Policy Title: Member Disenrollment From the Health Home Program
Policy number: HH0007
Effective date: November 1, 2018
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Applicable to: This policy pertains to adults and children enrolled in the Health Home Program.

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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. Wherever 'member' is mentioned throughout this policy it also includes the Parent, Guardian and/or Legally Authorized Representative for those children under the age of 18 years old and who cannot self-consent.

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 HHCM services are no longer needed. The duration of member enrollment is determined by the member's goals, taking into consideration their needs and preferences including the impact of social determinants of health on the member's ability to fully engage in and manage their own care and services. From the point of engagement, HHCMs need to discuss with members the process of moving forward toward disenrollment which includes graduation from the Health Home program and stepping down to a less intensive care management program such as a Patient Centered Medical Home (PCMH) or Medicaid Managed Care Plan (MMCP). 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 (e.g., member choice), steps must be 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, HCBS, 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 (or Parent, Guardian, Legally Authorized Representative), member's Medicaid Managed Care Plan (MMCP), member'scare team, and supports. All communication must be reciprocal in nature to ensure responsibilities are clearly defined. Disenrollment must include steps to assure: member choice; member

notification; provision of essential post disenrollment care andservice 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, HCBS, HIV SNP, etc.) and the potential for member re-engagement following disenrollment, if necessary.

HHs must ensure that CMAs have policies and procedures in place that outline the necessary steps to be taken to identify members for disenrollment including those eligible for graduation or step down, and for ensuring safe and appropriate discharge planning procedures are implemented and monitored.

Through ongoing evaluation of their network performance related to enrollment and retention rates, HHs must identify and address issues related to member disenrollment and must implement strategies for improvements that enhance the overall performance of the HH network.

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 previously issued versions of this policy.

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. Additionally, for children policies specific to children/youth enrolled in HCBS, refer to policies listed on the 1915(c) Children's Waiver website, Overview of 1915c Children's Waiver and 1115 Waiver (ny.gov)

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 ensure an appropriate transition plan is in place and monitored to support the member's disenrollment and post disenrollment plan. 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 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

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NOTE: For information related to previous use of forms for disenrollment, refer to the December 17, 2021 version of this policy, which can be accessed via the Health Home

Policy and Updates webpage at:
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/greater6.htm - under ARCHIVE

The HH website contains various resources referenced in this policy:

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*:

Policies and procedures can be found on the *Health Home Policy and Updates* webpage at:
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/greater6.htm

- Health Home Quality Management Program policy #HH0003 under: *Performance and Quality Management*
- Health Home Notices of Determination and Fair Hearing policy #HH0004 under: *Eligibility*
- Continuity of Care and Re-engagement for Enrolled Health Home Members policy #HH0006 under: *General Health Home*
- Access to/Sharing of Personal Health Information (PHI) and the Use of Health Home Consents #HH0009 under: *Consent*

Guidance documents:

Guidance documents related to the roles and responsibilities of HH/CMAs/CM/MMCPs in the transfer of HH enrolled members can be found:

- *Health Home Standards and Requirements for Health Homes, Care Management Agencies, and Managed Care Organizations*
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/index.htm - under *Health Home Standards and Requirements*

- *Transfer Process Between Health Homes and Waiver Programs for Care Management Services*
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/greater6.htm - under: *General Health Home*

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- *Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS)* https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/mapp/index.htm - *under: Tracking System Updates and File Formats*
- *Overview of 1915c Children's Waiver and 1115 Waiver (ny.gov)*https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/1115_waiver_amend.htm – on the *1915(c) Children's Waiver and 1115 Waiver Amendments* page.

Definitions

The following definitions are provided as guidance when conducting activities to disenroll members from the HH program.

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

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

Member: 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.

Step Down: The process through which members, identified as no longer needing the level and intensity of HHCM services, are prepared for disenrollment to ensure a warm handoff to care and services needed post disenrollment (e.g. PCMH, MMCP, etc.)

Procedures

Enrollment in the Health Home Program is voluntary; therefore, individuals have the right to exercise their independent choice to disenroll (e.g. the member, guardian, legally authorized representative are no longer interested in Health Home services). Member requests to disenroll from the Health Home Program must be honored and managed bythe 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,

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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 the chronic condition(s) that made her/him eligible for Health Home HHCM services, and no longer needs the intensive level of HHCM services (e.g., no longer meets the appropriateness criteria for Health Homes) e.g., graduation

   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's care management needs can be managed through a less intensive level other care coordination such as, PCMH, MMCP, etc. e.g., step down;

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

5. 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).

6. member's care team concurs with the member that all goals have been met and there are no new goals identified that require the support of a HHCM;
7. disengaged member is not located after HHCM/CMA conducts required search efforts (as described in *Continuity of Care and Enrolled Member Re-*

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engagement policy HH0006);

8. member has moved out of NYS;

9. member is in an excluded setting (e.g., inpatient, hospitalization, institution or residential facility; incarceration; nursing home, etc.) and the length of stay is anticipated to be longer than six months (as described in *Continuity of Care and Enrolled Member Re-engagement* policy HH0006) or, 90 days for children/youth who received HCBS;

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 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).

Step Down for HH Members Preparing for Disenrollment

From the point of engagement HHCMs must discuss with members the eligibility and appropriateness criteria that supports HH program enrollment and the process to evaluate for continued enrollment.

Health Homes and network CMAs must have a plan in place for monitoring member activity to identify whether members are: eligible for graduation or for step down to a lower intensity of care management services (e.g. PCMH, MMCP, etc.); in need of continued HHCM services (e.g., to prevent rapid decompensation in the absence of HHCM services); or, step up to a more intensive level of HHCM service (e.g., HARP, HH+ for AOT, HH+ for SMI, HH+ for HIV services; etc.). HHCMs must work with the member and their supports, MMCP, and the care team and hold care conferences as appropriate to ensure all steps are considered whenplans to step down/up, graduate or maintain HHCM services are determined. The entire process must be supported through documentation in the member's record, assessments, evaluations, and plan of

care updates. Graduation and step down mustinclude a process that supports re-

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enrollment of members experiencing decompensation post disenrollment requiring the intensity of HHCM services.

The step down plan supports the disenrollment process by helping members prepare in advance, building on their needs and abilities to facilitate a post disenrollment plan that supports the coordination and continuation of healthcare and services. *Step down*

occurs over a period of time, determined by the member's needs and preferences and includes assessment of the member's ability and strategies for managing their own care and services. Health Homes must have policies and procedures in place that address criteria for identifying members appropriate for step down planning (e.g. members under the 1873 rate category), and how to establish an appropriate plan. The approach must be member-focused, developed collaboratively between the HHCM, member, MMCP, member's care team and supports. A timeline for completing transition activities must be specific to each member's needs and preferences and may require adjustment throughout the step down period.

For members *stepping down* to an alternate or lower level of care management services, the following end reasons will be used:

- Transitioned to PCMH or other Healthcare Provider Care Management
- Transitioned to MCO or MLTC Care Management
- Transitioned to Standard HHCM

For members *stepping down* and not utilizing care management services, the following end reason should be used:

- Member has graduated from HH program

Disenrollment Process

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

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

6. 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;

7. hold a case review with member and care team including MMCP, 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;

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

9. issue written notification to the member on agency letterhead clearly describing the reason for and the date of disenrollment, means for notification to HHCM/CMA by member (Parent, Guardian, Legally Authorized Representative, etc.), the date all sharing of PHI and other information will cease, and how member may request consideration for re-enrollment at a later time, if desired. 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;

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e. any other documents as appropriate.

NOTE: If the HHCM is unsuccessful in attempting to contact the member to discuss disenrollment, the CMA must send the notification letter (per #9 above) 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-e above.

10. 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.

11. inform member of his/her Fair Hearing rights, as applicable.

    NOTE: specific procedures apply in relation to when the Notice of Determination must be issued to the member. Refer to:

    - *HH and/or HHCM Decision to Disenroll Member* on page 11 of this policy under 2b.; and,
    - *HealthHome Notice of Determination and Fair Hearing* policy #HH0004

12. 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 HHs and CMAs.

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

13. update *Member Status in Medicaid Analytics Performance Portal Health Home Tracking System (MAPP HHTS)*. HHs and CMAs must evaluate each event related to a member's disenrollment 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, or a member who has graduated versus stepped down, etc.) The member's segment in MAPP HHTS is ended to show the last day of the month in which the member is disenrolled from the HH program. HHs must have a system in place to track disenrollment reason codes for all member's disenrolled from their network.

    - *MAPP HHTS Segment End Date Category & Reason Codes Crosswalk and Guidance Chart* document can be found on the

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Health Home Policy and Updates page at: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/greater6.htm - under: General Health Home

- Refer to: *Medicaid Analytics Performance Portal (MAPP)* Health Home Tracking System (HHTS) webpage on the Health Home website (expand **Tracking System Updates and File Formats** and see *Appendix D: Segment End Date Reason Codes & Categories* of the most recent MAPP HHTS File Specifications Document) https://www.health.ny.gov/health_care/medicaid/program/medicaid_healt h_homes/mapp/index.htm

NOTE: Specific procedures related to MAPP-HHTS must be followed by HHs 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* #HH0004.

NOTE: For members choosing to transition to a waiver program e.g., NHTD, TBI, or OPWDD, HH/CMAs must also follow steps in the *Transfer Process Between Health Homes and Waiver Programs for Care Management Services* guidance document at: https://www.health.ny.gov/health_care/medicaid/program/medicaid_healt h_homes/policy/greater6.htm - under: General Health Home

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, 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. 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;

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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;

   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 #HH0004*

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 including but not limited to: identifying members that no longer require or desire to receive continued HHCM services; determining members appropriate for transitional care and the process to create and manage a transition plan; establishing post disenrollment and safety plans including reengagement of disenrolled members; protections related to member privacy and sharing of PHI; conducting oversight of the CMAs disenrollment process; billing

requirements related to member disenrollment; use of HH consent(s) and issuance of the Notice of Determination (NOD) during disenrollment process.

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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, for example:
    - HHCM services are no longer desired or utilized by the member;
    - Member no longer meets HH eligibility or appropriateness criteria;
    - Lack of appropriate HHCM activities to support *core* HHCM services;
    - Member requires alternate level or type of services (e.g. PCMH, MMCP, etc.)
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 (e.g., disenrollment occurred timely in relation to member choice);
4. HHCM supervisory involvement;
5. Use of transitional planning to help member prepare for disenrollment, as indicated;
6. completion of required documents (e.g., discharge and safety plan; written notification of disenrollment on agency letterhead sent to the member with required information, etc.);
7. management of member refusal/inability to participate in disenrollment activities;
8. notification to member's care team and outcome of case reviews;
9. member's plan of care was updated;
10. member status updates in MAPP HHTS;
11. appropriate billing activities;
12. timely notification to HH for issuance of NOD, as applicable;
13. QI plan including implementation timeline to address outcomes identified through quality monitoring activities; and,
14. appropriate training is provided to HH and CMA staff in response to outcomes

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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. 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 the *Health Home Standards and Requirements for Health Homes, Care Management Agencies, and Managed Care Organizations*

The member's situation at the time of re-engagement must be evaluated to determine whether a new or updated consent, new assessment(s), new plan of care, and so forth are 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.

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