

## **Q/A Health Home Consent: Updated December 2012**

1. What are the goals of the Health Home consent (DOH-Form 5055)?

The ultimate goal of the Health Home consent form is to get the member into a Health Home, able to receive coordinated services based on a reasonable understanding of the member's health care needs and medical history. The Health Home consent allows partners in the member's Health Home team to share appropriate information to assist the member. The members served by health homes are chronically ill, often disenfranchised from even the fragmented system of health care they access and often have hierarchical concerns for food and shelter. They often have low trust of the system and low health literacy, both adding to their concerns of interacting with the health care system. This single consent signed opens the Health Home gateway of care to quickly meet critical care needs, build trust in accessing the system of care, and build self-reliance skills in managing health care conditions.

2. Why has the consent form been revised?

The original consent form as a multi-entity consent form was difficult for some Health Homes and RHIOs to operationalize. Additionally, it was tied directly to the RHIO consent so that if a member withdrew their Health Home consent, it impacted the RHIO consent process. We have since modified it to accommodate those RHIOs that use a single-entity consent. This separated the Health Home consent from the RHIO consent process except for the lead Health Home which still has its RHIO consent tied to DOH-Form 5055. Health Home partners must still obtain a signed RHIO consent form to allow those partners direct access to the RHIO.

The original consent form was approved by all the appropriate state agencies. Likewise, this consent has been reviewed and approved by OMH, OASAS and DOH. It includes the necessary language from the NYeC consent.

3. What will the signed Health Home consent (DOH-Form 5055) allow?

The signing of the Health Home consent (DOH-Form 5055) will serve two distinct functions. It will allow the Health Home care providers to share patient information, and it will allow the lead Health Home to access patient information directly from the local RHIO

4. Will the RHIO consent form automatically allow a Health Home lead or any Health Home partner access to and sharing of Health Home member's medical records/care plan stored in the RHIO?

A signed RHIO consent form will only allow access to the RHIO if the organization is a member of that local RHIO.

5. Who is responsible for the payment of any RHIO membership fees?

Each individual entity or organization that seeks membership in a RHIO is responsible to pay for their membership in that RHIO.

6. Is the Health Home consent form (DOH-Form 5055) a proxy for a RHIO consent form?

The Health Home consent form (DOH-Form 5055) is only a proxy for the RHIO consent form for the lead Health Home. It is not the RHIO consent for all other Health Home partners. They will need to follow the consenting process in place for their local RHIO. The Health Home consent form is for data sharing among the relevant members of the Health Home and allows only the lead Health Home data sharing with the RHIO.

7. What if the RHIO uses a multi-entity RHIO consent form?

A multi-entity RHIO consent form is permitted but is not required

8. Can the RHIO use the Health Home consent form as their multi-entity consent form?

The RHIO can use the Health Home consent form as their multi-entity consent form but if the member withdraws consent (DOH-Form 5058) from the Health Home, the RHIO consent would be lost as well.

If a member signs a withdrawal form from the Health Home (where a single-entity RHIO consent was used) (DOH-Form 5058), only the lead Health Home's access to the RHIO for that member is ended.

9. Is the signing of a Health Home consent form (DOH-Form 5055) tied to Health Home enrollment?

No, a Health Home member is considered enrolled in a Health Home once the member is assigned to a Health Home.

10. Is the signing of a Health Home consent form (DOH-Form 5055) tied to Health Home active care management?

A Health Home member can start active care management services without having a Health Home consent form signed. Without a consent, there is a limited ability to share member health information. This defeats the purpose of the Health Home. However, if the care manager is able to do successful care management without a member consent signed, care management can be continued.

11. Do Health Homes have to have the member sign the consent (DOH-Form 5055) within a specific period of time?

No, a member can remain in a Health Home and in active care management without a DOH-Form 5055 as long as the care manager can demonstrate he/she can advance the member's care plan and improve the member's health status without a signed consent. Care Managers need to work with members so they understand the importance of signing a consent.

12. Can a signed Health Home consent form allow a lead Health Home to access more than one RHIO?

A signed Health Home consent form can allow a lead Health Home access to more than one RHIO if each of the RHIOs that will be directly accessed is named on the consent form. In other words, the member must give permission for each of the RHIOs the Health Home is directly accessing for his/her health information. The consent is adequate if the information from the other RHIOs is coming through a connection the named RHIO has to the SHIN-NY. The Health Home must be a member of each RHIO that it directly accesses for Health Home member information.

13. Does the Health Home lead entity need to join a RHIO?

The lead entity Health Home must be able to transmit and receive data electronically with its associated organizations and providers. Health information exchange through a RHIO would be the preferred way to do this. However access for data sharing managed in a RHIO would be the appropriate mechanism. RHIOs may require an entity to become a member of the RHIO and sign a participation agreement. Some may have a service charge for data transmission or membership fees. The RHIO manages this as it would for any other data sharing entity.

14. If a Health Home member already signed an original Health Home consent (DOH-Form 5055), do they need to resign the updated version of the consent form? What happens to all consents already signed?

If the RHIO can operationalize the original version of (DOH-Form 5055), the member will not be required to sign the updated version. If the RHIO cannot operationalize the original consent form, the newer version will need to be signed again.

15. What happens to the RHIO consent when a DOH-Form 5058 (withdrawal of Health Home consent) is signed? Does this take away Health Home access to the RHIO?

If a Health Home withdrawal (DOH-Form 5058) is signed, permission to share new data among Health Home partners is negated and the lead Health Home loses RHIO access for that patient. It is important to remember that any patient data that has already been shared prior to the signing of the 5058 does not have to be removed from the Health Home lead or partners EHR or Care Management Plan.

16. Why is a Health Home different from a health care provider (PCMH, e.g.)?

The Health Home is an entity that performs care management functions established by CMS and the State of NY DOH. The lead agency Health Home performs financial transactions, IT connectivity, legal functions (contracting) and quality assurance functions. They may do care management or they may contract with other agencies to do the care management.

The Lead Health Home has a data sharing agreement (DEAA [data exchange agreement application] with BAA [Business Associate Agreement]) with the NYS DOH and will execute contracts including the DEAA and BAA with subcontractors in the network. The NYSDOH maintains copies of these contracts. The Lead Health Home also contracts with Managed Care Organizations and these entities have BAAs.

The Lead Health Home either directly provides or contracts to have provided care management consistent with CMS and DOH criteria. They do not provide direct physical or mental health care. They will ensure this type of care is available to the member and will coordinate such care.

The Lead Health Home develops a network of providers including medical, behavioral health, nursing, and ancillary services such as housing, transportation, and hotline services, etc. to use to coordinate the care provided to its members. These networks may take a number of forms from a loose confederation to a legal entity. A specific form or model has not been mandated. Data sharing agreements must be in place within this network.

One of the requirements for the Health Home is to have IT connectivity for information sharing. This includes connection to a RHIO [Regional Health Information Organization].

17. Is Health Home data exchange different from a 1:1?

It is likely that many of the data exchanges in a Health Home would fall under 1:1 exchanges both within and outside the network. The Health Home member consent should cover such an exchange. However, without a RHIO consent in place, the Health Home cannot pull data from the HIE. Given the fragmented health care and lack of provider loyalty that many of these members have had, it will be crucial at least in the beginning to be able to pull data and not just push data or be the recipient of a 1:1 push of data.

18. What business problems does the Health Home have to solve?

- Requirement to intensely coordinate care for members traditionally disengaged from the health care system.
- Requirement to establish a type of care management network of multiple providers and provider types that work together in a coordinated fashion, essentially a new model of care.
- Requirement to obtain and share data across many providers while still maintaining member's right to privacy.
- Need to rapidly engage with disengaged, often untrusting, members and provide this care coordination service.

What business problems does the RHIO have to solve?

- Platform efficiency – the need to not have to build “one off” solutions for the platform (i.e., an efficient platform would meet the needs of most users without needing single solution tweaks)
- Sustainability
- Compliance with privacy mandates/laws

What business problems does the member have to solve?

- Trust with a system that in the past has been fragmented and not helpful
- Rapid access to needed services
- Ability to gain stable health in a stable and safe living environment

19. Are Health Homes a covered entity in the sense of HIPAA?

Yes

20. Is the Health Home a legal entity?

The Health Home and its network works as a federated model, with contracting between the members and the lead Health Home. The Lead Health Home is a legal entity. It should be noted that the structures of Health Home and networks are constantly evolving with some having joint governance for Health Home services.

21. Who signs the Health Home contracts?

The lead Health Home organization has signed the appropriate forms from the NYS DOH to be a Health Home. They will establish all contracts with other related entities.

22. Who signs and updates the Health Home member care plan?

The care plan manager is tasked with signing and updating the care plan for the Health Home member.

## New

23. If a patient signs a RHIO consent form and selects “No” so no personal information may be shared via the RHIO, then signs the Health Home consent (DOH-Form 5055) “Yes”, can the Health Home lead access that patients data in the RHIO?

Yes. If the Health Home member signs the Health Home consent form after the RHIO consent has been signed (regardless of yes/no), the intent of the second form overrides the intent of the first and the lead Health Home can access whatever is available through the HIE.

24. If a patient signs a Health Home consent (DOH-Form 5055) “Yes”, then signs a RHIO consent form “No”, can the Health Home lead access that patients data in the RHIO?

No. By the same policy as in question 21, the "No" would override the Health Home consent (DOH-Form 5055) for accessing the HIE. This would not override the Health Home consent form for Health Home partners to share information about the member.

Exception: If the RHIO adding a “value added” service by hosting a care plan and sharing via portal, that may be ok, as long as the information isn't conglomerated from various RHIO sources.

25. If a patient signs the RHIO consent “Yes”, then signs the Health Home consent “Yes”, than later, the patient signs the Health Home withdrawal form because they are changing Health Homes, can the original Health Home lead still access the patients data in the RHIO?

No. The original Health Home lead would need to get a new RHIO consent. The signing of the Health Home withdrawal of consent severs the ties from the original Health Home lead to the HIE.

26. Is the guidance on the consent form (not being required for enrollment) related to all Health Home eligibles, or just TCM/COBRA Health Home eligibles?

Consent is not what triggers enrollment but it does trigger consent for the sharing of health information. Therefore, Health Homes will want to secure consent for all of their existing Health Home members, converting TCM/COBRA members and new Health Home members, in order to share health information with the member's Health Home team and provide comprehensive care management.

27. Since the guidance gives latitude to the Health Home to determine what constitutes enrollment, what triggers billing at 100% PMPM?

- a. Initiation of baseline risk assessment;
- b. Completion of baseline risk assessment; and/or
- c. Obtainment of consent.

Note: Baseline risk assessment typically requires two hours to complete.

Health Home is an opt-out program; therefore, the member is enrolled upon assignment but the Health Home must decide when the member is under active case management (receiving Health Home services) or if the Health Home is doing outreach and engagement. The examples above, except letter c could all be used to determine if the member is enrolled in their Health Home, and when they would switch from outreach and engagement to active care management at 100% PMPM.

28. If a Health Home is unable to obtain consent, can an eligible member still enroll? If so, how do you demonstrate Care Coordination without the consent to share information with other care providers?

Members are enrolled upon assignment, but Health Homes must decide when the member is receiving Health Home services and active care management. Health Homes must decide if and how they can deliver quality Health Home services and care coordination without a member's consent to share information, and for how long without their consent. It is the expectation that case managers will assist the member in understanding the benefits of the program and the impact of having a signed consent can have in contributing to providing their total care. (See # 10 and #11 above)

29. Some clients are concerned and will not sign the consent because the consent includes a list of several partners, many of whom do not apply to them. Is it possible for the client to give consent for only their providers and place a line through those providers that the client does not wish to consent? What happens if the person refuses to sign the HH consent form? Is there a time frame established in which the person must sign by?

The consent should include only the partners directly involved with the care of the member. The list should be personalized. Please see questions #9, #10, and #11 above.

30. Are consent forms required for members enrolled in legacy slots?

Yes. The provider must work with the member to obtain the Health Home consent (DOH-Form 5055).