NEW YORK STATE | Department of Health | Medicaid Redesign Team

Health Home Weekly Webinar

August 3, 2016

Agenda

- Community Based Referral FAQs
- Non Medical Transportation FAQs
- Consent FAQs
- Open Discussion/Next Steps

Community Based Referral

✓ Contacting the individuals' Managed Care Plan (if applicable) or using PSYCKES to confirm Health Home Status- assigned, enrolled, in outreach

- Upcoming PSYCKES flag to indicate "HARP enrolled, not HH enrolled"

✓ If the member is connected to a Health Home, contact that Health Home or Care Manager to notify them of the hospitalization or upcoming discharge.

✓ If referral is needed:

1. Speak with the individual about the benefits of a HH (some HHs will provide scripts)
2. Obtain consent
3. Send referral to the Health Home of choice. Despite assignment, the individual does have a choice of what HH they enroll in as long as the Health Home is in Managed Care Plan's network.

-The HH will then assign a downstream care management provider

OR

Send referral to care management agency of interest

- The Care Manager can then enroll the individual into the Health Home network "Lead HH".

4. If there are barriers to HH linkage, please contact DOH Provider hotline (518) 473-5569.

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MAPP HHTS Tasks – Enrolling members in Hiatus Outreach

- If a member in a hiatus outreach segment with your HH agrees to enroll with your HH:
  - Create an enrollment segment using the online options **OR**
  - Submit a create record in the tracking file upload to create the enrollment segment
- What to do if a member in hiatus outreach with another HH:
  - Contact the other HH and request that the HH end the member's hiatus outreach segment
  - Once hiatus outreach segment is ended, submit an enrollment segment using the referral wizard
  - **HHs should be prepared to conduct this process over the phone**

MAPP-HHTS Enrollment Tasks

- Health Homes
  - Currently require manual phone contact
  - Hiatus segments must be end dated prior to enrollment segment being created
- MCOs
  - When a referral is created it is imperative that an approval is made as quickly as possible
  - Plans must approve a new referral or reassignment for the HH to assign individual to a CMA
- http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/mapp_webinar_5_24_2016.pdf

MCO Feedback

- PSYCKES Access LIMITED

- All Plans are required to have a dedicated Health Home Phone Line
  - Next steps: crosswalk of MCOs and Home Contact Information
  - Perhaps added to MCTAC MCO contact grid

FAQ- Non Medical Transportation

FAQs

What number should we list as the designated phone contact for health homes to populate the transportation grid?

- The number listed on the Non-Medical Transportation (NMT) Grid should direct the Transportation Manager (LogistiCare or Medical Answering Services) to the Utilization Manager/Care Manager staff at the MCO that have reviewed and approved the Plan of Care (POC) and/or sent the completed Grid.

Who will be calling this number (e.g. the member, health home, CMA, or LogistiCare)? What reasons would we be contacted about transportation?

- A contact number should be included for the MCO in the event that LogistiCare (or MAS for ROS) has questions about the Grid that has been sent from the MCO or needs more information in order to approve the NMT.

FAQs

When requesting non-HCBS transportation (i.e. specifically tied to a goal, time-limited, non-routine), requests must include the trip frequency with start and end dates, all of which should be included in the POC... How is that level of detail available, particularly since we're accepting partial POCs that are based off of the HCBS brief assessment?

- The NMT Grid should be completed with the information that is currently available, i.e. it may initially only include transportation for the initial appointments for admission assessments with BH HCBS providers. Once frequency, duration and scope is determined, the Grid should be updated to reflect the new information. The Grid should be revised and re-sent to the Transportation Manager any time there is a change in the individual's need for NMT.

Which party is responsible for completing each section of the grid?

- For individuals who are enrolled in Health Homes, the Health Home Care Managers are responsible for completing the Grid based on the information that they have included in the individual's POC. Care Managers should send the Grid with the POC to the MCO if NMT is included in the POC. The MCO will then send the Grid to the Transportation Manager upon Level of Service Determination or POC approval. The Care Manager will continue to be responsible for updating the Grid when there are changes to the POC that impact NMT, and the MCO will continue to be responsible for reviewing and sending the Grid to the Transportation Manager as a signal of approval.
- For individuals who are not enrolled in Health Homes, the MCO should complete the Grid based on the individual's POC if NMT is included and then send the completed Grid to the Transportation Manager. The MCO will be responsible for updating the Grid and re-sending if there are changes to the POC that impact NMT.

FAQs

What reasons would the MCO be contacted about transportation?

- The MCO may be contacted by the Transportation Manager in the event of questions about the Grid that has been sent by the MCO or for additional information in order to approve the NMT.

FAQs

What's the process to approve the grid? There's no place to indicate approval.

- An MCO will only send the Grid to the Transportation Manager once it has been approved. This signals to the Transportation Manager that the goals, services/activities and locations included in the POC have been approved and therefore the Transportation Manager can approve the trips to such locations.

Does LogistiCare need to be included in member consent forms? What information are we allowed to exchange with LogistiCare regarding the member?

- The information in the Grid is the only documentation that the Transportation Manager needs to approve trips. The MCO should NOT send the Transportation Manager copies of individual assessments or the individuals full POC.

FAQs

How does LogistiCare contact the member? Will they be contacting MCO? Will they be accessing MAPP to pull the member's contact info?

- The Transportation Manager will not have access to MAPP and will not be contacting MCOs for individual's contact information. If an individual is requesting a trip, they will contact the Transportation Manager. The Transportation Manager will verify whether the trip requested can be authorized by checking the Grid that would be on file if it were submitted for that individual.

Given the revised POC submission workflow, what if we get a request for non-medical transportation prior to receiving the full POC, and are not able to confirm the appropriateness of this service against the POC? Can we still approve? (Non-medical transportation may or may not show up on the initial Level of Service Determination request).

- The requests for NMT that would be received prior to receiving the full POC would likely only include trips to BH HCBS providers for the initial admission assessment appointments, and therefore if an MCO is issuing a Level of Service Determination for those services, they should also approve the NMT request by sending the Grid to the Transportation Manager. Once the frequency, duration and scope is determined for the services and the services are approved, the POC is updated and the Grid should also be updated to reflect the necessary NMT trips that support the goals, activities, and services in the POC. Then, the MCO would send the updated Grid to the Transportation Manager.

FAQs

Given the revised POC submission workflow, what if we get a request for non-medical transportation prior to receiving the full POC, and are not able to confirm the appropriateness of this service against the POC? Can we still approve? (Non-medical transportation may or may not show up on the initial Level of Service Determination request).

- The requests for NMT that would be received prior to receiving the full POC would likely only include trips to BH HCBS providers for the initial admission assessment appointments, and therefore if an MCO is issuing a Level of Service Determination for those services, they should also approve the NMT request by sending the Grid to the Transportation Manager. Once the frequency, duration and scope is determined for the services and the services are approved, the POC is updated and the Grid should also be updated to reflect the necessary NMT trips that support the goals, activities, and services in the POC. Then, the MCO would send the updated Grid to the Transportation Manager.

FAQ - Consent

Health Home Patient Information Sharing Consent (DOH 5055)

- The ultimate goal of the Health Home consent form (DOH 5055) is to allow the Health Home to share protected health information (PHI) on the member with other downstream partners agreed upon by the member and identified in the consent form.

- When PHI is properly shared, services can be coordinated based on a reasonable understanding of the member's health care needs and medical history.

Health Home Patient Information Sharing Consent (DOH 5055)

- A DOH numbered form such as the DOH 5055 consent, may not be altered in any way.
  - e.g., use of agency logo, changing original content, attaching forms and other pages, altering DOH form number or date, or adding bar codes are prohibited.

Using the Health Home Patient Information Sharing Consent (DOH 5055)

- The consent must be reviewed with the member to assure understanding and level of comfort with completing and signing the consent.
- The member has the right to refuse to sign the consent. Care Managers need to work with members so they understand the importance of signing the consent.
- If the member limits access or sharing of PHI, this must be clearly indicated on the consent.
- The consent must be tailored to the needs of each member.
- DOH 5055 is available in eight languages, which can be downloaded from the Health Home website: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/forms/index.htm

Completing the Health Home Patient Information Sharing Consent (DOH 5055)

When completing any form with a member, the care manager should:

1. Give consideration to the member's level of understanding and comfort. Legal representation (e.g., guardian) must be involved as appropriate;
2. Use the form in the language most suitable for the member. If the form is not available in the individual's chosen language, assure the presence of an interpreter;
3. Complete all sections of the form as indicated, using full name of Health Home, other entities, phone numbers, etc.;
4. Review the completed form in full with member and assure understanding prior to signing;
5. Provide a copy of the completed and signed form to the member; and,
6. Maintain the original signed form, whether hardcopy or electronic, in the member's record.

Completing the Health Home Patient Information Sharing Consent (DOH 5055)

One of the following options must be used when completing page 3 of the Health Home Patient Information Sharing Consent (DOH-5055):

- Member-centered, including the names of only those downstream providers and other entities approved by the member, with their initial and the date the provider was listed.; or
- A list of all of the Health Home's downstream partners, and any other entities as approved by the member, with the entities the members does NOT want involved in their care crossed out, with the member's initials and the date next to those crossed out.

The Health Home Patient Information Sharing Consent (DOH 5055) – Page 1

NEW YORK STATE DEPARTMENT OF HEALTH
Medicaid

Health Home Patient Information Sharing Consent

Healthy Health Home
Name of Health Home

By signing this form, you agree to be in the Healthy Health Home Health Home. To be in a Health Home, health care providers and other people involved in your care need to be able to talk to each other about your care and share your health information with each other to give you better care. While being in a Health Home will help make sure you get the care you need, you will still be able to get health care and health insurance even if you do not sign this form or do not want to be in the Health Home.

The Health Home may get your health information, including your health records, from partners listed at the end of this form and/or from others through a computer system run by the Healthy Health Home RHIO/PSYCKES program, a Regional Health Information Organization (RHIO) and/or a computer system called PSYCKES run by the New York State Office of Mental Health. A RHIO uses a computer system to collect and store your health information, including medical records, from your doctors and health care providers who are part of the RHIO. The RHIO can only share your health information with the people who you say can see or get your health information. PSYCKES is a computer system to collect and store your health treatment from your doctors and health care providers who are part of the Medicaid program.

If you agree and sign this form, the Health Home and the partners listed on this form are allowed to get, see, read and copy, and share with each other, ALL of your health information (including all of your health information the Health Home obtains from the RHIO and/or from PSYCKES) that they need to give you care, manage your care or study your care to make health care better for patients. The health information they may get, see, read, copy and share may be from before and after the date you sign this form, Your health records may have information about illnesses or injuries you had or may have had before; test results, like X-rays or blood tests; and the medicines you are now taking or have taken before. Your health records may also have information on:

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The Health Home Patient Information Sharing Consent (DOH 5055) – Page 2

Details About Patient Information and the Consent Process

1. **How will partners use my information?**
   If you agree, partners will use your health information to:
   - Give you health care and manage your care;
   - Check if you have health insurance and what it pays for; and
   - Study and make health care for patients better.

   The choice you make does NOT let health insurers see your information to decide whether to give you health insurance or pay your bills. You can make that choice in a separate form that health insurers must use.

2. **Where does my health information come from?**
   Your health information comes from places and people that gave you health care or health insurance in the past. These may include hospitals, doctors, drugstores, laboratories, health plans (insurance companies), the Medicaid program, and other groups that share health information. You can get a list of all the places and people by calling Healthy Health Home, 518-555-5555 or talking to your care manager.

3. **What laws and rules cover how my health information can be shared?**
   These laws and regulations include New York Mental Hygiene Law Section 33.13, New York Public Health Law Article 27-F, and federal confidentiality rules, including 42 CFR Part 2 and 45 CFR Parts 160 and 164 (which are the rules referred to as "HIPAA").

4. **If I agree, who can get and see my information?**
   The only people who can see your health information are those who you agree can get and see it, like doctors and other people who work for a Health Home partner and who are involved in your health care; health care providers who are working for a Health Home partner who is giving you care; and people who work for a Health Home partner who is giving you care to help them check your health insurance or to study and make health care better for all patients. When you get care from a person who is not your usual doctor or provider, like a new drugstore, new hospital, or other provider, some information, like what your health plan pays for or the name of your Health Home provider, may be given to them or seen by them.

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The Health Home Patient Information Sharing Consent (DOH 5055) – Page 2

4. **If I agree, who can get and see my information?**
   The only people who can see your health information are those who you agree can get and see it, like doctors and other people who work for a Health Home partner and who are involved in your health care; health care providers who are working for a Health Home partner who is giving you care; and people who work for a Health Home partner who is giving you care to help them check your health insurance or to study and make health care better for all patients. When you get care from a person who is not your usual doctor or provider, like a new drugstore, new hospital, or other provider, some information, like what your health plan pays for or the name of your Health Home provider, may be given to them or seen by them.

5. **What if a person uses my information and I didn't agree to let them use it?**
   If you think a person used your information, and you did not agree to give the person your information, call one of the partners you have said can see your records or call Healthy Health Home member referral line at (518) 123-4567 or the Medicaid Helpline at 1-800-541-2831.

6. **How long does my consent last?**
   Your consent will last until the day you take back your consent, or if you leave the Health Home program, or if the Health Home stops working.

7. **What if I change my mind later and want to take back my consent?**
   You can take back your consent at any time by signing a Withdrawal of Consent Form (DOH-5058) and giving it to one of the Health Home partners. If you agree to share your information, all Health Home partners listed at the end of this form will be able to get your health information. If you do not wish the Health Home partners listed on this form to get your health information, you need to take away your consent from the Health Home program. You can get this form by calling Healthy Health Home 518-555-5555. Your care manager will help you fill out this form if you want. Note: Even if you later decide to take back your consent, providers who already have your information do not have to give your information back to you or take it out of their records.

8. **How do I get a copy of this form?**
   You can have a copy of this form after you sign it.

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The Health Home Patient Information Sharing Consent (DOH 5055)

Please read all the information on this form before you sign it.

☐ **I AGREE to be in the** Healthy Health Home **Health Home and agree that the Health Home can get ALL of my health information from the partners listed at the end of this form and from others through** Healthy Health Home RHIO and/or through PSYCKES to give me care or manage my care, to check if I am in a health plan and what it covers and to study and make the care of all patients better. I also AGREE that the Health Home and the partners listed at the end of this form may share my health information with each other. I understand this Consent Form takes the place of other Health Home Patient Information Sharing Consent Forms I may have signed before to share my health information. I can change my mind and take back my consent at any time by signing a Withdrawal of Consent Form (DOH-5058) and giving it to one of the Health Home partners.

Print Name of Patient

Patient Date of Birth

Signature of Patient or Patient's Legal Representative

Date

Print Name of Legal Representative
(If Applicable)

Relationship of Legal Representative to Patient
(If Applicable)

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The Health Home Patient Information Sharing Consent (DOH 5055) – Page 3 *correct*

Healthy Health Home
Health Home Name

Participating Partners

Copy this page as necessary to list all participating partners

Patient Initials		Date
		5/18/2016
Name of Participating Partner		
Managed Care Plan (from Medicaid Card)	PE	5/18/2016
Name of Participating Partner		
BHO (from Medicaid Card)	PE	5/18/2016
Name of Participating Partner		
PCP	PE	5/18/2016
Name of Participating Partner		
LGU	PE	5/18/2016
Name of Participating Partner		
CMA 1	PE	6/1/2016
Name of Participating Partner		
CMA 2	PE	7/18/2016
Name of Participating Partner		

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The Health Home Patient Information Sharing Consent (DOH 5055) – Page 3 *correct*

Healthy Health Home
Health Home Name

Participating Partners

Copy this page as necessary to list all participating partners

Patient Initials		Date
		5/18/2016
Managed Care Plan (from Medicaid Card)	PE	5/18/2016
BHO (from Medicaid Card)	PE	5/18/2016
PCP	PE	5/18/2016
LGU	PE	5/18/2016
~~CMA 1~~	~~PE~~	~~6/1/2016~~ PE 7/18/206
CMA 2	PE	7/18/2016

Name of Participating Partner

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Consent Resources

- http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/2014-03-05_implement_update_session.pdf
- https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/forms/form_instructions.htm#sec1
- https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/forms/index.htm

FAQ

What consent or documentation would the Health Home need to obtain from the hospital upon initial referral PRIOR to enrollment?

The hospital can either use one of their consent forms or a verbal approval from the patient, to access the system in order to determine eligibility and a referral to a Health Home for enrollment.

Please clarify next steps when a patient is AOT and refuses to sign consent?

According to the guidance for HH+, if an AOT member refuses to sign a consent form, the court order which mandates care management is the consent.

Can the DOH 5055 form be altered by the Health Home to accommodate annual dates and patient initials on each line?

A DOH numbered form, such as the DOH 5055 consent, may not be altered in any way. Use of agency logo, changing original content, attaching forms and other pages documents, altering DOH form number or date, or adding bar codes are prohibited.

FAQ

What is the guidance on pre-populating page three on the DOH 5055?

Page three should be completed with the key, pertinent, and relevant partners the Health Home member approves. This would include the Managed Care Organization and the Behavioral Health Organization, both of which can be obtained from the member's Medicaid card. Correct completion of page three of the consent form is *one* of the following:

- Member-centered, including the names of only those downstream providers and other entities approved by the member, with their initial and the date the provider was listed.
- A list of all of the Health Home's downstream partners, and any other entities as approved by the member, with the entities the members does NOT want involved in their care crossed out, and the member's initials and the date next to those crossed out.

FAQ

If a member does not consent to be part of a Health Home but still wants HCBS Services, who pays the Health Home to do the eligibility, the plan of care, and the full CMHA? How does this process play out in general?

The billing process for non-Health Home members is still under discussion.

The DOH 5055 form has a place for a date and initials at the top of the page, yet a DOH re-designation visit alerted our Health Home that the patient needs to initial and date each line. Please clarify.

Correct completion of page three of the consent form is *one* of the following:

- Member-centered, including the names of only those downstream providers and other entities approved by the member, with their initial and the date the provider was listed.
- A list of all of the Health Home's downstream partners, and any other entities as approved by the member, with the entities the members does NOT want involved in their care crossed out, and the member's initials and the date next to those crossed out.

FAQ

Could you clarify if and how the 42 CFR provisions are covered under the 5055? If not, is there any additional guidance for CMAs to keep in mind?

The DOH 5055 form was developed with the assistance of OASAS and is legally sufficient to facilitate the disclosure of patient-identifying information which may be protected by the federal confidentiality regulations, 42 CFR Part 2.

Does the consent allow a delegated provider for a managed care organization the ability to receive behavioral health and substance use information from the Health Home?

Page three should be completed with the key, pertinent, and relevant partners the Health Home member approves. This would include the Managed Care Organization and the Behavioral Health Organization, both of which can be obtained from the member's Medicaid card.

As the client signs for HIXNY, on the 5055, is this sufficient to obtain the HIXNY information and /or is there a link to submit this consent to HIXNY? I ask because often the HIXNY is for emergency only.

A signed RHIO consent form will allow access to the RHIO's Health Information Exchange (HIE) if the organization is a member of or has a data sharing relationship with that local RHIO. The current DOH 5055 Health Home consent is single entity consent for RHIO purposes. It allows the Health Home to access member health information through the HIE. If the RHIO can support the use of a multi-entity consent form, such a form is permitted. The Health Home can either use the RHIO's multi-entity consent in addition to the DOH 5055 or contact DOH to discuss use of the original Health Home consent form. A signed Health Home consent allows a Health Home to access more than one RHIO's HIE if each of the RHIOs that will be directly accessed is named on the consent form. Health Homes must also have a data sharing agreement with each of the RHIOs. The member must give permission, for each of the RHIOs that the Health Home is directly accessing, for their health information.

FAQ

Is there any guidance on storage of the DOH 5055 originals?

When completing any form with a member, the care manager must maintain the original signed form in the member's record, whether in hardcopy or electronically.

The lines on the DOH 5055 is not long enough to add details like limitations to PHI info, address, relationship, etc. Is there a work around for this? For example, can the care manager use a few lines?

It is acceptable to take up additional space as needed to clearly identify the name, location, and contact information of providers, other individuals, or resources that the member is consenting the Health Home care manager to coordinate care with.

Is this the most up to date consent form? I have seen one with boxes to check / uncheck on page three.

The most up-to-date version of the DOH 5055 is the 12/13 version located on the Health Home website.

FAQ

Is there an update requirement when a member changes managed care plans?

Page three should be completed with the key, pertinent, and relevant partners the Health Home member approves. This would include the Managed Care Organization and the Behavioral Health Organization, both of which can be obtained from the member's Medicaid card. The DOH 5055, as best practice, should be reviewed with the member during their care conferences, when there is a change in provider (including a change in managed care plans), or minimally on an annual basis at the completion of the annual comprehensive assessment to assure it is current and reflects member choice regarding the sharing of PHI.

Just for clarification, PHI includes HIV/AIDS, Substance Use/alcohol health information; so agencies are not required to complete the AIDS Institute consent form?

The DOH 5055 has taken the place of the AI HIPAA form.

FAQs

We prepopulate page 3 with our network providers, so that the care managers don't have to write them in. But, they are not pre-SELECTED. The member and care manager still individually choose the providers to check off. If that is the case, is it sufficient to initial and date the top of the page? We haven't understood that doing that for each and every line was necessary.

Page three should be completed with the key, pertinent, and relevant partners the Health Home member approves. This would include the Managed Care Organization and the Behavioral Health Organization, both of which can be obtained from the member's Medicaid card. Correct completion of page three of the consent form is *one* of the following:

- Member-centered, including the names of only those downstream providers and other entities approved by the member, with their initial and the date the provider was listed.
- A list of all of the Health Home's downstream partners, and any other entities as approved by the member, with the entities the members does NOT want involved in their care crossed out, with the member's initials and the date next to those crossed out

FAQ

We have been having our CMAs update page three a minimum of annually as well as as-needed when providers are added/removed. However, we have not been re-consenting the page 1 based on the wording on page 2, "How long does my consent last? Your consent will last until the day you take back your consent, or if you leave the Health Home program, or if the Health Home stops working." Is that not correct?

The consent does not expire unless the member disenrolls, or the CMA and/or Health Home cease to exist. Although there is no current requirement to re-consent, it is essential that the DOH 5055 is updated routinely with the member should there be any new relationships or should the individual determine they would like to revoke consent or the provider relationship is no longer active.

Please restate the reason for the necessity to identify the MCO on the consent form? Once a member has been enrolled in a Health Home, it has been our understanding that the Managed Care's access to the patient information when sharing with a provider (e.g. CMA, lead health home, etc.) is protected by the "Treatment, Payment and Operations" provision of HIPAA.

Page three should be completed with the key, pertinent, and relevant partners the Health Home member approves. This would include the Managed Care Organization and the Behavioral Health Organization, both of which can be obtained from the member's Medicaid card. Managed care plans need to see their name in writing, in order to ensure the member has consented.

FAQ

Does the MCO need to obtain a copy of the DOH 5055 consent in order to share DOH information with the Heath Home or CMA?

Health Homes that will be sharing data with their network partners prior to obtaining member consent, e.g. with care management entities to do outreach and engagement with members, must first have an approved subcontractor documentation packet (which includes a Business Associate Agreement) on file with DOH.

What can an MCO do if consents are not received?

In the absence of consent or a BAA with the CMA, the MCOs will need to communicate through the lead Health Home. This is inefficient and lends itself to bifurcated communication that is avoidable simply by updating the DOH 5055.

- 10 Plans contract with Beacon for Behavioral Health Utilization Management- it is essential that Beacon or (other BHO when applicable) be identified as well as the Health Plan to the DOH 5055 to expedite communication and BH HCBS –POC approval.