Health Home Consent Update

Revisions To Health Home Consents

June 6, 2018

Agenda

Today's Presentation will cover three (3) specific items:

1. Consent Forms Updates and Why Changes were made
2. Children's Health Home Consent Guidance Document Updates
3. Specific Guidance Surrounding – Health Home Information Sharing Consent DOH 5055 and DOH 5201

HH Consent Forms Update and Why Changes were Made?

Health Home Forms That Have Been Revised

- **DOH 5055** Health Home Patient Information Sharing Consent
- **DOH 5058** Health Home Patient Information Sharing – Withdrawal of Consent
- **DOH 5059** Health Home Opt–Out
- Health Home Consent Frequently Asked Questions (**FAQ**) for use with Children and Adolescents Under 18 Years of Age
- **DOH 5201** Health Home Consent Information Sharing For Use with Children and Adolescents Under 18 Years of Age
- **DOH 5202** Health Home Withdrawal of Health Home Enrollment and Information Sharing Consent Form For Use with Children and Adolescents Under 18 Years of Age

➢ The date of each revised consent form is: **03/18**

Office for People With Developmental Disabilities (OPWDD)

- Health Homes are authorized under Section 2703 of the Patient Protection and Affordable Care Act (1945 of the Social Security Act). New York's approved State Plan Amendment (SPA) #17-0025 authorizes inclusion of individuals with intellectual and/or developmental disabilities (I/DD) to receive Health Home services.

- The program will be known as the *NYS Care Coordination Organizations/Health Homes (CCO/HHs) Serving Individuals with Intellectual and Developmental Disabilities (I/DD) Program*.

- Health Homes authorized under this State Plan will be known as *Care Coordination Organizations/Health Homes (CCO/HHs)*.

- Effective **July 1, 2018**, OPWDD is transitioning their Medicaid Service Coordination (MSC) services to Care Coordination Organizations/Health Homes (CCO/HHs).

- In order to enroll individuals with intellectual and/or developmental disabilities (I/DD) into CCO/HHs, current Health Home consent forms were revised.

Expansion of Minor Consent for HIV Treatment Access and Prevention

Amendment of sections 23.1 and 23.2 of Title 10 NYCRR

Purpose: To allow qualified clinicians to provide antiretrovirals for treatment and prophylaxis.

Minor/Adolescent Consent to HIV Prevention and Treatment Services

Amendments to New York's Health Regulation (10 NYCRR Part 23):

- HIV now defined as a Sexually Transmitted Infection (STI)
- Minors can consent to their own HIV Testing and Treatment Services without parental/guardian/legally authorized representative consent.
- Minors can consent to their own HIV Prevention Services without parental/guardian legally authorized representative consent.
- Access to Pre-exposure prophylaxis (PrEP) and Post-exposure prophylaxis (PEP).

Note: Although minors/adolescents can consent to HIV Prevention and Treatment, minors/adolescents can NOT consent to care coordination in Health Homes without parent/guardian/legal authorized representative consent.

Exceptions: Minor/adolescent who is Pregnant, Parent, Married or 18 years and older can self-consent

Practical Considerations for DOH 5201–HH Consent Information Sharing For Use with Children Under 18 Years of Age

DOH 5201, Section 2

- To be completed only by the minor/adolescent with the Health Home care manager and not with parent, guardian, or legally authorized representative present
- Minor/Adolescent can keep private any information related to Sexual Transmitted Infection (including HIV) testing and treatment services and HIV Prevention Services
- Consent to share information is applicable to any minor who had the capacity to consent. Best practice usually considers this to be minors/adolescents aged 10 years and older

Practical Considerations for DOH 5201–HH Consent Information Sharing For Use with Children Under 18 Years of Age

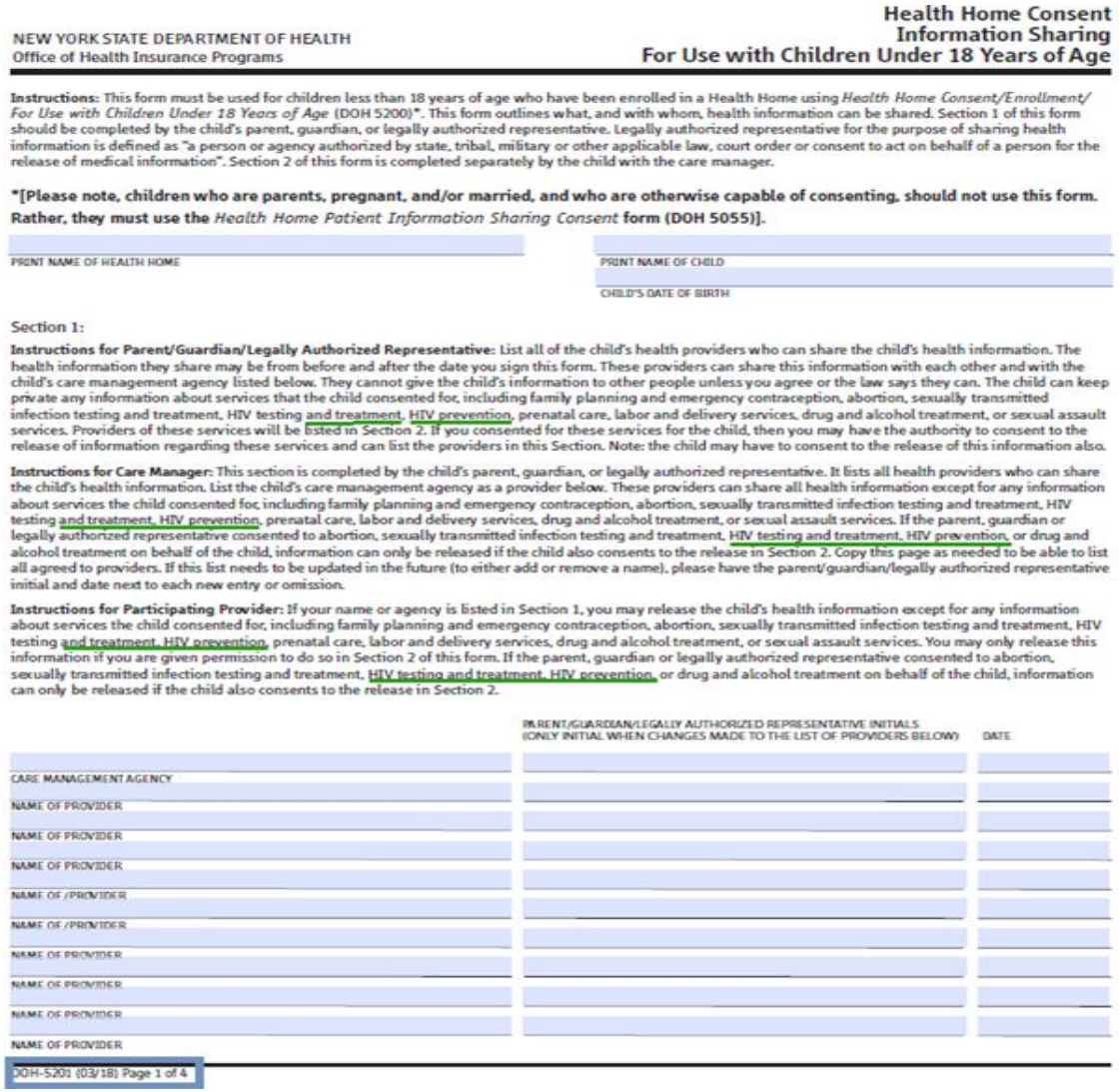
DOH 5201, Section 2 (cont.)

- If the child/adolescent is unable or unwilling to complete section 2 of Health Home Consent Information Sharing (Form DOH 5201), it should be left blank and proper documentation is needed to highlight why the Health Home care manager was unable to meet with the child/adolescent alone and if the child/adolescent refused to sign

- If the parent, guardian, or legally authorized representative consented for these services (in Sec. 2) on behalf of the minor/adolescent, then the parent, guardian, or legally authorized representative may have the authority to consent for the release of information for these services. However, the child/adolescent must also consent to the release of this information.

➢ Proper documentation is needed in the member's record

DOH 5201 – HH Consent Information Sharing For Use with Children Under 18 Years of Age



NEW YORK STATE DEPARTMENT OF HEALTH
Office of Health Insurance Programs

Health Home Consent Information Sharing For Use with Children Under 18 Years of Age

Instructions: This form must be used for children less than 18 years of age who have been enrolled in a Health Home using *Health Home Consent/Enrollment/ For Use with Children Under 18 Years of Age* (DOH 5200)*. This form outlines what, and with whom, health information can be shared. Section 1 of this form should be completed by the child's parent, guardian, or legally authorized representative. Legally authorized representative for the purpose of sharing health information is defined as "a person or agency authorized by state, tribal, military or other applicable law, court order or consent to act on behalf of a person for the release of medical information". Section 2 of this form is completed separately by the child with the care manager.

***[Please note, children who are parents, pregnant, and/or married, and who are otherwise capable of consenting, should not use this form. Rather, they must use the *Health Home Patient Information Sharing Consent* form (DOH 5055)].**

PRINT NAME OF HEALTH HOME

PRINT NAME OF CHILD

CHILD'S DATE OF BIRTH

Section 1:

Instructions for Parent/Guardian/Legally Authorized Representative: List all of the child's health providers who can share the child's health information. The health information they share may be from before and after the date you sign this form. These providers can share this information with each other and with the child's care management agency listed below. They cannot give the child's information to other people unless you agree or the law says they can. The child can keep private any information about services that the child consented for, including family planning and emergency contraception, abortion, sexually transmitted infection testing and treatment, HIV testing and treatment, HIV prevention, prenatal care, labor and delivery services, drug and alcohol treatment, or sexual assault services. Providers of these services will be listed in Section 2. If you consented for these services for the child, then you may have the authority to consent to the release of information regarding these services and can list the providers in this Section. Note: the child may have to consent to the release of this information also.

Instructions for Care Manager: This section is completed by the child's parent, guardian, or legally authorized representative. It lists all health providers who can share the child's health information. List the child's care management agency as a provider below. These providers can share all health information except for any information about services the child consented for, including family planning and emergency contraception, abortion, sexually transmitted infection testing and treatment, HIV testing and treatment, HIV prevention, prenatal care, labor and delivery services, drug and alcohol treatment, or sexual assault services. If the parent, guardian or legally authorized representative consented to abortion, sexually transmitted infection testing and treatment, HIV testing and treatment, HIV prevention, or drug and alcohol treatment on behalf of the child, information can only be released if the child also consents to the release in Section 2. Copy this page as needed to be able to list all agreed to providers. If this list needs to be updated in the future (to either add or remove a name), please have the parent/guardian/legally authorized representative initial and date next to each new entry or omission.

Instructions for Participating Provider: If your name or agency is listed in Section 1, you may release the child's health information except for any information about services the child consented for, including family planning and emergency contraception, abortion, sexually transmitted infection testing and treatment, HIV testing and treatment, HIV prevention, prenatal care, labor and delivery services, drug and alcohol treatment, or sexual assault services. You may only release this information if you are given permission to do so in Section 2 of this form. If the parent, guardian or legally authorized representative consented to abortion, sexually transmitted infection testing and treatment, HIV testing and treatment, HIV prevention, or drug and alcohol treatment on behalf of the child, information can only be released if the child also consents to the release in Section 2.

	PARENT/GUARDIAN/LEGALLY AUTHORIZED REPRESENTATIVE INITIALS (ONLY INITIAL WHEN CHANGES MADE TO THE LIST OF PROVIDERS BELOW)	DATE
CARE MANAGEMENT AGENCY		
NAME OF PROVIDER		
NAME OF PROVIDER		
NAME OF PROVIDER		
NAME OF PROVIDER		
NAME OF PROVIDER		
NAME OF PROVIDER		
NAME OF PROVIDER		
NAME OF PROVIDER		
NAME OF PROVIDER		
NAME OF PROVIDER		

DOH-5201 (03/18) Page 1 of 4

UPDATES MADE TO PAGE 1- SECTION 1:

Expanded language related to HIV:

- ***'HIV treatment, prevention, and testing'***

DOH 5201 – HH Consent Information Sharing For Use with Children Under 18 Years of Age

By signing this form, I agree that:

1. The child listed above is enrolled in the Health Home listed above,
2. I have signed a consent for enrollment form with the Health Home indicated above for the child listed above,
3. I have had the chance to review the Health Home FAQ sheet and have had my questions answered,
4. The Health Home and anyone I have named in Section 1 of this form can share _____ (NAME OF CHILD) health information, as outlined in the instructions above, with each other. They may share information from before and after the date I sign this form, and
5. The child's Health Home and Managed Care Plan, if applicable, can share information with those listed as providers above and with each other.

I can change this form at any time. If I make changes, I have to initial and date next to those changes. By crossing out information, I am taking away permission to share the health information that I previously allowed.

I understand that this consent form takes the place of other Health Home information sharing consent forms I may have signed before on behalf of the child. This consent stays in place until:

- I withdraw it, or
- The child is no longer eligible for a Health Home.
- The Health Home is no longer in business.

I can always take back this consent on behalf of the child by signing a *Health Home Consent/Withdrawal of Health Home Enrollment and Information Sharing/For Use with Children Under 18 Years* form (DOH 5202).

If I do not sign this consent form, I understand that the child's information will not be shared.

PRINT NAME OF CHILD'S PARENT, GUARDIAN OR LEGALLY AUTHORIZED REPRESENTATIVE

RELATIONSHIP OF PARENT, GUARDIAN OR LEGALLY AUTHORIZED REPRESENTATIVE TO CHILD

SIGNATURE OF CHILD'S PARENT, GUARDIAN OR LEGALLY AUTHORIZED REPRESENTATIVE

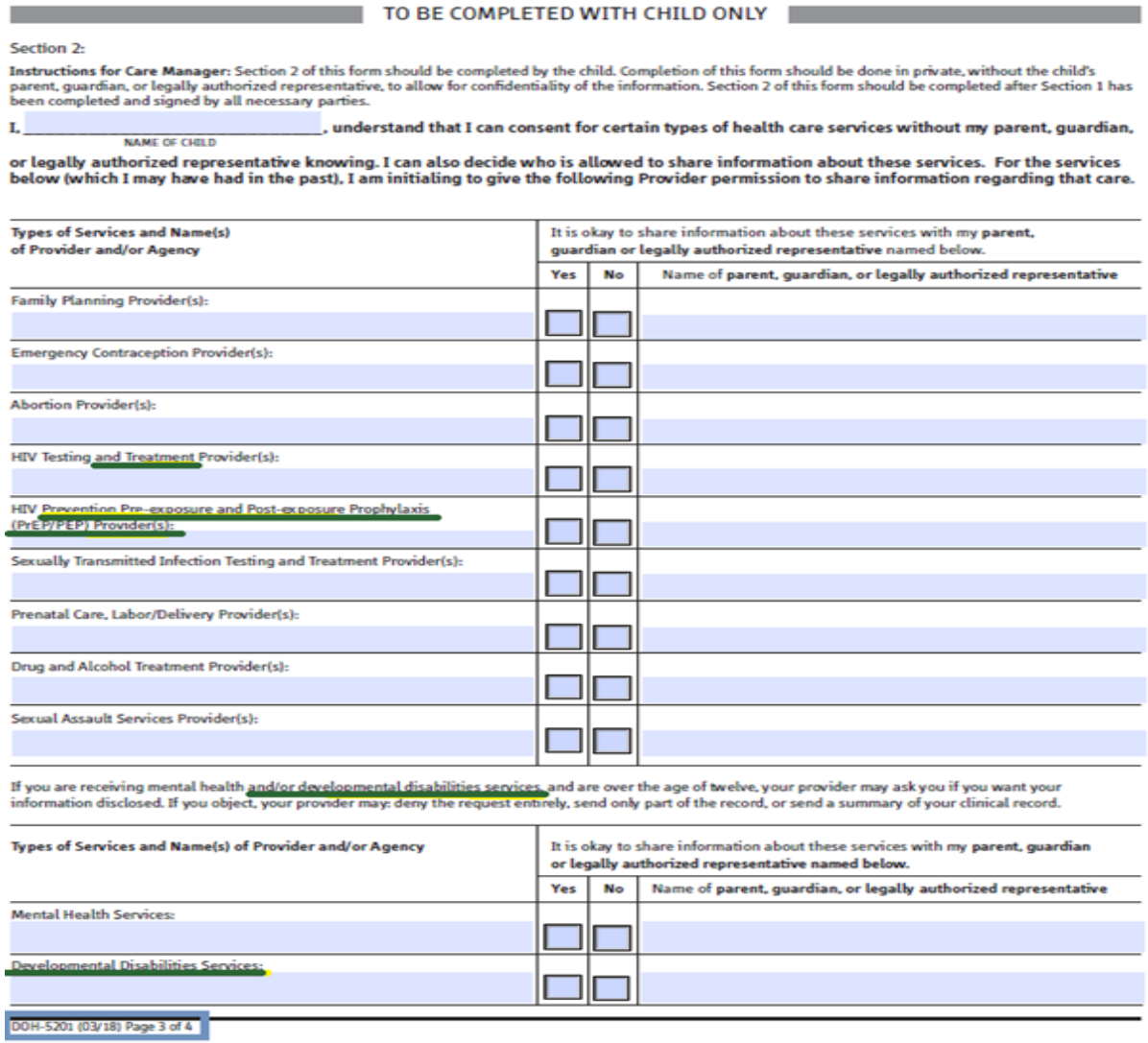
DATE

UPDATES MADE TO PAGE 2 – SECTION 1:

Added:

- ***'The Health Home is no longer in business'***

DOH 5201 – HH Consent Information Sharing For Use with Children Under 18 Years of Age



TO BE COMPLETED WITH CHILD ONLY

Section 2:

Instructions for Care Manager: Section 2 of this form should be completed by the child. Completion of this form should be done in private, without the child's parent, guardian, or legally authorized representative, to allow for confidentiality of the information. Section 2 of this form should be completed after Section 1 has been completed and signed by all necessary parties.

I, _____ (NAME OF CHILD), understand that I can consent for certain types of health care services without my parent, guardian, or legally authorized representative knowing. I can also decide who is allowed to share information about these services. For the services below (which I may have had in the past), I am initialing to give the following Provider permission to share information regarding that care.

Types of Services and Name(s) of Provider and/or Agency	It is okay to share information about these services with my parent, guardian or legally authorized representative named below.		
	Yes	No	Name of parent, guardian, or legally authorized representative
Family Planning Provider(s):	☐	☐	
Emergency Contraception Provider(s):	☐	☐	
Abortion Provider(s):	☐	☐	
HIV Testing and Treatment Provider(s):	☐	☐	
HIV Prevention Pre-exposure and Post-exposure Prophylaxis (PrEP/PEP) Provider(s):	☐	☐	
Sexually Transmitted Infection Testing and Treatment Provider(s):	☐	☐	
Prenatal Care, Labor/Delivery Provider(s):	☐	☐	
Drug and Alcohol Treatment Provider(s):	☐	☐	
Sexual Assault Services Provider(s):	☐	☐	

If you are receiving mental health and/or developmental disabilities services and are over the age of twelve, your provider may ask you if you want your information disclosed. If you object, your provider may: deny the request entirely, send only part of the record, or send a summary of your clinical record.

Types of Services and Name(s) of Provider and/or Agency	It is okay to share information about these services with my parent, guardian or legally authorized representative named below.		
	Yes	No	Name of parent, guardian, or legally authorized representative
Mental Health Services:	☐	☐	
Developmental Disabilities Services:	☐	☐	

DOH-5201 (03/18) Page 3 of 4

UPDATES MADE TO PAGE 3 – SECTION 2:

Expanded language related to HIV:

- ***HIV Testing 'and Treatment'***
- ***HIV 'Prevention Pre-exposure and Post-exposure Prophylaxis (PrEP/PEP) Provider(s):'***

Added:

- ***'and/or developmental disabilities services'***
- ***'Developmental Disabilities Services:'***

Health Home Consent Frequently Asked Questions (FAQ) For Use with Children Under 18 Years of Age

UPDATES MADE:

Named: *FAQ for DOH 5200 DOH 5201 (03/18)*

QI: Added:
- *Developmental disabilities providers*

Q5: Removed:
- *HIV/AIDS*

Changed:
- Sexually Transmitted Diseases to:
  - *Sexually Transmitted Infection (including HIV) Testing and Treatment*
  - *HIV Prevention (Pre-exposure and Post-exposure Prophylaxis (PrEP/PEP)*

Added:
- *Developmental Disabilities*

Q9: Expanded:
- *Sexually Transmitted Infection (including HIV) Testing and Treatment*

Added:
- *HIV Prevention Pre-exposure and Post-Exposure Prophylaxis (PrEP/PEP)*
- *and/or developmental disabilities*

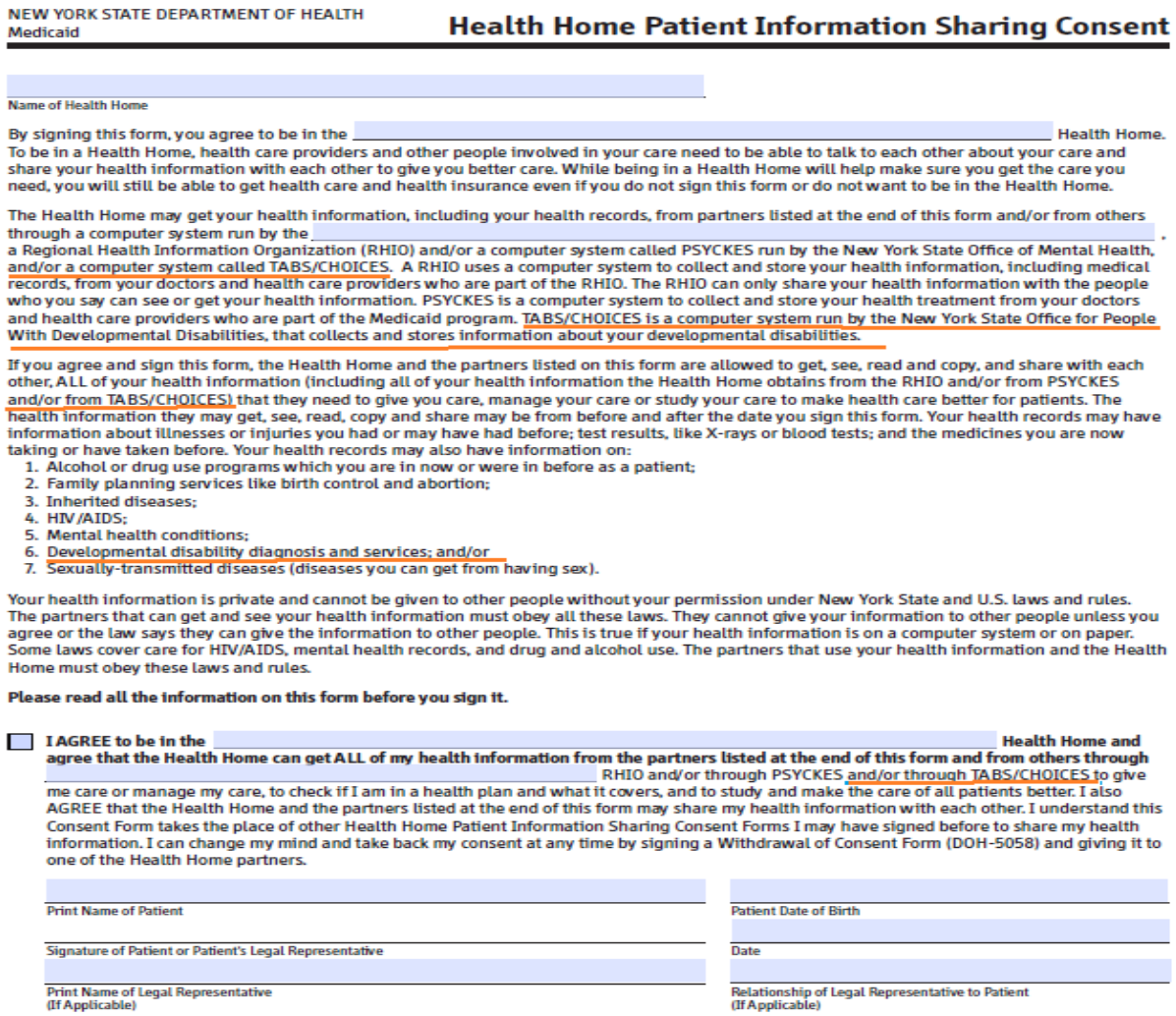
UPDATES MADE:

Q11 language was expanded for:
- *contact information to file a complaint related to misuse of PHI, and a new link added*

Q16 *addition of* new question/answer:
- *16. 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 is no longer in business."*

Q17 expanded answer to include:
- Yes. You may be enrolled at any time, *if you are still found eligible.*

DOH 5055 - HH Patient Information Sharing Consent



NEW YORK STATE DEPARTMENT OF HEALTH
Medicaid

Health Home Patient Information Sharing Consent

Name of Health Home

By signing this form, you agree to be in the _____ 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 _____. a Regional Health Information Organization (RHIO) and/or a computer system called PSYCKES run by the New York State Office of Mental Health, and/or a computer system called TABS/CHOICES. 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. TABS/CHOICES is a computer system run by the New York State Office for People With Developmental Disabilities, that collects and stores information about your developmental disabilities.

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 and/or from TABS/CHOICES) 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:

1. Alcohol or drug use programs which you are in now or were in before as a patient;
2. Family planning services like birth control and abortion;
3. Inherited diseases;
4. HIV/AIDS;
5. Mental health conditions;
6. Developmental disability diagnosis and services; and/or
7. Sexually-transmitted diseases (diseases you can get from having sex).

Your health information is private and cannot be given to other people without your permission under New York State and U.S. laws and rules. The partners that can get and see your health information must obey all these laws. They cannot give your information to other people unless you agree or the law says they can give the information to other people. This is true if your health information is on a computer system or on paper. Some laws cover care for HIV/AIDS, mental health records, and drug and alcohol use. The partners that use your health information and the Health Home must obey these laws and rules.

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

☐ **I AGREE to be in the _____ 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** _____ RHIO and/or through PSYCKES and/or through TABS/CHOICES 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)

DOH-5055 (03/18) p 1 of 3

UPDATES MADE TO PAGE 1:

Added:

- *TABS/CHOICES*
- *Developmental Disability diagnosis and services*

DOH 5055 - continued

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, developmental disability providers, 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 _____ 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.

5. **What if a person uses my information and I didn't agree to let them use it?**
   If this happens, you can:
   - call the Medicaid Helpline at 1-800-541-2831, or
   - contact the US Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019, or submit a written complaint at: https://www.hhs.gov/hipaa/filing-a-complaint/index.html

   You may also want to:
   - call one of the providers you have said can see your records,
   - call your care manager or health home: _____ at _____, or
   - call your Managed Care Plan if you belong to a Managed Care Plan.

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 _____.
   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.

DOH-5055 (03/18) p 2 of 3

UPDATES MADE TO PAGE 2:

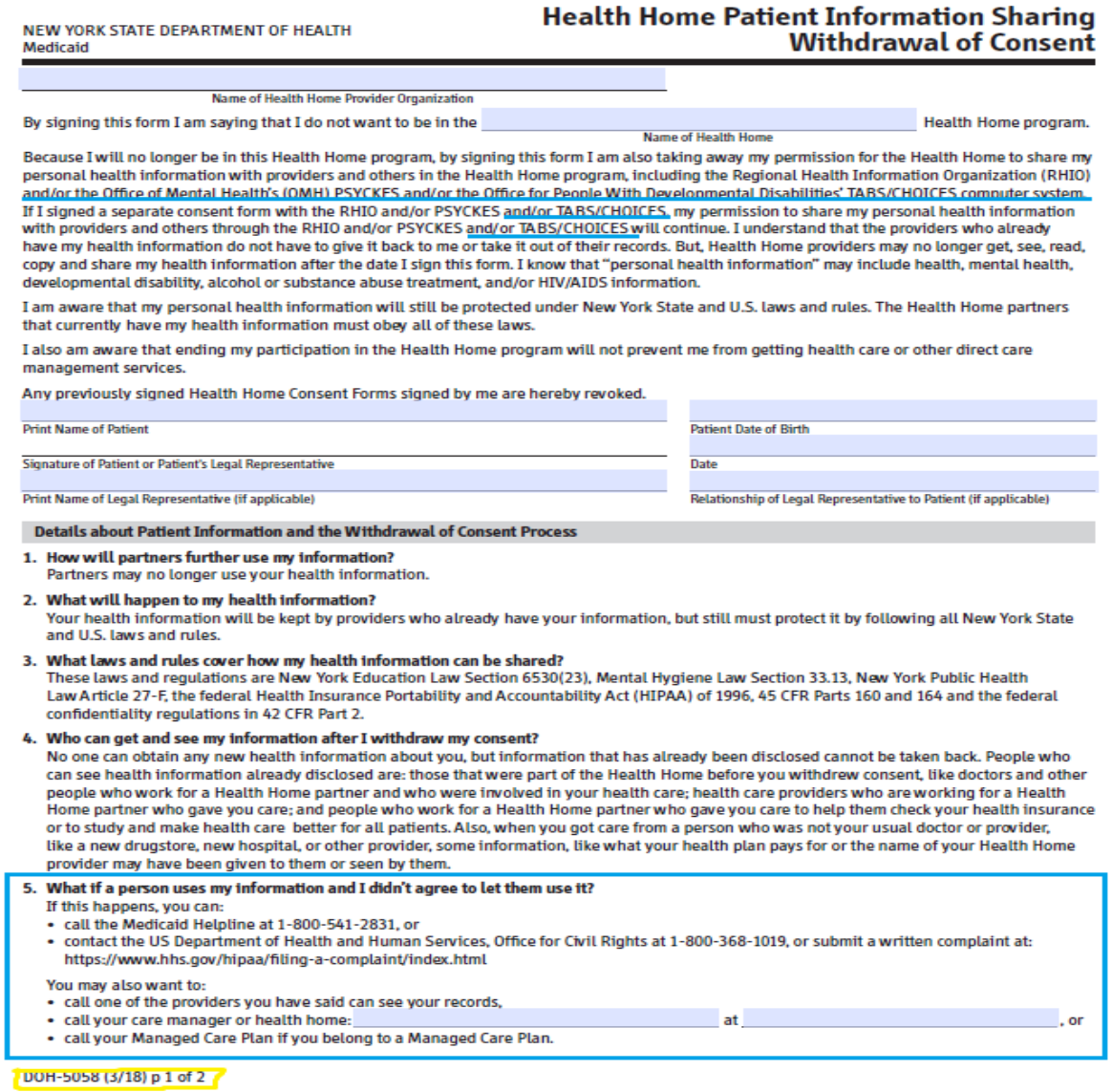
language was expanded to include:

- contact information for filing a complaint related to misuse of PHI, and a new link

******Please Note******

The DOH 5055 is sufficient consent for CMAs to attest within the UAS NYS Eligibility Assessment for HARP Health Home Enrolled members

DOH 5058 - HH Patient Information Sharing Withdrawal of Consent



NEW YORK STATE DEPARTMENT OF HEALTH
Medicaid

Health Home Patient Information Sharing Withdrawal of Consent

Name of Health Home Provider Organization

By signing this form I am saying that I do not want to be in the _____ Health Home program.
Name of Health Home

Because I will no longer be in this Health Home program, by signing this form I am also taking away my permission for the Health Home to share my personal health information with providers and others in the Health Home program, including the Regional Health Information Organization (RHIO) and/or the Office of Mental Health's (OMH) PSYCKES and/or the Office for People With Developmental Disabilities' TABS/CHOICES computer system. If I signed a separate consent form with the RHIO and/or PSYCKES and/or TABS/CHOICES, my permission to share my personal health information with providers and others through the RHIO and/or PSYCKES and/or TABS/CHOICES will continue. I understand that the providers who already have my health information do not have to give it back to me or take it out of their records. But, Health Home providers may no longer get, see, read, copy and share my health information after the date I sign this form. I know that "personal health information" may include health, mental health, developmental disability, alcohol or substance abuse treatment, and/or HIV/AIDS information.

I am aware that my personal health information will still be protected under New York State and U.S. laws and rules. The Health Home partners that currently have my health information must obey all of these laws.

I also am aware that ending my participation in the Health Home program will not prevent me from getting health care or other direct care management services.

Any previously signed Health Home Consent Forms signed by me are hereby revoked.

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)

Details about Patient Information and the Withdrawal of Consent Process

1. **How will partners further use my information?**
   Partners may no longer use your health information.
2. **What will happen to my health information?**
   Your health information will be kept by providers who already have your information, but still must protect it by following all New York State and U.S. laws and rules.
3. **What laws and rules cover how my health information can be shared?**
   These laws and regulations are New York Education Law Section 6530(23), Mental Hygiene Law Section 33.13, New York Public Health Law Article 27-F, the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996, 45 CFR Parts 160 and 164 and the federal confidentiality regulations in 42 CFR Part 2.
4. **Who can get and see my information after I withdraw my consent?**
   No one can obtain any new health information about you, but information that has already been disclosed cannot be taken back. People who can see health information already disclosed are: those that were part of the Health Home before you withdrew consent, like doctors and other people who work for a Health Home partner and who were involved in your health care; health care providers who are working for a Health Home partner who gave you care; and people who work for a Health Home partner who gave you care to help them check your health insurance or to study and make health care better for all patients. Also, when you got care from a person who was 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 have been 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 this happens, you can:
   - call the Medicaid Helpline at 1-800-541-2831, or
   - contact the US Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019, or submit a written complaint at: https://www.hhs.gov/hipaa/filing-a-complaint/index.html

   You may also want to:
   - call one of the providers you have said can see your records,
   - call your care manager or health home: _____ at _____, or
   - call your Managed Care Plan if you belong to a Managed Care Plan.

DOH-5058 (3/18) p 1 of 2

UPDATES MADE:

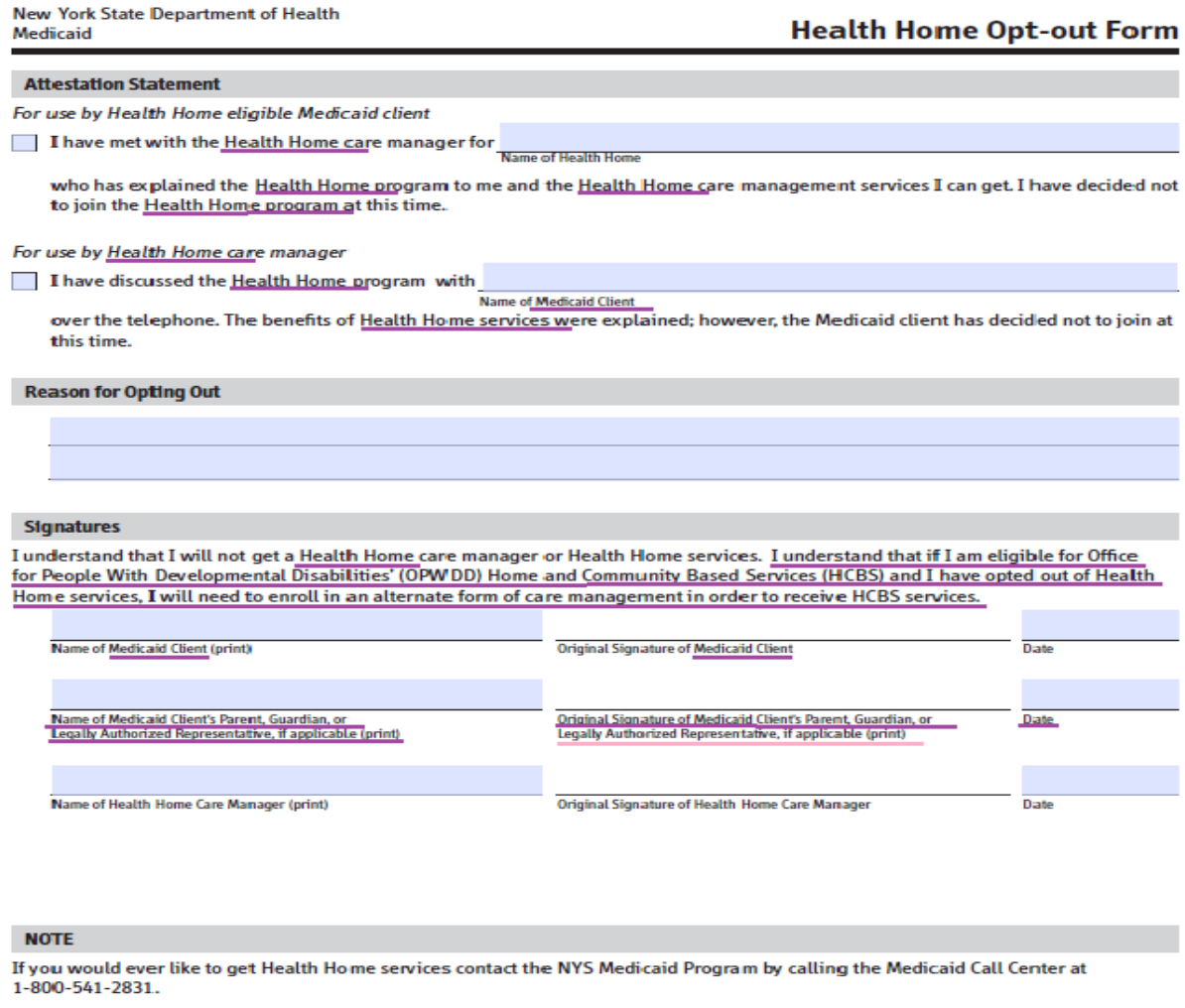
Added:

- *and/or the Office for People With Developmental Disabilities' TABS/CHOICES computer system*

#5: language was expanded to include:

- *contact information for filing a complaint related to misuse of PHI, and a new link*

DOH 5059 – HH Opt-out Form



New York State Department of Health
Medicaid

Health Home Opt-out Form

Attestation Statement

For use by Health Home eligible Medicaid client

☐ I have met with the Health Home care manager for _____
Name of Health Home

who has explained the Health Home program to me and the Health Home care management services I can get. I have decided not to join the Health Home program at this time.

For use by Health Home care manager

☐ I have discussed the Health Home program with _____
Name of Medicaid Client

over the telephone. The benefits of Health Home services were explained; however, the Medicaid client has decided not to join at this time.

Reason for Opting Out

Signatures

I understand that I will not get a Health Home care manager or Health Home services. I understand that if I am eligible for Office for People With Developmental Disabilities' (OPWDD) Home and Community Based Services (HCBS) and I have opted out of Health Home services, I will need to enroll in an alternate form of care management in order to receive HCBS services.

Name of Medicaid Client (print)	Original Signature of Medicaid Client	Date
Name of Medicaid Client's Parent, Guardian, or Legally Authorized Representative, if applicable (print)	Original Signature of Medicaid Client's Parent, Guardian, or Legally Authorized Representative, if applicable (print)	Date
Name of Health Home Care Manager (print)	Original Signature of Health Home Care Manager	Date

NOTE

If you would ever like to get Health Home services contact the NYS Medicaid Program by calling the Medicaid Call Center at 1-800-541-2831.

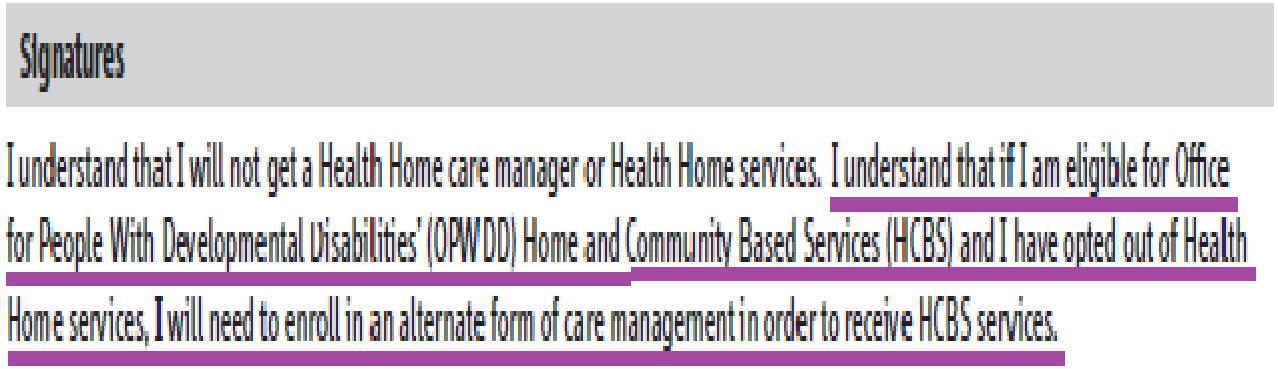
DOH-5059 (3/18)

UPDATES MADE:

Added:

- *"Health Home"* in the top sections of the form
- *"Medicaid Client"* consistently throughout the form
- *"Name of Health Home Care Manager"* (print and signature line)
- *"Name of Medicaid Client's Parent, Guardian, or Legally Authorized Representative, if applicable"* (print and signature line)

DOH 5059 - Continued



Signatures

I understand that I will not get a Health Home care manager or Health Home services. I understand that if I am eligible for Office for People With Developmental Disabilities' (OPWDD) Home and Community Based Services (HCBS) and I have opted out of Health Home services, I will need to enroll in an alternate form of care management in order to receive HCBS services.

Language was added to the *Signatures* section explaining:

- if an individual with intellectual and/or developmental disabilities (I/DD) is eligible for services under OPWDD, but choses not to enroll in a Care Coordination Organization Health Home (CCO/HH), they must enroll in Home and Community Based Services (HCBS) under OPWDD to receive care management services.

DOH 5202 – HH Consent Withdrawal of Health Home Enrollment and Information Sharing For Use with Children under 18 Years of Age

5. What if a person uses this child's 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, you can:

- Call the Medicaid Helpline at 1-800-541-2831, or
- Contact the US Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019, or submit a written complaint at: https://www.hhs.gov/hipaa/filing-a-complaint/index.html

You may also want to:

- call one of the providers you have said can see your records,
- call your care manager or health home: _____ at _____, or
- call your Managed Care Plan if you belong to a Managed Care Plan.

UPDATES MADE TO PAGE 2:

#5 language was expanded to include:

- **contact information for filing a complaint related to misuse of PHI, and a new link**

Children's Health Home Consent Guidance Document Updates

Children's HH Consent Guidance Document Updates

Prior to the launch of the Health Home Serving Children's program in December 2016, the children's consent forms were developed and released as well as a Consent Guidance document

> *The purpose of the guidance is to provide important information regarding the proper utilization of the required consent forms needed for Children's Health Homes.*

The Guidance Document has been updated and will be re-released and posted after this webinar. The following slides, highlight some of the various changes:

Frequently Asked Questions (FAQ) For Use with Children Under 18 Years of Age

It is required that the child/adolescent under age 18, and the parent, guardian or legally authorized representative must be provided a copy of *Health Home Consent Frequently Asked Questions (FAQ) For Use with Children Under 18 Years of Age* prior to completing the DOH 5200 *Health Home Consent Enrollment For Use with Children Under 18 Years of Age*

The DOH 5200 *Health Home Consent Enrollment For Use with Children Under 18 Years of Age* contains statements confirming that the FAQ document was reviewed and understood by the child and their parents, guardians or legally authorized representatives.

- Separate documents or copies of the FAQ are not needed
- Documentation in the case record that the FAQ was given and reviewed is sufficient with the proper information completed on the DOH 5200

HH Consent Information Sharing (Form DOH 5201) For Use with Children Under 18 Years of Age

The DOH-5201 has two sections:

- Section 1 - for the parent, guardian or legally authorized representative to complete **and**

- Section 2 - for the child/adolescent to complete separately with the Health Home care manager.

HH Consent Information Sharing (Form DOH 5201) For Use with Children Under 18 Years of Age – Section 1

Section 1:

To be completed, only, by the parent, guardian or legally authorized representative of children under the age of 18. The parents, guardians or legally authorized representative should be informed that:

- Health providers may share information before or after the signature date on the consent form.
- Consent to share information can be recorded, modified and withdrawn at any time.
- The child can keep private any information about services that the child/adolescent has the right to self–consent to receive (see Section 2).

HH Consent Information Sharing (Form DOH 5201) For Use with Children Under 18 Years of Age – Section 2

Section 2:

To be completed, only, by the child/adolescent separately with the Health Home care manager and not with the parents, guardians, or legally authorized representative.

- The child/adolescent can keep private any of their information regarding family planning, emergency contraception, abortion, sexually transmitted infection testing and treatment, HIV testing, HIV treatment and prevention, prenatal care, labor and delivery services, drug and alcohol treatment, or sexual assault services.

HH Consent Information Sharing (Form DOH 5201) For Use with Children Under 18 Years of Age – Section 2 continued

- Consent to share information regarding these types of protected services is applicable to children/adolescents aged 10 years or older.
- In addition, if child/adolescent is specifically receiving mental health or developmental disabilities and is over the age of 12, the mental health or developmental disabilities provider may ask the child/adolescent if they want their information disclosed.
  - If the parent, guardian, or legally authorized representative consented for these services (mentioned above) on behalf of the child/adolescent, then the parent, guardian, or legal authorized representative may have the authority to consent for the release of information for these services. However, the child/adolescent must also consent to the release of this information.

➢ **NOTE:** If the consent was signed prior to the member turning age 10, then when the member becomes age 10, the section 2 should be reviewed with the member

HH Consent Information Sharing (Form DOH 5201) For Use with Children Under 18 Years of Age – Section 2 continued

IMPORTANT FACTORS

- If the parent does not want the Health Home care manager (HHCM) to meet alone with the child, or the child is unable/unwilling to complete section 2 of the DOH 5201, then the HHCM must document such in the member's case record.
- Absence of section 2 completion should in no way prohibit the child's enrollment.
- The HHCM must be cognizant of restrictions posed when section 2 is not completed and act accordingly as the providers listed on section 2 of the 5201 will not be able to share information relating to these health services.
- The HHCM should re-approach the parent and/or child again whenever section 2 is not completed to attempt to obtain the necessary information to complete section 2.
- Section 2 can always be revisited, especially if initially, the child did not want to review section 2 or then becomes of age, or willing and able to complete section 2

Health Home Consent Information Sharing Release of Educational Records (DOH 5203)

Obtaining the DOH 5203 does not impact the enrollment process

- Consent for release of educational records for children and adolescents under age 18 must be provided by the parent (see definition of parent in Question 5 of the consent form, as it may differ from the HH requirements)
- Consent for release of educational records for those aged 18 and over must be provided by the individual.
- HHCM is required to obtain this consent for all children and adolescents attending school
- HHCMs must discuss completion of this form with the individual or parent, guardian or legally authorized representative as outline on the consent DOH 5203 and document any instances where this consent is not signed and the reason why

Circumstances which Warrant a New Consent

There are situations that warrant the completion of a new consent form(s), such as when the following occurs:

- if a Health Home changes its name (e.g., upon submission of the *Health Home Notification Letter* to the NYS Department of Health);
- if the child/adolescent turns 18 years old, only if he/she did not previously consent for him/herself;
- if the child/adolescent changes from foster care to non-foster care or non-foster care to foster care;
- if the child/adolescent under age 18 gets married, becomes pregnant or becomes a parent;
- the consenter for children under 18 years of age changes;
- the child changes schools/districts (refers to use of DOH 5203 for HHSC);
- if the member re-enrolls in the Health Home program following disenrollment;
- when a member changes Health Homes

When a New Consent Is Obtained

When a new consent form is needed due to the circumstances previously listed, the new consent form to enroll and information sharing MUST occur within the month of the event and/or the date of birth, to ensure continuity of care management services and the ability to bill for such services

Unusual Events - Which Consent (DOH 5055/DOH 5201)?

- HHCMs need to consider the member's circumstances/living situation when unusual events occur to determine which is the proper consent
- Documentation is KEY to support the type of consent that was signed by the member
- Minor/adolescent who is Pregnant, Parent, Married or 18 years and older can self-consent

Which Consent – DOH 5055 or 5201?

Unusual Circumstance Examples:

Q: The member was pregnant but is no longer pregnant because they lost the child before birth Or if the member had a child but the child passed away?

A: The member would be asked to sign a new children's consents, however if the member's parents were not involved or disowned the member for being pregnant, continue the adult DOH 5055 consent with supporting documentation.

Q: The member was married and now divorce?

A: They were married and now just divorced, so can still self-consent

Q: What about a member in foster care and pregnant?

A: The LDSS is responsible to determine who should sign consent and if the LDSS needs to sign per DOH/OCFS guidance.

A: Any member in foster care, who is pregnant, parent or 18 years old and older; the member should be consulted to sign consent forms along with the LDSS

LDSS consent guidance
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_children/hhsc_consent_for_children.htm

Specific Guidance:

Sharing of Information Health Home Consent DOH 5055 and DOH 5201

HH Consent Information Sharing (DOH 5055/5201)

HH consent forms are active, without expiration date until:

1. The member or parent/guardian/legal authorized representative withdraws consent,
2. Dis-enrolls from the HH program **or**
3. Based upon the previously list reasons why a new consent form is needed

Required Providers on HH Consent Information Sharing (DOH 5055/5201)

Health Home care managers MUST assure that the Information Sharing Consent Forms DOH 5055 and DOH 5201 includes, at a minimum:

- The name of the CMA, **and**
- The member's Medicaid Managed Care Plan (MMCP), if applicable **and**
- A primary care physician and/or healthcare provider from whom the member receives the majority of care (e.g. mental health, substance use, etc.) reflective of the chronic conditions the member was enrolled in the HH program

Adding and Eliminating Providers on HH Consent Information Sharing (DOH 5055/5201)

On DOH 5055 Page #3 and DOH 5201 Page #1 forms, list providers and their care team working with the member to share information

Adding Providers:

- Add provider's name, date and initial of member or parent/guardian/legal authorized representative

Removing Providers:

- A line strike through provider's name, date and initial of member or parent/guardian/legal authorized representative

➢ Documentation in the member's record should be made regarding changes to consents and to the care team/multi-disciplinary team

Evaluating Sharing Personal Health Information(PHI)

All providers listed on the Information Sharing Consent Forms DOH 5055 and DOH 5201 are able to obtain all PHI regarding the member.

- HH Care managers should evaluate with the member or parent/guardian/legal authorized representative whether the type of provider needs all PHI regarding the member
- All providers involved with the member are vital members of the care team but may not need all PHI regarding the member
- Examples of involved Care Team participants who may not need PHI:
  - Housing Providers
  - Religious / Spiritual organizations
  - Emergency or crisis plan contact individuals
- In these cases: Care Management Agency's own release of information / consent forms can be utilized instead of DOH form 5055 or DOH 5201

➢ Proper documentation should be noted in the members case record indicating the informed choice of the member or parent/guardian/legal authorized representative regarding who PHI should be shared with

Next Steps…

- Implementation of updated consent forms ***July 1, 2018***
- Health Homes must assure their network CMAs are informed of the changes and prepared to explain changes and implement
- Health Homes/care management agencies will continue to use Health Home consent forms for adults and children currently posted on the DOH Health Home website through June 30, 2018.
- For members enrolled *prior* to July 1, 2018, Health Homes must assure that members complete and sign a revised consent form(s):
  - For adults: by the member's next annual review, at minimum
  - For children: by September 30, 2018
- Updated consent forms will be posted to the website and sent out to the listserv prior to July 1, 2018
- Children's Guidance Document will be posted and sent out to the listserv this week

Questions and Discussion

Health Home Consent Resources

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*

For more information, visit the Medicaid Health Homes website at:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/

To contact us:

- Health Homes Bureau Mail Log (BML) at: https://apps.health.ny.gov/pubdoh/health_care/medicaid/program/medicaid_health_homes/emailHealthHome.action Subject: *Consent/Opt Out/Withdrawal of Consent/Information Sharing*

or,

Medicaid Health Homes website under “Contact Us” - *E–mail the Health Home Program*

- Health Home Provider Support Line at: 518-473-5569