

AUTHORIZATION TO SHARE CONFIDENTIAL MEDI-CAL INFORMATION (ASCFI): PILOT EVALUATION REPORT

January 2024

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Executive Summary

In 2023, the Department of Health Care Services (DHCS) tested the use of the Authorization to Share Confidential Medi-Cal Information Form (the “ASCMI Form”) and community-based electronic consent management services (collectively referred to as the “ASCMI tools” hereafter), which sought to support the sharing of Medi-Cal Members’ (the “Members”) sensitive health and social services information (HSSI) through a standard consent process. The ASCMI Form is a standard release of information (ROI) that is intended to inform Members of their rights and allow them to express preferences for sharing their sensitive HSSI. The forms were designed to be securely stored and managed by contracted health and community information exchange (HIE/CIE) organizations and can be accessed by the Member and their providers, health plans, county agencies, and others involved in the delivery of services to Members through a consent management service.

DHCS tested the following hypotheses in the ASCMI Pilot:

- 1.** A universal consent form containing only the minimum necessary language that was vetted by DHCS and a stakeholder group will encourage information sharing, in terms of both:
 - a.** Member willingness to consent to the sharing of their information; and
 - b.** Provider willingness to share Member information with the Member’s other care partners.
- 2.** Providing optionality for 42 C.F.R. Part 2-protected (“Part 2”) substance use disorder (SUD) information in the form will increase acceptance of the ASCMI Form by Medi-Cal Partners and Members.
- 3.** Having providers explain the ASCMI Form to Members and collaborating with them to develop supplementary frequently asked questions (FAQs) would support the health literacy of Members with respect to their data privacy rights.
- 4.** HIE/CIEs have the necessary infrastructure in place to support regional consent management services that could operate in a federated model to support a statewide rollout. This includes the ability to consume, store, and manage signed ASCMI Forms and the ability to exchange this information with health and social service organizations in the community.

Results from the ASCMI Pilot support the case for DHCS to pursue broader rollout of a standardized consent management process for all Medi-Cal Members.

Key Findings

The ASCMI Pilot demonstrated...

1. The majority of Members who participated in the Pilot want to allow their HSSI, including SUD information, to be shared for the purpose of care coordination.
2. The majority of Medi-Cal partners who participated in the Pilot support a state-sanctioned, universal, standardized consent form.
3. Many institutions who participated in the Pilot are still relying on faxed and other paper-based workflow processes.
4. Technical assistance, training, and education resources are needed to roll out standard consent management forms, tools, and processes.
5. More time was needed for implementation, especially for securing acceptance of consent tools.
6. Additional work is needed to improve the readability of the ASCMI Form and develop supplemental resources for educating Members.
7. A federated consent management service that leverages regional and community-based information exchanges is feasible.

The full report includes the following:

- » Contextual overview of data-sharing barriers and the case for a standard consent management process.
- » Summary of the design, implementation, and launch process for the ASCMI tools.
- » Analysis of the Pilot outcomes and a discussion of key lessons learned.

FULL REPORT



The Issue

In 2022, California embarked on a multiyear journey to [transform Medi-Cal](#) and provide Members with more coordinated, person-centered, and equitable care. The level of integration envisioned by DHCS requires the robust and secure exchange of Member information, including an array of HSSI across sectors. Broad and secure access to HSSI is limited, in part, by complex rules governing the collection and use of behavioral health and social services information, the use of paper forms instead of electronic tools in many instances, and a fragmented and incomplete HSSI exchange ecosystem composed of a combination of direct exchange between providers and users of national and regional health information exchange networks that primarily serve only physical health providers.¹

The complex and onerous data exchange rules and regulations that govern HSSI result in many institutions choosing not to share that type of information or participate in data exchange out of fear of violating federal and state privacy rules.² This issue is particularly acute for behavioral health and social services data for two reasons:

1. Behavioral health and social services providers have, in many cases, not kept pace with the technological advances that have been made by the majority of healthcare providers, including adopting Certified Electronic Health Record technology (“Certified EHRs”). This may be partly due to cost and partly due to federal focus on subsidizing other healthcare sectors, while not supporting adoption of Certified EHRs for many social services and behavioral health providers.³
2. Some SUD information is subject to Part 2, a federal regulation that protects the confidentiality of some, but not all, types of SUD information.⁴ When Part 2 applies, disclosure of information for treatment or care coordination purposes requires documented patient consent. Part 2 is widely misunderstood because

¹ [Why California Needs Better Data Exchange: Challenges, Impacts, and Policy Options for a 21st Century Health System](#) (California Health Care Foundation (CHCF)).

² Ibid.

³ The Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009.

⁴ At the time of publication, there is a [pending federal regulation](#) that would revise elements of Part 2, including the circumstances under which a recipient of Part 2 information could share that information with others (U.S. Department of Health and Human Services).

many institutions interpret the law and believe that it applies to any SUD information; however, the regulation only applies to any record “created by federally assisted SUD treatment programs.”⁵

Moreover, documented patient consent is a best practice and should not be seen as a hurdle to sharing data for the purpose of care coordination.

California’s [Whole Person Care \(WPC\)](#) Pilot program, which sought to comprehensively coordinate Members’ health and social services, illuminated the gaps in HSSI data exchange. WPC Pilot participants frequently encountered data-sharing challenges and indicated that a standard, state-sanctioned form, process, and consent management service could address much of the burden that has historically hindered the sharing of SUD and other information that requires patient consent.⁶ By standardizing how a Member’s consent preferences are obtained, documented, and managed electronically, providers would have a clearly documented and unambiguous approach for complying with the complex data-exchange rules that govern patient consent requirements such as Part 2.

To assess the need and feasibility of standardizing consent processes and tools, DHCS partnered with HIE/CIE organizations to launch three Pilots in Santa Cruz, San Diego, and San Joaquin counties. DHCS had three primary objectives for the Pilots (see Table 1).

Table 1: ASCMI Pilot Objectives and Goals	
1. Encourage Market Adoption	i. Establish robust user base to collect data and feedback on the form and its implementation.
2. Support Infrastructure Development	i. Test and build capacity for electronic consent management services. ii. Identify infrastructure gaps and technical assistance needs in the market ahead of a broader rollout.

⁵ [Fact Sheet: SAMHSA 42 CFR Part 2 Revised Rule](#) (SAMHSA).

⁶ [CalAIM and Health Data Sharing: A Road Map for Effective Implementation of Enhanced Care Management and In Lieu of Services](#) (CHCF).

Table 1: ASCMI Pilot Objectives and Goals

<p>3. Improve Care Coordination</p>	<ul style="list-style-type: none"> i. Support data exchange between managed care plans (MCPs), community-based providers and organizations, and county agencies that provide behavioral health services including Specialty Mental Health Services (SMHS), Drug Medi-Cal (DMC), Drug Medi-Cal Organized Delivery System (DMC-ODS), correctional institutions, and others. ii. Support Medi-Cal Transformation initiatives aimed at delivering whole-person care, including Enhanced Care Management (ECM) and Community Supports.
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The ASCMI Pilot

Creating a Standardized ROI Form

In summer 2022, DHCS set out to develop a standard ROI consent form (the “ASCMI Form”). The goal was to develop a form that was simple to understand and could be used across the various health and social services sectors that serve Members.

During the design phase, DHCS worked with health privacy attorneys to ensure that the form would be compliant with state and federal law. DHCS also reviewed multiple ROI forms that were used in various counties to better understand how similar forms were being employed at a local level. Finally, DHCS sought input and feedback on initial ASCMI Form drafts from the CalAIM Data

Example Use Cases for the ASCMI Form

Justice-Involved: A Member has co-occurring hypertension and SUD conditions and is receiving treatment for both while incarcerated. He signs the ASCMI Form prior to his release from county jail. The case manager working at the jail may share the Member’s post-release treatment plan, which contains information subject to Health Insurance Portability and Accountability Act (HIPAA) and Part 2 privacy regulations, with his new community-based provider post release.

ECM: A Member who has been unhoused is enrolled in ECM. She signs the ASCMI Form, which allows her housing case worker to share her housing status and other demographic and social service information with her primary care provider and managed care plan so that she can be authorized to access Community Supports housing services.

Sharing Advisory Group, the [California Center for Data Insights and Innovation \(CDII\)](#), and other stakeholders.

The ASCMI Form consists of five parts:

- » The **form** that Members review and fill out to authorize data sharing of their sensitive HSSI.
- » **Attachments A – C:** Templates for three lists of entities tailored to each Pilot site that the Member would consent to having their information shared with. This information must be provided for the ASCMI Form to be used in authorizing the disclosure of Part 2-protected data.⁷
 - **Attachment A:** Managed Care Plans
 - **Attachment B:** Community-Based Organizations and Providers
 - **Attachment C:** County Agencies
- » **Attachment D:** Additional information for Members, including a glossary of key terms used in the form and a list of FAQs with answers.

Hypotheses Tested in the ASCMI Pilot:

- (1) A universal consent form containing only the minimum necessary language that was vetted by DHCS and a stakeholder group will encourage information sharing, in terms of both:
 - a. Member willingness to consent to the sharing of their information; and
 - b. Provider willingness to share Member information with the Member's other care partners.
- (2) Providing optionality for Part 2 SUD information in the form will increase acceptance of the ASCMI Form by Medi-Cal Partners and Members.
- (3) Having providers explain the ASCMI Form to Members and collaborating with them to develop supplementary FAQs would support the health literacy of Members with respect to their data privacy rights.

By segmenting the form and using attachments that listed entities that information can be shared with and other supporting documentation, DHCS kept the primary form to four pages while ensuring the ASCMI Form in its entirety was compliant with state and federal laws. (See Table 2 for the types of information authorized to be shared by the

⁷ [42 CFR 2.31\(a\)\(4\)\(i\)](#)

ASCEMI Form and Table 3 for the types of organizations involved in the data exchange, either as a source or recipient of a Member’s data.)

Table 2: Types of Information Authorized to be Shared by the ASCMI Form	
	Protected health information (PHI) , including health information, medical history, lab test results, Member conditions, and treatment.
	Mental health information , including diagnoses and treatment history, but not including psychotherapy notes.
	Individualized Education Programs and other information about social services provided in schools.
	Medi-Cal eligibility/enrollment information , including income and other demographic information pertaining to Member eligibility for services and benefits.
	Housing/homelessness information , including housing status, history, and housing support services received.
	Limited criminal justice information , including booking data, dates and location of incarceration, and supervision status. This does not include criminal history, charges, or immigration status.
	Substance use disorder (SUD) information , including alcohol and other substance use diagnoses, medications, treatment, lab tests, trauma history, and facility discharges. This includes substance use disorder information subject to 42 C.F.R. Part 2.

Except for Part 2 SUD information, Members could not select specific types of information they authorized for disclosure or specific entities as sources/recipients of their information—meaning their consent applied to everything listed on the form. Based on consumer and stakeholder feedback regarding sensitivities surrounding SUD information, DHCS added a checkbox that Members were required to check off to authorize the disclosure of SUD information (see Figure 1).

7. Authorization

By signing this form, I authorize certain organizations and individuals to use and share my health and other confidential information for purposes described in part 1 of this form. Also, if I voluntarily include my phone number above, I consent to the receipt of texts or calls to communicate with me about my consent choices and how my information may be shared (standard message and data rates may apply).

By checking this box, I also authorize the disclosure of substance use disorder information about me that comes from providers subject to federal substance use confidentiality regulations (42 C.F.R. Part 2).

If you are signing on your own behalf, fill out the 1st line. If you are signing on behalf of someone else, fill out the 2nd line. If you are signing on behalf of a minor aged 12-17, the minor should fill out the 1st line and you should fill out the 2nd line.

Beneficiary's Name	Beneficiary's Signature	Date (mm/dd/yyyy)
Representative's Name	Representative's Signature	Date (mm/dd/yyyy)

Figure 1: Screenshot of Authorization Section in the ASCMI Form

Table 3: Sources and Recipients of Member Information
a) Healthcare providers , such as hospitals, clinics, physicians, pharmacies, and behavioral health providers.
b) Managed care plans (MCPs) , which administer Medi-Cal benefits and pay for Medi-Cal services.
c) Certain community-based organizations (CBOs) that must comply with federal healthcare privacy laws, including some medically tailored meal providers, housing providers, and asthma remediation providers.
d) School-based providers of health or social services , such as nurses, social workers, and counselors.
e) State health agencies , specifically, the California Departments of Health Care Services, Public Health, Social Services, and Developmental Services.
f) County agencies , including mental health plans, human/social services or welfare departments, drug Medi-Cal organized delivery systems, and health and public health departments.
g) Providers and case managers at correctional facilities , including jails, state prisons, and youth correctional facilities, only for the purposes enumerated on the ASCMI form (see appendix).

Designing a Consent Management Service

Hypotheses Tested in the ASCMI Pilots *(continued)*:

- (4) HIE/CIEs have the necessary infrastructure in place to support regional consent management services that could operate in a federated model to support a statewide rollout. This includes the ability to consume, store and manage signed ASCMI Forms and the ability to exchange this information

DHCS designed the Pilot to leverage the state’s existing HIE/CIE infrastructure. In the evaluation surveys conducted during the Pilot, approximately **40%** of Pilot participants reported relying primarily on fax and other transmittal methods involving paper to communicate their patients’ consent to share confidential information with other care team partners prior to the Pilot.

Each Pilot was designed to have a secure, regional electronic service that stored and managed the consent preferences of each Member documented by a signed ASCMI Form. The Pilot required the service to grant access to Members so that they could see and—if desired—change and/or retract their consent preferences. DHCS also intended for Members to be able to see with whom their information had been shared; however, this feature was

ultimately not in the Pilot due to time constraints. Providers needing to share a Member’s information with their other care partners could access the service to quickly check if there was a signed ASCMI Form on record.

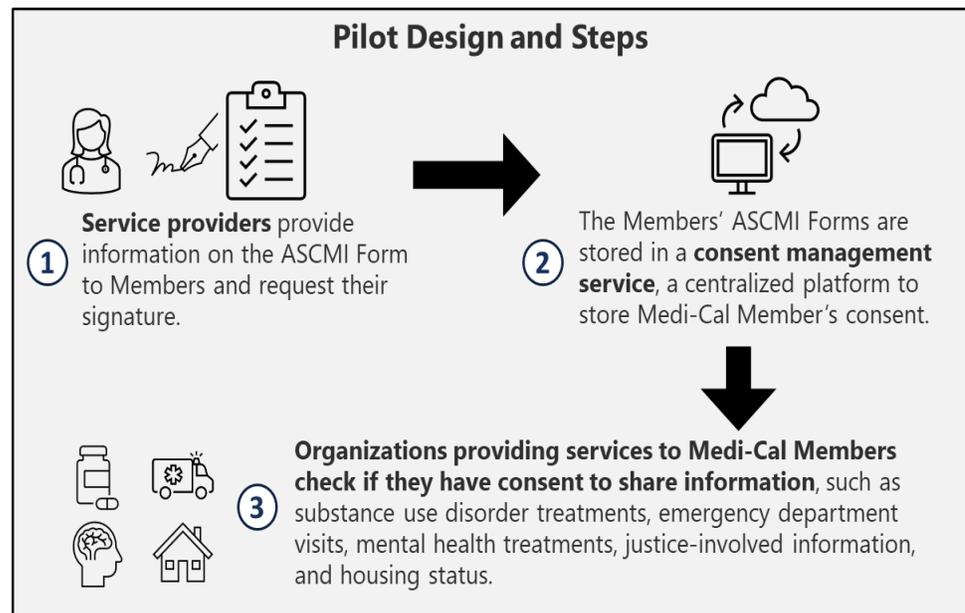


Figure 2: ASCMI Pilot Design

Launching the ASCMI Pilots

In November 2022, DHCS conducted a [request for information \(RFI\)](#) to identify California-based HIE/CIEs that had the infrastructure necessary to support the requisite consent management service and were interested in Piloting the ASCMI Form. Each Pilot site was required to have one HIE/CIE, one or more county agency, one or more Medi-Cal MCP, and multiple health and social service providers. The HIE/CIEs served as the Pilot site leads and were responsible for:

- » Contracting with DHCS;
- » Recruiting and establishing contracts with county agencies and their network providers, as well as MCPs and their network providers, to test the service and ASCMI Form; and
- » Developing a budget and managing Pilot funds from DHCS.

DHCS selected three Pilot sites (see Figure 3). In the selection process, DHCS prioritized applicant groups that included SMHS, ECM, and Community Supports providers in selecting the Pilot sites. Each Pilot site was awarded \$300,000 to implement and test the ASCMI tools. Funds were used for the following purposes:

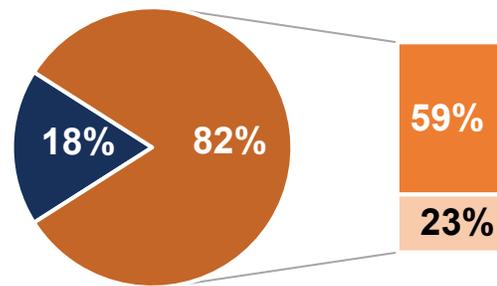
- » Securing providers to conduct the Pilot;
- » Building, launching, and operating the consent management service;
- » Training and providing ongoing technical assistance for providers on how to use the ASCMI tools and on how to educate their patients on data sharing; and
- » Collecting Pilot data and completing an evaluation at the end of the Pilot.



To evaluate the Pilot, DHCS surveyed all Pilot participants. All HIE/CIEs, MCPs, county agencies, and providers were required to complete surveys at the end of the Pilot. After Members were provided information on the ASCMI Form and their signatures requested, Members were also asked to complete an optional brief survey. All Members were asked to complete the optional survey regardless of whether they signed the form.

Pilot Outcomes

Across all three Pilots, **310** Members were asked by a provider to sign the ASCMI Form, and **254** Members (**82%** of all Members asked) signed the ASCMI Form. Of the Members who signed the ASCMI Form, **184** (**59%** of all Members asked) also checked the box authorizing the disclosure of information subject to 42 C.F.R. Part 2 (see Figure 4).



N=310 Members

A	Total percentage of Members asked to sign the ASCMI Form who declined
B	Total percentage of Members asked to sign the ASCMI Form who signed
C	Breakdown of percentage in B: Percentage of Members asked to sign the ASCMI Form who signed and authorized the disclosure of SUD information
D	Breakdown of percentage in B: Percentage of Members asked to sign the ASCMI Form who signed but did not authorize the disclosure of SUD information

Key Takeaways and Lessons Learned

Despite its short duration (five to six weeks, depending on the Pilot site), the Pilot provided valuable data and insights into the feasibility of and considerations for implementing the ASCMI Form and consent management services on a broader scale in California.

1. The majority of Members who participated in the Pilot want to allow HSSI, including SUD information, to be shared for the purpose of care coordination.

When presented with the option to have their HSSI shared, **82%** of Members in the Pilot agreed to do so. Further, **72%** of those Members agreed to the sharing of SUD information, even with the additional step required (see Figure 1).

In the optional Member survey, Members who declined to sign were asked to select from a list of reasons for declining (see Figure 5). The top two most common reasons for not signing the form were associated with the Member's preference to not share any sensitive information or not share it with specific organizations listed on the form. These

issues could potentially be addressed by giving Members the option to select what types of information they consent to sharing and with whom, instead of the ASCMI Form’s blanket consent.

Most importantly, a lack of understanding of the ASCMI Form and its intended use was the least commonly cited reason by respondents for declining to sign it. The findings indicate the majority of Members participating in the pilot embraced the ASCMI tools and the ability to make an informed decision about sharing sensitive HSSI information.

DHCS had hypothesized that providing optionality

for Part 2 SUD information in the form would increase acceptance of the ASCMI Form by Medi-Cal Partners and Members. There is not enough information to say definitively whether this is true; however, the Pilot did show that Members are willing to share their SUD information and suggested that it is worth exploring whether the reticence around Part 2 is more related to Medi-Cal Partners than Members.

2. The majority of Medi-Cal partners who participated in the Pilot support a state-sanctioned, universal, standardized consent form.

Pilot participants across all sites overwhelmingly supported a broader statewide ASCMI rollout. Additionally, **17** providers (**53%** of providers in the Pilot) found the ASCMI tools to be helpful. County agencies, MCPs, and providers all noted in their feedback how a standardized consent form could reduce administrative burden, enabling more timely care for Members.

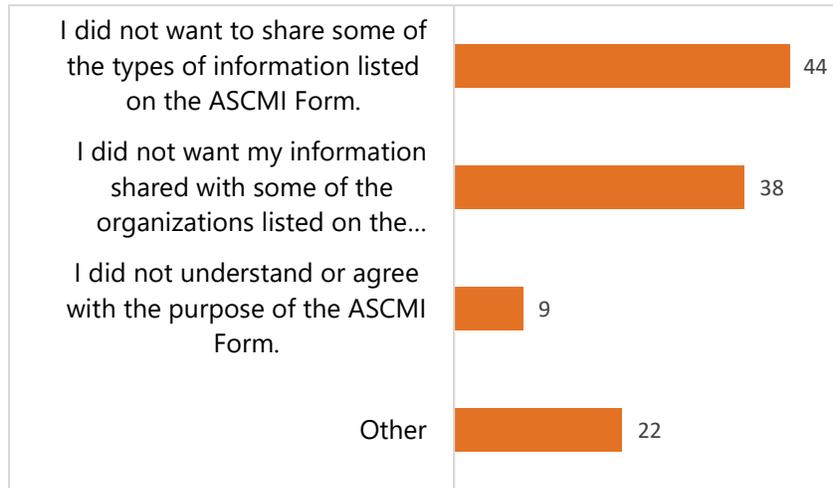


Figure 5: Reasons for Declining to Sign the ASCMI Form
 N=54 Members
 Note: Survey respondents were Members who declined to sign the ASCMI Form. The survey was optional for Members. In all, 301 Members completed the survey. Of those, 247 had signed the ASCMI Form, and 54 had declined to sign. Respondents could select more than one choice.

Pilot participants support DHCS involvement and believe DHCS is well positioned to convene stakeholders to address privacy issues and concerns, the first step to achieving more widespread acceptance and adoption of ASCMI. 2-

1-1 San Diego noted DHCS' involvement is critical in bringing together compliance officers, legal counsels, and program directors across sectors and across counties to advance a standard consent form statewide



Long-Term Interest in ASCMI Tools

82% of MCPs and county agencies supported a broader rollout of the ASCMI tools.

53% of providers found the ASCMI Form helpful and that it improved their organization's consent management process.*

59% of providers found the consent management service helpful.*

**All other providers were neutral. No providers found the ASCMI Form or consent management service to not be helpful.*



"Having a standardized consent and standardized process **approved at the state level** for use and access would decrease administrative burden and improve timely access across the continuum of care as well as the overall satisfaction rate in Medi-Cal. We can focus more on meeting the needs and overall health and well-being of the beneficiaries versus [on] the 'paperwork.'"

– Provider, San Diego Pilot

"We would use the consent management service to review patients' consent status and share, or not share, information requested by outside organizations accordingly. This would streamline our process and allow us to respond more quickly and efficiently to requests."

– MCP, Santa Cruz Pilot

It is worth noting, however, that there have been many efforts at a county level and a regional level to implement a standard consent form. Notably, 2-1-1 San Diego had a local consent form in place that did not include Part 2 data prior to the ASCMI Pilot. It took years and many conversations with compliance officers across sectors to get agreement on the language used in that form. While 2-1-1 San Diego had strong local support, they noted many organizations that extend into other counties have requested

multiple regional versions, which may complicate rollout of an alternative, statewide form.

Thus, while DHCS' leadership is critical, their role as a convenor may not be sufficient to move stakeholders to fully embrace a single universal consent form and process. Incentivizing and requiring use of a standardized form, tools, and set of processes may be needed to spread and sustain adoption statewide.

3. Many institutions who participated in the Pilot are still relying on faxed and other paper-based workflow processes.

DHCS launched the ASCMI Pilot with the hypothesis that HIE/CIEs had the infrastructure in place to be able to support a consent management service. This included the ability to consume and store signed ASCMI Forms and the ability to exchange this information with health and social service providers in the community. The ASCMI Pilot was designed to support an electronic consent management process and a centralized and accessible consent management service. DHCS understood that the Pilots needed to accommodate different modalities that participants would use to document and access consent forms, which is why a stand-alone portal was a required design element of the Pilot. An online portal would allow any authorized individual or entity with a secure internet connection to access it.

One outcome of the Pilot was that out of the **17** providers who completed the

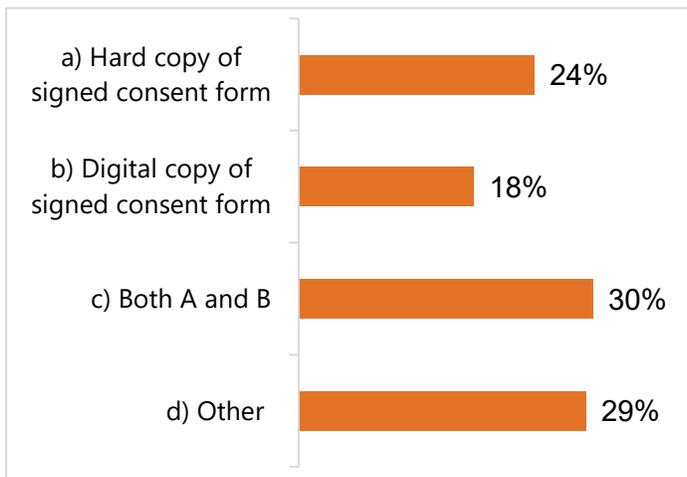


Figure 6: Provider Methods for Documenting Consent (Prior to ASCMI Pilot)

N=17 providers

Note: Total may be greater than 100% due to rounding.

evaluation survey, **4 (24%)** reported relying on a paper-based signed consent form to document a Member's consent prior to the ASCMI Pilot (see Figure 6). And **7** of them (**41%**) reported fax (or another transmittal method involving paper) as one of the most common forms of communicating consent with the Member's other care partners prior to the ASCMI Pilot (see Figure 7). So, while the HIE/CIEs had the infrastructure in place to be able to support a consent management service, the providers themselves are limited in terms of their

ability to make use of technology effectively to maximize the utility of the electronic form and service.

The findings suggest that many organizations would benefit from investments in information technology (IT) infrastructure and technical assistance to help redesign workflows and migrate away from paper-based processes, and that workflows would benefit from having the consent management service accessible directly from an institution’s electronic health record or other electronic documentation system.

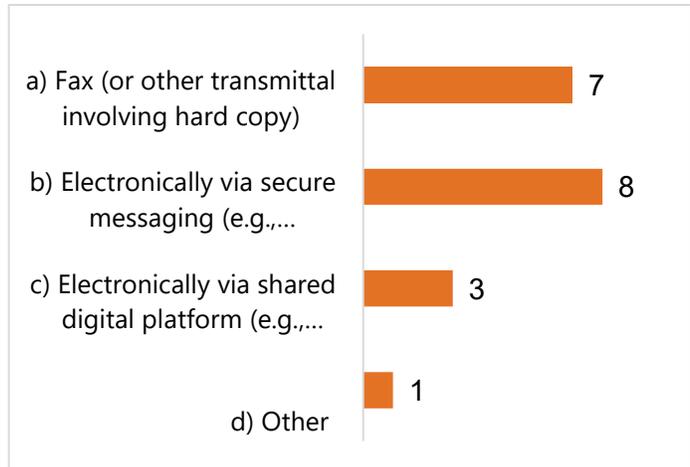


Figure 7: Provider Methods for Communicating Consent (Prior to ASCMI Pilot)

N=17 providers

Note: Survey respondents were providers. Respondents could select more than one choice.

Why Multiple Modalities Are Critical—*Insights From SCHIO:*

SCHIO designed a consent management service that could be accessed through three modalities:

1) Tablet at provider site



2) Paper upload



3) Mobile app



SCHIO found that paper (**57, 79%** of ASCMI signatures collected in the Santa Cruz pilot) and tablet (**11, 15%** of ASCMI signatures) were the most used modalities. The paper upload option was critical, as some providers did not have reliable Wi-Fi. The mobile app was the least used, which could be attributed to not all patients having their own mobile device or their unwillingness to download an app.

4. Technical assistance, training, and education resources are needed to roll out standard consent management forms, tools, and processes.

HIE/CIEs were required to use a portion of Pilot grant funding to conduct onboarding and training and to provide ongoing technical assistance for providers on using the ASCMI tools. For the ASCMI Form, DHCS provided guidance through a FAQs document that provided standardized responses to anticipated Member questions for providers.

The Santa Cruz Health Information Organization (SCHIO) shared feedback from providers, noting “the FAQs were helpful in leading conversations with patients.” Trainings and technical assistance for the consent management service varied, as they were tailored to each Pilot site’s service.

All three HIE/CIEs used a combination of group training for providers as well as ongoing asynchronous (e.g., via email) and synchronous (e.g., via office hours and one-on-one meetings) technical assistance. While general information about the ASCMI Form could be conducted in group trainings, the HIE/CIEs found that one-on-one engagement was critical to supporting providers in integrating the ASCMI tools into their workflows. For example, 2-1-1 San Diego and SCHIO met with providers to develop organization-specific workflows for integrating the ASCMI Form. Manifest MedEx cited the need for more time to work with provider organizations’ IT departments to conduct accessibility testing and address issues such as internal firewalls that prevented providers from accessing the service. Providers across all Pilot sites had generally positive feedback with the trainings provided by the HIE/CIEs.

Common Feedback on ASCMI Form
(not exhaustive)

- » Adjust the language and verbiage of the entire form to ensure it meets all Medi-Cal standards and requirements for health education materials, including ensuring an appropriate reading level.
- » Be more explicit that signing this authorization is voluntary and not a condition of healthcare treatment, benefits, or coverage.
- » Provide Members the option to select which types of information they authorized to be shared.
- » Provide Members the option to select the sources and recipients of their information

5. More time was needed for implementation, especially for securing acceptance of consent tools.

Due to a potential expiration of funds on June 30, 2023, DHCS implemented an aggressive timeline for the Pilot to run from April 1 to June 30, 2023. However, most Pilot sites did not launch until late May due to contractual, implementation, and other unforeseen delays. One of the key issues causing delays was securing agreements to use the form (see “Common Feedback on ASCMI Form” below). This led to a protracted contracting process and cascading delays to other implementation activities (e.g., onboarding and training providers). All three Pilot sites were live for between five and six weeks in duration, which limited the ASCMI Pilot to testing only user acceptance of

the ASCMI tools (see steps 1 and 2 in Figure 2). The Pilot sites collected signatures but did not use the ASCMI Form to authorize data sharing, preventing step 3 in Figure 2 and the goals of the ASCMI Pilot from being fully realized.

6. Additional work is needed to improve the readability of the ASCMI Form and develop supplemental resources for educating Members.

The ASCMI Form was designed to be brief, complete, and understandable for anyone without a legal background. Keeping the form brief was a key design priority. However, multiple MCPs and county agencies deemed the ASCMI Form, both the English and Spanish translation, to be at a reading level that was not fully accessible to Members. Furthermore, privacy and compliance officers for MCPs and county agencies had questions and concerns with some of the legal terminology. Due to the constrained timeline, DHCS was unable to make substantial revisions to the ASCMI Form after the Pilots were selected but collected feedback through the Pilot to revise the ASCMI Form for future iterations.

DHCS did allow Pilot sites to make minor modifications to the form if the HIE/CIE deemed the revision would support acceptance from other Pilot participants. However, all Pilot sites proceeded with the version provided by DHCS. The combination of readability and legal concerns led to the protracted contracting process and ultimate decision to move forward without any data sharing. Should the ASCMI Form be rolled out more broadly, additional engagement with legal and program officers from MCPs, county agencies, providers, and other stakeholders in updating the form will be needed.

In the Pilot, providers played a significant role in sharing information with Members and addressing their questions. 2-1-1 San Diego and SCHIO specifically mentioned incorporating “conversation starters” and other best practices for discussing the ASCMI Form with members as part of their training. The effectiveness of provider trainings was made evident by the fact that only **9** Members (**16%** of Member survey respondents who had declined to sign the form) selected “I did not understand or agree with the purpose of the form” as one of their reasons for declining (see Figure 5). This finding underscored the important role providers play in informing patients and the need to ensure providers are adequately prepared to explain the purpose of ASCMI tools and address patient questions. Providing tools and guidance such as the FAQs can enable more effective communication between providers and Members.

7. A federated consent management service that leverages regional and community-based information exchanges is feasible.

DHCS launched the Pilots under the hypothesis that a federated model, one with multiple consent management service platforms, may be a feasible pathway to a statewide approach for consent management. A single statewide consent management service would be costly and likely take many years to fully realize. The Pilot demonstrated that, while the form needs to be standardized statewide, selected HIEs and CIEs have the infrastructure in place to serve as a consent management service regionally and support a broader rollout of the ASCMI Form. A federated system would leverage HIE/CIEs' existing technical capabilities and connectivity with health and social services providers to quickly build up regional consent management services. However, a federated system would still require a central repository to facilitate and link the exchange of consent information between regional consent management services.

Conclusion

Improving data exchange is fundamental to the success of Medi-Cal's transformation initiatives, including [ECM](#), [Community Supports](#), and the [Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment Demonstration \(BH-CONNECT\)](#), which require coordination and data sharing across health and social service sectors. Simplifying and standardizing the consent management process would help alleviate this barrier. The ASCMI Pilot focused on supporting the exchange of information, including behavioral health data, which has long been an issue in California as well as nationally. Pilot participants have also shared their interest in other use cases, including the [Justice-Involved Initiative](#).

Despite timeline constraints and challenges from MCPs and counties in adopting the ASCMI Form, the ASCMI Pilot:

- » Highlighted data privacy rights and authorization requirements as an area Medi-Cal partners and Members need more guidance on;
- » Validated market interest in universal, standard consent management tools and processes; and
- » Demonstrated that Members, when informed of the purpose and their rights, are often willing to share their sensitive HSSI information, including their SUD information.

Given the outcomes, evidence suggests that individuals and institutions in California are eager to engage in a process to establish universal, standardized consent management tools. While the majority of Medi-Cal Partners participating in the Pilot support a

universal, standardized consent management process, the readability and legal suitability of the Form prevented full adoption and use of the ASCMI tools and will need to be addressed to support broader rollout.

The ultimate goal is to establish a cohesive, statewide approach to consent management that is user friendly. In 2024, DHCS will collaborate with stakeholders to:

- » Explore options and approaches for implementing ASCMI tools more broadly;
- » Refine the ASCMI tools based on lessons learned from the Pilot, and secure additional interest in their adoption; and
- » Assess funding needs and explore funding sources to support implementation.

Future updates will be posted on the [DHCS ASCMI website](#).

Appendix A: ASCMI Pilot Participants

Table 5: List of All Pilot Participants

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Pilot Site	San Diego	Santa Cruz	San Joaquin
Pilot Start Date	5/24/2023	5/22/2023	6/1/2023
Pilot End Date	6/30/2023	6/30/2023	6/30/2023
HIE/CIE	2-1-1 San Diego	SCHIO	Manifest MedEx
County Agencies	County of San Diego, Health and Human Services Agency: <ul style="list-style-type: none"> • Behavioral Health Services • Medical Care Services • San Diego Advancing Innovating Medi-Cal Unit 	County of Santa Cruz: <ul style="list-style-type: none"> • Health Services Agency - Clinic Services Division • Santa Cruz County Behavioral Health - Adult Access 	County of San Joaquin: <ul style="list-style-type: none"> • Whole Person Care • Behavioral Health Services
MCPs	<ul style="list-style-type: none"> • Health Net 	<ul style="list-style-type: none"> • Central California Alliance for Health 	<ul style="list-style-type: none"> • Health Plan of San Joaquin • Health Net
Providers	<ul style="list-style-type: none"> • McAlister Institute • Metropolitan Advisory Committee on Anti-Poverty (MAAC) • People Assisting the Homeless (PATH) • San Ysidro Health 	<ul style="list-style-type: none"> • Salud Para La Gente • Front St. Inc. • County of Santa Cruz Health Services Agency, Federally Qualified Health Center (FQHC) 	<ul style="list-style-type: none"> • TeleCare Corp • Community Medical Centers
Other Partners	<ul style="list-style-type: none"> • San Diego Health Connect 	<ul style="list-style-type: none"> • Intrepid Ascent • Pulsar Health 	

Appendix B: ASCMI Form (Pilot Version)

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Version 1.0 [Pilot]*December 2022*

Disclaimer: The ASCMI Form is intended to be used solely by ASCMI Pilot participants. DHCS makes no representation about the suitability of this form for uses outside of the ASCMI Pilot. The ASCMI Form, including attachments, are subject to change.

First Name	Last Name	Date of Birth	
Mailing Address	City	State	Zip Code
Residential Address	City	State	Zip Code
Phone Number(s)	Email	Beneficiary Identification Card (BIC)	

By signing this form, you authorize certain organizations and individuals to use and share your health and other confidential information for the purposes described in section 1.

1. Purposes

By signing, you authorize your health and other confidential information to be shared only to:

- (a) Provide you with, refer you to, or help you access healthcare treatment, benefits, programs, social services, case management, community resources, and other supports (“Services”) to meet your needs.
- (b) Identify, support, coordinate, improve, and arrange payment for Services that may be provided to you.
- (c) Help Medi-Cal provide better care through evaluation, reporting, and population health management.

2. Types of Your Information that You Authorize to be Shared

By signing, you authorize the below types of health and other confidential information about you to be shared only for the purposes stated above.

- (a) Protected health information (PHI), including information regarding your health care, medical history, lab test results, and current or future conditions and treatments.

- (b) Mental health information, including current and past diagnoses and treatments of your mental health conditions. This does not include psychotherapy notes, which are only shared if you separately consent.
- (c) Substance use disorder information, including your current and past alcohol or drug use diagnoses, medications, treatment, lab tests, trauma history, facility discharges. This includes substance use disorder information about you that comes from a substance/alcohol use disorder provider subject to federal substance use confidentiality regulations (42 C.F.R. Part 2) if you check the box at the end of this form.
- (d) Individualized Education Programs, and other information about social services provided in schools.
- (e) Medi-Cal eligibility/enrollment information, which includes income and certain other demographic and geographic information pertaining to your eligibility for Services and benefits.
- (f) Housing/homelessness information, including your housing status, history, and supports.
- (g) Limited criminal justice information, including booking data, dates and location of incarceration, and supervision status. Your consent does not apply to your criminal history, charges, and immigration status.

3. Sources and Recipients of Your Information

By signing, you agree to allow a health information exchange or community information exchange (“HIE/CIE”) facilitate the exchange of your health and other confidential information with and between your care partners from which you have received, are receiving, or will receive benefits, treatment, or services (“Your Care Partners”). Information may be shared only for the purposes in part 1. Your Care Partners may include the following:

- (a) Healthcare providers, such as hospitals, clinics, physicians, pharmacies, and behavioral health providers.
- (b) Managed care plans (MCPs), which administer Medi-Cal benefits and pay for services you receive under Medi-Cal. A list of MCPs can be found in [Attachment A](#), which is part of this form.
- (c) Certain community-based organizations (CBOs) that must comply with federal health care privacy laws, including some medically tailored meal providers, housing providers, and asthma remediation providers. A list of such CBOs can be found in [Attachment B](#), which is part of this form.

- (d) School-based providers of health or social services, such as nurses, social workers, and counselors.
- (e) State health agencies, specifically, the California Departments of Health Care Services, Public Health, Social Services, and Developmental Services.
- (f) County agencies, including mental health plans, human/social services or welfare departments, drug Medi-Cal organized delivery systems, and health and public health departments. A list of such agencies can be found in [Attachment C](#), which is part of this form.
- (g) Providers & case managers at correctional facilities, such as those at jails, prisons, and youth correctional facilities, only for the purposes in part 1 of this form. You do not consent to the use of your information for criminal investigations or prosecutions, sentencing, parole or probation monitoring, immigration enforcement, or family court proceedings.

Your Care Partners and their contractors agree to obey all applicable laws protecting your information.

4. Expiration, Revocation, or Change of This Form

Once signed, this form will be effective until the first of the following occurs:

- (a) 24 months from the date on which you were last enrolled in Medi-Cal;
- (b) you revoke this form; or
- (c) you make any change to this form, and the modified form becomes effective.

5. Your Rights

You understand that:

- (a) you can revoke this form at any time through the consent management service portal or by sending a revocation request signed by you or your representative to the HIE/CIE;
- (b) a revocation is effective when received but may not apply to information already shared based on your past executed form, which may not be recalled or deleted;
- (c) you may decline to sign this form and doing so will not affect your treatment or care, your eligibility for or ability to receive Services, or the payment for Services;
- (d) you have a right to receive a copy of this form;
- (e) the information you authorize for release could be re-disclosed by Your Care Partners, but only in compliance with this form and applicable law; and
- (f) you may obtain a list of Your Care Partners to which your information has been disclosed by contacting the HIE/CIE.

Each of these rights extend to your representative if authorized by you under applicable law.

6. Sharing Information Without Your Consent

You understand that even if you do not sign this form, under federal and state privacy laws some of Your Care Partners may share your confidential information for treatment, payment, and other purposes, but providers subject to federal substance use confidentiality laws generally may not share your substance use disorder information without your consent.

7. Authorization

By signing this form, I authorize certain organizations and individuals to use and share my health and other confidential information for purposes described in part 1 of this form. Also, if I voluntarily include my phone number above, I consent to the receipt of texts or calls to communicate with me about my consent choices and how my information may be shared (standard message and data rates may apply).

- By checking this box, I also authorize the disclosure of substance use disorder information about me that comes from providers subject to federal substance use confidentiality regulations (42 C.F.R. Part 2).

If you are signing on your own behalf, fill out the 1st line. If you are signing on behalf of someone else, fill out the 2nd line. If you are signing on behalf of a minor aged 12-17, the minor should fill out the 1st line and you should fill out the 2nd line.

Beneficiary’s Name	Beneficiary’s Signature	Date (mm/dd/yyyy)
Representative’s Name	Representative’s Signature	Date (mm/dd/yyyy)