may be fewer than three (3) consecutive months.

6. If contact is made with the Member at any point while Diligent Search Efforts to locate the Member are underway, a discussion should occur with the Member regarding his or her current Plan of Care and the goals, objectives and interventions that are ongoing. Attempts should be made to re-engage the Member in working on those outstanding goals, objectives and interventions.

7. If the Member is re-engaged in services, a Contact Note must be written in CareManager changing the Member's status from Diligent Search Efforts to Enrolled. In addition, a new Initial Appropriateness Screening tool must be completed in CareManager.

8. If the Member cannot be re-engaged and the Member chooses to cease services with the Health Home, the steps in Section G of this policy must be followed to close the Member's case.

9. If contact is not made with the Member during the up to three (3) months that the Diligent Search Efforts are underway, the Members case should be closed in accordance with Section G of this policy.

F. Member Re-engagement

1. If at any point, a Member is successfully re-engaged with Health Home services following any period of dis-engagement or lack of contact, upon re-engagement the Care Coordinator must:
   a. Ensure the Member's status is changed back to Enrolled via a Contact Note in CareManager
   b. Complete the Initial Appropriateness Screening in CareManager
   c. Discuss with the Member and document any reasons for the disruption in continuity of care and possible ways to prevent it in the future
   d. Ensure all providers and their consents are still accurate and up-to-date and make changes as needed
   e. Discuss with the Member's care team any issues identified to collaborate on possible ways to prevent reoccurrence and support Member retention and safety
   f. Screen the Member for any additional risk factors and complete the appropriate screening tools and assessments, as indicated
   g. Update the Member's Plan of Care if any changes are identified in the Member's goals, objectives, interventions or needs
   h. Conduct a case review with the Care Coordinator and Supervisor or Care Team, as appropriate

2. If at any point, a Member who was deemed disengaged is located and the Member is inpatient at a hospital or rehabilitation program or is incarcerated or in a nursing home, the Care Coordinator must complete the following activities to support re-engagement when the Member is discharged or released from the setting. In these instances the requirements in Section C of this policy must be followed.
    a. Whenever possible make contact with the Member or discharge planning staff of the setting to provide notification of the Member's Health Home enrollment, confirm the Member's admission/incarceration date and anticipated length of stay, and to collaborate on discharge planning procedures. If these contacts cannot be made, attempts must be documented.
    b. Care Coordinators and Supervisors must review the outcomes of any discussions with the Member or facility staff and establish a plan for Member re-engagement, or member disenrollment.
    c. The Care Coordinator must notify the Member's care team of the Member's current placement.
    d. The Member's Plan of Care should be updated to reflect his or her current status and plan for re-engagement.

G. Documentation Requirements at Case Closure

1. Prior to discharging or dis-enrolling a Member – regardless of the reason for closure – the Care Coordinator must make and document attempts to discuss the Member's current physical, mental and social supports status to ensure that discharge is the appropriate option. The discussion should occur with not only the Member, but also his or her MCO and other consented providers.

2. For Member's graduating or stepping down from services, the Plan of Care must be updated to reflect this status, meaning that Objectives and Interventions are closed as completed or show progress toward completion. Because Plans should be updated in real time, this should largely be completed by the time discharge occurs.

3. Plans of Care must also be reviewed with Members choosing to disenroll from services despite outstanding Objectives and Interventions on the Plan of Care. Members should be offered resources or supports, to the extent available, to accomplish those outstanding Objectives and Interventions post-disenrollment from Health Home services.

4. If the decision is made to discharge a Member because he or she is no longer eligible or appropriate for Health Home services or the Member is closed due to loss of contact, the DOH 5235 *Notification of Disenrollment in the Health Home Program* must be completed and given to the Member at least ten (10) days prior to the actual case closing and within five (5) days of determination of the disenrollment.

Members who are no longer eligible for Health Home services include those who are: enrolled in another Health Home program, or in an excluded setting, or no longer meet Health Home chronic condition eligibility, or no longer have appropriate Medicaid coverage.

Members who are no longer appropriate for Health Home services include those who no longer meet the appropriateness criteria set forth by NYS DOH.

Members who are lost to contact are those who were placed in Diligent Search Efforts in accordance with this policy.

The DOH 5235 Notification of Disenrollment in the Health Home Program is not required and must not be sent if the Member agrees with the closure. The purpose of the DOH 5235 is to inform the Member of their right to contest the decision to discharge. If a Member requests or agrees to discharge, the Member cannot contest the decision.

5. At the time of discharge a letter must be sent to the Member letting him or her know that the case is being closed and that he or she may contact the Health Home to reinstate services or request case documentation. Such documentation may include his or her current Plan or Care, the discharge summary or a list of current providers / referrals made. To ensure no required information is missed in the letter, CMAs must use the template provided in Attachment B of this policy. Letters should be customized, where indicated, to the Member's unique situation at time of closure and must be on agency letterhead.

6. Prior to closing a case and discharging a Member, the RHIO Consent (if the Member has one) must be ended in CareManager. This is done by opening the Electronic HIE consent in the Consent Tab of CareManager, clicking Edit and changing the Client Opt-in/Out drop down select to Client Opt-out. This is the only way to end a consent in the RHIO Provider Portal and it must be done prior to discharging the Member in CareManager.

7. Prior to closing a case and discharging a Member, the Care Coordinator must complete a discharge summary for the Member. The discharge summary, documented in CareManager in the Discharge Tab Summary field, must include the, the events that led up to closure, any outstanding needs at the time of closure, references to documentation sent to the Member at time of closure and providers notified of the closure. In the event that required forms cannot be completed with or sent to the Member due to lack of current contact information such as address, this must be noted in the Discharge Summary.

8. The Member's case must be closed in CareManager via the Discharge Tab by selecting the appropriate closure reason. Closing the case in CareManager will automatically end the Member's current MAPP segment and end date all consents entered into CareManager. Attachment C provides an overview of the discharge closure codes and when each should be used.

See Attachment D for a Discharge / Disenrollment workflow guide.

REFERENCES

New York State Department of Health (March 4, 2019). Continuity of Care and Re-engagement for Enrolled Health Home Members. (https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/docs/hh0006_continuity_of_care_policy.pdf)

New York State Department of Health (March 1, 2019). Member Disenrollment from the Health Home Program. (https://health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/docs/hh0007_member_disenrollment_policy.pdf)

New York State Department of Health (October 2, 2015). Health Home Standards and Requirements for Health Homes, Care Management Providers and Managed Care Organizations. (https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_mco_cm_standards.pdf)

New York State Department of Health (January 9, 2014). Health Home Provider Manual: Billing Policy and Guidance. (https://www.emedny.org/ProviderManuals/HealthHomes/PDFS/Health_Homes_Provider_Manual.pdf)

Approving Official: Senior Vice President, Population Health, Advocacy		**Effective Date: March 1, 2026**
Key Sponsor: Regional Health Home Director		
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Search Terms:		***Reviewed, No Revisions** ****Revised without Full Review**

Replaces: Case Closure
Case Closure and Re-engagement (May 1, 2017)
Case Closure and Re-engagement (June 1, 2018)
Case Closure and Re-engagement (April 15, 2019)
Case Closure and Re-engagement (August 1, 2019)
Case Closure and Re-engagement (June 1, 2021)
Case Closure and Re-engagement (May 2, 2022)
Case Closure and Re-engagement (March 1, 2023)
Case Closure and Re-engagement (December 1, 2023)

Attachment A: Discharge Readiness Questionnaire

ST. JOSEPH'S HEALTH
A Member of Trinity Health

ST PETER'S HEALTH PARTNERS
A Member of Trinity Health

Discharge: Graduation Readiness Questionnaire

Graduation / discharge should be considered when the Care Coordinator and the Member have discussed the current Plan of Care and determined that the articulated goals have been achieved to the extent they can be under Health Home services and there are no additional goals to pursue related to the Member's overall wellness. This questionnaire may be used to help determine if additional goals should be worked on with the Member.

The intention of this questionnaire is not to create set criteria for discharge/graduation. Decisions to discharge someone should be made on a case-by-case basis and discussed with the Member and Care Coordinator's Supervisor. This checklist may serve as a guide when discussing graduation readiness.

Utilization	Yes	No	N/A
Has the Member managed to avoid unnecessary ED visits in the past six months?	☐	☐	☐
Has the Member managed to avoid unnecessary inpatient hospitalizations in the past six months?	☐	☐	☐
Comments:			

Follow-up and Continuing Care	All	Some	None	N/A
Is the Member connected with all needed service providers (medical, behavioral health, substance abuse)?	☐	☐	☐	☐
Does the Member understand who his/her providers are and why s/he would contact them?	☐	☐	☐	☐
Can the Member make appointments independently with the providers?	☐	☐	☐	☐
Does the Member understand the frequency of follow-up that is required for each provider?	☐	☐	☐	☐
Is the Member able to arrange for transportation independently?	☐	☐	☐	☐
Comments:				

Medication Compliance and Health Literacy	All	Some	None	N/A
Has the Member been compliant with all prescribed medications for the past six months?	☐	☐	☐	☐
Has the Member verbalized an understanding of his or her current health conditions, including the risks of poor compliance with medical visits and medications?	☐	☐	☐	☐
Comments:				

Mental Health	Yes	No	N/A
Has the Member demonstrated stable mental health, without decompensation over the past six months?	☐	☐	☐
Has the Member been compliant with mental health providers over the past six months?	☐	☐	☐
Has the patient followed through with treatment recommendations over the past six months?	☐	☐	☐
Has the Member maintained stability without the assistance of crisis management over the past six months?	☐	☐	☐
Comments:			

Substance Abuse	Yes	No	N/A
Has the Member abstained from abuse of substances for the past three months?	☐	☐	☐
Has the Member followed through with smoking cessation services offered?	☐	☐	☐
Comments:			

Finances/Entitlements/Benefits	Yes	No	N/A
Is the Member aware and capable of following through with his or her next recertification for SSI and/or Medicaid?	☐	☐	☐
Is the Member able to manage his or her finances (i.e., pay bills, pay rent, budget, etc.)?	☐	☐	☐
Comments:			

Housing	Yes	No	N/A
Has the Member had stable housing over the past six months?	☐	☐	☐
Is the Member's current housing without major deficiencies or safety issues?	☐	☐	☐
Is the Member's current housing stable without immediate risk of eviction?	☐	☐	☐
Comments:			

Legal and Safety	Yes	No	N/A
Has the Member remained out of danger to him/herself or others for the past six months?	☐	☐	☐
Have domestic violence issues been addressed, including development of a safety plan?	☐	☐	☐
Comments:			

Support and Leisure Activities	Yes	No	N/A
Has the Member identified a support system to assist with need of the Member's chronic conditions?	☐	☐	☐
Is the Member's family or caregivers involved with and aware of the Member's needs and how they can assist as needed?	☐	☐	☐
Comments:			

Additional Assessment	Yes	No	N/A
Has graduation been discussed with other (consented) providers?	☐	☐	☐
Has graduation been discussed with the Member?	☐	☐	☐
Does the Member agree to graduation and demonstrate an understanding of his or her plans post-discharge?	☐	☐	☐
Comments:			

Discharge: Lack of Meaningful Engagement

When Members have goals identified but are not meaningfully engaged with the program and working towards those goals, the following should be considered in the decision to discharge the Member from Health Home Services.

Questions to Consider	Yes	No
Will the Member be at significant risk in terms of medical, mental health or substance abuse needs if the case is closed?	☐	☐
Although he or she is not making significant progress, is the Member still	☐	☐

Questions to Consider	Yes	No
benefiting from Health Home services?		
Are the goals in the current Plan of Care the goals that the Member is ready to work towards achieving?	☐	☐
Comments:		

Required Tasks at Case Closing

If a Member is deemed ready for discharge / graduation from the Health Home Program, please ensure the following activities are completed.

Care Coordinator Closing Tasks	
If the Member's case is closed due to ineligibility, inappropriateness or loss of contact, provide the DOH 5235 *Notification of Disenrollment in the NY Health Home Program* to Member at least ten (10 days) in advance of closing case and upload a copy into CareManager	☐
Regardless of closure reason the CHC Disenrollment Letter must be sent to the Member letting him or her know that the case is being closed. Please be sure to update all information to tailor the letter to your Member and their reason for closure and put the letter on your agency's letterhead.	☐
End the Consent in CareManager by opened the Electronic HIE consent, clicking Edit and changing the value in the Client Opt-in/Out drop down to "Client Opt-out" and save.	☐
Complete a Discharge Summary in CareManager documenting the rational for the case closure. (*Note: If required forms cannot be completed without or sent to the Member due to lack of current contact information such as address, this must be noted in the Discharge Summary.)*	☐
Complete the final HML in CareManager	☐
Review any paper records in the Member's file and ensure ALL documents in the file are uploaded.	
Bring paper chart and written discharge summary to Supervisor for closure.	

Attachment B: Disenrollment Letter Template

INSERT AGENCY LETTERHEAD

Member Name
Member Address
Member Address 2
City, State, Zip

[DATE OF LETTER]

Dear [MEMBER NAME],

This letter is to let you know that you are officially being disenrolled from the Health Home program at [CMA NAME]. Your case is being closed because [INSERT REASON].

This means that effective [CLOSURE DATE] all consents you signed for the program are no longer valid, active consents.

If you need help with care coordination in the future or would like any of the documents we completed together, please contact us at [PHONE NUMBER]. You can also contact any of the numbers below in you need help in the future.

Community Health Connections, your Health Home at [CMA NAME]	[CMA NUMBER]
Your Managed Care Organization (MCO): _____	[MCO NUMBER]
New York State Medicaid Helpline	800-541-2831
New York State Medicaid Choice	800-505-5678
New York State Office of Temporary Disability Assistance (OTDA)	518-473-1090

I have enjoyed working with you.

Sincerely,

CARE COORDINATOR NAME
Care Coordinator

Attachment C: Discharge Closure Codes

Outreach Closure Codes

Code	Code Description	Definition	Examples of Use
2	Candidate opted-out (pre-consent only)	Candidate has voluntarily opted out. Individual does not want to receive Health Home services and case is manually closed in CareManager as "Client Opts Out of Health Home Services"	Candidate expressed s/he does not want to be enrolled in Health Homes
16	Inability to contact/locate Candidate	Candidate is unreachable during outreach attempts and case is auto-opted out in CareManager or manually closed as "Client Opts Out of Health Home Services" due to inability to locate	Closed in Client Search status (before auto-closure) because cannot locate Candidate

Member Decision to Close

Code	Code Description	Definition	Examples of Use
14	Enrolled Health Home Member disengaged from services	Member is considered disengaged when diligent search efforts do not result in location of the Member.	Member's case is closed after entering DSE, or for new enrollments (first 60 days) and DSE is not pursued. *See CHC policy C6: Case Closure and Re-engagement* **DOH 5235 required in these situations**
29	Member withdrew consent to enroll	Member chooses to disenroll from the Health Home program. Also used when Member is moving out of service area but does not want a referral to another Health Home.	The Member chooses to end services. The Member expresses a desire to have their case closed.

Code	Code Description	Definition	Examples of Use
21	Member has graduated from the Health Home program	Member can successfully self-manage and monitor their chronic conditions.	Individual no longer meets the appropriateness criteria, in that they can successfully self-manage and monitor the chronic conditions that made him/her eligible for the Health Home program. These Members are not referred to any step-down programs.
46	Step down to MCO or MTC Care Management	The Member is fully disenrolled from the Health Home program, but receiving MCO care management	This is used specifically when a Member completed step down and was disenrolled from the HH program to an MCO for the provision of care management services
47	Step down to PCMH or other healthcare provider Care Management	The member is fully disenrolled from the Health Home program, but receiving PCMH care management services	This is used specifically when a Member completed step down and was disenrolled from the HH program to their PCMH for the provision of care management services
49	Step Down	For members stepping down and not utilizing care management services	This is used specifically when a Member is stepped down to a program other than a PCMH or MCO program

Member Deceased

Code	Code Description	Definition	Examples of Use
4	Individual deceased	HH has been informed that the individual is deceased	Member deceased, regardless of reason

Transfers to Other Health Home Programs

Code	Code Description	Definition	Additional Explanation
1	Transferred to another HH	Member or potential member is working with or wants to work with another Health Home agency	Member leaves the CHC service area and is no longer within the geographic catchment areas of CHC. Member may or may not be referred to a new Health Home in the new county. This is NOT used when the Member moves out of state.
3	Transferred to another CMA	Member is working with another Care Management Agency within the same Health Home and a case transfer is not being pursued	Used when a CHC case transfer is not pursues and the Member is instead closed and re-referred to another CMA within CHC.
43	Individual moved between HHSC and HHSA	When a Member who previously received services as a child transitions to adult, or an adult transitioning back to HHSC.	An individual previously receiving Health Home services as a child or adult is transitioned to the other program based on individual preferences or age (i.e. child in HHSC services transitions to adult HH services).

Program Compatibility Reasons

Code	Code Description	Definition	Additional Explanation
7	Closed for health, welfare, and safety concerns	Disenrollment due to health, welfare, and safety concerns for member and/or staff (formerly for behavior)	Member is closed due to safety concerns. This closure type will only be used after attempts (involving the Lead) are made to serve the Member safely. **DOH 5235 is required in these situations**
9	Individual moved out of state	Member moved out of New York State	Member no longer resides in NYS.
11	Individual incarcerated	Individual is incarcerated where the length of stay is anticipated to be longer than 6 months	Member will be incarcerated for six months or longer, in accordance with *CHC policy C6: Case Closure and Re-engagement.* **DOH 5235 is required in these situations**
13	Individual is in an inpatient facility	Member is in an excluded setting and the length of stay is anticipated to be longer than 6 months.	Member will be in an inpatient setting (inpatient, hospitalization, institution, nursing home, etc.) for six months or longer, in accordance with *CHC policy C6: Case*

Code	Code Description	Definition	Additional Explanation
			Closure and Re-engagement. **DOH 5235 is required in these situations**
19	Individual doesn't meet HH eligibility and appropriateness criteria	Individual does not/no longer meets eligibility criteria required for enrollment/continued enrollment	This code is used when the Member is no longer eligible, but is not graduating as there are still outstanding goals/ objectives **DOH 5235 may be required in these situations**
24	Individual is not/no longer eligible for Medicaid	Individual no longer qualifies or meets eligibility requirements for Medicaid.	This code should be used *only* when appropriate measures have been initiated to reinstate benefits **DOH 5235 may be required in these situations**
41	Coverage not compatible	Individual's Medicaid coverage is not compatible with HH	See *Guide to Coverage Codes and Health Home Services* for examples of Medicaid coverage that is not compatible with the Health Home program. **DOH 5235 may be required in these situations**
42	Program not compatible	Individual chooses to move to another program not compatible with HH program	Individual chooses to move to another program not compatible with Health Home program or individual is found to be currently enrolled in non-compatible program. See the *Guide to Restriction Exception (RE) Codes and Health Home Services* for examples of programs that are not compatible with the Health Home program. **DOH 5235 may be required in these situations**

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Technical / Administrative Closure Reasons

Code	Code Description	Definition	Additional Explanation
5	Individual has a new CIN	The individual is assigned a new Medicaid CIN	If the Medicaid CIN changes for a Health Home enrolled/outreached individual, the segment should be: 1) ended under the old CIN using this reason, 2) the new CIN should be typed in the comments box, and 3) a new segment should be created using the new CIN.
25	Individual moved from Outreach to Enrollment (can be system generated)	System generated – When an enrollment segment is created prior to the end of an outreach segment the system will automatically end date the outreach segment on the last day of the month prior to the start date of the enrollment segment using this reason code. User selected – When user ends an outreach segment because the individual has been found during outreach.	When user selected, end outreach segment when individual is found and eligible for Health Home services and begin enrollment segment.
28	Health Home change MMIS ID Provider ID	CMA or HH MMIS ID changes within MAPP HHTS	This code is used to indicate that the individual's segment is ended under the old ID and will be started under the new ID with no loss to Health Home services for the individual.
32	Provider Closed	For use when HH or CMA closes business and member is transferred to another HH and/or CMA	Use when a Health Home or CMA closes business and member must be transferred to new Health Home and/or CMA.
33	Merger	In the instance of a merger between two HH or CMAs	This is used in the instance of a merger between two Health Homes or CMAs. Notification of Change Form is used to inform the NYS Department of Health of any changes made to Health Home from originally approved Health Home application and designation letter.
44	Segment Correction	For use only if directed by DOH in order for HH RE codes to be correctly attributed to the member	Only use if directed by DOH - This code should be used when it is necessary to end a segment and create a new one in order for Health Home RE codes to be correctly attributed to the member.

Attachment D: Case Closure Workflow

ST. JOSEPH'S HEALTH
A Member of Trinity Health

ST PETER'S HEALTH PARTNERS
A Member of Trinity Health

The following workflow follows CHC Policy and Procedure C6. Care Coordination Case Closure and Re-Engagement. This document seeks to outline the required paperwork and documentation at time of case closure.

Discharge Readiness
☐ Discuss discharge with the Member to ensure readiness and prepare the Member. This preparation may take more than on meeting or contact – discharge is a process, not an event.
☐ Review the Plan of Care with the Member and update Objectives or Interventions as appropriate. Close out any that were achieved. Be sure to at least leave on the Care Coordination activities so you can continue to document billable notes as needed.
☐ If there are unmet needs, be sure the Member has the appropriate resources or supports in place to address them post-discharge.
☐ Contact any relevant and engaged providers on the Care Team to let them know about the upcoming discharge including the anticipated timeframe. Be sure to solicit for their thoughts on the Members readiness for discharge.
☐ Communicate the discharge to the MCO if applicable. Don't forget that Members with Fidelis may be able to benefit from their telephonic case management services.

Documentation Requirements
☐ If the Member's case is closed due to ineligibility, inappropriateness or loss of contact, provide the DOH 5235 *Notification of Disenrollment in the NY Health Home Program* to Member at least ten (10) days in advance of closing case and upload a copy into CareManager.
☐ Regardless of closure reason the CHC Disenrollment Letter must be sent to the Member letting him or her know that the case is being closed. Please be sure to update all information to tailor the letter to your Member and their reason for closure and put the letter on your agency's letterhead.
☐ If the Member has an active Hixny Consent, end the Consent in CareManager but opened the Electronic HIE consent, clicking Edit and changing the value in the Client Opt-in/Out drop down to "Client Opt-out" and save.
☐ Complete a Discharge Summary in CareManager documenting the rational for the case closure. The summary will essentially be a summary of everything you did in terms of Discharge Readiness. *(Note: If required forms cannot be completed with or sent to the Member due to lack of current contact information such as address, this must be noted in the Discharge Summary.)*
☐ Complete the final HML in CareManager.
☐ Review any paper records in the Member's file and ensure ALL documents in the file are uploaded.
☐ Bring paper chart and written discharge summary to Supervisor for closure.