CalAIM Data Sharing Authorization Guidance

VERSION 2.0
June 2023 (DRAFT FOR PUBLIC COMMENT)

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1. Guidance Background and Overview

(1) Guidance Overview

A major transformation of the Medi-Cal program is underway to improve the health and well-being of its members. These changes, including initiatives under the California Advancing and Innovating Medi-Cal (CalAIM) Section 1115 waiver, are part of a broad Medi-Cal transformation to create a more coordinated, person-centered, and equitable health system that works for all Californians. CalAIM integrates care coordination and case management across physical health, behavioral health, and social services providers for those enrolled in Medi-Cal. The level of integration envisioned by CalAIM requires the exchange of information about individuals enrolled in Medi-Cal, including an array of administrative, clinical, social, and human services information across sectors. This exchange must occur in compliance with federal and state data privacy and data sharing consent laws, regulations, and other data sharing rules.

CalAIM introduced new considerations when determining what is allowed for data sharing, particularly in light of Assembly Bill (AB) 133—a 2021 law (discussed in this chapter and in Chapter 3 of this document) that permits disclosure of personal information if such disclosure helps implement CalAIM and is consistent with federal law—that makes it easier for providers to share data. This guidance document was created to help bridge the gap between the changed application of certain laws in California as a result of AB 133 and existing published guidance, which was developed outside the context of AB 133.

(2) Purpose of Guidance

► For Whom Is This Guidance Intended?

This document is intended to **provide guidance to a wide range of individuals and organizations that are providing or overseeing the delivery of health services ("Medi-Cal Partners;" see box on the right) to people receiving services under the conditions of AB 133 (see section below)**. This document provides specific guidance on data privacy and data sharing consent laws, regulations, and rules for Medi-Cal Partners while also navigating important legal protections.

Medi-Cal Partners

In this document, "Medi-Cal Partners" broadly refers to Medi-Cal Managed Care Plans (MCPs), Tribal Health Programs, health care providers, community-based social and human service organizations and providers, local health jurisdictions, correctional facility health care providers, and county and other public agencies that provide services and manage care for individuals enrolled in Medi-Cal.

For example:

1. Legal and other advisors who work with Medi-Cal Partners may find this guidance (especially Chapters 2, 3, and 4) helpful when determining how to counsel the care

manager on the laws protecting such information and what consent from the individuals enrolled in Medi-Cal must be obtained by the care manager.
2. Care managers may leverage the data sharing use cases (Chapter 5) to better understand the application of these laws.

In addition, this document includes a description of processes and scenarios that illustrate how data may be shared to support the provision of Enhanced Care Management (ECM) and Community Supports services, which are interdisciplinary approaches to care that address whole-person needs for individuals enrolled in Medi-Cal managed care through systematic coordination of services and comprehensive care management that is community-based, high-touch, and person-centered. ECM and Community Supports services are central components of CalAIM.

Lastly, this document is intended to help Medi-Cal Partners better understand their obligations under existing laws at the time of this document's publication. **This document does not propose new laws, regulations, or rules for Medi-Cal Partners.**

► To Whom Does This Guidance Apply?

The guidance in this document addresses the exchange of information about persons for whom data sharing is governed by AB 133, namely individuals enrolled in Medi-Cal who are also enrolled in: managed care plans (MCPs), county mental health plans (MHPs), and/or Drug Medi-Cal Organized Delivery Systems (DMC-ODS), and also includes justice-involved populations that qualify for Justice-Involved Reentry Initiative[1] pre-release services. For the sake of simplicity, we refer to these individuals as "Members" throughout this document.

Members

The guidance in this document applies to those individuals enrolled in a managed care plan within Medi-Cal as well as applicable justice-involved individuals. For simplicity, in this document, we use the term "Members."

This guidance does not apply to those who receive care exclusively under the Medi-Cal fee-for-service system and/or who are not qualified inmates.

► Statutory Reason for Limiting This Guidance to Individuals Enrolled in Managed Care Within Medi-Cal and Justice-Involved Populations

The AB 133 State Law Applicability Provision applies only in cases where information is exchanged to "implement applicable CalAIM components described in this article and the CalAIM Terms and Conditions." This provision only applies to individuals enrolled in

[1] https://www.dhcs.ca.gov/CalAIM/Pages/Justice.aspx.

Medi-Cal who are also enrolled in managed care and/or qualify for Justice-Involved Reentry Initiative pre-release services.

Coverage of Managed Care Participants. Whenever Medi-Cal Partners share information for purposes of providing care to, coordinating care of, or improving the quality of care delivered to individuals enrolled in Medi-Cal (or receiving reimbursement for such services), such organizations are sharing information to "implement applicable CalAIM components," and therefore the AB 133 State Law Applicability Provision applies. CalAIM is a program primarily designed to improve care for those enrolled in Medi-Cal managed care, which includes both comprehensive managed care offered by MCPs as well as care under the Medi-Cal Specialty Mental Health Services (SMHS) program and the DMC-ODS program.[2] The AB 133 State Law Applicability Provision applies both to children and adults enrolled in managed care, including children who receive services under either the California Children's Services or Child Health Disability Prevention programs, if such children are enrolled in a Medi-Cal MCP, an MHP, or the DMC-ODS. Similarly, the law applies to Members who do not receive ECM, since ECM is just one component of CalAIM.

In short, the AB 133 State Law Applicability Provision applies whenever information is being shared about a Member for purposes of providing or coordinating care, improving quality of care, or providing payment for such care, regardless of whether the service itself is being reimbursed by an MCP. The alternative—to have a different set of information sharing rules apply depending on whether an MCP or the fee-for-service program is paying for a service—would conflict with the purposes of CalAIM as set forth in AB 133.

Coverage of Justice-Involved Individuals. AB 133 establishes targeted pre-release Medi-Cal benefits for qualified inmates as a component of CalAIM.[3] Therefore, the AB 133 State Law Applicability Provision applies to all qualifying inmates of public institutions who receive pre-release Medi-Cal benefits, even in cases where those individuals receive care solely through the fee-for-service program or solely from an MHP or the DMC-ODS.

Noncoverage of Fee-for-Service. In contrast, the AB 133 State Law Applicability Provision does <u>not</u> apply to individuals enrolled in Medi-Cal who receive care <u>exclusively</u> under the fee-for-service system and who are not qualified inmates. This situation is rare; most Californians enrolled in Medi-Cal are in managed care or are transitioning to managed care. Nevertheless, there may be specific instances where an

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[2] *See* Welfare and Institutions Code Section 14184.102(a) (defining CalAIM initiatives to include these managed care programs).

[3] *See* Welfare and Institutions Code Section 14184.102(a)(9).

individual enrolled in Medi-Cal receives services solely under the fee-for-service system, such as if a person is receiving fee-for-service care from only one provider and receives permission to continue to receive services from that provider for a period of time.

► Application to Different Organizations

Medi-Cal Partners include not only the types of persons specifically listed in the AB 133 State Law Applicability Provision—such as MCPs, health care providers, and counties—but also all "other authorized provider or plan entities." Any person or organization that has been authorized to provide health care, social services, or housing services to Members is a Medi-Cal Partner. In addition, the AB 133 State Law Applicability Provision permits disclosures to "contractors" of Medi-Cal Partners. These include but are not limited to business associates[4] that facilitate the exchange of PII. Therefore, Medi-Cal Partners may exchange PII through health information exchanges, community information exchanges, and other entities that permit the sharing of PII in accordance with federal law.[5]

► Impact on Federal Law Requirements

Medi-Cal Partners remain fully responsible for complying with federal privacy laws, and many such laws may apply to disclosures that occur under CalAIM. Such laws may include but are not necessarily limited to:

- HIPAA and its Privacy and Security Rules;
- The federal SUD regulations in 42 C.F.R. Part 2;
- FERPA and IDEA;
- The Centers for Medicare & Medicaid Services statutes;
- Regulations and guidance limiting the disclosure of Medicaid records to purposes directly related to Medicaid administration; and
- United States Department of Agriculture statutes, regulations, and guidance limiting disclosures under the Supplemental Nutrition Assistance Program (known in California as CalFresh) and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

It is key that readers of this document recognize that federal requirements related to the use and disclosure of Medi-Cal data—and DHCS guidance interpreting those federal requirements—remain in effect. This means that counties remain responsible for

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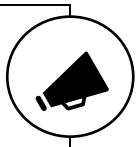
[4] "A 'business associate' is a person or entity that performs certain functions or activities that involve the use or disclosure of PHI on behalf of, or provides services to, a covered entity" (Business Associates, HHS).

[5] If a community information exchange or other intermediary provides Medi-Cal reimbursable services, such organization may also be a Medi-Cal Partner.

entering into written agreements with their contractors that have access to Medi-Cal PII in accordance with DHCS guidance.

Similarly, MCPs must abide by the applicable terms of their contracts with DHCS relating to ensuring their contractors and vendors properly safeguard Medi-Cal data.

Disclaimer



As the state's Medi-Cal agency, DHCS does not have the authority to interpret or enforce many of the federal privacy laws that apply to the disclosure of information under CalAIM. Further, as noted earlier, DHCS cannot provide legal advice to Medi-Cal Partners regarding when disclosures comply with applicable privacy laws.

Additional Data Sharing Resources

The California Health and Human Services Agency's Center for Data Insights and Innovation has produced informational documents with examples and scenarios, called "State Health Information Guidance (SHIG)" documents. There are several SHIG documents, including one for data sharing related to foster youth and minors in California. These may serve as useful resources to understand data sharing privacy laws applicable to California minors. However**, the SHIG documents may not reflect the impact of AB 133 on the applicability of certain state privacy laws.** See Chapter 3, "AB 133's Data Sharing Provisions and Related Guidance," for more information.

(3) Guidance Road Map

The initial version of this document, released in March 2022, focused on data sharing to promote the coordination of care for **adult** individuals enrolled in Medi-Cal under CalAIM. It also included a discussion of the impact of CalAIM on **justice-involved populations**.[6]

This version expands the scope of the original document to include additional information on the disclosure of a **minor's**[7] records in recognition of the expansion of ECM to the children and youth populations of focus on July 1, 2023, as well as additional state-level initiatives focused on children.[8] The document also includes new use cases relevant to behavioral health data sharing and the No Wrong Door for Mental Health Services Policy.[9]

► Guidance Outline

1. **Chapter 2, Overview of Key Privacy Laws**, is a summary of the privacy laws most relevant to CalAIM and its data sharing efforts. It directs readers who require additional background to Appendix A, which contains more on these privacy laws.
2. **Chapter 3** is a discussion of **AB 133's Data Sharing Provisions and Related Guidance.** Some of the information included about AB 133 was in the first version of the document, but the discussion has been expanded in this update.
3. **Chapter 4, Guidance on Consent and Required Authorization Elements,** includes:
   - Use of electronic signatures and verbal consent;
   - Key privacy laws governing the content of authorization forms; and

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[6] Guidance on the exchange of data and information for enrollment—as opposed to service provision—in Pre-Release Medi-Cal services is not included in this document. More information can be found in DHCS All County Welfare Directors Letter No.: 22-27.

[7] Under California law, a "minor" is a person under age 18. *See* California Family Code Section 6500. This means that different rules apply for those under 18 with respect to consenting to services and consenting to the disclosure of information about services. Note that in other contexts, such as for certain Medi-Cal enrollment categories, individuals aged 18–20 are considered to be children and Medicaid's EPSDT benefits apply to children and adolescents enrolled in Medi-Cal under age 21.

[8] In order for ECM to address the whole-person needs under CalAIM of eligible children and youth in Medi-Cal, ECM providers will need to be able to coordinate across various systems, including physical health, behavioral health, developmental, social services, juvenile justice, and education. It is imperative that providers understand and adhere to the privacy and consent laws, regulations, and rules unique to each of these systems. The use cases in Chapter 5 may be helpful in applying the guidance regarding minors.

[9] The No Wrong Door for Mental Health Services Policy is a DHCS initiative aimed at ensuring that Medi-Cal beneficiaries receive mental health services without delay regardless of whether they initially seek care. More information can be found in DHCS Behavioral Health Information Notice No: 22-011.

- An analysis of consent and data sharing authorizations for children and youth populations.

4. **Chapter 5, Data Sharing Authorization Use Cases,** describes how various data types may be shared by stakeholders in support of CalAIM goals.

2. Overview of Key Privacy Laws

This document provides background on the legal and regulatory requirements that may be applicable to CalAIM to help Medi-Cal Partners better understand applicable privacy and consent laws across four pertinent areas of data privacy:

1. Health care
2. Substance use disorder (SUD) treatment
3. Educational records
4. Child welfare records

Treatment/Care Coordination Consent Exception

In this document, a law has a **treatment/care coordination consent exception** if the law typically requires an individual's consent for the sharing of that individual's personal identifiable information (PII) but does not require such consent if the individual's PII is being disclosed for the purposes of providing treatment to, or coordinating the care of, that individual.

Key laws and regulations within these areas—and their application to Medi-Cal Partners—are summarized at a high level in this section. This section also identifies whether there is an **applicable consent exception** in each law that Medi-Cal Partners could use **when sharing data for the purpose of providing health care treatment to, or coordinating care for, Members** (referred to in the text as a "treatment/care coordination consent exception"). In general, the key privacy laws summarized in this document contain treatment/care coordination consent exceptions that would enable Medi-Cal Partners to share data for treatment to, or care coordination for, Members. A notable deviation from this general trend, however, is that most child welfare privacy laws do not contain such an exception, meaning that the ability for Medi-Cal Partners to exchange child welfare data is limited.

The discussion below contains a high-level summary of these laws and any applicable treatment/care coordination consent exceptions. Appendix A provides a more detailed overview of the laws governing these four areas of data privacy and their implications for the exchange of information under CalAIM. In most cases, an individual's authorization is required for the disclosure of information under CalAIM to meet its two goals of: (1) coordinating care for individuals enrolled in managed care; and (2) connecting an individual with health insurance or mental health services following release from jail.

(1) Health Care

The **Health Insurance Portability and Accountability Act (HIPAA)** is a federal law that regulates "protected health information" (PHI) that is created or received by a "covered entity." The law permits disclosure of PHI for certain purposes—including treatment, payment, or health care operations such as care coordination—without

patient authorization. Disclosure can also be made for other purposes if the patient who is the subject of the PHI (or in some cases, their parent/guardian) authorizes its disclosure on a signed consent form.

Has a treatment/care coordination consent exception? Yes.

The **Confidentiality of Medical Information Act (CMIA)** is California's state health privacy law that mirrors HIPAA in many ways. The laws, however, do have some differences. For example, the CMIA extends to certain organizations, such as personal health record vendors that may not be subject to HIPAA, and it has different requirements for consent forms.[10]

Has a treatment/care coordination consent exception? Yes.

The **Lanterman-Petris-Short Act** is California's mental health privacy law that applies to many providers of mental health services in the state. It has been amended several times to align more closely with HIPAA; for instance, it currently permits disclosures to business associates and for health care operations in accordance with HIPAA.[11] However, like the CMIA, it differs from HIPAA in certain respects; for instance, it has different requirements for consent forms.[12]

Has a treatment/care coordination consent exception? Yes.

(2) Substance Use

42 C.F.R. Part 2 (often referred to as "Part 2") is a federal regulation that protects the confidentiality of some **but not all** types of SUD information. The regulation applies to SUD programs that hold themselves out as providing such services and which receive federal assistance. When Part 2 applies, it is often stricter than HIPAA, in part because the regulation does not permit disclosures of information for treatment or care coordination purposes without patient consent. Part 2 also does not permit disclosures of Part 2 information for payment purposes without consent, meaning Part 2 programs need their patients to provide a written consent if they want to submit claims to their patients' health insurers, including Medi-Cal. As of May 2023, 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. If finalized as proposed, that rule would mean that if the patient signs an authorization for disclosure one time, the patient's information could be redisclosed for treatment, payment, and health care operations.

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[10] California Civil Code Sections 56.05 and 56.11.
[11] Welfare and Institutions Code Section 5328(a)(25).
[12] Welfare and Institutions Code Section 5328.7.

Has a treatment/care coordination consent exception? No

California Health and Safety Code Section 11845.5 is California's own SUD privacy law. It mirrors Part 2 in many respects but applies to a broader class of providers.

Has a treatment/care coordination consent exception? No.

(3) Education

The **Family Educational Rights and Privacy Act (FERPA)** is a federal law protecting the privacy of certain education records maintained by an educational agency or institution or a person acting on behalf of an educational agency or institution. A student's health-related records may be protected under FERPA, depending on where the health care was furnished and who furnished it.

Has a treatment/care coordination consent exception? No.

California "Pupil Records" Law, codified at Education Code Section 490610 et al., is California's education record privacy law. It largely mirrors FERPA.

Has a treatment/care coordination consent exception? No.

The **Individuals with Disabilities Education Act (IDEA), Parts B and C** is a federal law that protects the education records of children with disabilities, including Individualized Education Programs (IEPs) and early intervention program records.

Has a treatment/care coordination consent exception? No.

(4) Child Welfare

The **Child Abuse Prevention and Treatment Act (CAPTA)** is a federal law that requires states receiving grants under the law to maintain the confidentiality of all records made and maintained in connection with such grants, including child protective services records relating to the intake, screening, and investigation of child abuse or neglect, as well as case management files relating to the delivery of services and treatment provided to children and their families.[13]

[13] 42 U.S.C. §§ 5106a(a) and 5106a(b)(2)(B)(viii).

The concept of a treatment/care coordination consent exception does not apply here because CAPTA is a requirement imposed on states rather than a requirement imposed on providers.

California Welfare and Institutions Code Section 827 protects "juvenile case files," which may include data in a child welfare case file. Under Section 827, multidisciplinary teams, persons, or agencies providing treatment or supervision of the minor may "**inspect**" but may not receive copies of these protected records without a court order.

Has a treatment/care coordination consent exception? Yes, but only permits inspection (as opposed to sharing) of records by multidisciplinary team members.

California Welfare and Institutions Code Section 10850 protects the confidentiality of certain records maintained in connection with the administration of federally funded public social services. The protections of Section 10850 apply to child welfare records.

Has a treatment/care coordination consent exception? No, except to the extent that it permits employees of a child welfare agency to disclose information to one another for the purpose of multidisciplinary teamwork in the prevention, intervention, management, or treatment of child abuse or neglect or neglect or abuse of an elder or dependent adult.[14]

[14] Welfare and Institutions Code Section 10850(e).

3. Assembly Bill (AB) 133's Data Sharing Provisions and Related Guidance

Recognizing the importance of information sharing for the successful implementation of CalAIM, AB 133, enacted in July 2021, added new provisions to California state law under: (1) the Welfare and Institutions Code; and (2) the Penal Code, in order to promote data exchange and care coordination **by allowing such data exchange even in cases where state privacy laws otherwise might prohibit such disclosure without signed consent**.[15] In addition to these new provisions, AB 133 requires the issuance of guidance to implement these new provisions as they relate to CalAIM. This guidance document fulfills DHCS' obligations under AB 133 to issue guidance identifying permissible data sharing arrangements, both under CalAIM and for the coordination of inmates' post-release behavioral health care.

Key Takeaway

AB 133 limits the application of certain state privacy laws so that information can be shared more easily in order to coordinate care.

Chapter 3 of this document has four sections:

- **Section 1** lays out the text of AB 133 and explains what the law modifies, what it does not, whom it covers, and the interplay with other requirements, including federal requirements.
- **Section 2** explains how AB 133 impacts information sharing for the justice involved.
- **Section 3** delves into data sharing requirements.
- **Section 4** describes the California Data Exchange Framework (DxF).

[15] This was authorized in the health omnibus trailer bill legislation for the 2021–2022 California Budget (AB 133; Chapter 143 of Statutes of 2021), which was signed into law by Governor Gavin Newsom on July 27, 2021. AB 133 added Section 14184.102 to the Welfare and Institutions Code.

(1) California Welfare and Institutions Code Section 14184.102(j)

California Welfare and Institutions Code Section 14184.102(j)

Notwithstanding any other state or local law, including but not limited to Section 5328 of this code and Sections 11812 and 11845.5 of the Health and Safety Code, the sharing of health, social services, housing, and criminal justice information, records, and other data with and among the department [of health care services], other state departments, including the State Department of Public Health and the State Department of Social Services, Medi-Cal managed care plans, Medi-Cal Behavioral Health Delivery Systems, counties, health care providers, social services organizations, care coordination and case management teams, and other authorized provider or plan entities, and contractors of all of those entities, shall be permitted to the extent necessary to implement applicable CalAIM components described in this article and the CalAIM Terms and Conditions, and to the extent consistent with federal law. The department [of health care services] shall issue guidance identifying permissible data sharing arrangements to implement CalAIM.

AB 133 amended California Welfare and Institutions Code Section 14184.102(j) to permit Medi-Cal Partners to disclose PII among one another so long as such disclosure helps implement CalAIM and is consistent with federal law (in this document, this amendment is referred to as the "AB 133 State Law Applicability Provision").

► Limited Changes to State Law

The permitted disclosures authorized by the new subsection mean that other provisions of state law do not prevent the sharing of information, so long as Medi-Cal Partners:

1. Disclose information for purposes of providing services or coordinating care for Members (*see below*), receiving reimbursement for such services or care coordination, or improving the quality of care delivered to Members; and
2. Comply with federal law.

Disclosures for the purposes described above are permitted because one of the primary goals of CalAIM is to "identify and manage the risk and needs of Medi-Cal beneficiaries through whole person care approaches and addressing social determinants of health" as well as to improve quality outcomes and reduce health disparities.[16] Further, **where**

[16] Further, since Medi-Cal Partners cannot effectively provide and coordinate care if they are not reimbursed for such services, Section 14184.100(j) also permits disclosures for payment purposes.

state laws contain specific requirements with respect to required form elements that go beyond the requirements of federal law, **these requirements do not need to be followed by Medi-Cal Partners** that share information about Members for the purposes described above.

For instance, California's Lanterman-Petris-Short Act (LPSA) permits disclosures related to the provision of services or for appropriate referrals with "qualified professional persons."[17] This restriction could be interpreted to mean that an individual must sign a consent form if the disclosure is being made to a person who is not a licensed health care professional (assuming there is no other basis in the LPSA for such disclosure). As a result of the AB 133 State Law Applicability Provision, a Medi-Cal Partner subject to the LPSA could share a Member's PII with another organization that is providing other services to the Member, such as an organization seeking to provide housing-related services. This is true even if the Member had not signed a form relating to such disclosure and even if the recipient was not a licensed health care professional, as long as the information exchange was permitted under federal law. As another example, the LPSA also goes beyond HIPAA by requiring authorization forms to include "the name of the responsible individual" who has obtained the authorization to share information.[18] Under AB 133, Medi-Cal Partners are not required to abide by this particular requirement when sharing information for Members.

Specific statutes impacted. The state laws impacted by the AB 133 State Law Applicability Provision include not only the laws specifically referenced in that section (namely, Sections 11812 and 11845.5 of the Health and Safety Code and Section 5328 of the Welfare and Institutions Code (the LPSA's privacy provision)), but also any other state and local laws that may otherwise restrict the disclosure of information about Members. Such laws include but are not limited to California's Civil Code Sections 56 et seq. (the CMIA), Health and Safety Code Section 120985 (regarding HIV test results), Welfare and Institutions Code Section 10850 (governing public social services records), and state and local laws that may prevent the disclosure of inmates' release dates and other inmate information relevant to providing services under CalAIM.

While the AB 133 State Law Applicability Provision impacts the circumstances under which a Medi-Cal Partner must ask a Member for authorization for the disclosure of information and the form of such authorization (if required), it does not affect other legal protections for Members. For example, the following categories of laws are not affected by the AB 133 State Law Applicability Provision:

- Antidiscrimination laws;

[17] Welfare and Institutions Code Section 5328(a)(1).
[18] Welfare and Institutions Code Section 5238.7.

- Laws that provide individuals enrolled in Medi-Cal with rights[19] to request that their information not be shared;
- Laws that require consent for treatment and, in the case of minors, who must provide such consent;
- Laws limiting the sharing of a minor's information with a parent or guardian (e.g., restrictions on sharing a minor's reproductive health information with the minor's parent or guardian);
- California's breach reporting laws;[20]
- The CMIA's requirement for health care service plans to engage in confidential communications with their individuals enrolled in Medi-Cal with respect to sensitive services they receive;[21] and
- Privilege rules limiting the use of information in legal proceedings.

AB 133 also does not impact child welfare privacy laws. Given the requirements of federal law regarding the need for privacy protections for records related to child abuse and neglect, DHCS does not interpret the AB 133 State Law Applicability Provision as applying to any state laws that protect the confidentiality of child welfare records. Notably, CAPTA is a federal law that requires states receiving CAPTA grants to maintain the confidentiality of all records made and maintained in connection with CAPTA (including child protective services records relating to the intake, screening, and investigation of child abuse or neglect as well as case management files relating to the delivery of services and treatment provided to children and their families). CAPTA requires states to determine when records made and maintained under CAPTA may be disclosed.[22] The AB 133 State Law Applicability Provision cannot create new exceptions to California child welfare privacy laws because doing so could potentially result in California becoming out of compliance with CAPTA. For more information, *see* Appendix A.

[19] Welfare and Institutions Code Section 5238.7.
[20] *See*, for example, California Health and Safety Code Section 1280.15 and California Civil Code Section 1798.29.
[21] California Civil Code Section 56.107. This right can apply, for example, if a minor receives reproductive health care from a Medi-Cal MCP and does not want the plan to send communications to the home with respect to that service that could be seen by the minor's parent(s) or guardian(s).
[22] 42 U.S.C. §§ 5106a(a) and 5106a(b)(2)(B)(viii).

(2) California Penal Code Section 4011.11(h)

California Penal Code Section 4011.11(h)

(4) (A) The department shall develop the data elements required to implement this section, in consultation with interested stakeholders that include representatives of counties, county sheriffs, county probation agencies, and whole person care pilot lead entities with experience working with incarcerated individuals.
(B) Notwithstanding any other law, the department, counties, county sheriffs, and county probation agencies shall share the information and data necessary to facilitate the enrollment of inmates in health insurance affordability programs on or before their date of release and to appropriately suspend and unsuspend Medi-Cal coverage for beneficiaries.

(5) (A) No sooner than January 1, 2023, the State Department of Health Care Services, in consultation with counties, Medi-Cal managed care plans, and Medi-Cal Behavioral Health Delivery Systems, shall develop and implement a mandatory process by which county jails and county juvenile facilities coordinate with Medi-Cal managed care plans and Medi-Cal Behavioral Health Delivery Systems to facilitate continued behavioral health treatment in the community for county jail inmates and juvenile inmates that were receiving behavioral health services prior to their release.
(B) Notwithstanding any other law, including, but not limited to, Sections 11812 and 11845.5 of the Health and Safety Code and Section 5328 of the Welfare and Institutions Code, the sharing of health information, records, and other data with and among counties, Medi-Cal managed care plans, Medi-Cal Behavioral Health Delivery Systems, and other authorized providers or plan entities shall be permitted to the extent necessary to implement this paragraph. The department shall issue guidance identifying permissible data sharing arrangements.
(C) For purposes of this paragraph, the following definitions shall apply:
(i) "Medi-Cal Behavioral Health Delivery System" shall have the same meaning as set forth in subdivision (i) of Section 14184.101 of the Welfare and Institutions Code.
(ii) "Medi-Cal managed care plan" shall have the same meaning as set forth in subdivision (j) of Section 14184.101 of the Welfare and Institutions Code.

► How AB 133 Impacts Sharing of Information for the Justice-Involved

AB 133 amended Penal Code Section 4011.11 to add subdivision (h) to promote the provision of services to those exiting jails and youth correctional facilities. This section

of the guidance explains how AB 133 impacts the sharing of information for the purpose of coordinating care for Medi-Cal Partners who are justice-involved.[23] The new Penal Code sections apply to county jails and county youth correctional facilities; the law does not apply directly to state prisons.

► Impact on State Law

The new Penal Code subdivision permits the disclosure of PII, even when such disclosure would otherwise conflict with state privacy laws,[24,12] when data sharing is for the purposes of:

1. Assisting jail and youth correctional inmates with applying for health insurance affordability programs (Medi-Cal, the Children's Health Insurance Program (CHIP), and qualified health plans offered through Covered California; this may include applying for those programs while incarcerated or after release); and
2. Ensuring those inmates have access to behavioral health services post-release.

The two goals are interconnected since obtaining health insurance is often critical to obtaining continued access to behavioral health services. Under Penal Code Section 4011.11(h)(4)(B), a disclosure of PII is permitted if the disclosure:

1. Is reasonably necessary to facilitate a county jail or youth correctional inmate's enrollment in a health insurance affordability program;
2. Occurs between various county agencies (inclusive of county jails, youth correctional facilities, county health departments, and county law enforcement agencies) or between a county agency and DHCS; and
3. Complies with federal law.

Similarly, under Penal Code Section 4011.11(h)(5)(B), a disclosure of PII is permitted if the disclosure:

1. Is reasonably necessary to facilitate a county jail or youth correctional inmate's behavioral health treatment post-release;
2. Occurs between various county agencies (inclusive of county jails and youth correctional facilities, county health departments, and county law enforcement agencies), DHCS, Medi-Cal MCPs, Medi-Cal behavioral health delivery

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[23] A future version of this guidance will introduce use cases relevant to the justice context. Guidance on the exchange of data and information for enrollment in Pre-Release Medi-Cal services is not included in this document. More information can be found in DHCS All County Welfare Directors Letter No.: 22-27.
[24] The same data privacy laws discussed in Section 2 of this guidance apply to justice-involved populations. Additional laws protect the disclosure of criminal justice records and case files, but this guidance does not provide an overview of such laws.

systems, health care providers, or other persons involved in behavioral health treatment; and
3. Complies with federal law.

Under both provisions, **disclosures may be made while the individual is incarcerated, or they may be made post-release**.[25] Disclosed PII may consist of "health information," but it may also include other data intended to serve the purposes of these disclosures.[26] Organizations have the discretion to determine the appropriate means of exchange, which, as with the case of disclosures under CalAIM, may include the exchange of information through contractors such as health or community information exchanges.

► Impact on Federal Law Requirements

As is the case with the AB 133 State Law Applicability Provision, the Penal Code additions have no impact on federal legal requirements. Organizations disclosing information under subdivision (h) remain fully responsible for complying with applicable federal privacy laws. Similarly, the new Penal Code sections have no impact on other state laws that protect individual rights, such as antidiscrimination laws, as well as California child welfare privacy laws (*see* prior section on other categories of laws not impacted by the AB 133 State Law Applicability Provision). However, unlike the AB 133 State Law Applicability Provision, disclosures that occur under Penal Code Sections 4011.11(h)(4)(B) and (5)(B) are not limited to those that occur under CalAIM. That is, Penal Code Section 4011.11(h)(4) may apply even if an individual is not enrolled in Medi-Cal and is not applying for Medi-Cal.

(3) Required Data Sharing

Under the new Penal Code sections, the exchange of information is required if such disclosure is necessary to facilitate enrollment in health insurance affordability programs or for continued behavioral health treatment post-release, occurs between persons described in the applicable statutory provision, and complies with federal law.[27]

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[25] Assuming the individual enrolls in a Medi-Cal MCP post-release, then the AB 133 State Law Applicability Provision would apply as well, meaning Medi-Cal Partners still would be able to exchange information about the individual in accordance with the AB 133 State Law Applicability Provision.
[26] Data that may be shared under the conditions of Penal Code Section 4011.11(h)(4)(B) may include the inmate's incarceration date, release date, and identifying demographic information.
[27] Penal Code Section 4011.11(h)(4)(B) states that DHCS, counties, county sheriffs, and county probation agencies shall share information necessary to facilitate the enrollment of inmates in health insurance affordability programs on or before their date of release and to appropriately suspend and unsuspend Medi-Cal coverage. Similarly, Penal Code Section 4011.11(h)(5)(A) states that the facilitation of continued behavioral health treatment is a "mandatory process."

Counties may <u>not</u> withhold information based on their own policies, procedures, or preferences if those are more restrictive than the requirements under Penal Code Sections 4011.11(h)(4) or (5) or federal law. This includes county health agencies, county law enforcement agencies, county probation departments, and jails and youth correctional facilities operated by counties, as well as Medi-Cal MCPs, Medi-Cal behavioral health delivery systems, health care providers, and other persons or organizations involved in health insurance affordability enrollment and/or behavioral health treatment. For instance, if federal law permits a jail and an MCP to exchange an individual's PII for the purposes of connecting that individual with behavioral health treatment post-release without obtaining written consent, such jail and MCP should not refuse to share information based on their own internal policy that requires written consent for disclosure.

Cures Act

In 2016, the **21st Century Cures Act** made sharing electronic health information (EHI) the expected norm in health care by authorizing the U.S. Department of Health and Human Services (HHS) secretary to identify "reasonable and necessary activities that do not constitute information blocking."

Information blocking is a practice by an "actor" that is likely to interfere with the access, exchange, or use of EHI, except as required by law or specified in an information blocking exception.

Visit HealthIT.gov to learn more.

Health care providers must comply with the federal information blocking rule. Medi-Cal Partners that meet the definition of a "health care provider" under the Public Health Service Act[28] are subject to the federal information blocking rule, which took effect on April 5, 2021 (see the call-out box above under **"information blocking**"). This means that a refusal to disclose electronic health information (EHI) in response to the request of another Medi-Cal Partner may conflict with such rule, unless it is based on legal requirements or fits within an information blocking exception.[29]

Other than the Penal Code provisions requiring disclosures of information related to certain incarcerated individuals, no statute specifically mandates the disclosure of PII to

[28] 42 U.S.C. § 300jj.

[29] In general, information blocking is a practice by a health IT developer of certified health IT, health information network, health information exchange, or health care provider (collectively referred to as "actors") that, except as required by law or specified by the Secretary of HHS as a reasonable and necessary activity, is likely to interfere with access, exchange, or use of EHI. The federal information blocking rule describes categories with specific conditions that must be met for an actor to fit within an information blocking exception. In addition to meeting the definition of "health care provider," some Medi-Cal Partners could fall within the definition of a health information network/health information exchange or health IT developer. Legal counsel should review considerations related to information blocking.

Medi-Cal Partners. However, the sharing of information among Medi-Cal Partners, consistent with state and federal law, including the California DxF Data Sharing Agreement and its policies and procedures, is necessary for the successful implementation of CalAIM.

DHCS encourages Medi-Cal Partners to examine their policies and procedures, as well as any other data sharing practices and standard contractual terms, to ensure they are not unnecessarily restrictive. DHCS notes that agreements that require recipients to abide by security best practices, such as agreements to require organizations not subject to HIPAA to meet certain security standards with respect to the PII they receive, may be appropriate if they comply with the information blocking rule.

In some cases, a person can choose not to have their information shared. Note that organizations may withhold information if the individual who is the subject of that information requests that their information not be shared. In addition, if federal law requires an individual's express authorization prior to disclosure of information, the Penal Code provisions do not enable Medi-Cal Partners to share PII; in that case Medi-Cal Partners must withhold PII unless the authorization required under the applicable federal law is obtained.[30]

(4) California Data Exchange Framework (DxF)

In addition to modifying the Welfare and Institutions Code and the Penal Code, AB 133 directed the California Health and Human Services Agency (CalHHS) to develop and publish the California Health and Human Services DxF by July 1, 2022, which includes a single Data Sharing Agreement (DSA) and a common set of policies and procedures governing the exchange of EHI across the state.[31] Medi-Cal Partners that sign the DSA will have additional obligations to exchange data under the terms of that agreement.[32]

The DSA includes a common set of terms, conditions, and obligations that signatories to the DSA must meet to support secure, real-time access to and exchange of health and social services information in compliance with applicable federal, state, and local laws, regulations, and policies. The DSA is supported by a set of policies and procedures that provide more detailed guidance in a number of areas, including how required data elements will be exchanged, privacy and security safeguards, individual access issues, processes for modifying these rules, and other policies. DSA signatories must adhere to

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[30] MCPs subject to AB 1184 shall abide by requirements related to "confidential communication requests" under that law. Confidential communication requests involve communications between a plan and a Member, not communications between two organizations coordinating the care of a Member of such plan.

[31] Executive Summary: CalHHS DxF – An Essential Next Step Toward Equitable, Affordable, Whole Person Care.

[32] *See* the California DxF webpage for more information.

the applicable standards for electronic information collection, exchange, and use identified by the California DxF.[33,34]

Beginning January 2024, the following health care entities are required to share electronic health and social services information and use it in accordance with the DSA and the DxF policies and procedures:[35]

- General acute care hospitals
- Physician organizations and medical groups
- Skilled nursing facilities
- Health service plans
- Disability insurers
- Medi-Cal MCPs
- Clinical laboratories
- Acute psychiatric hospitals

[33] CalHHS Center for Data Insights and Innovation DxF Guiding Principles (July 2022).
[34] CalHHS DxF: Single DSA (November 2022).
[35] Executive Summary: CalHHS DxF – An Essential Next Step Toward Equitable, Affordable, Whole Person Care.

4. Guidance on Consent to Disclose Information and Required Authorization Elements

Because federal requirements remain applicable to disclosures under both the new Welfare and Institutions Code and Penal Code sections added by AB 133, **in most cases, an individual's authorization is required for the disclosure of information under CalAIM to meet its two goals of (1) coordinating care for individuals enrolled in managed care and (2) connecting an individual with health insurance or mental health services following release from jail.**

Chapter 4 provides resources related to consent.

- **Section 1** lays out authorization form requirements.
- **Section 2** describes specific considerations for **consent related to minors**, including when the minor is involved with the child welfare system and considerations for education data.

(1) Authorization Form Requirements

► Use of Electronic Signatures and Verbal Consent

The new AB 133 provisions allow Medi-Cal Partners to use electronic signatures on data sharing authorization forms, assuming such signatures otherwise comply with federal law.

Both federal and California law allow the use of electronic signatures that meet certain standards. HIPAA permits the use of electronic signatures so long as their use complies with otherwise applicable laws, such as the Electronic Signatures in Global and National Commerce Act.[36] Additionally, California's Uniform Electronic Transactions Act (UETA) permits the use of electronic signatures in many circumstances.[37]

However, the UETA's presumption that electronic signatures are valid does not currently apply to authorizations required under the CMIA: If an authorization is required under the CMIA, then the UETA's presumption that electronic signatures are valid has not applied. However, the new provisions in AB 133 change this framework. If a disclosure occurs in compliance with the AB 133 State Law Applicability Provision or Penal Code Section 4011.11(h)(4)(B) or (5)(B), then other state laws such as the CMIA no longer limit such disclosure. Since the CMIA's authorization form requirements are no longer applicable, the CMIA exception to California's UETA is no longer applicable either.

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[36] How do HIPAA authorizations apply to an electronic health information exchange environment?, Office of Civil Rights, HHS.
[37] California Civil Code Section 1633.7.

Therefore, Medi-Cal Partners may recognize authorization forms executed by electronic signatures so long as Medi-Cal Partners follow federal and UETA requirements governing the use of electronic signatures.[38] Under those laws, **audio recordings may meet federal requirements for electronic signatures in some circumstances**. However, Medi-Cal Partners should note that unrecorded verbal statements do not qualify as electronic signatures, even if there is a notation in an electronic health or other record that indicates that the individual orally provided consent.[39]

► Permissible Authorization Forms

A number of permissible authorization forms may be used by Medi-Cal Partners in order to secure consent for data sharing, including the Authorization to Share Confidential Medi-Cal Information (ASCMI) form and Medi-Cal Partner forms.

ASCMI Form: DHCS is piloting the ASCMI form and consent management service (collectively referred to as the "ASCMI Pilot") in 2023. The ASCMI form is a voluntary release of information that supports the sharing of Members' physical, behavioral, and social health information through a standard consent process. The form is designed to comply with all applicable legal requirements, including those under HIPAA, Part 2, FERPA, and IDEA. The consent management service is an electronic service that can store and manage consent forms of individuals enrolled in Medi-Cal. DHCS intends that the form be a resource to Medi-Cal Partners and does not intend at this time to mandate its use.[40]

Medi-Cal Partner Forms: In addition, Medi-Cal Partner authorization forms should comply with applicable law. Authorization forms may be administered by MCPs, providers, or other Medi-Cal Partners that will be responsible for ensuring that the authorization forms comply with applicable law.

If PII is disclosed consistent with CalAIM guidance on data sharing, then the authorization form should be permissible under state law pursuant to the AB 133 State Law Applicability Provision, but the form will still need to comply with federal standards for authorization forms.

Similarly, if a disclosure of PII is reasonably necessary to facilitate a county jail or youth correctional inmate's enrollment in a health insurance affordability program or to

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[38] Recognition of electronic signatures is also consistent with AB 2520, enacted in 2020, which permits health care providers to honor requests for disclosure of records based on electronic signatures.
[39] This guidance addresses the applicability of electronic signatures to authorizations that permit the disclosure of PII. Nothing in this guidance changes prior guidance related to the use of electronic signatures for Medi-Cal applications or renewals. *See* All County Welfare Directors Letter (ACWDL) 19-17 and Medi-Cal Eligibility Division Information Letter 21-38.
[40] *See* the DHCS ASCMI webpage for more information.

facilitate post-release behavioral health treatment, and such disclosure occurs between the organizations described in Penal Code Section 4011.11(h)(4) or (5), as applicable, then the disclosure is consistent with state law and any authorization form requirements are dictated by federal legal requirements.

► Key Privacy Laws[41]

DHCS has developed the **CalAIM Repository of Data Sharing Forms and Agreements**, which compiles data sharing forms and agreements that have been used by some counties and health plans for the exchange of various types of PII to improve the coordination of care.

Health care privacy laws HIPAA and **Part 2**[42,43,44] require certain components in authorization forms in order for them to be compliant. These components include but are not limited to:

- Specifics regarding the data being shared;
- The respective parties to the sharing;
- The potential uses of the data;
- An expiration date or event; and
- A right to revocation.

The HIPAA and Part 2 authorization form rules are similar in many respects, but Part 2 has some stricter requirements. For instance, HIPAA allows the form to describe a "class of persons" as an information recipient, but Part 2 sometimes requires the name of the recipient to be included on the form.[45] In practice, compliance with Part 2 requires specific reference to the types of SUD information that may be disclosed. This can easily be accomplished on the same form used for HIPAA as long as there is specificity.

There are certain common misconceptions about authorization form requirements, such as specific time limits for the expiration of an authorization, so all components should be reviewed by legal counsel. Best practices also include soliciting consumer feedback and

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[41] Several volumes of State Health Information Guidance (Center for Data Insights and Innovation) provide important information about authorization form requirements under applicable law.
[42] In addition to the authorization form requirements that appear in the regulation itself (42 C.F.R. § 2.31), the Substance Abuse and Mental Health Services Administration (SAMHSA) has issued guidance on Part 2 authorization form requirements in a document titled FAQ: Applying the Substance Use Confidentiality Regulations to Health Information Exchange (HIE).
[43] Section 3221 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act modified the statute that is the basis for 42 C.F.R. Part 2 in a way that may impact the requirements of a Part 2 authorization form.
[44] HHS has proposed amendments to the Part 2 regulations to implement Section 3221, but those proposed changes have not yet been finalized. 87 Fed. Reg. 74216 (Dec. 2, 2022).
[45] 45 C.F.R. § 164.508(c)(1)(iii); 42 C.F.R. § 2.31(a)(4).

exhibiting cultural competency (i.e., appropriate language) and/or health literacy, as well as consumer engagement with potential electronic consent options (e.g., "I Agree" click button, oral recording).

Note that both HIPAA and Part 2 provide some flexibility as to who may obtain consent. That is, the organization that discloses the PII does not need to have obtained consent directly from the individual but may rely on a valid authorization provided by another party, such as another Medi-Cal Partner that provides services to that individual. Further, both laws permit authorization forms to be used for multiple purposes. For instance, if a Medi-Cal Partner is a Part 2 program that is already asking its patients for consent to share information with Medi-Cal or an MCP for reimbursement purposes, the Medi-Cal Partner may use an authorization form that also asks for the individual's consent to permit Medi-Cal/the MCP to use the information for care coordination and quality improvement purposes as well.

Health Privacy Laws and Verbal Consents

Both HIPAA and 42 CFR Part 2 permit the use of electronic signatures and, as noted below, audio recordings of a verbal consent can qualify as an electronic signatures in some cases. However, 42 CFR Part 2, unlike HIPAA, specifies that authorization forms must be written.

Therefore:

- Medi-Cal Partners should make sure to use written forms if they intend for those forms to be used for the disclosure of data subject to 42 CFR Part 2.
- An audio recording without a written form may be sufficient if the information being shared is subject to HIPAA only and not 42 CFR Part 2.

Education privacy laws include FERPA,[46] IDEA Parts B[47] and C,[48] the National School Lunch Act (NSLA),[49] and Education Code Sections 49558 and 49075.

As is the case under HIPAA, some education laws have specific requirements about what must be included in the authorization form. For example, an authorization form seeking disclosure of FERPA-protected records must specify the records that may be disclosed, state the purpose of the disclosure, and identify the party to whom the disclosure may be made.[50] However, while HIPAA permits minors to sign authorization forms in many circumstances, typically the parent/guardian must sign such forms with respect to records protected by FERPA.

(2) Consent on Behalf of Minors

[46] 20 U.S.C. § 1232g; 34 C.F.R. Part 99.
[47] 34 C.F.R. Part 300; 20 U.S.C. Subchapter II.
[48] 34 C.F.R. Part 303; 20 U.S.C. Subchapter III.
[49] 42 U.S.C. § 1766; 7 C.F.R. Part 245.
[50] 34 C.F.R. § 99.30; Education Code Section 49075(a).

If an individual receiving services under CalAIM is a minor and an authorization form is needed for disclosure of that person's personal information, a Medi-Cal Partner must determine from whom to obtain consent. Depending on the circumstances, consent can be sought from the minor; a parent, guardian, or other person acting in place of the parent; or both.

► Sharing Records of Health Care Services a Minor Independently Consented to Receive

There are a couple of general overarching principles to keep in mind:

1. Typically, **a parent/guardian has the right to consent** to the sharing of their child's health and other personal information. Under HIPAA, the parent/guardian of an unemancipated minor has authority to consent to the release of PHI if the parent/guardian has the authority to act on behalf of the minor in making health care decisions. This is because a person who has authority to act on behalf of an individual in making health care decisions is the minor's "Personal Representative."[51]
2. **When the minor has the ability to consent to receive a particular service**, independent of their parents, it is often **the minor**, not the parent/guardian, who **will sign any authorization forms** that permit the disclosure of information about that service.

Whether the parent/guardian has the authority to act on behalf of the minor in making health care decisions is a matter of

Dual Consents

In some cases, Medi-Cal Partners may provide some services to a minor for which a minor may provide consent and other services for which a parent, guardian, or other person acting in place of the parent must also provide consent. For example, under 42 C.F.R. Part 2, providers furnishing care to minors under the age of 12 must obtain consent from the minor and their parent/guardian. Such cases are referred to as **"dual consents**."

Medi-Cal Partners should consider using forms that ask both the minor and the parent, guardian, or other person acting in place of the parent to provide consent to ensure that all individuals who must provide consent under the law have done so. However, asking for dual consent is not appropriate in all circumstances, and Medi-Cal Partners should ensure that the use of dual consents does not result in unlawful sharing of PHI. For instance, a provider offering a reproductive health service to a minor typically should not request consent from the minor and the minor's parent/guardian, since doing so could breach the minor's privacy.

[51] 45 C.F.R. § 164.502(g)(3)(i).

state, not federal, law.[52] Therefore, if a minor may lawfully consent to receive a particular health care service without the consent of a parent/guardian under California law, Medi-Cal Partners should rely on the minor's signed authorization to disclose PHI related to such service. In this case, the parent/guardian is not a Personal Representative with authority to act on the minor's behalf with respect to such service, and therefore Medi-Cal Partners generally must ensure that these "minor consent" records are not shared with the parent/guardian.[53]

Under California law, minors may independently consent to the following health care services without parent/guardian consent, meaning that minors may also consent to the release of records pertaining to such health care services without parent/guardian consent.

Table 1. Health Care Services Minors May Independently Consent to Without Parent/Guardian Consent, Under California Law

Age	Consent (without parent/guardian)
All minors	• Reproductive services, including care related to the prevention or treatment of pregnancy, including birth control and contraception, but excluding sterilization.[54] • Abortions.[55] • Diagnosis of and treatment in the case of sexual assault, including the collection of medical evidence related to the alleged sexual assault.[56] • Treatment in the case of abuse/neglect, including skeletal X-rays taken for the purposes of diagnosing possible child abuse or neglect, or determining the extent of the same.[57]

[52] Welfare and Institutions Code Section 14184.102(j), as added by AB 133, does not change the reliance on state law. While such provision requires the exchange of data "to the extent consistent with federal law," applicable federal law indicates that state law rules apply to the issue of who should sign an authorization form.
[53] 45 C.F.R. § 164.502(g)(3)(i)(A).
[54] Family Code Section 6925.
[55] Although Health and Safety Code Section 123450 requires parent/guardian consent, the Supreme Court of California declared the law unconstitutional in *American Academy of Pediatrics v. Lungren*, 16 Cal. 4th 307 (1997).
[56] Family Code Section 6928. Sexual assault for the purposes of this provision includes but is not limited to "rape" (as defined in Penal Code Section 261), certain instances of "sodomy" (as defined in Penal Code Section 286), and certain instances of "oral copulation" (as defined in Penal Code Section 287). Another provision separately gives minors over the age of 12 the right to consent to the diagnosis and treatment of an alleged rape. *See* Family Code Section 6927.
[57] Penal Code Section 11171.2(a).

Table 1. Health Care Services Minors May Independently Consent to Without Parent/Guardian Consent, Under California Law	
Age	**Consent (without parent/guardian)**

Minors over the age of 12	• Health care services listed above for "all minors."
	• Treatment related to infectious, contagious, or communicable diseases, including medical care related to the prevention of a sexually transmitted disease such as HIV.[58]
	• Treatment related to injuries resulting from intimate partner violence.[59]
	• Some behavioral health services, including:
	  ○ Outpatient mental health treatment or counseling services if, in the opinion of a mental health professional, the minor is mature enough to participate intelligently in the treatment or services.[60]
	  ○ Residential shelter services if (1) the provider determines the minor is mature enough to participate intelligently in the services; and (2) either (a) the minor would present a danger of serious physical or mental harm to themself or others without the services, or (b) the minor is the alleged victim of incest or child abuse.[61]
	• Some medical care[62] and counseling relating to the diagnosis and treatment of an SUD.[63]

[58] Family Code Section 6926.
[59] Family Code Section 6930. This provision defines "intimate partner violence" as "an intentional or reckless infliction of bodily harm that is perpetrated by a person with whom the minor has or has had a sexual, dating, or spousal relationship."
[60] Health and Safety Code Section 124260(b)(1). Such services may be provided by a variety of professionals, including psychologists, social workers, and marriage and family therapists. Note that for services billed under Medi-Cal, a minor's independent consent for outpatient mental health treatment or counseling services is only valid if (1) the provider determines the minor is mature enough to participate intelligently in the services; and (2) either (a) the minor would present a danger of serious physical or mental harm to themself or others without the services, or (b) the minor is the alleged victim of incest or child abuse. Family Code Section 6924.
[61] Family Code Section 6924.
[62] "Medical care" is defined as including "X-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care under the general or special supervision and upon the advice of or to be rendered by" a physician or surgeon. Family Code Section 6903.

Table 1. Health Care Services Minors May Independently Consent to Without Parent/Guardian Consent, Under California Law	
Age	**Consent (without parent/guardian)**
Minors over the age of 15 who live separate and apart from their parent/guardian and manage their own financial affairs	• All health care services.[64]
Emancipated minors[65]	• All health care services.[66]

Even if a service does not fall within one of the above categories, there may be circumstances where the minor can legally provide consent for the disclosure of information about the service. These circumstances are highly individual, but, for example, if a parent/guardian assents to a confidentiality agreement between a minor and the minor's health care provider, only the minor, and not the parent/guardian, may consent to the release of any information related to the health care services covered by that agreement.[67] Similarly, if a minor may obtain a service without the consent of the parent/guardian or any other person acting *in loco parentis* (in place of the parent)—as may occur in some states where a minor may obtain an abortion with a court's approval under a judicial bypass procedure—then the minor may consent to disclosure of information about that service.[68]

► Sharing Records of Health Care Services the Minor Did Not Independently Consent to Receive

If none of the circumstances described above apply—that is, if the minor did not legally consent to the underlying service and the minor did not have the right to obtain such service without parental consent—then generally, the parent/guardian, not the minor,

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[63] Family Code Section 6929(b). This provision does not authorize a minor to independently consent to receive replacement narcotic abuse treatment in a licensed Narcotic Treatment Program. Family Code Section 6929(e). Conversely, the provision does not permit a minor to *refuse* medical care and counseling for a drug- or alcohol-related problem that their parent/guardian has consented to. Family Code Section 6929(f).

[64] Family Code Section 6922.

[65] Pursuant to California law, a person under the age of 18 is considered an emancipated minor if (1) the person has entered into a valid marriage or domestic partnership, even if the marriage or domestic partnership has since been dissolved; (2) the person is on active duty with the United States Armed Forces; or (3) the person has obtained a declaration of emancipation issued by a court. Family Code Section 7002.

[66] 45 C.F.R. § 164.502(g)(2).

[67] 45 C.F.R. § 164.502(g)(3)(i)(C).

[68] 45 C.F.R. § 164.502(g)(3)(i)(B).

must sign any authorization for disclosure of information about that service.[69] Further, if the records being disclosed are not health care records subject to HIPAA but instead are education records subject to FERPA or IDEA, then the parent/guardian must always sign any authorization form permitting the disclosure of such education records.[70]

Health-Related Information in Education Records

Unlike HIPAA, parental/guardian consent is required under FERPA and IDEA even if the record relates to a service for which the minor provided consent. For example, if a school nurse provides birth control to a student and the record of such visit is subject to FERPA, then the parent/guardian will need to sign any authorization that permits the disclosure of such birth control record, even though the child obtained the birth control without parental consent.

In some cases, a parent with legal custody can allow another adult to provide consent for a child's services. Under California law, a parent/guardian may authorize a caregiver to approve medical care on behalf of a minor using a Caregiver's Affidavit if the caregiver meets certain conditions, even if the caregiver does not have custody of the child.[71] Depending on the rights granted by the child's parent/guardian, the authorization may only extend to "school-related medical care," which may include medical care required for enrollment, such as immunizations, physical examinations, and medical examinations conducted in school.[72] If a caregiver has been authorized to provide such care, the caregiver may provide consent for release of the related information regarding the care, unless the parent/guardian supersedes that authority.[73]

► Consent for Minors Involved with the Child Welfare System or Receiving Foster Care

In the case of a minor subject to the child welfare system, determining who qualifies as the child's Personal Representative can be complex.

1. **In cases where a parent/guardian retains parental rights over a child,** including the right to consent to health care services for the child, then that parent/guardian also continues to have the right to consent to the disclosure of information related to such services.
2. **In cases of suspected abuse or neglect where a parent/guardian does not retain the right to consent to health care services for a child,** a court may place limits on the parent's/guardian's right to consent to the child's medical care,

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[69] As noted above, if the underlying record is subject to 42 C.F.R. Part 2, then both the minor and the parent/guardian must sign the authorization form. 42 C.F.R. § 2.14(b).
[70] *See* 34 C.F.R. § 99.30(a); 34 C.F.R. § 300.622; 34 C.F.R. § 303.7.
[71] Family Code Section 6550.
[72] Family Code Section 6550.
[73] Family Code Section 6550.

and others may instead provide such consent in place of the parent/guardian.[74] In such cases, those parties, described in the chart below, must sign any authorization for the disclosure of the minor's information if they are acting *in loco parentis*, and such authorization may apply not only to PHI subject to HIPAA but also to Part 2 and FERPA information.

Those who may consent on behalf of a minor subject to the child welfare system include:

Table 2. Individuals Who May Consent to Health Care Services on Behalf of a Minor Subject to the Child Welfare System[75]

Who May Consent	Under What Circumstances	Requirements
Parents/guardians	• Parent/guardian retains parental rights over a child, including the right to consent to health care services for the child.	None.
Juvenile court judges	• The minor is the subject of a custody petition; • A juvenile court believes the minor may need medical care; and • An attending physician provides written authorization for the performance of medical care.	The court must notify the minor's parent/guardian.[76]
Social workers	• The minor has been taken into temporary custody; • A social worker believes the minor may need medical, surgical, dental, or other remedial care; and • An attending physician authorizes the performance of medical care.	• The social worker must notify the minor's parent/guardian. • If the parent/guardian then objects to the care, a court order from the juvenile court is required.[77]

[74] HIPAA permits individuals who are not parents or guardians to provide consent on behalf of a minor in cases where those individuals are acting *in loco parentis*. 45 C.F.R. § 164.502(g)(3)(i). Similarly, FERPA permits individuals to act in the place of a parent in the absence of a parent or guardian. 34 C.F.R. § 99.33 (definition of "parent").

[75] Note: Being in the child welfare system has no impact on the minor's ability to consent to services for which the minor has the legal right to provide consent.

[76] Welfare and Institutions Code Section 369(b).

[77] Welfare and Institutions Code Section 369(a).

Table 2. Individuals Who May Consent to Health Care Services on Behalf of a Minor Subject to the Child Welfare System[75]		
Who May Consent	**Under What Circumstances**	**Requirements**
	• The court issues an order authorizing the social worker to provide consent for the minor's health care services; and • The minor is declared a dependent child of the juvenile court; and • The court places the minor under the care, custody, or supervision of a social worker; and • It appears to the court that there is no parent/guardian willing to make health care decisions on behalf of the minor.	• The court must notify the parent/guardian.[78]
Foster parents or others authorized to provide residential foster care	• The foster parent is licensed or approved to provide residential foster care; and • Either a juvenile court has placed the child with the foster parent or the person with legal custody has voluntarily placed the child with the foster parent.	• The foster parent may consent to "ordinary medical and dental treatment for the child, including but not limited to immunizations, physical examinations, and X-rays," unless the juvenile court reserves to itself the right to consent to such services.[79] • Foster parents do not have the right to consent to health care services that are not considered "ordinary."

[78] Welfare and Institutions Code Section 369(c).
[79] Health and Safety Code Section 1530.6(a)(3).

Table 2. Individuals Who May Consent to Health Care Services on Behalf of a Minor Subject to the Child Welfare System[75]		
Who May Consent	**Under What Circumstances**	**Requirements**
Relatives/kinship arrangements	• The court orders the placement of a minor in a planned permanent living arrangement with a relative; and • The court authorizes the relative to provide consent for the receipt of health care services.[80]	

Note that the individuals described above often will be acting *in loco parentis* and therefore will have the right to consent to both treatment and the disclosure of information.[81] Further, being in the child welfare system has no impact on the minor's ability to consent to services for which the minor has the legal right to provide consent. For example, children in California have the right to consent to reproductive health services regardless of whether they are in foster care, subject to the age limitations set forth in Table 1 above.

[80] Welfare and Institutions Code Section 366.27.

[81] *See In re Danielle W.*, 207 Cal. App. 3d 1227, 1235 (Cal. App. 1989) (finding the Los Angeles County Department of Children's Services acted *in loco parentis* with respect to a 12-year-old in the county's child welfare system). However, in cases where they are not acting in place of a parent, the minor would make decisions about the applicable records.

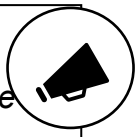
5. Data Sharing Use Cases

(1) Overview

The following use case scenarios are intended to assist Medi-Cal Partners in understanding the circumstances under which PII, including PHI subject to HIPAA, may be disclosed under CalAIM.

Medi-Cal Partners may be able to exchange PII in situations that are not addressed by any of these use cases and therefore should not interpret these use cases as being the only categories of permissible information sharing under CalAIM. A disclosure may comply with applicable law even if it does not fit within one of the following use cases, and whether the Member has signed a data sharing authorization form may impact the scope of data that may be shared.

Disclaimer



This guidance is not intended to be legal advice, and it should not be construed as legal advice. DHCS cannot provide an authoritative interpretation of federal privacy laws that are determinative of whether PII may be disclosed. Medi-Cal Partners should confer with their legal counsel to ensure that their information sharing practices comply with applicable law.

The use cases assume that the AB 133 State Law Applicability Provision applies, and therefore the use cases focus on federal law requirements. The use cases only address laws that are applicable to the disclosure of PII. They do not address restrictions that may exist in policies or procedures or in contracts.[82] Medi-Cal Partners are responsible for understanding what requirements may exist outside law and regulation and when they should be followed.[83] In addition, Medi-Cal Partners have the discretion to determine the means of exchange of PII.[84]

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[82] For example, the United States Department of Housing and Urban Development (HUD) has said that data in a Homeless Management Information System (HMIS) may be disclosed without a Member's written consent for purposes of coordinating care in cases where the homeless organization makes clear in its privacy notice that it may do so, but many continuums of care in California that operate an HMIS have adopted policies that require written consent even when disclosures are made for care coordination purposes. Similarly, some health information exchanges in California may have adopted policies that limit disclosures of PHI even in circumstances where such disclosures are permitted by HIPAA.

[83] As noted in the Data Sharing Provisions in Chapter 3 above, there may be circumstances under which following a policy that is unnecessarily restrictive may conflict with other obligations imposed on Medi-Cal Partners, such as the need to comply with the information blocking rule.

[84] As noted above, AB 133 permits Medi-Cal Partners to disclose PII through contractors, so long as they do so in compliance with federal law and for purposes of implementing CalAIM. Such contractors may include health information exchanges, community information exchanges, and other intermediaries that facilitate the exchange of PII.

(2) Guiding Principles

Information in the use cases is subject to the following assumptions. If one or more of these assumptions are not true, Medi-Cal Partners may still be permitted to disclose PII in accordance with applicable law, but the analysis in the use cases would be inapplicable. Information in the use cases and their following analyses are subject to the following assumptions:

- A Member may be either an adult or a minor.
- If a Member provides authorization for disclosure of the Member's information, that Member has the legal capacity to provide such consent. If another person (such as a friend or family member of the Member) provides authorization on behalf of that Member, then that other person has the legal authority to provide such consent—i.e., such a person is a Personal Representative of the Member.[85]
- Medi-Cal Partners are disclosing PII in order to coordinate the care of Members as previously defined in this document. Therefore, the Welfare and Institutions Code Section 14184.100(j) applies.
- If jail release dates or other criminal justice information are requested to be shared, then the requester does not have direct access to a criminal justice information system, meaning that the requester is unable to access a system containing detailed criminal histories of Members.
- Any criminal justice information provided by jails may include release dates, incarceration dates, and limited demographic information such as name, date of birth, sex, and race, but does not consist of the full criminal history of a Member or a criminal identification and information (CII) number.
- Providers sharing information under CalAIM are not subject to (1) the Violence Against Women Act (VAWA) or similar federal laws limiting the disclosure of information related to domestic violence treatment providers; or (2) FERPA. VAWA and FERPA often require an individual's consent for disclosures, even in cases where such consent is not required under HIPAA.
- Psychotherapy notes, as defined under HIPAA, are not disclosed.[86]
- Any disclosures comply with all applicable security requirements, including the requirements of the HIPAA Security Rule, if applicable.
- Any data sharing entities exchanging PII have undergone all legally required privacy and security training, including HIPAA training, if applicable.

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[85] For example, a parent or guardian may be a Personal Representative of a minor child or sign the form on behalf of the child; in the case of a minor in the child welfare system, the Personal Representative signing the authorization may also be a judge, a social worker, a foster parent, or a relative in certain cases.

[86] Under HIPAA, psychotherapy notes are "notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record." 45 C.F.R. Section 164.501.

- Housing providers may be subject to HMIS requirements because they use an HMIS to share or receive information, but no other housing data privacy laws are applicable.
- If PHI is being disclosed, the Medi-Cal Partner abides by HIPAA's minimum necessary standard, when applicable.[87]
- Social Security numbers are not disclosed.
- Medically tailored meal providers may be subject to HIPAA—either because they are HIPAA-covered entities or because they act as business associates of HIPAA-covered entities—but they are not subject to United States Department of Agriculture data privacy rules because they do not accept funding from the USDA to provide such meals. If a medically tailored meal provider is acting as a business associate of a covered entity, its business associate agreement permits the business associate to disclose for care coordination purposes the PHI it holds.

(3) Use Cases

In the following diagrams, information marked in green may be able to be disclosed in compliance with applicable law. Information marked in red denotes a significant likelihood that disclosure without consent would violate one or more laws. ***DHCS emphasizes that a definitive interpretation of applicable law cannot be made, and Medi-Cal Partners should rely on their attorneys to decide when PII can be disclosed***. **A note about justice-involved population referrals**: Referrals to ECM and Community Supports with respect to an individual who resides in a jail or prison are subject to the same legal rules as referrals of a person who is not in jail or prison, so long as such individual is a Member. When an individual is incarcerated in a state prison, county jail, or youth correctional facility, the correctional facility screens the individual for eligibility for pre-release services and for ECM, ensures the delivery of pre-release services including care management, and then coordinates care with an ECM provider (if applicable; the County may be the ECM provider) through a warm hand-off.[88]

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[87] Under HIPAA, the minimum necessary standard means that "[w]hen using or disclosing protected health information or when requesting protected health information from another covered entity or business associate, a covered entity or business associate must make reasonable efforts to limit protected health information to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request." 45 C.F.R. Section 164.502(b). This standard does not always apply. For example, the standard does not apply if the information is being shared with a health care provider for treatment purposes.

[88] The scenarios discussed apply to justice-involved individuals who did not receive pre-release services, but there are different use cases for those who receive pre-release services that will be published at a later date.

Table 3. Data Sharing Use Case Examples		
Use Cases	**Description**	**Data Flow**
1. Member identification, review, and authorization for ECM and Community Supports	MCPs identify Members for ECM and Community Supports by compiling and analyzing their own administrative, physical, behavioral, dental, and social services data; by analyzing cross-system information they receive from DHCS; and through referrals received from counties, providers, members, families, and others.	• 1-1: DHCS sends cross delivery system claims/encounter data to MCPs. • 1-2: Providers and CBOs send referrals and other records with Member information to MCPs.
2. ECM assignment and member engagement	MCPs assign each ECM eligible Member to an ECM Provider based on the Member's previous provider relationships, health needs, and known preferences; ECM Providers use available information to reach out to and engage with assigned Members.	• 2-1: MCP sends assignment files to ECM Providers. • 2-2: ECM Provider reports Member engagement back to MCP.
3. Care coordination and referral management	Under Basic Population Health Management within MCPs' Population Health Management program requirements, MCPs must support provider referrals across their community, county, social services, and Community Supports provider networks.	• 3-1: Provider sends referral and other information to medical, behavioral, or Community Supports provider. • 3-2: Medical, behavioral, or Community Supports provider informs referring provider of receipt of services.

Table 3. Data Sharing Use Case Examples		
Use Cases	**Description**	**Data Flow**
4. Billing and encounter reporting practices	Providers submit claims/invoices to MCPs for services rendered, and MCPs report complete and accurate encounters of all services provided to DHCS.	• 4-1: Provider sends claims to MCP. • 4-2: MCP sends encounter data to DHCS.
5. MCP coordination of behavioral health services	MCPs are responsible for coordinating mental health services with county Mental Health Plans (MHPs) and SUD services with county Drug Medi-Cal/Drug Medi-Cal Organization Delivery System (DMC/DMC-ODS).	• 5-1: MCP sends referral to county MHP or DMC/DMC-ODS. • 5-2: County MHP or DMC/DMC-ODS notifies MCP of the services provided.

► 1. Member Identification, Review, and Authorization for ECM and Community Supports

MCPs are responsible for identifying their members who meet ECM Populations of Focus criteria by compiling and analyzing information from a broad range of sources. While MCPs have their own data that provides insights on their members (for example, avoidable Emergency Department utilization), many ECM Population of Focus criteria are based on high levels of need that have not traditionally been transparent to MCPs (for example, being at risk of homelessness). Churn between MCPs may also mean that the MCPs lack detailed history on a portion of their members. Thus, MCPs are expected to encourage referrals of individuals enrolled in Medi-Cal and who may be eligible for ECM and Community Supports from their provider networks and from CBOs, as well as self-referral by individuals enrolled in Medi-Cal. They are also expected to use data sources from outside their MCP to support identification of their individuals enrolled in Medi-Cal who are being served by other delivery systems, including county SMHS and DMC/DMC-ODS.

Illustrative Examples:[89]

- Children and Youth involved in Child Welfare are an ECM Population of Focus starting in July 2023. MCPs have access to aid codes and eligibility groups as part of Medi-Cal eligibility data they receive from DHCS that can help identify

[89] See ECM Policy Guide for more information on ECM Populations of Focus and options for MCPs to identify members of each population.

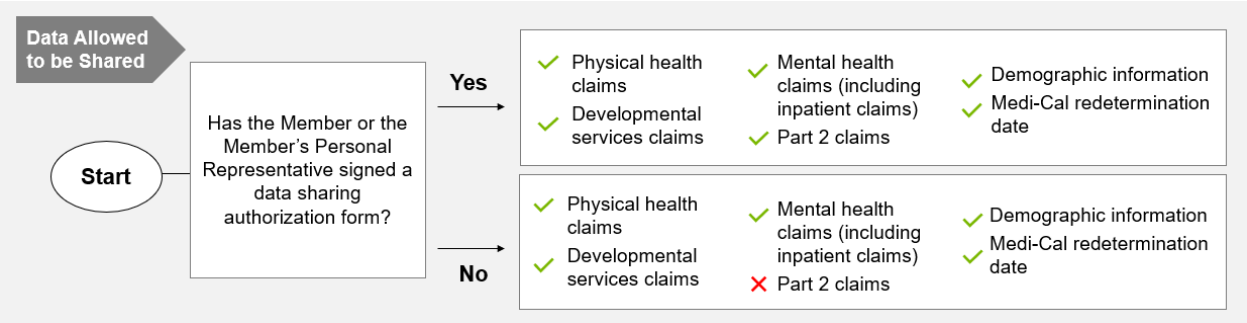
children and youth involved in child welfare, specifically for children receiving foster care, children with an approved relative caregiver, children who are in the former foster care youth eligibility group, and children who are in the Adoption Assistance Program.

- Adults with Serious Mental Health and/or SUD Needs are an ECM Population of Focus since launch in 2022, and children with these needs are eligible for ECM beginning July 2023. DHCS supports data exchange between the Short Doyle system (county SMHS and DMC/DMC-ODS) and MCPs, which can support ECM and Community Supports eligibility identification by MCPs. Some MCPs and counties exchange data directly. An MCP uses SMHS claims and encounters to identify an adult with serious mental health needs and co-occurring chronic physical conditions and housing instability for ECM.
- MCPs must have processes to receive referrals from providers for their members who can benefit from Community Supports. For example, an individual enrolled in an MCP who is currently homeless and is recovering from surgery in an inpatient hospital setting. Their doctor determines they no longer require hospitalization, but still need to heal from their surgery and will also need support in accessing housing. The doctor sends a referral to the MCP for Recuperative Care (Medical Respite) containing information about the member's physical and housing needs.
- ECM Providers may refer patients or clients to the MCP for ECM, beyond those already engaged in ECM. DHCS has a standard format for ECM Providers to perform this function, called the "Potential ECM Member Referral File.[90]" A physician working at an FQHC that is serving as an ECM Provider sees a pregnant patient with housing instability and works with the FQHC's ECM care management team to refer this patient to their MCP for ECM.

[90] See https://www.dhcs.ca.gov/Documents/MCQMD/Member-Level-Information-Sharing-Between-MCPs-ECM-Providers.pdf, p. 29.

Use Case 1-1: DHCS sends cross delivery system claims/encounter data to MCPs.
Data Exchanged: Administrative (claims and encounter)
Function: Member identification and authorization for ECM and Community Supports
Originating Entities: County SMHS, DMC/DMC-ODS; Medi-Cal Rx; DHCS
Receiving Entity: MCP

Use Case 1-1 Visualization



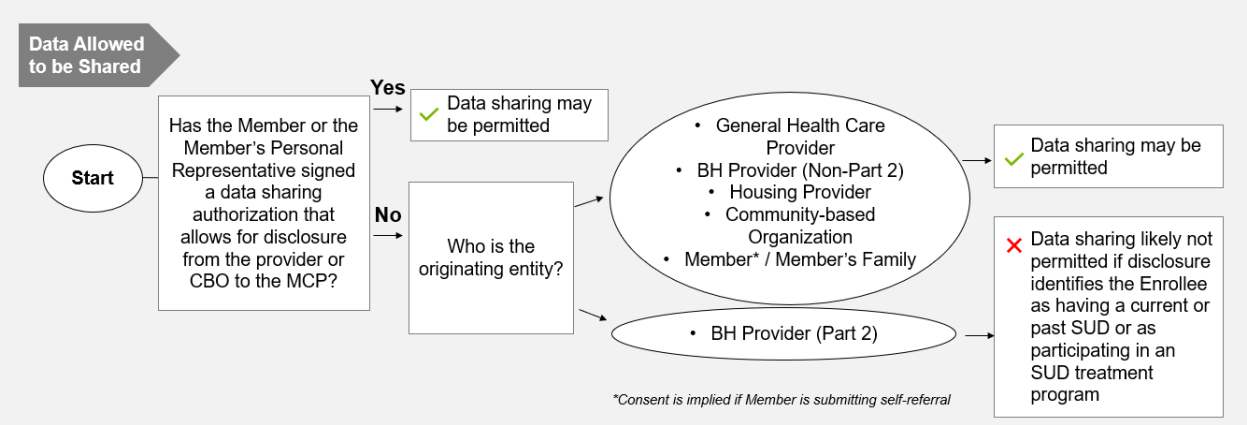
Legal Rationale
Physical health, mental health, and developmental services claims/encounters, as well as demographic information and Medi-Cal redetermination dates potentially may be shared in accordance with HIPAA since the disclosure is being made for a health care operations purpose—care management and care coordination—of the entity receiving the information; both the payer that is the source of the data (DHCS, MHP, or DMC-ODS) and the MCP have a relationship with the Member whose data is being disclosed, and the disclosure pertains to such relationship.

- Further, the disclosure potentially may occur in accordance with Social Security Act Section 1902(a)(7) since the disclosure is being made for a Medi-Cal administration purpose. Part 2 records would need to be removed from claims/encounter data files originating from another MCP unless the Member has signed an authorization form compliant with Part 2.[91]

[91] An MCP may have claims subject to Part 2 if Part 2 providers submit claims to the MCP and inform the MCP that such information is Part 2 data. The requirement to obtain additional consent would change under a new Part 2 final rule: if the new Part 2 rule is finalized as proposed, then the Part 2 data could be redisclosed without further consent.

Use Case 1-2**: **Providers and CBOs send referrals and other records with Member information to MCP.
Data Exchanged: Records with Member information
Function: Referral for ECM and Community Supports services
Originating Entities: Medi-Cal MCP members and/or their families; general health care providers; behavioral health care (including SMHS) providers, housing providers, CBOs; counties; social services entities[92]
Receiving Entity: MCP

Use Case 1-2 Visualization



Legal Rationale

Records with Member information potentially may be disclosed from an entity to the Member's MCP if the entity is a:

- general health care provider or a behavioral health provider not subject to Part 2 since, under HIPAA, the disclosure is being made in order to permit the MCP to engage in a health care operations purpose (care coordination), both the health care or behavioral health provider and MCP have a relationship with the Member whose data is being disclosed, and the disclosure pertains to such a relationship;[93]
- community-based organization; if such provider is subject to HIPAA, it may disclose its information in compliance with HIPAA for the reasons stated above (if the community-based organization is not subject to HIPAA, then no federal or state law would prohibit disclosure, provided the assumptions prior to these use cases apply);

[92] Additional jails/prisons use cases may be reflected in a future iteration of this guidance.
[93] The disclosure likely would be considered for a health care operations purpose, not a treatment purpose, because the entity coordinating care is a health plan, not a health care provider. Under HIPAA, only health care providers can engage in treatment. 45 C.F.R. Section 164.501

- housing provider, as federal HMIS requirements permit disclosures without written consent for purposes of care coordination and the MCP is seeking information in order to better coordinate care; and
- jail/prison (with regard to housing location, incarceration date, release dates, and limited demographic information) since federal law does not prohibit disclosures of this information.

Behavioral health providers subject to Part 2 may not disclose information to an MCP without authorization since there are no applicable Part 2 consent exceptions.

► 2. ECM Assignment and Member Engagement

MCPs identify the providers each Member (i.e., an individual receiving ECM services) has engaged with and determine the most appropriate provider for ECM assignment based on that Member's physical health, behavioral health, and social needs, including cultural and linguistic competency, as well as their preferences. After assignment is confirmed, MCPs are required to create a Member Information File to send to the ECM Provider, the purpose of which is to equip the ECM Provider with whole-person information about the Member that the MCP has, but the ECM Provider may not otherwise have access to. ECM Providers then use available information to reach out to and engage with Members. Once Members are engaged in ECM, ECM Providers regularly share back with the MCP the status of whether each Member is actively engaged in the benefit, as well as the identity of the lead Care Manager and any updated Member information where the ECM Provider may have more recent information than the MCP, such as address and telephone number.

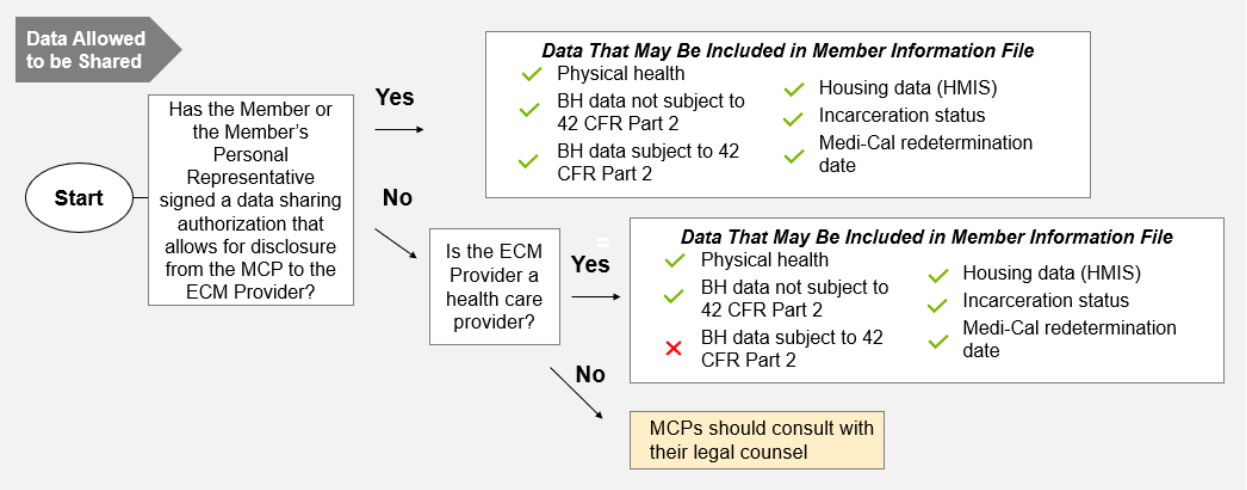
Illustrative Examples

- Member engagement:
  - After identifying that a child meets the Children and Youth Involved in Child Welfare ECM Population of Focus, the MCP populates a Member Information File containing demographic, health care utilization, medication, and other information to share with entities, including the local health department that has been contracted by the MCP to serve as an ECM Provider.
  - After identifying that an adult meets the Homeless ECM Population of Focus eligibility criteria using HMIS data, the MCP populates a Member Information file for that Member containing demographic, health care utilization, medication and other information to share with the FQHC/street medicine provider that has been contracted to serve as the ECM Provider.
- Engagement tracking:
  - An MCP Member with Serious Mental Illness and SUD is engaged in ECM by the county behavioral health team with which she already has a relationship. The county BH team sends to the MCP the Return

Transmission File once a month as agreed by the MCP; the file includes updated information about this Member as well as any other Members of that MCP served in ECM by the county team. The Return Transmission File gives the MCP information about how many times the team interacted with the Member during the reporting period and who the lead care manager is.

Use Case 2-1: MCP sends assignment files to ECM Providers.
Data Exchanged: MCP member information[94]
Function: Member engagement for ECM services
Originating Entity: MCP
Receiving Entity: ECM Provider

Use Case 2-1 Visualization



Legal Rationale

When the Member has not signed an authorization that allows for disclosure from the MCP to the ECM provider, data—including physical health and behavioral health information not subject to Part 2, housing history, incarceration status, Medi-Cal redetermination dates, and demographic data—potentially may be disclosed from the MCP to the ECM provider under HIPAA if the ECM Provider is a health care provider, because the disclosure is being made to a health care provider for a treatment purpose. If the ECM Provider is not a health care provider under HIPAA and the Member has not consented to disclosure, the treatment exception under HIPAA may not apply.[95] HIPAA

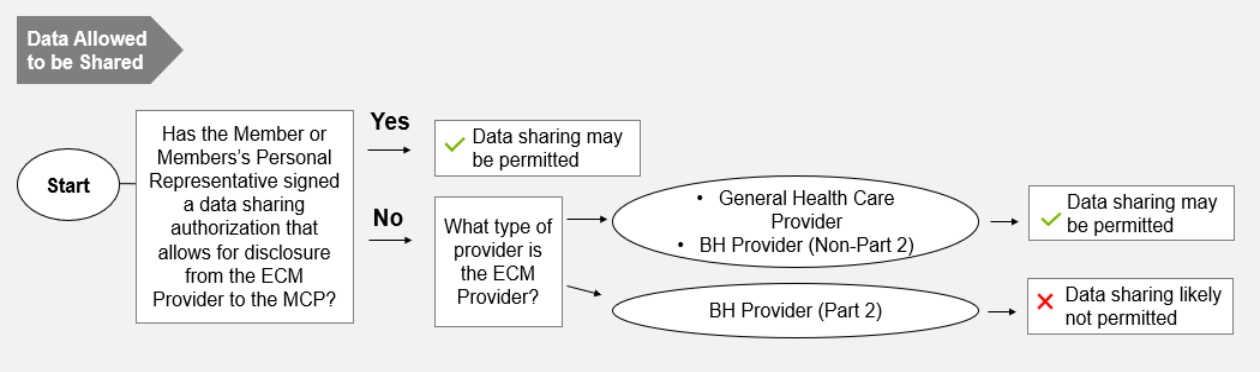
[94] The MCP Member information file data elements can be found in CalAIM Data Guidance: Member-Level Information Sharing Between MCPs and ECM Providers (April 2023).

[95] In contrast to Use Case 3-1 where the disclosing entity may be a health care provider, in this use case the disclosing entity is a health plan. Therefore, federal guidance related to disclosures from health care providers to community-based organizations is not directly applicable.

does permit a health plan to disclose PHI for care coordination purposes to organizations that are not HIPAA-covered entities if those organizations act as business associates of the health plan. MCPs, in consultation with their legal counsel, should consider whether it is appropriate to enter into business associate agreements with their ECM Providers that are not covered entities.

Use Case 2-2: ECM Provider reports Member engagement back to MCP.
Data Exchanged: Member engagement information[96]
Function: Updating MCP on engagement and ECM services performed for a member
Originating Entity: ECM Provider
Receiving Entity: MCP

Use Case 2-2 Visualization



Legal Rationale
When the Member has not signed an authorization that allows for disclosure, ECM Providers that are (1) general health care providers or (2) behavioral health providers not subject to Part 2 potentially may disclose Member engagement information to their MCPs, because covered entities may disclose PHI to health plans if both parties have a relationship with the Member. This is assuming the disclosure pertains to such relationship and the MCP is seeking the data for a health care operations purpose (to coordinate care). ECM Providers that are behavioral health providers subject to Part 2 may not disclose Member engagement information since disclosure is not allowed for health care operations purposes without consent.

[96] This includes Return Transmission Files and ECM Provider Initial Outreach Trackers, and Potential ECM Member Referral Files; *see* CalAIM Data Guidance: Member-Level Information Sharing Between MCPs and ECM Providers (December 2021).

► 3. Care Coordination and Referral Management

All MCP Members receive basic population health management (BPHM), regardless of their level of need. BPHM includes care coordination, navigation, and referrals across all health and social services, including Community Supports. To support effective BPHM, MCPs are required to implement information-sharing processes and referral support infrastructure.[97] This section discusses appropriate sharing and exchange of Member information and medical records in compliance with state and federal privacy laws and regulations.

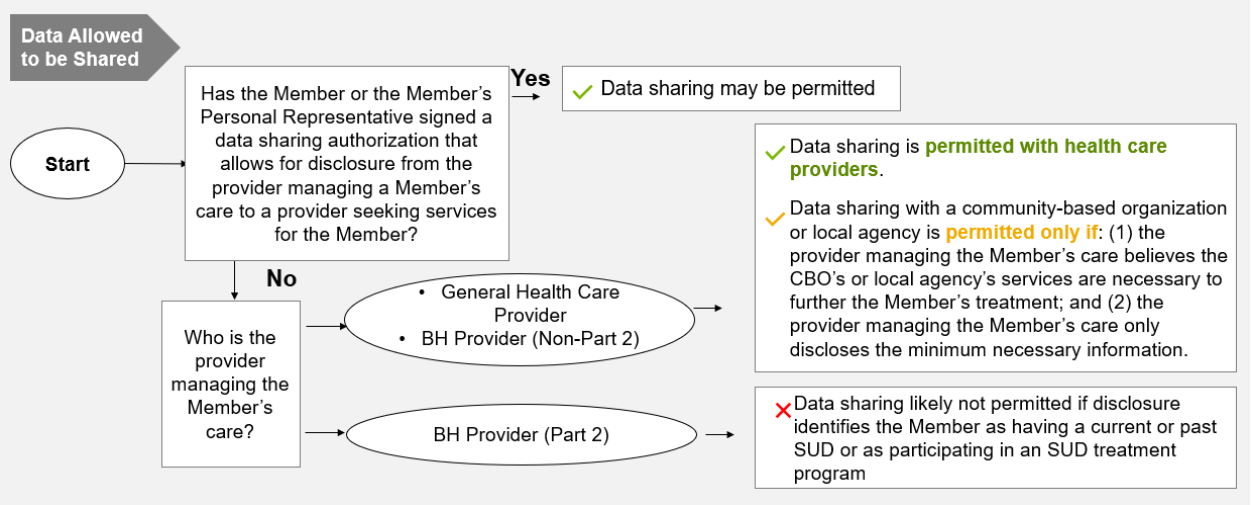
Illustrative Examples:

- An individual enrolled in Medi-Cal is experiencing food insecurity and is eligible for but not enrolled in CalFresh. Their assigned primary care provider refers them to the California Department of Social Services (CDSS) and follows up to confirm the Member is enrolled and receiving CalFresh services.
- An individual receiving ECM services is eligible for the Special Supplemental Nutrition Program for Women, Infant, and Children (WIC). Their ECM Provider, the local health department, seeks to share the Member's information that is necessary for eligibility determination and enrollment with the local WIC agency.
- An individual receiving ECM services requires assistance finding housing after completing a residential alcohol detox program. Their ECM Provider, who is a DMC-ODS provider, coordinates a referral for the Housing Transition Navigation Services Community Supports service.

[97] See PHM Policy Guide for more information on MCPs' care coordination and referral management requirements.

Use Case 3-1: Provider sends referral and other information to medical, behavioral, or Community Supports provider.
Data Exchanged: Information such as diagnoses, care plan, and goals
Function: Care coordination
Originating Entity: Provider that is responsible for coordinating a Member's care
Receiving Entity: Provider of physical health, behavioral health, or social services whose case the ECM Provider is coordinating on behalf of the Provider that has provided services to a Member and/or has received a referral to provide services to a Member under CalAIM specifically

Use Case 3-1 Visualization



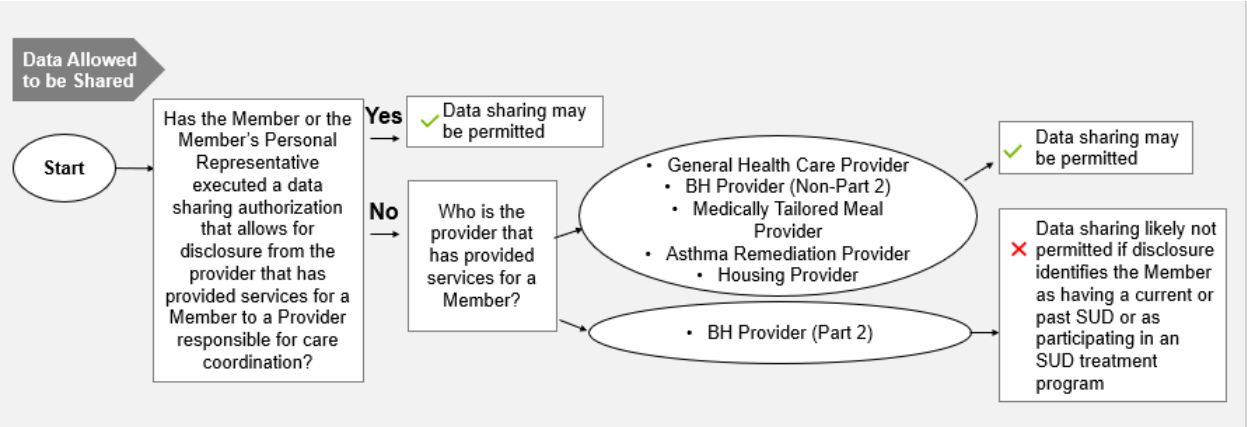
Legal Rationale

When the Member has not signed an authorization that allows for disclosure, general health care providers or behavioral health providers not subject to Part 2 potentially may disclose information to health care providers since covered entities may disclose PHI to health care providers for treatment purposes. If the recipient is a community-based organization or another entity that is not a HIPAA-covered entity under guidance issued by the Office for Civil Rights, then disclosure is permitted if the disclosing health care provider believes that the disclosure helps advance the Member's treatment, and only the minimum necessary information is disclosed.[98] Behavioral health providers subject to Part 2 **may not** disclose information since disclosure is not allowed for care coordination purposes without consent.

[98] HIPAA FAQ, HHS. Note in some circumstances the disclosure could also be permitted if the community-based organization is acting as a business associate of a HIPAA covered entity.

Use Case 3-2: Medical, behavioral, or Community Supports provider informs referring provider of receipt of services.
Data Exchanged: Confirmation of services rendered that may include encounter information, screenings, diagnoses, services rendered, procedures, etc.
Function: Care coordination
Originating Entity: Provider that has provided services to a Member and/or has received a referral to provide services to a Member under CalAIM specifically
Receiving Entity: Provider that is responsible for coordinating the Member's care

Use Case 3-2 Visualization



Legal Rationale
When the Member has not signed an authorization that allows for disclosure, data sharing regarding confirmation of services potentially may be permitted from a provider to another provider responsible for coordinating the Member's care if the provider that is sharing information is a:

- General health provider or behavioral health provider not subject to Part 2, since covered entities may disclose PHI for care coordination purposes under HIPAA;
- Community-based organization; if such a provider is subject to HIPAA, then it may disclose its information in compliance with HIPAA for care coordination purposes (if the CBO is not subject to HIPAA, then no federal or state law would prohibit disclosure, provided the assumptions prior to these use cases apply); or
- Housing provider, since federal HMIS requirements permit disclosures without consent for purposes of payment.

A behavioral health provider subject to Part 2 may not disclose Member information to another provider for care coordination purposes without authorization.

Due to Welfare and Institutions Code Section 14184.100(j), the limitation in the Lanterman-Petris-Short Act allowing disclosures accompanying referrals solely to "qualified professional persons" does not apply. This means that a behavioral health provider subject to that law may share PII with a provider responsible for coordinating a

Member's care even if the recipient of the data is not a physician or other type of clinician.

► 4. Billing and Encounter Reporting Practices

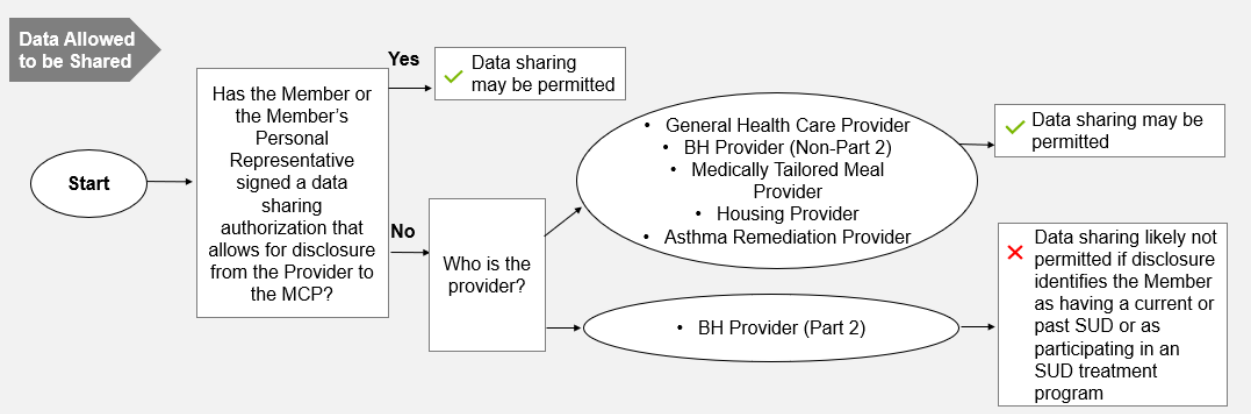
Providers submit claims/invoices to MCPs for services rendered. MCPs report complete and accurate encounters of services to DHCS, including supplemental reports that DHCS may use to verify encounter data completeness.

Illustrative Example:

- An individual receiving ECM services seeks treatment for substance use disorder (SUD). Their ECM Provider, a Federally Qualified Health Center (FQHC), coordinates a referral for DMC-ODS services. The DMC-ODS provider seeks to disclose information to DHCS in order to be reimbursed for the services.

Use Case 4-1: Provider sends claims to MCP.
Data Exchanged: Claims information[99]
Function: Billing for payment of services
Originating Entity: Provider
Receiving Entity: MCP

Use Case 4-1 Visualization



Legal Rationale
Claims information potentially may be disclosed from a provider to an MCP if the provider is a:

- general health provider or behavioral health provider not subject to Part 2, since covered entities may disclose PHI to a health plan for payment purposes under HIPAA;

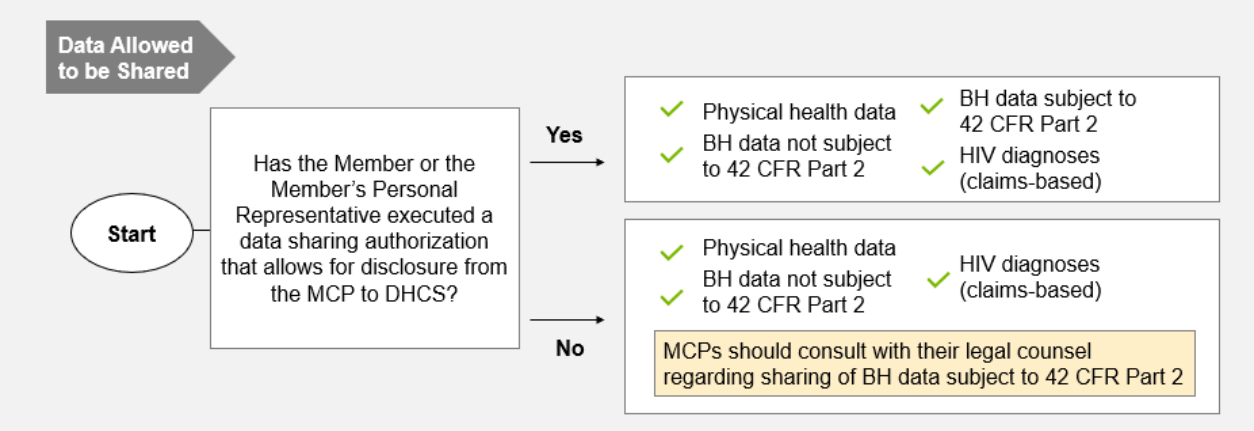
[99] This also includes service invoices or service claims—*see* CalAIM Data Guidance: Billing and Invoicing between ECM / Community Supports Providers and MCPs (January 2022).

- community-based organization; if such provider is subject to HIPAA, then it may disclose its information in compliance with HIPAA for the reasons stated above; and
- housing provider, since federal HMIS requirements permit disclosures without written consent for purposes of payment.

A behavioral health provider subject to Part 2 **may not** submit invoices with Part 2 information to the MCP without consent; there is no exception under Part 2 that permits disclosures for payment purposes without authorization.

Use Case 4-2**: **MCP sends encounter data to DHCS.
Data Exchanged: Encounter information
Function: Encounter reporting
Originating Entity: MCP
Receiving Entity: DHCS

Use Case 4-2 Visualization



Legal Rationale
Encounter data containing general health information, behavioral health information not subject to Part 2, HIV information, or demographic data potentially may be disclosed to DHCS under HIPAA since such disclosure is required by virtue of provider contracts with the Medicaid agency. Part 2 records could be included in claims/encounter data files if the Member has signed an authorization form compliant with Part 2 that permits disclosure to DHCS.[100] If the authorization form did not reference disclosures to DHCS, Part 2 records could be included if the disclosure met the "audit and evaluation" exception at 42 C.F.R. Section 2.53 or complied with Section 3221 of the CARES Act; MCPs should discuss such disclosures with their legal counsel.

[100] If the form named DHCS as a potential recipient in addition to the MCP and said the data could be shared with DHCS for payment and health care operations purposes, then the MCP could share the Part 2 records with DHCS in accordance with the terms of the form. In addition, if the new Part 2 rule is finalized as proposed, then the MCP will be permitted to redisclose the data to DHCS for payment and health care operations purposes even if DHCS is not specifically identified as a potential recipient.

► 5. MCP Coordination of Behavioral Health Services

MCPs are responsible for coordinating behavioral health services with the county MHP and SUD services with the county DMC/DMC-ODS. An MCP is required to enter into a memorandum of understanding with counties to ensure that behavioral health services are coordinated and nonduplicative. If an MCP learns that a Member could benefit from SMHS provided by an MHP, or SUD services provided by a DMC/DMC-ODS, the MCP may provide a referral to the MHP or the DMC/DMC-ODS, as appropriate. For example, a Member may be admitted to an emergency room (ER) related to a mental health condition or SUD, and such ER visit may be covered by the MCP. Upon learning of such visit, the MCP may legally notify the MHP or DMC/DMC-ODS, as applicable, that the Member meets the criteria for SMHS or DMC/DMC-ODS services and provide documentation related to the ER visit describing how the Member meets such criteria.

For Members who are using services provided by an MHP or the DMC/DMC-ODS, the MCP will need to coordinate with the MHP or DMC/DMC-ODS on an ongoing basis.

Illustrative Examples

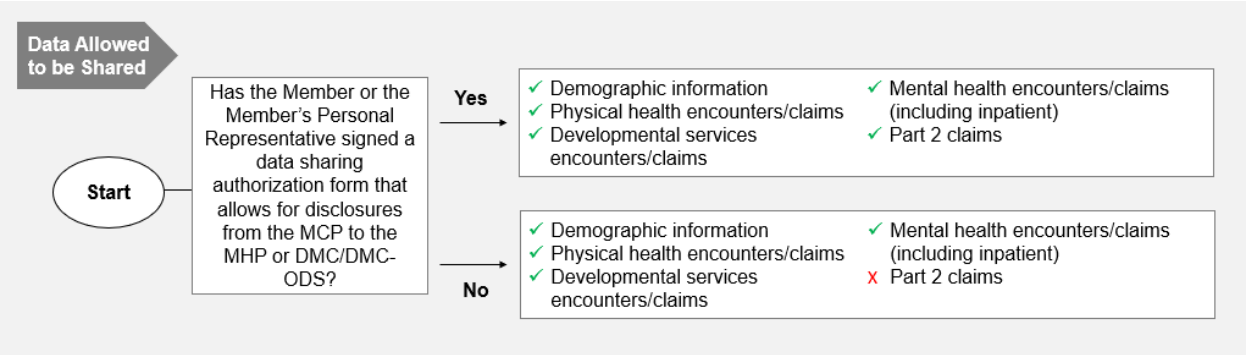
- The Member, who is under 21, has an eating disorder and attends group psychotherapy through an MCP provider; the Member is experiencing trauma from involvement in the child welfare system and begins receiving treatment for PTSD through SMHS while continuing to attend group psychotherapy for their eating disorder.
- The Member has a mild anxiety disorder and was recently diagnosed with an SUD; the Member takes medication for their anxiety disorder, which is managed by an outpatient psychiatrist whose services are covered by the MCP. The Member will begin receiving intensive SUD treatment delivered by a DMC/DMC-ODS provider.

The requirements for providing co-occurring SUD treatment and non-specialty mental health services (NSMHS) are outlined in the No Wrong Door for Mental Health Services Policy.[101]

[101] BHIN No.: 22-011 No Wrong Door for Mental Health Services Policy.

Use Case 5-1: MCP sends referral to county MHP or DMC/DMC-ODS.
Data Exchanged: Referral inclusive of PHI documenting the need for SMHS or DMC/DMC-ODS services
Function: Inform of the need for SMHS or DMC/DMC-ODS services
Originating Entity: MCP or physical health provider
Receiving Entity: MHP or DMC/DMC-ODS

Use Case 5-1 Visualization



Legal Rationale
When the Member has not signed an authorization that allows for the disclosure from the MCP to the MHP or DMC/DMC-ODS, HIPAA nevertheless permits such disclosure since it is made for purposes of coordinating care and both parties are HIPAA-covered entities. If the referral contains information subject to Part 2 by virtue of who holds the information, then consent from the Member would be needed for such disclosure under Part 2 rules in effect as of May 2023.[102]

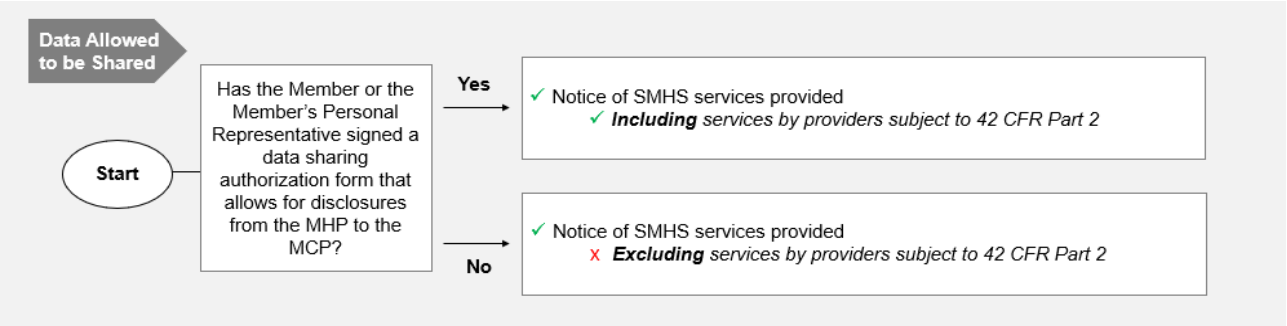
Illustrative Examples:

- A Member with undiagnosed and untreated schizophrenia presents to the ED with hallucinations and delirium. In assessing the Member, the provider determines the member meets the access criteria for SMHS.
- A Member presents to the ED having overdosed on fentanyl. After being stabilized, the Member is discharged to an inpatient detox facility.

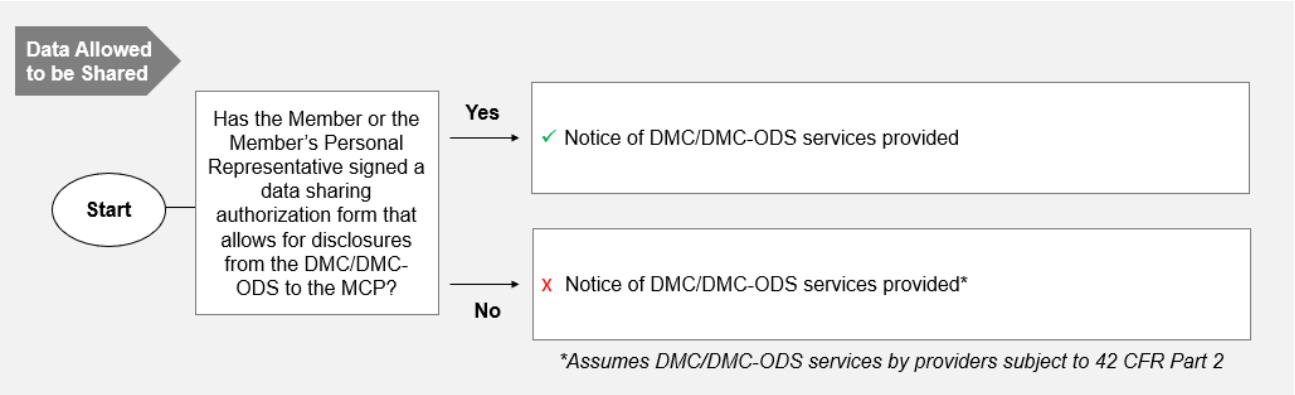
[102] Many forms of SUD information held by MCPs will not be subject to 42 C.F.R. Part 2. For instance, SUD data originating from emergency departments, such as described in the illustrative examples, typically will not be subject to Part 2. However, an MCP could obtain Part 2 information if, for example, it receives claims for non-specialty mental health services from clinicians that hold themselves out as providing SUD care and such clinicians obtain patient consent for submitting such claims to the MCP. (If a new Part 2 rule is finalized as proposed, then the Part 2 data could be redisclosed without further consent.)

Use Case 5-2: County MHP or DMC/DMC-ODS notifies MCP of the services provided.
Data Exchanged: Notification of SMHS or DMC/DMC-ODS services provided
Function: Closed-loop referral informing MCP that SMHS or DMC/DMC-ODS services are being provided
Originating Entities: MHP or DMC/DMC-ODS
Receiving Entity: MCP

Use Case 5-2 (MHP) Visualization



Use Case 5-2 (DMC/DMC-ODS) Visualization



Legal Rationale

HIPAA permits disclosure from the MHP or DMC/DMC-ODS to the MCP because both parties are HIPAA-covered entities, and the disclosure is made for the purposes of coordinating care. However, Part 2 requires the Member's consent for the disclosure of any information from the DMC/DMC-ODS that is subject to Part 2.[103]

[103] While the federal government has proposed to modify the circumstances under which a recipient of Part 2 data may disclose such data without additional consent, under current rules a lawful holder of Part 2 information may only redisclose that data without obtaining further consent "as may be necessary for its

Due to Welfare and Institutions Code Section 14184.100(j), the limitation in the Lanterman-Petris-Short Act allowing disclosures accompanying referrals solely to "qualified professional persons" does not apply. This means that an MHP disclosing PII that is subject to that law may share such PII with the MCP pursuant to a referral even if the recipient of the data is not a physician or other type of clinician.

Illustrative Examples

- A Member who has been receiving intensive outpatient treatment for an SUD is transitioning from that level of care to outpatient therapy, which is covered by the MCP.
- A youth under 21 has received SMHS intensive behavioral health services at home but is ready to transition to outpatient therapy, which is covered by the MCP.

contractors, subcontractors, or legal representatives to carry out payment and/or health care operations on behalf of such lawful holder." 42 C.F.R. Section 2.33(b).

Appendix A

This Appendix A contains an in-depth summary of privacy laws pertaining to (1) health information, (2) SUD treatment, (3) education records, and (4) child welfare records, expanding on the high-level overview contained in Chapter 2.

(1) SUD Privacy Laws (42 C.F.R. Part 2)

Other health care privacy laws apply specifically to SUD information.
This section covers:

- A general description of Part 2;
- Which providers are subject to Part 2; and
- Applicability of Part 2 to organizations that receive SUD information.

► 42 C.F.R. Part 2

42 C.F.R. Part 2 is a federal regulation that protects the confidentiality of some types of SUD information. Often referred to simply as Part 2, the regulation applies to some but not all categories of SUD information. **When Part 2 applies, it is often stricter than HIPAA, in part because the regulation does not permit disclosures of information for treatment or care coordination purposes without patient consent.**
Part 2 does not apply to all SUD information. The regulation applies only to information that has been obtained by a Part 2 provider, sometimes called a Part 2 program, and that would identify an individual as having or having had an SUD.[104]

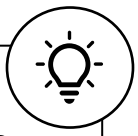
Because Medi-Cal Partners provide services to Members with SUDs, the Part 2 regulations will apply to some of the information exchanged under CalAIM. Part 2 often requires consent for the disclosure of information in circumstances where HIPAA does not; therefore, Medi-Cal Partners need to assess if the information is subject to Part 2.

Below we highlight key aspects of Part 2 and guidance from SAMHSA, the federal agency that has implemented Part 2, regarding which types of providers and what type of information are subject to Part 2.

[104] 42 C.F.R. § 2.12(a)(1).

Providers Subject to Part 2

A Part 2 provider is a federally assisted program that "holds itself out as providing, and provides, [SUD] diagnosis, treatment, or referral for treatment."[105] SAMHSA has explained that a provider may "hold itself out" as providing SUD services if it, among other activities, obtains a state license specifically to provide SUD services, advertises SUD services, has a certification in addiction medicine, or posts statements on its website about the SUD services it provides.[106] Individual clinicians, as well as clinics, hospitals, and other health care facilities, can be Part 2 providers; a physician can be subject to Part 2 even if that physician works in a facility that is not subject to the regulation.



Key Takeaway

Providers often avoid sharing SUD information because 42 C.F.R. Part 2 is widely misunderstood.

Part 2 does not permit disclosures of SUD information for treatment or care coordination purposes without patient consent; **it applies only to SUD information originating from providers covered by Part 2, not all SUD information**.

- In guidance, SAMHSA has said the following providers, among others, meet the definition of a Part 2 provider:
  - A SAMHSA-certified opioid treatment program that advertises its SUD services.
  - A physician at a community mental health center who is identified as the center's leading SUD practitioner and who primarily treats patients with SUDs.
- By contrast, SAMHSA has said the following providers are not subject to Part 2:
  - A psychiatrist who provides mental health services to patients with SUDs.
  - A physician who treats a diverse group of patients and occasionally provides medication-assisted treatment with buprenorphine to treat opioid dependency.
  - Emergency room personnel who refer a patient to the intensive care unit for an apparent overdose, unless the primary function of such personnel is the provision of SUD diagnosis, treatment, or referral for treatment, and they are identified as providing such services, or the emergency room has promoted itself to the community as a provider of such services.[107]

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[105] The regulation also applies to "(2) [a]n identified unit within a general medical facility that holds itself out as providing, and provides, [SUD] diagnosis, treatment, or referral for treatment; or (3) [m]edical personnel or other staff in a general medical facility whose primary function is the provision of [SUD] diagnosis, treatment, or referral for treatment, and who are identified as such providers." 42 C.F.R. § 2.11.

[106] Applying the Substance Abuse Confidentiality Regulations, SAMHSA.

[107] Disclosure of Substance Use Disorder Patient Records, Does Part 2 Apply to Me?, SAMHSA; 42 C.F.R. § 2.12(e)(1).

While Medi-Cal Partners are likely to be "federally assisted" by virtue of receiving Medi-Cal funds, many Medi-Cal Partners or providers that obtain SUD information will not be subject to Part 2 because they do not "hold themselves out" as providing SUD services as described above.

Applicability of Part 2 to Organizations That Receive SUD Information

Information that comes from an organization that is not subject to Part 2: SAMHSA has explained that if an organization is not subject to Part 2, then information that such organization collects from a screening, brief intervention, and referral to treatment is not subject to Part 2, even if that information identifies individuals as having an SUD.[108]

- Therefore, member information files developed by MCPs that identify certain Members as having an SUD may not be subject to Part 2 if the lists are based on screenings, assessments, or other data sources that were generated by organizations that are not subject to Part 2.
- By contrast, if a Member's SUD status in a member information file is based on information provided by a Part 2 provider—which could occur, for example, if the information came from a claim or medical record provided by an opioid treatment program—then such entry in the file would be subject to Part 2.

Information that comes from an organization that is subject to Part 2: Part 2 does apply to recipients of SUD information from Part 2 providers in some circumstances. However, the regulation's restrictions on disclosures typically apply to recipients of SUD information only if the disclosing party has notified the recipient that the information is subject to Part 2.[109] Further, if a Part 2 provider shares information orally with another provider and that second provider reduces that information to writing, then that second provider's notes are not subject to Part 2.[110]

- In cases where an organization determines that the SUD information it has received from another source is subject to Part 2, that organization may still be able to use and disclose such information in certain circumstances.
- 42 C.F.R. § 2.33 permits organizations that receive records subject to Part 2 in accordance with an individual's consent (described as "lawful holders") to redisclose such information to their contractors for payment or health care operations purposes (e.g., care coordination and care management), so long as they follow certain safeguards, such as contractually requiring the contractor to abide by Part 2.
- In addition, under Section 3221 of the CARES Act, organizations that receive Part 2 information with a patient's consent may redisclose such information if

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[108] Applying the Substance Abuse Confidentiality Regulations, SAMHSA.

[109] Disclosure of Substance Use Disorder Patient Records, Does Part 2 Apply to Me?, SAMHSA; 42 C.F.R. § 2.12(d)(2)(i).

[110] 42 C.F.R. § 2.11 (definition of "Records").

permitted by HIPAA.[111] However, the federal government has not yet finalized a regulation that would codify this new flexibility.[112]

► California Health and Safety Code Section 11845.5

California also has its own SUD confidentiality law,[113] which mirrors the federal substance use treatment disclosure regulations in many respects but applies to a broader class of providers.

(2) Education Privacy Laws

Medi-Cal Partners seeking access to school records of minor Members must comply with various federal and state laws that protect the confidentiality of such information. These include laws that protect education records generally as well as laws that apply to certain types of education records (e.g., IEPs and school lunch enrollment records).

► Family Educational Rights and Privacy Act (FERPA)

At the federal level, the primary applicable education information privacy law is FERPA, which applies to materials that contain information directly related to a student and that are maintained by an educational agency or institution, such as a school or the California Department of Education, or a person acting on behalf of an educational agency or institution ("Education Records").[114]

Importantly, what qualifies as a protected Education Record under FERPA is defined by who maintains the Education Record rather than the contents of the Education Record. As a result, some health-related records may be subject to privacy protections under FERPA. For example, to the extent that a school's nurse, acting as an employee of the school, maintains immunization records for a student at the school, those records would be subject to FERPA.[115] By contrast, if a health care provider unaffiliated with a school records information related to the student's education, such record would not be subject to FERPA.

Unlike HIPAA, FERPA does not typically permit schools to disclose education records of students for purposes of treatment or care coordination, and therefore parental consent

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[111] 42 U.S.C. § 290dd-2(b)(B).
[112] Section 3221 of the CARES Act directed HHS to make amendments to Part 2 regulations "such that such amendments shall apply with respect to uses and disclosures of information occurring on or after" March 27, 2021. HHS proposed revisions to the Part 2 regulations to enact the CARES Act in December 2022, but the proposed revisions have not been finalized as of the date of this guidance. *See* Confidentiality of SUD Patient Records, HHS.
[113] California Health and Safety Code Section 11845.5.
[114] 20 U.S.C. § 1232g; 34 C.F.R. Part 99.
[115] *See Joint Guidance on the Application of the Family Educational Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to Student Health Records* (December 2019 Update), U.S. HHS and Department of Education.

is often needed for the disclosure of Education Records. However, in limited circumstances, no such consent is needed. Schools, for example, may disclose Education Records in an emergency if knowledge of the information is necessary to protect the health or safety of the student or other individuals.[116] Schools can also share "directory information"—such as name, address, and dates of attendance—without consent.[117]

► California Education Code

California has a privacy law (Education Code Section 49061) that applies to certain education records. Section 49061 protects "Pupil Records," which include any information directly related to an identifiable pupil that is maintained by a school or a school employee in the performance of their duties.[118] This state law largely mirrors FERPA with regard to when educational records are protected from disclosure absent parental consent; like FERPA, it permits disclosure of Pupil Records when needed in an emergency and often permits the disclosure of directory information without consent.[119]

► Individuals with Disabilities Education Act (IDEA)

Certain education records are subject to IDEA in addition to FERPA.[120]

- Part B of IDEA[121] protects the education records of children with disabilities,[122] including IEPs, which Medi-Cal Partners may seek to obtain if they are coordinating the care of a child with a disability.
- Part C of IDEA[123] applies to all records maintained under the state's early intervention program for children under the age of six.[124]

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[116] 34 C.F.R. § 99.36(a).
[117] 34 C.F.R. §§ 99.3 and 99.37. Information about a homeless child's living situation is not considered "directory information." 42 U.S.C. § 11432(g)(3)(G).
[118] Education Code Section 49061(b).
[119] Education Code Sections 49061(b), (c), 49073, and 49076(a)(2)(A). While the state educational privacy law generally permits disclosure of directory information without consent, the law requires consent for the disclosure of directory information about a homeless child or youth.
[120] 34 C.F.R. Parts 300 and 303; 20 U.S.C. Subchapter II.
[121] 34 C.F.R. Part 300; 20 U.S.C. Subchapter II.
[122] The term "child with disabilities," as defined under 34 C.F.R. §§ 300.8 and 300.11, includes a child "having an intellectual disability, a hearing impairment (including deafness), a speech or language impairment, a visual impairment (including blindness), a serious emotional disturbance (referred to in this part as 'emotional disturbance'), an orthopedic impairment, autism, traumatic brain injury, and other health impairment, a specific learning disability, deaf-blindness, or multiple disabilities, and who, by reason thereof, needs special education and related services."
[123] 34 C.F.R. Part 303; 20 U.S.C. Subchapter II.
[124] 34 C.F.R. §§ 303.403 and 303.6.

Parent/guardian consent typically is required for disclosures of information protected under Parts B and C of IDEA.[125,126]

► National School Lunch Act (NSLA) and California Equivalent

The NSLA[127] is a federal law that applies to eligibility information obtained through the process to determine eligibility for the federal free or reduced-price meal or free milk programs.[128,105] California law contains an equivalent privacy law that applies to eligibility information obtained through applications to California's state-equivalent free or reduced-price meal program.[129]

Similar to FERPA and IDEA, the NSLA privacy provisions and their California equivalent apply only to government records related to eligibility for these meal programs; these laws do not apply to a health care practitioner's written assessment that notes a child is enrolled in a free or reduced-price meal program, for example. Medi-Cal Partners that need access to information protected by the NSLA generally will need parental consent to obtain it.[130] For example, an ECM provider may use free or reduced-price meal eligibility information to identify and refer the individual receiving ECM services for other nutrition support services.

(3) Child Welfare Privacy Laws

Some but not all records about minors who are in foster care, are wards of the state, are victims of abuse or neglect, or are involved in family law, guardianship, or probate cases (child welfare records) are subject to special privacy protections. California law has strict requirements about when such records may be accessed; as a result, Medi-Cal Partners generally will be unable to obtain child welfare records for purposes of coordinating care under CalAIM. Instead, consent will need to be obtained from the person who has the ability to sign for the youth (*see* Chapter 4).

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[125] 34 C.F.R. §§ 300.622(b)(2) and 303.7.
[126] Under both FERPA and IDEA Part B, once a student turns 18 or attends postsecondary education, records that are made or maintained only for the provision of treatment by a physician, psychiatrist, psychologist, or other recognized health professional or paraprofessional are no longer considered protected records. 34 C.F.R. § 300.611; 20 U.S.C. § 1232g; 34 C.F.R. § 99.3. In addition, once a student turns 18 or attends postsecondary education, they may consent to the disclosure of their own records under FERPA and IDEA Part B (i.e., parental consent is no longer required). No such exceptions exist under IDEA Part C.
[127] 42 U.S.C. § 1766; 7 C.F.R. Part 245.
[128] 7 C.F.R. § 245.6(f)(3).
[129] Education Code Section 49558.
[130] The NSLA permits disclosure of records without parental consent only in limited circumstances that typically will not occur under CalAIM. For example, in addition to the Medicaid and state CHIP exceptions noted above, the law permits disclosures to persons directly connected with the administration or enforcement of school meal programs. 7 C.F.R. § 245.6(f).

► California Child Abuse and Neglect Reporting Act (CANRA)

CANRA implements the federal CAPTA by setting forth requirements for the confidentiality of child abuse or neglect records in California.[131] The law protects the privacy of records made in connection with mandated reports of child abuse or neglect, as well as child abuse and neglect investigative reports that result in a summary report being filed with the Department of Justice.

Under CANRA, protected records may be disclosed only in limited circumstances, absent a court order permitting such disclosure. For example, such records may be shared with "multidisciplinary personnel teams" without a court order.[132,133] "Multidisciplinary personnel" is defined as including "any team of three or more persons who are trained in the prevention, identification, management, or treatment of child abuse or neglect cases[,] and who are qualified to provide a broad range of services related to child abuse and neglect."[134] Multidisciplinary teams may consist of service providers such as psychiatrists, psychologists, marriage and family therapists, clinical social workers, professional clinical counselors, and other trained counseling personnel.[135]

Some laws, like HIPAA, Part 2, and the educational privacy laws, allow disclosure of protected information beyond the limited exceptions set forth in the laws themselves as long as the subject of the protected records—and/or their parent/guardian—consents to

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[131] CAPTA requires that states receiving CAPTA grants maintain the confidentiality of all records made and maintained in connection with CAPTA (including child protective services records relating to the intake, screening, and investigation of child abuse or neglect as well as case management files relating to the delivery of services and treatment provided to children and their families). CAPTA does not enumerate the scenarios in which disclosure of these records is permissible; instead, it requires states to determine when records made and maintained under CAPTA may be disclosed. 42 U.S.C. §§ 5106a(a) and 5106a(b)(2)(B)(viii).

[132] Penal Code Section 11167.5(b)(4).

[133] Note that a "multidisciplinary personnel team" is not the same as a "child and family team" as defined by Welfare and Institutions Code Sections 16501 et seq. The child and family team is "a group of individuals who are convened by [a] placing agency and who are engaged through a variety of team-based processes to identify the strengths and needs of the youth or child and their family, and to help achieve positive outcomes for safety, permanency, and well-being." Unlike a multidisciplinary personnel team, the primary purpose of a child and family team is not to provide treatment or health care to the child or youth under its care. For guidance on child and family team information sharing, *see* https://www.cdss.ca.gov/Portals/9/Additional-Resources/Letters-and-Notices/ACLs/2022/22-73.pdf.

[134] Welfare and Institutions Code Section 18951(d).

[135] Other potential team members include police officers and other law enforcement agents; medical personnel with sufficient training to provide health services; social workers with experience or training in child abuse prevention, identification, management, or treatment; schoolteachers and administrative officers; supervisors of child welfare and attendance; certified pupil personnel employees; CalWORKs case managers whose primary responsibilities are to provide cross-program case planning and coordination of CalWORKs and child welfare services; and representatives of local child abuse prevention councils or family-strengthening organizations, such as family resource centers. *Id.*

the disclosure by signing an authorization form. In contrast, CANRA has no provision that explicitly permits the disclosure of an individual's CANRA-protected records to any person with the written consent of the individual or their parent/guardian, unless another exception applies. Therefore, Medi-Cal Partners typically will not be able to access records subject to CANRA except where a court order permits disclosure to Medi-Cal Partners. Such Medi-Cal Partners consist of multidisciplinary personnel teams who provide services related to child abuse or neglect.

► Juvenile Case Files

Some child welfare records are subject to privacy restrictions governing a "juvenile case file." Section 827 of the California Welfare and Institutions Code defines a "juvenile case file" as including "a petition filed in any juvenile court proceeding, reports of the probation officer, and all other documents filed in that case or made available to the probation officer . . ., or to the judge, referee, or other hearing officer, and thereafter retained by the probation officer, judge, referee, or other hearing officer."[136] Guidance published on the California Judicial Branch website states, "Some courts have interpreted the definition of juvenile case file … broadly to include any documents and other information housed in a county child welfare agency file regarding a child who has suffered or is at serious risk of suffering abuse or neglect that brings the child within the jurisdiction of the juvenile court …[.]This includes information in agency files where no juvenile court proceedings have been instituted and the matter is handled informally."[137]

Under Section 827, "members of children's multidisciplinary teams, persons, or agencies providing treatment or supervision of the minor" may "**inspect**," but may not receive copies of, these protected records without a court order.[138] Although Section 827 does allow the disclosure of copies of protected information in certain instances, none of them is applicable for purposes of CalAIM.[139] Thus, in order to obtain copies of information protected by Section 827, Medi-Cal Partners typically will need a court order.

► Section 10850 of the California Welfare and Institutions Code

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[136] Welfare and Institutions Code Section 827(e).
[137] Sharing Information From Juvenile Agency Files Regarding Children in Foster Care, Judicial Council of California. *See also In re Elijah S.*, (2005) 125 Cal. App. 4th 1532; 87 Ops. Cal. Atty. Gen. 72, 75 (2004).
[138] Welfare and Institutions Code Sections 827(a)(1)(K) and 827(a)(5). Unlike in Penal Code Section 11167.5 and several other unrelated provisions of California law that employ the concept of a multidisciplinary team, the term is not defined for the purposes of Welfare and Institutions Code Section 827. In addition, to the extent that the juvenile case file contains information protected by any other state or federal laws or regulations, the proposed recipient of the information must be entitled, under authority of such other state or federal laws or regulations, to access the information without a court order. Welfare and Institutions Code Section 827(a)(3)(A).
[139] Welfare and Institutions Code Section 827. *See also* Sharing Information From Juvenile Agency Files Regarding Children in Foster Care Appendix A, Judicial Council of California.

Lastly, Section 10850 of the California Welfare and Institutions Code protects the confidentiality of all applications and records "made or kept by a public officer or agency in connection with the administration of any form of public social services for which grants-in-aid are received" by the state of California from the federal government.[140] Protected information under Section 10850 includes applications or records kept by an agency in connection with the administration of child welfare records.[141] Section 10850 does not prohibit disclosure for "purposes directly connected with the administration of public social services." However, the definition of "public social services" specifically excludes Medi-Cal.[142]

The Child Welfare Services/Case Management System (CWS/CMS), a central repository of certain child welfare-related data maintained by the California Department of Social Services (CDSS), is subject to Section 10850 and its corresponding disclosure prohibitions.[143] Disclosure of data from CWS/CMS for purposes unrelated to child welfare case management typically requires a court order. CDSS guidance indicates that "[t]he access and utilization of confidential client data in CWS/CMS is for child welfare and juvenile probation foster care case management business purposes only."[144] This includes county staff undertaking abuse and licensing referrals/investigations, placement documentation and decisions, and extended family member assessments.

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[140] Welfare and Institutions Code Section 10850(a).

[141] *See* Sharing Information From Juvenile Agency Files Regarding Children in Foster Care, Judicial Council of California. Although Welfare and Institutions Code Section 10850 makes no explicit mention of its application to child welfare records, in *In re Keisha T.*, (1985) 38 Cal. App. 4th 220, 238, the California Court of Appeal acknowledged that there is overlap in the protections afforded by Welfare and Institutions Code Sections 18050 and 827 "because records of public social service agencies may become part of juvenile court records." California guidance documents also indicate that Section 10850 protects disclosure of child welfare information. *See, e.g.,* Notice of Intent to Revise Administrative Order No. 12/003-903 Re: Exchange of Information, Superior County of California, County of Orange (citing Welfare and Institutions Code Section 10850 in its discussion of releasing information from a juvenile case file); CWS Policy Manual, Confidentiality – General, Sadie County (citing Welfare and Institutions Code Section 10850 as a law "governing the confidentiality of Child Welfare records").

[142] Welfare and Institutions Code Sections 10850(d) and 10850(k).

[143] *See* All County Information Notice No. I-33-11 (Jul. 7, 2011), California Department of Social Services (indicating that a court order is required to obtain information in the CWS/CMS database that is subject to Welfare and Institutions Code Section 10850).

[144] *Id.*

Disclaimer

CalAIM Participants should remember that not all records relating to SUD, education, or child welfare are subject to the privacy laws described in this section. For example, if a health care practitioner notes in an electronic health record that a teenager has received treatment for opioid addiction, receives school lunches for free, and is in foster care, such information may be subject to HIPAA but not to other privacy laws. By contrast, a record maintained by an opioid treatment program, a school, or a child welfare agency is likely to be subject to different privacy laws, even if the underlying information kept in such record is largely the same as the health care practitioner's note. CalAIM Participants should check with their attorneys to determine what laws actually apply to the SUD, education, or child welfare records they would like to exchange.

Appendix B: Use Cases Glossary

The following definitions apply to the terms used in the use cases. These definitions are intended to assist with the use case analysis, but they may differ from how organizations use these terms in other contexts. For example, the definition of "community-based organization" excludes HIPAA-covered entities to illustrate how HIPAA rules differ for noncovered entities.

- **Behavioral health provider (non-Part 2):** a health care provider that provides mental health or SUD services, or services for Members with developmental disabilities, not subject to 42 C.F.R. Part 2. This may include providers that provide some SUD services but do not "hold themselves out" as providing such services, such as hospital emergency rooms and mental health counselors who may treat Members with SUDs.
- **Community-based organization (CBO):** noncovered entities that are based in the community (i.e., nongovernmental) that provide a range of social and human services and are not health care providers. CBOs include asthma remediation providers, housing providers, and medically tailored meal providers that are neither health care providers nor covered entities.
- **Community Supports provider:** a provider of the specific Medi-Cal service called Community Supports, which may be a CBO or a health care provider.
- **Covered entity:** a health care provider, health plan, or health care clearinghouse that is subject to HIPAA.
- **Demographic information:** basic patient information such as name (including any previous name(s)), date of birth, address, phone number, email address, race, ethnicity, sex, sexual orientation, gender identity, and preferred language(s).
- **ECM provider:** a health care provider that is responsible for the coordination or management of a Member's care under CalAIM.
- **General health care provider:** a health care provider that is not a behavioral health or Part 2 provider.
- **General health information:** PHI that is subject to HIPAA and the CMIA but no other health care privacy laws.
- **Health care provider:** as defined under HIPAA, a person or organization that furnishes, bills, or is paid for providing health care in the normal course of business.
- **HIV information:** PHI that identifies a person as having or not having HIV or AIDS, including HIV test results, but not including HIV information held by a state or local public health agency.
- **Housing provider:** an organization that records, uses, or processes PII to help provide housing to individuals, including housing navigation and transition services.

- **Local agency:** a county, city, or tribal agency that operates a social services program and that is not a health care provider or covered entity. Local agencies include agencies that administer WIC.
- **Medically tailored meal provider:** an entity that provides medically tailored meals to Members. Medically tailored meal providers may or may not be HIPAA-covered entities.
- **Medi-Cal redetermination date:** the effective date of a Member's last determination of eligibility for Medi-Cal.
- **Part 2 provider:** a health care provider that provides SUD services and is subject to 42 C.F.R. Part 2. To be considered a Part 2 provider, providers must hold themselves out as providing, and provide, diagnosis, treatment, or referral for treatment for an SUD. A provider "holds itself out" as providing SUD care if the provider engages in any activity that would lead another person to reasonably conclude that the individual or organization provides SUD diagnosis, treatment, or referral for treatment.
- **Personal Representative:** an individual authorized to make medical decisions on behalf of a Member. For example, a parent or guardian is considered the Personal Representative of a minor in many circumstances.
- **Provider:**[145] any individual or entity that is engaged in the delivery of services—or ordering or referring for those services—to Members under the Medi-Cal program and is licensed, certified, or contracted to do so. Providers include health care providers, CBOs, and county health systems.

[145] The definition of "provider" differs from similar terms defined under other laws and regulations. For example, it is not the same as the definition of "health care provider" under HIPAA.

Appendix C: Resources

Table 4. Other Data Sharing Authorization Guidance Resources	
Category	**Resources**
CalAIM ECM and Community Supports Initiatives	• DHCS ECM and Community Supports webpage
CalAIM Justice-Involved Initiative	• DHCS CalAIM Justice-Involved webpage • ACWDL 22-26 (October 28, 2022): Implementation of Senate Bill 184, Extension of the Suspension of Medi-Cal Benefits for Adult Inmates, Redetermination Requirements, and Suspension Timeline Guidelines • ACWDL 22-27 (November 10, 2022): CalAIM Mandatory Pre-Release Medi-Cal Application Process for Inmates and Youth of County Correctional Facilities and County Youth Correctional Facilities
CalAIM Data Sharing Forms and Agreements	• DHCS ASCMI webpage • CalAIM ASCMI form (ASCMI Pilot) • CalAIM Repository of Data Sharing Forms and Agreements
California DxF	• CalHHS California DxF webpage • DxF Guiding Principles (July 2022) • DxF Data Sharing Agreement (November 2022)
Guidance (Child Welfare)	• Sharing Information From Juvenile Agency Files Regarding Children in Foster Care (Judicial Council of California)
Guidance (Education Privacy Laws)	• Joint Guidance on the Application of FERPA and HIPAA to Student Health Records (U.S. HHS and Department of Education) • HIPAA or FERPA: A Primer on Sharing School Health Information in California (National Center for Youth Law)
Guidance (42 C.F.R. Part 2)	• Disclosure of Substance Use Disorder Patient Records: Does Part 2 Apply to Me? (SAMHSA)

Table 4. Other Data Sharing Authorization Guidance Resources	
Category	**Resources**

Guidance (General)	• CalHHS Center for Data Insights and Innovation SHIG Documents:
	  ○ Sharing Behavioral Health Information in California
	  ○ Sharing Health Information to Address Food and Nutrition Insecurity in California
	  ○ Sharing HIV/AIDS Information in California
	  ○ Sharing Health Information of People Living with Intellectual and/or Developmental Disabilities in California
	  ○ Sharing Minors and Foster Youth Health Information in California

Guidance (Health Care Privacy Laws)	• DHCS HIPAA webpage