DATA SHARING AUTHORIZATION GUIDANCE: REENTRY INITIATIVE TOOLKIT

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INTRODUCTION TO THE REENTRY INITIATIVE TOOLKIT

Overview of the Reentry Initiative

The Reentry Initiative, also referred to as the Justice-Involved Initiative, is part of California's 1115 Demonstration Waiver that was approved by the Centers for Medicare and Medicaid Services. Its goal is to establish a coordinated community reentry process that will help people who are leaving incarcerations connect with the physical and behavioral health (BH) services they need prior to release and when reentering their communities. These efforts include:

- Allowing eligible Californians who are currently incarcerated to enroll in Medi-Cal and receive a targeted set of services (e.g., case management, clinical consultations, medication and medication administration laboratory and radiology services, medications for substance use disorders (SUD), and community health worker services) for up to 90 days prior to their release into the community, as well as medications and durable medical equipment (DME) in-hand upon release
- Ensuring continuity of health care coverage and services before, during, and immediately after an individual's release to the community.

Disclaimer

As the state's Medi-Cal agency, the California Department of Health Care Services (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 and that are discussed and referenced throughout this Toolkit. As such, DHCS cannot provide legal advice to Medi-Cal Partners regarding when disclosures comply with applicable privacy laws. This document is meant to provide guidance only. Medi-Cal Partners should consult with their individual legal counsels before making any determinations regarding data sharing and required consent.

Overview of the Reentry Initiative Toolkit

The Reentry Initiative Toolkit focuses on implementing data-sharing under the Reentry Initiative. Under the Reentry Initiative, county welfare departments (CWDs), county correctional facilities (CCFs), and county youth correctional facilities are required to

implement the mandatory Pre-Release Medi-Cal Application Process.[1] The All County Welfare Director Letter makes clear that the application process requires ongoing communication between CCFs and CWDs, and, furthermore, that California law permits sharing of records among CCFs and CWDs, provided such sharing complies with all applicable state and federal requirements. More information regarding the implementation and operational policies, including the coordination of data sharing, can be found in the Policy and Operational Guide for Planning and Implementing the CalAIM Justice-Involved Initiative.

This Toolkit describes specific scenarios that organizations and/or providers in the field may encounter when requesting and/or sharing health and social service information from Medi-Cal Partners. The goal is to provide operational guidance through real-world scenarios and diagrams regarding when consent may be needed to share information and help stakeholders understand the state and federal laws that are implicated when implementing the Reentry Initiative and coordinating care across institutions.[2]

Each scenario is based on a fictional Medi-Cal Member and illustrates the relevant factors and decision-points that determine whether Member consent is needed to share data, and why. **These scenarios are illustrative in nature and do not constitute legal advice.[3]**

This Toolkit does not contain scenarios in which data must be shared during a California state or federal "state of disaster or emergency." More information about data sharing under these circumstances can be found in the California Office of Health Information Integrity - Disaster Response and Information Sharing during Emergencies document.[4]

[1] California Department of Health Care Services, "All County Welfare Directors Letter No. 22-27" (November 10, 2022), *available at*: https://www.dhcs.ca.gov/services/medi-cal/eligibility/letters/Documents/22-27.pdf.

[2] In this document, any person or organization that provides Medi-Cal reimbursable health and social services to Members is a Medi-Cal Partner. This includes, but is not limited to, Medi-Cal managed care plans (MCPs), Tribal Health Programs, health care providers, community-based social and human services 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.

[3] "Member(s)" refers to people receiving services under the conditions of AB 133, which includes those who are or will be enrolled in a managed care plan within Medi-Cal, individuals who are participating in the reentry initiative and individuals not enrolled in managed care who receive behavioral health services. Other Medi-Cal members solely served by the fee for service delivery system for physical health, who are neither recipients of behavioral health services nor qualified inmates receiving targeted pre-release Medi-Cal benefits, are not included.

[4] California Office of Health Information Integrity – Disaster Response and Information Sharing during Emergencies *available at:* https://www.cdii.ca.gov/wp-content/uploads/2022/12/CalOHII-Disaster-Response-Info-Sharing-during-Emergency.pdf

In instances when individual consent is required to share sensitive information (e.g., SUD records protected by 42 C.F.R. Part 2), Medi-Cal Partners must use a consent to disclose information form that complies with federal and state data sharing laws (see *Overview of Applicable Laws and Regulations* for more information). Medi-Cal Partners should consult their legal and privacy officers to identify an acceptable consent to disclose information form. DHCS encourages Medi-Cal Partners to obtain Member consent using the forthcoming refined Authorization to Share Confidential Member Information (ASCMI)[5] Form. The ASCMI Form is intended for providers to obtain consent from members for the sharing of certain health and social service information, including Part 2 SUD records, as well as to inform individuals of their privacy rights and how they can indicate their consent preferences for data disclosures. DHCS piloted the ASCMI Form in 2023 and expects to publish an updated version in 2025.

Reentry Initiative Toolkit Program Services

Each Toolkit scenario will fall under one of the program service categories below:

- Pre- and Post-Release Services
- Care Management Services
- Additional Reentry Initiative-Related Clinical Services
- Behavioral Health Links *(see Appendix A for more information)*

Toolkit Actors

This Toolkit includes various scenarios that involve different individuals or "actors" carrying out the tasks described in each situation, all of which are listed below.[6] For specific definitions of terms, please see the glossary in *Appendix A*.

Reentry Initiative Individuals

- A Reentry Initiative Individual is someone who is currently or was formerly incarcerated within the past twelve months

State Departments

- DHCS
- County Social Services Departments (SSDs)

[5] CalAIM ASCMI Pilot.
[6] These are intended to be illustrative examples of individuals receiving services under the Reentry Initiative.

Pre-Release Providers

- Correctional Facility Clinical Staff (e.g., health care providers within the correctional facility)
- In-Reach Providers (e.g., clinical consultants, In-Reach Specialty Behavioral Health Providers)
- Pre-Release Care Managers (embedded and In-Reach)

Post-Release Providers

- DME Provider
- Post-Release Enhanced Care Management (ECM) Lead Care Manager
- Homeless System of Care – Continuum of Care (CoC) organizations and Homeless Services Providers

Community Organizations

- Community-Based Providers
- Community Health Workers (CHWs)

Additional Toolkit Actors

- Designated Support System
- Managed Care Plans (MCPs)
- MCP Reentry Liaisons
- Prior Treating Providers

OVERVIEW OF APPLICABLE LAWS AND REGULATIONS

Federal Laws and Regulations

Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA is a federal law that regulates "protected health information" (PHI). PHI is a subset of Personally Identifiable Information (PII) that consists of PII relating to an individual's health that is created or received by a "covered entity."[7] Covered entities include health care providers and payers, such as doctors, hospitals, clinics, behavioral health care providers, ECM providers, MCPs, and the Department of Health Care Services (DHCS). HIPAA also applies to business associates, which are entities that use or store PHI on behalf of covered entities and have entered into a contract with the covered entities (a "Business Associate Agreement" [BAA]) that governs such use.

HIPAA permits disclosure of PHI by covered entities for certain purposes including treatment, which is broadly defined to include care coordination, payment, or health care operations (certain administrative, legal, financial, and quality improvement activities, including care coordination and case management) – **without** patient authorization. Disclosures 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.

HIPAA permits covered entities, including MCPs, to disclose PHI without individual authorization to social services agencies, community-based organizations (CBOs), , and other similar third parties that provide health-related services to specific individuals for individual-level care coordination and case management, either as a treatment activity of a covered health care provider or as a health care operations activity of a covered health care provider or health plan.[8]

Disclaimer

For purposes of the scenarios in this Toolkit, providers in correctional facilities are considered to be covered entities, as they are providing healthcare and billing Medi-Cal electronically. Note that not all correctional facilities in California may be covered entities, nor may all providers delivering services in correctional facilities. Medi-Cal Partners should consult with their individual legal counsels before making any determinations regarding legal status relevant to data-sharing and required consent.

[7] US Department of Health and Human Services, "Covered Entities and Business Associates" (June 16, 2017), *available at*: https://www.hhs.gov/hipaa/for-professionals/covered-entities/index.html.
[8] 45 C.F.R. § 164.506(c)(1).

Notably, HIPAA contains an important requirement governing the *amount* of PHI that can be disclosed in most situations. Known as the "minimum necessary" rule, it requires that disclosures of PHI be limited to the minimum necessary to accomplish the intended purpose.[9] Importantly, HIPAA explicitly excludes requests by or disclosures to health care providers for treatment purposes from this requirement.[10] However, in the event that, for example, an individual's primary care provider or MCP wants to share information with a non-covered entity, such as a housing provider, to enable the housing provider to schedule appointments or assist with follow-up care, only the minimum amount of information necessary to facilitate that assistance can be disclosed.

Note: Assumptions for this Toolkit *Not all providers of health care are subject to HIPAA.[11] However, for purposes of the scenarios outlined in this Toolkit, we are assuming:*

- *The described health care providers, including ECM providers and those who deliver health care through behavioral health entities,* ***are*** *covered entities under HIPAA.*
- *County behavioral health agencies* ***are*** *covered entities under HIPAA.*
- *County SSDs and providers of health-related social services (e.g., housing support organizations) involved in the Toolkit's scenarios* ***are not*** *HIPAA covered entities.[12]*

Key Takeaway:

Health care providers and plans can disclose health information to organizations involved in an individuals' care, including with non-covered entities, such as housing support organizations, without the individuals' consent, if such disclosures are for purposes of treatment, care coordination and case management**.**

[9] 5 C.F.R. § 164.502(b).
[10] 45 C.F.R. §164.502(b).
[11] In order to be a covered entity under HIPAA, a provider must submit HIPAA transactions, such as claims for payment, electronically. For purposes of this Toolkit, we are assuming that the health care providers described in each scenario are Medi-Cal-enrolled providers that submit their claims for health care payment to Medi-Cal electronically and are thus subject to HIPAA.
[12] DHCS recognizes that there may be circumstances in which a BAA is present that makes a County SSD a HIPAA covered entity, but these would be outlying circumstances. Business Associates are entities that use or store PHI on behalf of covered entities and have entered into a contract with the covered entities (a BAA) that governs such use. For the purposes of this toolkit, County SSDs are not considered to be HIPAA covered entities.

42 C.F.R. Part 2: 42 C.F.R. Part 2 (or Part 2) is a set of federal regulations that protects the confidentiality of some types of SUD information. Part 2 does not apply to all SUD information, but only to information that has been obtained by a Part 2 provider or Part 2 program, and that would identify an individual as having or having had a SUD.

Key Consideration:

In order to be deemed a Part 2 provider or program, the provider must: (1) receive federal assistance; and (2) hold themselves out as providing and actually provide SUD diagnosis, treatment, or referral for treatment. This typically means that the program advertises SUD services or has a specialty SUD license. If a provider offers both SUD and non-SUD care, then the provider can elect to have Part 2 apply to only an identified unit that holds itself out as providing SUD care or staff identified as primarily providing SUD care, in lieu of the entire program. Many, but not all, SUD providers are "Part 2 providers." For more guidance regarding Part 2 providers, please see the Part 2 FAQs.

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.

Because Medi-Cal Partners provide services to members with SUDs, the Part 2 regulations apply to some of the information exchanged under CalAIM, and as a result, Medi-Cal Partners need to assess whether the information they are exchanging is subject to Part 2.

Under the 2024 Part 2 final rule, patients may now consent to current and future uses and disclosures of their SUD records for treatment, care coordination, and payment purposes using a single form (referred to in the rule as a "TPO consent"). Pursuant to this new rule, if an individual signs a treatment, payment, and health care operations (TPO) consent, a covered entity or business associate may use and disclose their SUD records for treatment, payment, and health care operations as permitted by the HIPAA regulations, until such time as the patient revokes such consent in writing.

Individuals may also now describe an entire category of people who can receive their SUD data (e.g., "housing support organizations," or "my treating providers, health plans, third party payers, and people helping to operate this program"), rather than having to

list the name of every potential recipient on the form. Consents may also have an expiration date of "none."

When individuals are signing a TPO consent for future disclosures of their health information, their Part 2 records may also now be re-disclosed by Part 2 record recipients **who are covered entities and business associates** without additional patient consent as long as such redisclosure is in accordance with the HIPAA Privacy Rule.[13] When recipients of Part 2 records are **not** covered entities or business associates (e.g., most providers of housing support services), individual authorization for redisclosure of Part 2 information is often required. Additional authorization is **not** required when non-covered entity or non-business associate recipients of Part 2 information for payment or health care operations activities are redisclosing those records as necessary for their contractors, subcontractors, or legal representatives to carry out the payment or health care operations specified in the consent.[14]

Key Takeaway:

Part 2 permits an individual:

- To describe an entire category of providers on a Part 2 consent form, such as "my housing support providers."
- To sign a single TPO consent for all future uses and disclosures of Part 2 information that are for treatment, payment, or healthcare operations purposes.

Part 2 data recipients that are covered entities or business associates may redisclose Part 2 data. without additional authorization when using or disclosing Part 2 in accordance with HIPAA.

Note: *The federal statute underlying Part 2 regulations incorporates the HIPAA Privacy Rule definitions of "treatment" and "health care operations," which, as explained above, include care coordination activities.*

[13] This permitted redisclosure excludes uses and disclosures for civil, criminal, administrative, and legislative proceedings against the patient. 45 C.F.R. §2.33(b)(1).
[14] 42 C.F.R §2.33(b)(3). The recipient must have in place a contract with the contractor or legal representative that meets certain requirements set forth in §2.33(c). Entities have until February 16, 2026, to comply with the updated Part 2 regulations.

As a result, the Part 2 rule updates allowing redisclosure of Part 2 records received by covered entities and their business associates for purposes of treatment, payment, and health care operations "as permitted by the HIPAA regulations" enable health care clinicians and managed care organizations to share these SUD records for purposes of care coordination without additional patient consent.

State Laws and Regulations

Assembly Bill (AB) 133: AB 133, a law passed in July 2021, changed California state law to promote data exchange and care coordination for people receiving services under CalAIM. (See section 3 in the Data Sharing Authorization Guidance, describing AB 133.[15]) AB 133 permits Medi-Cal Partners to exchange PII and PHI as long as such disclosures improve care coordination and health outcomes and are consistent with federal law, including HIPAA and Part 2.[16] In doing so, AB 133 limits the application of certain state privacy laws so that information can be shared more easily in order to coordinate care for purposes of implementing CalAIM. In effect, this means that AB 133 allows data-sharing **without consent** in situations where some California privacy laws would otherwise require consent.

AB 133 added new provisions to the WIC and the Penal Code to promote data exchange and care coordination between Medi-Cal Partners, including:

- Penal Code Section 4011.11, subdivision (h): requires the exchange of health information between DHCS, counties, county sheriffs, and county probation agencies to facilitate the enrollment of inmates in health insurance affordability programs on or prior to release, or for continued behavioral health treatment post-release, consistent with federal law.[1] Subdivision (h) of Penal Code Section 4011.11 applies to county jails and county youth correctional facilities, but does not apply directly to state prisons.

***Note**: This Toolkit does not analyze the impact of most of the California laws whose consent requirements are overridden by AB 133,[17] such as:*

[15] CA Department of Health Care Services, "CalAIM Data Sharing Authorization Guidance" (October 2023), *available at*: https://www.dhcs.ca.gov/CalAIM/ECM/Documents/CalAIM-Data-Sharing-Authorization-Guidance.pdf.
[16] In this document, any person or organization that provides Medi-Cal reimbursable health and social services to Members is a Medi-Cal Partner. This includes, but is not limited to, Medi-Cal managed care plans (MCPs), Tribal Health Programs, health care providers, community-based social and human services 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.
[17] CA Department of Health Care Services, "CalAIM Data Sharing Authorization Guidance" (October 2023), *available at*: https://www.dhcs.ca.gov/CalAIM/ECM/Documents/CalAIM-Data-Sharing-Authorization-Guidance.pdf.

- *Health and Safety Code § 11845.5 (which governs SUD records);*[18]
- *Health and Safety Code § 121010 (which governs HIV/AIDS information);*[19]
- *The Confidentiality of Medical Information Act which governs disclosures of medical information and has special protections for abortion-related information.*[20]

These analyses are not included because AB 133 applies in each of the Toolkit scenarios, overriding the consents required by those laws. You may wish to consult legal counsel to confirm whether AB 133 applies in your specific situation. If AB 133 does not apply, you may need to consider whether the above-mentioned or other California and/or Federal laws require consent to share data.

Overview of General Process Flows

The purpose of this high-level general process flow is to help Medi-Cal Partners understand how data-sharing can occur under HIPAA, and whether consent for each specified data exchange scenario is required.

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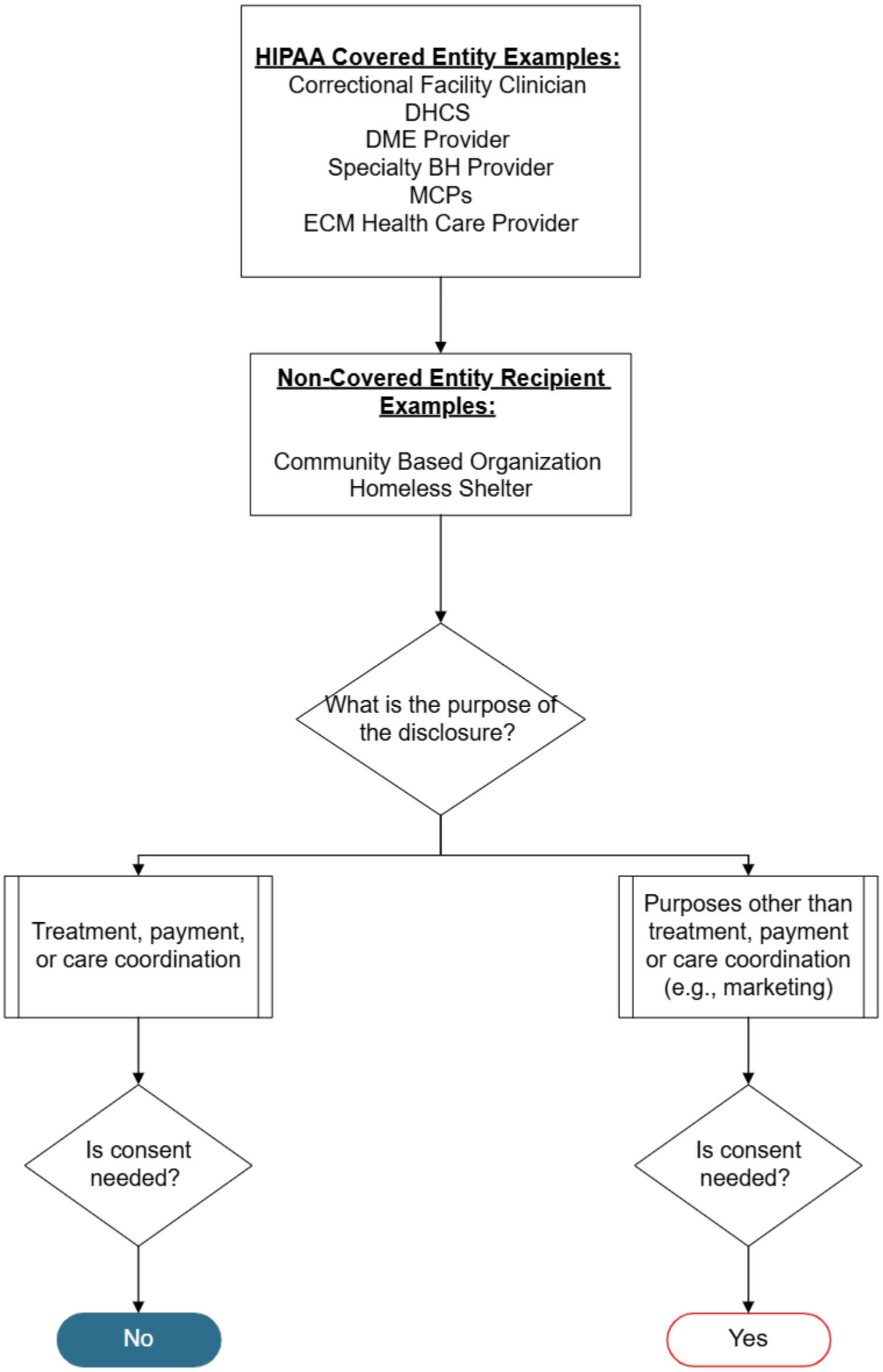
As the state's Medi-Cal agency, DHCS does not have the authority to interpret or enforce many of the federal privacy laws that apply to the disclosure of information under CalAIM and that are discussed and referenced throughout this Toolkit. As such, DHCS cannot provide legal advice to Medi-Cal Partners regarding when disclosures comply with applicable privacy laws. This document is meant to provide guidance only; Medi-Cal Partners should consult with their individual legal counsels before making any determinations regarding data-sharing and required consent.

Example of Data Exchange Governed by HIPAA

The following diagram provides an example of the exchange of PHI between HIPAA covered entities and non-covered entities, such as many housing providers. The diagram also provides examples of HIPAA covered entities and non-covered entities that will be highlighted throughout the Toolkit scenarios. In the example illustrated below, PHI does not include information that is also subject to 42 C.F.R. Part 2.

[18] Health and Safety Code *§ 11845.5 available at:* https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=HSC&sectionNum=11845.5.
[19] Health and Safety Code § 121010 *available at:* https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=HSC&sectionNum=121010.
[20] The Confidentiality Of Medical Information Act (CMIA) *available at:* https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=56.10.&lawCode=CIV.


HIPAA Covered Entity Examples:
Correctional Facility Clinician
DHCS
DME Provider
Specialty BH Provider
MCPs
ECM Health Care Provider
Non-Covered Entity Recipient Examples:
Community Based Organization
Homeless Shelter
What is the purpose of the disclosure?
Treatment, payment, or care coordination
Purposes other than treatment, payment or care coordination (e.g., marketing)
Is consent needed?
Is consent needed?
No
Yes

Frequently Asked Question Regarding Disclosures for Purposes of Healthcare Operations

Question: Can health care providers, such as ECM providers or specialty behavioral health providers, or health plans, such as Medi-Cal managed care, share health information with entities such as housing-support organizations for purposes of care coordination?

Answer: Yes. The HIPAA Privacy Rule permits covered entities – including health care providers and health plans – to use or disclose PHI, without an individual's authorization, for purposes of treatment, payment, and healthcare operations.[21] "Treatment" is broadly defined as the "provision, coordination, or management of health care and related services among health care providers or by a health care provider with a third party, consultation between health care providers regarding a patient, or the referral of a patient from one health care provider to another."[22] "Healthcare operations" are defined to include "case management and care coordination" activities of a covered entity.[23] For example, housing organizations are able to receive PHI from covered entities as part of their receipt of referrals for Medi-Cal-covered services. Housing organizations may also receive PHI from covered entities for coordinating non-Medicaid-covered services, such as BHSA-funded housing supports. A BAA is not necessary when a covered entity is making a disclosure for treatment, payment, or healthcare operations purposes, including to a non-covered entity recipient.

HHS has also been explicit in guidance that "HIPAA allows health care providers to disclose [PHI]…to other public or private sector entities providing social services (such as housing, income support, job training) in specified circumstances," and, further, that "health care providers who believe that disclosures to certain social service entities are a necessary component of, or may help further, the individual's health or mental health care may disclose the minimum necessary PHI to such entities without the individual's authorization. For example, a provider may disclose PHI about a patient needing mental health care supportive housing to a service agency that arranges such services for individuals."[24]

[21] 45 C.F.R. §164.506(a).
[22] HHS Guidance, "Uses and Disclosures for Treatment, Payment, and Health Care Operations," *available at*: https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/disclosures-treatment-payment-health-care-operations/index.html.
[23] 45 C.F.R. §164.501.
[24] HHS FAQ 3008

(For a more detailed analysis, please see *the* Health Insurance Portability and Accountability Act of 1996 (HIPAA) *section of this Toolkit.)*

Key Takeaway: Community Supports Housing Navigation and Support Services

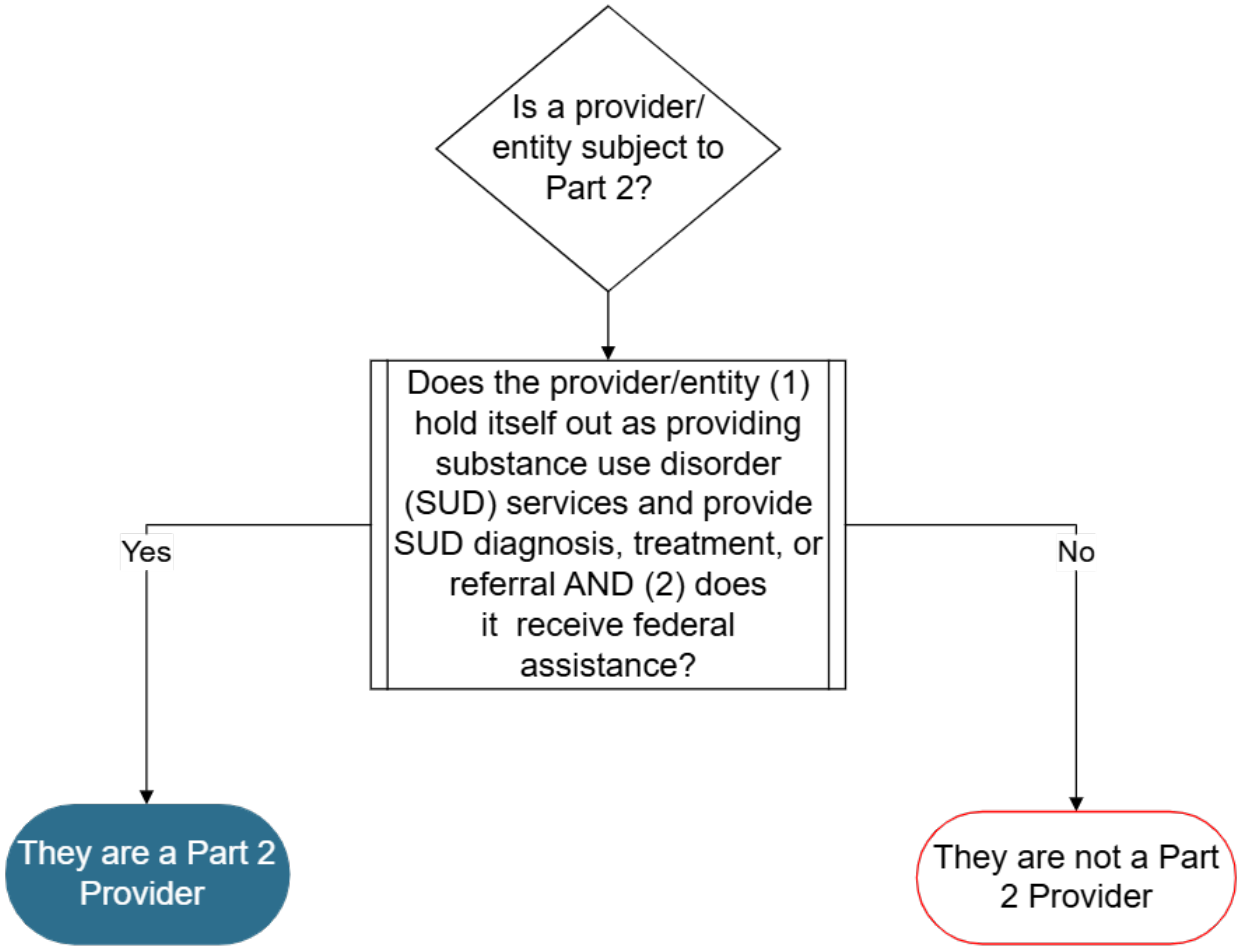
For the purposes of this Toolkit, the provision of Housing Community Supports services to Medi-Cal MCP Members by housing organizations is considered to fall within the scope of treatment and/or care coordination as defined by HIPAA.

General Process Flow – Part 2 Providers

How to Determine Whether an Individual or Entity is a Part 2 Provider

This diagram provides a high-level decision-tree regarding how to determine an individual or entity's status under Part 2. Note that even if a Partner is not a Part 2 provider, Part 2 may apply to records it has received from a Part 2 provider. (You may find more information on Part 2 and its requirements in the 42 C.F.R. Part 2 overview section of this toolkit.) We encourage Medi-Cal Partners to consult Substance Abuse and Mental Health Services Administration (SAMHSA) guidance (including that beginning on p. 20) and seek independent legal counsel to support determinations of Part 2 status.[25]

[25] HHS Guidance, "Uses and Disclosures for Treatment, Payment, and Health Care Operations," *available at*: https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/disclosures-treatment-payment-health-care-operations/index.html.


Is a provider/ entity subject to Part 2?
Does the provider/entity (1) hold itself out as providing substance use disorder (SUD) services and provide SUD diagnosis, treatment, or referral AND (2) does it receive federal assistance?
Yes
No
They are a Part 2 Provider
They are not a Part 2 Provider

Part 2 Frequently Asked Questions

This FAQ contains guidance published by SAMHSA, the agency within the U.S. HHS that leads public health efforts to advance behavioral health. All Part 2 providers must comply with all applicable federal requirements under Part 2, and these FAQs are relevant to all Part 2 providers rendering SUD services under the CalAIM 1115 Demonstration Waiver. These FAQs define several terms that are used throughout the Toolkit related to Part 2 providers.

Question: Is a correctional facility a Part 2 provider?

Answer: While generally correctional facilities do not hold themselves out to the public as providing SUD services and are thus likely not considered Part 2 providers, DHCS defers to the individual correctional facility to make a legal determination as to whether it meets the criteria to be considered a Part 2 provider.

Question: How do I know if I "hold myself out as providing SUD services and provide SUD diagnosis, treatment or referral"?

Answer: According to SAMHSA,[26] 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.[27] 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.[28]

Question: What is considered a federally assisted program?

Answer: A program (e.g., individual, entity (other than a general medical facility) is federally assisted[29] if it:

1. Is authorized, licensed, certified, or registered by the federal government;

[26] Substance Abuse and Mental Health Services Administration, "About Us" (February 14, 2024), *available at:* https://www.samhsa.gov/about-us.
[27] Substance Abuse and Mental Health Services Administration, "Substance Use and Confidentiality Regulations" (October 27, 2023), *available at*: https://www.samhsa.gov/about-us/who-we-are/laws-regulations/confidentiality-regulations-faqs.
[28] CA Department of Health Care Services, "CalAIM Data Sharing Authorization Guidance" (October 2023), *available at*: https://www.dhcs.ca.gov/CalAIM/ECM/Documents/CalAIM-Data-Sharing-Authorization-Guidance.pdf .
[29] Legal Action Center for Substance Abuse and Mental Health Services Administration, "Frequently Asked Questions: Applying the Substance Abuse Confidentiality Regulations to Health Information Exchange (HIE)" (2010_, *available at* https://www.samhsa.gov/sites/default/files/faqs-applying-confidentiality-regulations-to-hie.pdf.

2. Received federal funding in any form, even if the funds do not directly pay for the alcohol or drug use services;

3. Is assisted by the Internal Revenue Service through a grant of tax-exempt status or allowance of tax deductions for contributions;

4. Is authorized to conduct business by the federal government (e.g., certified as a Medicare provider, authorized to conduct methadone maintenance treatment, or registered with the Drug Enforcement Agency to dispense a controlled substance used in the treatment of alcohol or drug abuse);

5. Is conducted directly by the government.

Question: What are examples of providers that meet the definition of a Part 2 provider?

Answer: A provider can be either a person or a program. In guidance,[30] 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.[31]

Question: Does Part 2 apply to me even if I am not a Part 2 provider?

Answer: Part 2 records can be disclosed pursuant to an individual's authorization. If the individual signed a consent for all future uses and disclosures of SUD information for purposes of treatment, payment, or healthcare operations and the entity that received Part 2 records is a covered entity or business associate, such records may be redisclosed in accordance with HIPAA.[32] When recipients of Part 2 records are **not** covered entities or business associates (e.g., most providers of housing support services), individual authorization for redisclosure of Part 2 information may be required. Additional authorization is not required, however, when non-covered entity/non-business associate recipients of Part 2 information for payment or health care operations activities are redisclosing those records as necessary for their contractors, subcontractors, or legal

[30] Substance Abuse and Mental Health Services Administration, "Substance Use and Confidentiality Regulations" (October 27, 2023), *available at:* https://www.samhsa.gov/about-us/who-we-are/laws-regulations/confidentiality-regulations-faqs.

[31] CA Department of Health Care Services, "CalAIM Data Sharing Authorization Guidance" (October 2023), *available at*: https://www.dhcs.ca.gov/CalAIM/ECM/Documents/CalAIM-Data-Sharing-Authorization-Guidance.pdf.

[32] Department of Health and Human Services Fact Sheet 42 CFR Part 2 Final Rule, *available at*: https://www.hhs.gov/hipaa/for-professionals/regulatory-initiatives/fact-sheet-42-cfr-part-2-final-rule/index.html.

representatives to carry out the payment or health care operations specified in the consent.[33]

[33] 42 C.F.R §2.33(b)(3). The recipient must have in place a written contract with the contractor or legal representative that meets certain requirements set forth in §2.33(c).

TOOLKIT SCENARIOS: OVERVIEW

The scenarios in this Toolkit are intended to provide Medi-Cal Partners with guidance on how to navigate federal and state laws when sharing data, and how to determine whether consent for disclosure – pursuant to either HIPAA or Part 2 – is needed during various interactions expected over the course of the Reentry Initiative. The accompanying diagrams are intended to provide a visual representation of the legal analyses presented in the charts included in each scenario.

Please note that the legal analysis charts and associated diagrams are specific **only** to the information that is contemplated by the individual Toolkit scenario.

The scenarios cover pre- and post-release services, care management services, additional Reentry Initiative-related clinical services, and behavioral health links. **Each Toolkit scenario covers both an embedded care management model and In-Reach care management model**. The reader should pick the model in each instance that best applies to their own situation.

- Under an embedded care management model, care managers employed by or contracted with the correctional facilities ("embedded care managers") deliver pre-release care management services to individuals eligible for pre-release services.
- Under an In-Reach care management model, community-based care management providers deliver pre-release care management for individuals eligible for pre-release services, either in person or via telehealth. These can be community-based care managers enrolled in Medi-Cal fee-for-service (FFS) or MCP contractors or employees who are authorized to provide services in correctional facilities.

DHCS allows correctional facilities to use a mixed model approach that includes both embedded and In-Reach providers to provide pre-release services.

The Toolkit scenarios do not cover information on pre-release Medi-Cal applications, as DHCS has already published extensive guidance on pre-release Medi-Cal applications and suspensions processes.[34]

[34] CA Department of Health Care Services, "All County Welfare Directors Letter"(February 29, 2024), *available at*: https://www.dhcs.ca.gov/services/medi-cal/eligibility/letters/Documents/24-04.pdf.

Toolkit Scenarios: Administrative Tasks for Pre- and Post-Release Services

Activate Pre-Release Benefits

Embedded Care Management Model: Nico is a 25-year-old adult with co-occurring bipolar and opioid use disorders who was arrested for a drug offense and taken to the county jail. The correctional facility is not itself a Part 2 provider, nor is any of its clinical staff. Upon intake, the correctional facility completed an initial health screening and identified Nico as having serious mental illness and SUD, both qualifying conditions for pre-release services and for a behavioral health link.[35]

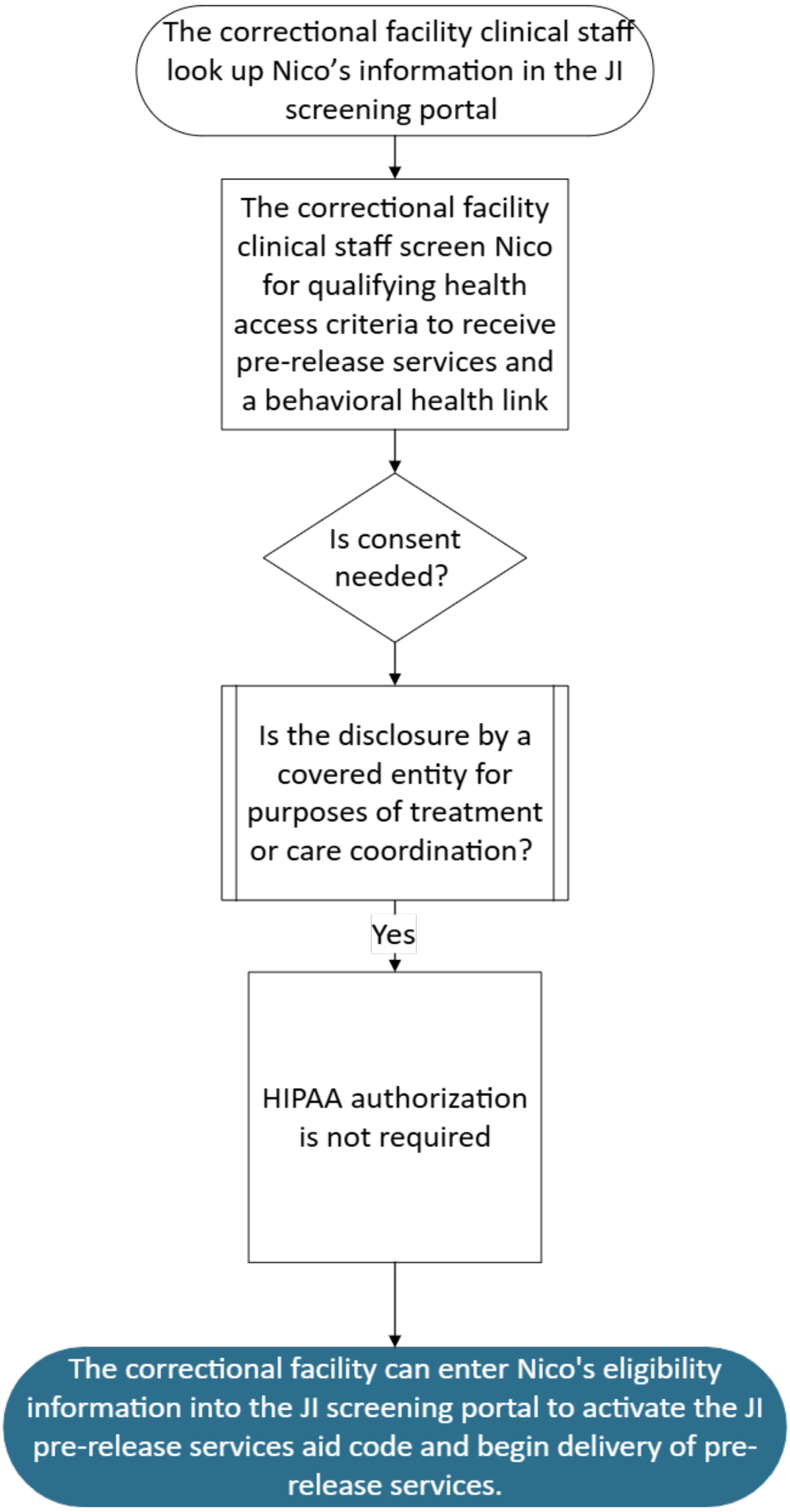
The correctional facility clinical staff wants to look up Nico's current Medi-Cal status (enrollment and MCP assignment) and activate pre-release services through the JI Screening Portal. To do that, the correctional facility must enter Nico's personal information to look him up, and, if enrolled in Medicaid, enter any of his qualifying clinical conditions into the JI Screening Portal. This information will be sent to DHCS to activate the JI pre-release services aid code to allow payment of pre-release services. The types of information to enter include incarceration date, projected release date, qualifying health condition categories (if known), and demographic information.

Law/Regulation	Applicable?	Key Questions	Consent to share information needed?
HIPAA	Yes	» Are Nico's correctional facility providers (the correctional facility clinical staff and the pre-release care manager) covered	No. Correctional facility clinical staff and DHCS are HIPAA-covered entities, and HIPAA permits disclosures of PHI for purposes of treatment, payment, and care coordination. In this scenario, information is being shared between the correctional facility and DHCS

[35] A behavioral health link is a referral process requiring correctional facilities to facilitate referrals to county SMHS, Drug Medi-Cal (DMC), the DMC-ODS, and/or Medi-Cal MCPs for incarcerated individuals who received behavioral health services while incarcerated to allow them to continue behavioral health treatment. For additional information, see CA Department of Health Care Services, "Policy and Operational Guide for Planning and Implementing the CalAIM Justice-Involved Initiative" (October 20, 2023), *available at*: https://www.dhcs.ca.gov/provgovpart/pharmacy/Documents/CalAIM-JI-Policy-and-Operations-Guide-FINAL-October-2023-updated.pdf.

Law/Regulation	Applicable?	Key Questions	Consent to share information needed?
		entities under HIPAA? » Are the necessary disclosures for the purpose of treatment, payment, or care coordination?	for purposes of both payment and care coordination, and thus no HIPAA authorization is required.
42 C.F.R. Part 2	No	» Is anyone seeking to obtain or disclose information covered by Part 2?	**No.** Even though Nico presents with a SUD, in this scenario, no one is seeking to obtain his SUD records from a Part 2 provider who may previously have treated him, and as a result **no Part 2 consent is required**.
AB 133	Yes	» Is the information being shared for the purposes of delivering services under CalAIM (e.g., Reentry Initiative)?	**No.** AB 133 permits the sharing of data among Medi-Cal partners for purposes of implementing CalAIM without individual authorization, so **no consent is required** under California state law for these disclosures.

Diagram for Embedded Care Management Model Under Activate Pre-Release Benefits Scenario



Coordination with the MCP JI Liaison and Post-Release ECM Provider Assignment

Embedded Care Management Model

The correctional facility contacts the MCP to whom Nico is assigned, through an agreed-to process or through the MCP's JI Liaison. The correctional facility clinical staff informs the JI Liaison of any additional needs (e.g., SUD or high-needs mental health, as determined by the correctional facility's screening) and confirms the correctional facility will use an embedded care management model.

The correctional facility staff shares client identifiers (e.g., demographic information) and relevant PHI with the MCP through an agreed-to process or through the MCP JI Liaison. The JI Liaison assigns Nico a Post-Release ECM Lead Care Manager who will participate in a warm handoff (see Warm Handoff scenario for more information) with the correctional facility's Pre-Release Care Manager prior to Nico's release and will continue to provide services post-release. Neither the Pre-Release Care Manager nor the Post-Release ECM Lead Care Manager is a Part 2 provider.

The correctional facility clinical staff also screens Nico during intake for behavioral health needs using a screening tool mutually agreed upon between the correctional facility and county behavioral health agency and identifies Nico as meeting the need for a behavioral health link. This means Nico's behavioral health needs will be served by a county-based SMHS provider and/or a Drug Medi-Cal (DMC) or DMC-ODS provider in the community.

The correctional facility clinical staff notifies the county behavioral health agency in the county in which Nico will be released to inform the county that Nico is eligible for a behavioral health link. The county behavioral health agency will work with the correctional facility clinical staff to complete the behavioral health link prior to Nico's release, including relevant data-sharing and a professional-to-professional clinical handoff.

The MCP and/or JI Liaison, Post-Release ECM Lead Care Manager, and the Pre-Release Care Manager want to exchange information about Nico's health, including previous medical history, for continuity of care.

In-Reach Care Management Model

The correctional facility contacts the assigned MCP through an agreed-to process or through the MCP's JI Liaison. The correctional facility clinical staff informs the JI Liaison of any additional needs (e.g., SUD or high-needs mental health, as determined by the correctional facility's screening) and confirms the correctional facility will use an In-Reach care management model, which means that a community-based care management provider (referred to as an In-Reach Pre-Release Care Manager) will

provide Nico's pre-release services while he's in jail, either in-person or via telehealth, and will also provide Nico's care management services once he's released from jail. The correctional facility clinical staff shares client identifiers (e.g., demographic information) and relevant PHI with the MCP through an agreed-to process or through the MCP JI Liaison. The JI Liaison assigns Nico an In-Reach Pre-Release Care Manager; the In-Reach Pre-Release Care Manager is not a Part 2 provider.

The MCP or the MCP JI Liaison wants to share client identifiers (e.g., demographic information) and PHI with the In-Reach Pre-Release Care Manager, as well as communicate this assignment back to the correctional facility clinical staff. The communication may occur through an agreed-to process between the In-Reach Care Management provider, the correctional facility, and the MCP.

The In-Reach care manager or In-Reach clinical staff screens Nico during intake for behavioral health needs using a screening tool mutually agreed upon between the correctional facility and county behavioral health agency and identifies Nico as meeting the need for a behavioral health link. This means Nico's behavioral health needs will be served by a county-based SMHS provider and/or a DMC or DMC-ODS provider in the community.

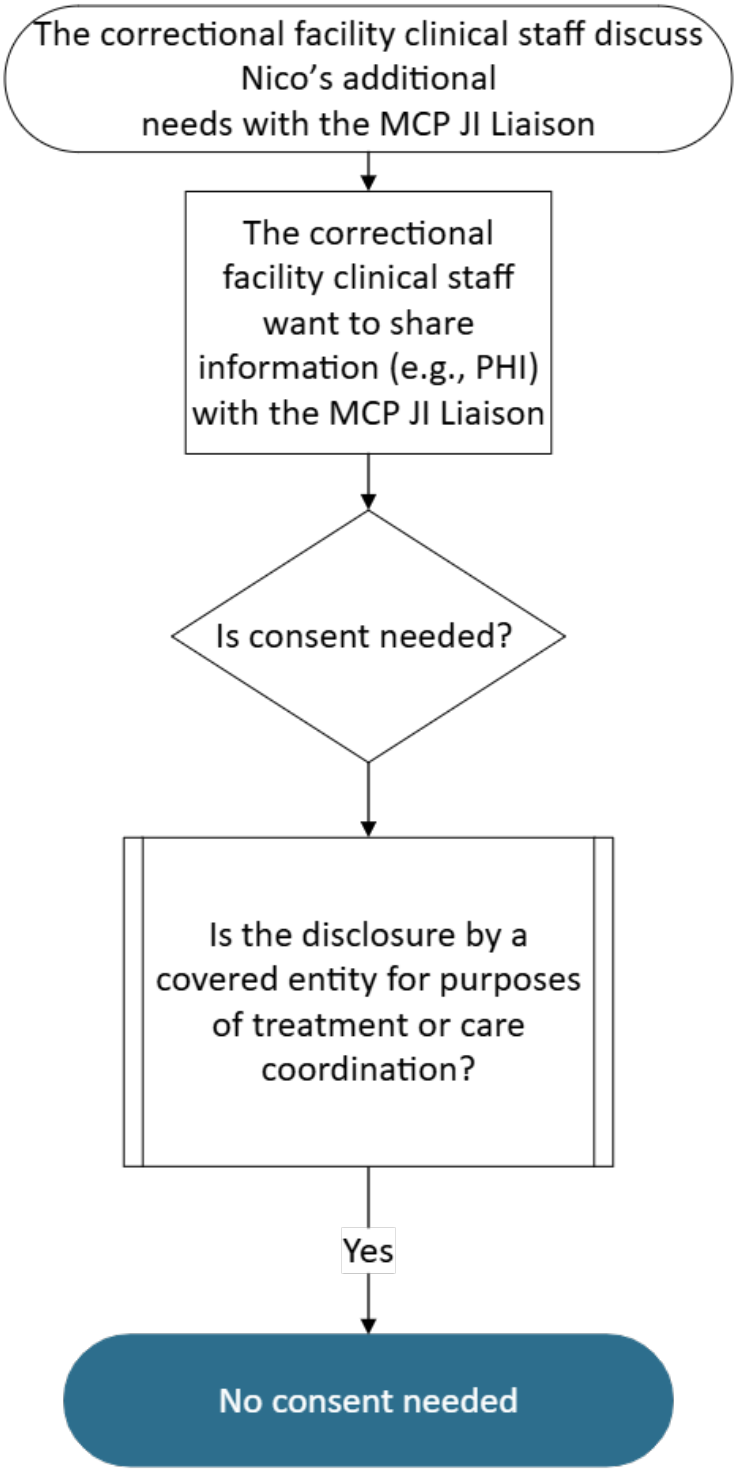
The correctional facility clinical staff notifies the county behavioral health agency in the county in which Nico will be released to inform the county that Nico is eligible for a behavioral health link. The county behavioral health agency will work with the correctional facility clinical staff to complete the behavioral health link prior to Nico's release, including relevant data-sharing and a professional-to-professional clinical handoff.

Law/Regulation	Applicable?	Key Questions	Consent to share information needed?
HIPAA	Yes	» Are the correctional facility clinical staff members covered entities under HIPAA? » Are the MCP JI Liaison, Post-Release ECM Lead Care Manager, and/or the Pre-Release Care Manager	**No.** The correctional facility clinical staff, the Pre-Release Care Managers, MCP JI Liaison, and Post-Release ECM Lead Care Manager are all HIPAA-covered entities, and the disclosures among them are for purposes of treatment and care coordination. As such, **these disclosures are permitted under HIPAA without individual**

Law/Regulation	Applicable?	Key Questions	Consent to share information needed?
		covered entities under HIPAA? » Is the In-Reach Pre-Release Care Manager a covered entity under HIPAA? » Are the desired disclosures for purposes of treatment and care coordination?	**authorization.**
42 C.F.R. Part 2	No	» Is anyone seeking to obtain or disclose information covered by Part 2?	**No.** Although Nico has a SUD, the information that the correctional facility clinical staff has about his SUD was not obtained from one of his previous SUD providers. Since the correctional facility and its clinical staff are not Part 2 providers, the SUD information they obtain during the screening is not considered Part 2 information. As a result, **no Part 2 consent is required.**
AB 133	Yes	» Is the information being shared for the purposes of delivering services under	**No.** AB 133 permits the sharing relevant PHI among Medi-Cal partners for purposes of implementing CalAIM without individual

Law/Regulation	Applicable?	Key Questions	Consent to share information needed?
		CalAIM (e.g., Community Supports)?	authorization. Services for the Reentry Initiative are part of CalAIM and therefore **no consent is required.**

Diagram for Embedded and In-Reach Care Management Models Under Coordination with the MCP JI Liaison and Post-Release ECM Provider Assignment Scenario



Toolkit Scenarios: Care Management Services

Health Risk Assessment

Pre-Release Care Management Model

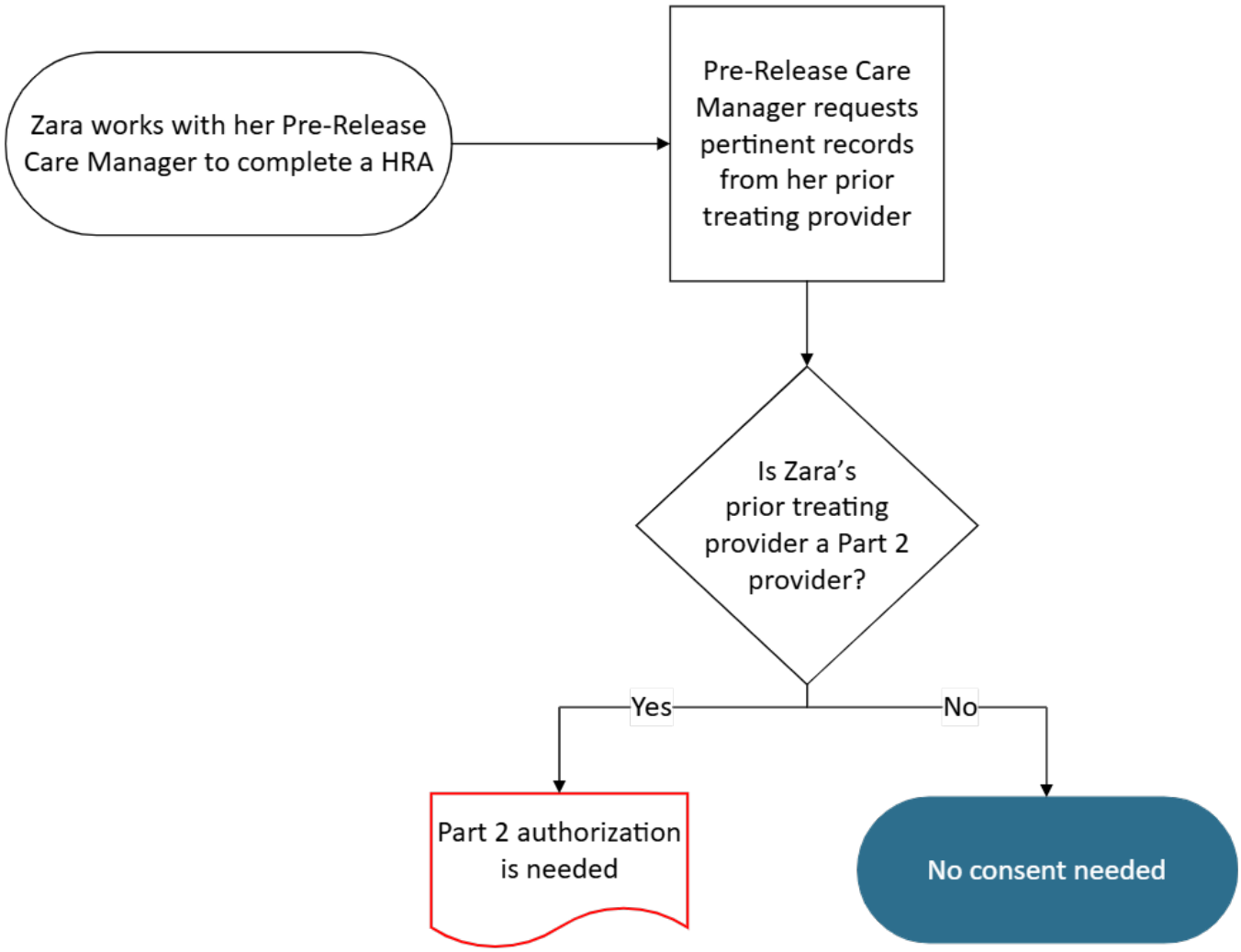
Dana is a 37-year-old woman who was recently incarcerated. She works with her embedded Pre-Release Care Manager, who is not a Part 2 provider, to complete a Health Risk Assessment (HRA), which includes screenings for mental health and SUD needs, to determine appropriate behavioral health links and referrals, physical health, and other health-related social and functional needs. The HRA is also informed by previous medical history. The Pre-Release Care Manager reaches out to Dana's prior treating providers to receive any pertinent records that would assist in her receiving appropriate treatment during the pre-release period and upon her release into the community (e.g., mental health treatment records, as well as other relevant medical records). Dana's relevant medical records are sent to the Pre-Release Care Manager by her prior treating providers. The Pre-Release Care Manager documents Dana's HRA in her medical records.

Note: In the In-Reach Care Management Model, Dana's Pre-Release Care Manager shares Dana's information with the correctional facility clinical staff. In the Embedded Care Management Model, this final step is not necessary.

Law/Regulation	Applicable?	Key Questions	Consent to share information needed?
HIPAA	Yes	» Is the Pre-Release Care Manager, whether embedded or In-Reach, a covered entity under HIPAA? » Are Dana's prior treating providers covered entities under HIPAA? » Are the desired disclosures for purposes of treatment or care coordination?	**No.** The prior treating providers and Pre-Release Care Managers are covered entities under HIPAA, and they are sharing information for purposes of treatment and care coordination. Because HIPAA permits disclosures for these purposes without individual authorization, **no consent is required.**

Law/Regulation	Applicable?	Key Questions	Consent to share information needed?
42 C.F.R. Part 2	It depends	» Are any of Dana's prior treating providers Part 2 providers?	**It depends.** If Dana's prior treating providers **are** Part 2 providers, Dana's consent to share her SUD records is required. If Dana's prior treating providers **are not** Part 2 providers, Dana's consent to share her SUD records is not necessary. For more information on Part 2, please see "How to Determine Whether an Individual or Entity is a Part 2 Provider."
AB 133	Yes	» Is the information being shared for the purposes of delivering services under CalAIM (e.g., Community Supports)?	**No.** AB 133 permits the sharing relevant PHI among Medi-Cal partners for purposes of implementing CalAIM without individual authorization. Services for the Reentry Initiative are part of CalAIM, and therefore **no consent is required.**

Diagram for Embedded and In-Reach Care Management Model Under Health Risk Assessment Scenario



Care Coordination for Housing

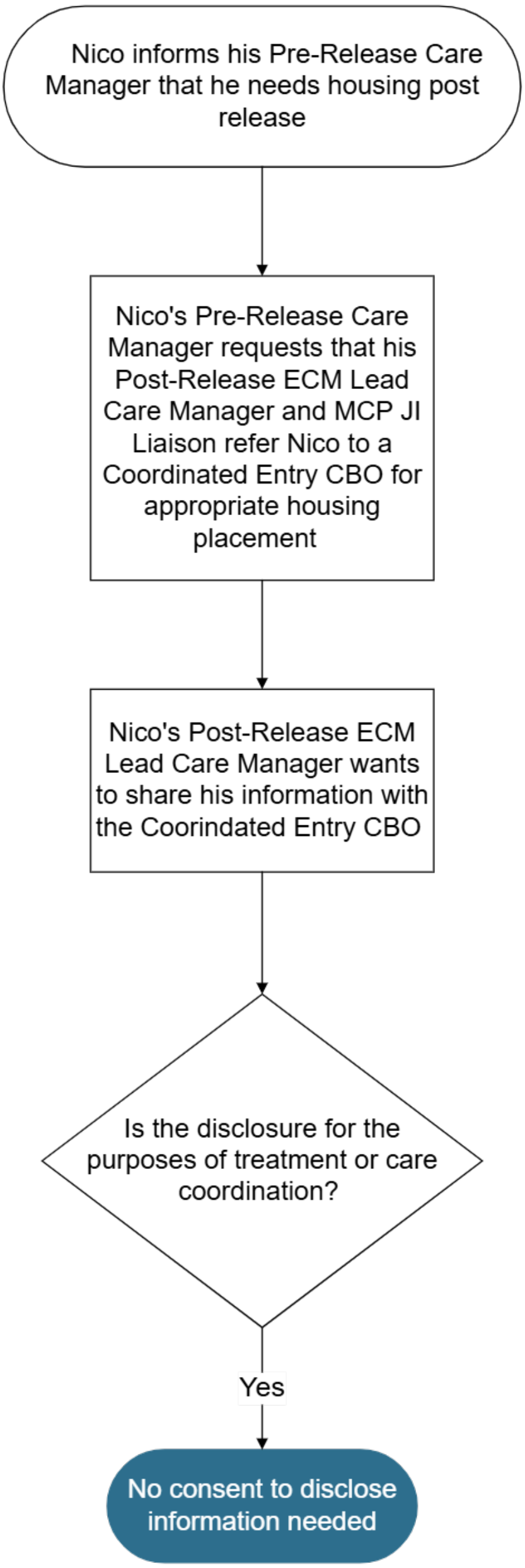
In-Reach/Embedded Pre-Release Care Management Model

The Pre-Release Care Manager (embedded or In-Reach, neither of which is a Part 2 provider) learns from Nico that he will need housing post-release and notifies the Post Release ECM Lead Care Manager, which is not a Part 2 provider, and MCP JI Liaison to identify and refer Nico to local CoC Coordinated Entry CBO for appropriate housing placement. The Post-Release ECM Lead Care Manager wants to share Nico's necessary information, such as name, age, demographic information, and relevant health status, with the Coordinated Entry CBO. None of the information held by the Pre-Release Care Manager or Post-Release Care Manager was originally obtained from a Part 2 provider.

Law/Regulation	Applicable?	Key Questions	Consent to share information needed?
HIPAA	Yes	» Is the Pre-Release Care Manager, whether embedded or In-Reach, a covered entity under HIPAA? » Are the MCP's referral staff covered entities under HIPAA? » Are the desired disclosures for purposes of treatment or care coordination?	**No.** The prior treating providers and Pre-Release Care Managers are covered entities under HIPAA, and they are sharing information for purposes of treatment and care coordination. **Because HIPAA permits disclosures for these purposes without individual authorization, no consent is required.**
42 C.F.R. Part 2	No	» Is anyone seeking to obtain or disclose information	**No.** Although Nico does have a SUD, in this scenario neither Nico's Pre-Release Care Manager or Post Release ECM Lead Care Manager is a Part 2 provider, nor are they disclosing information

Law/Regulation	Applicable?	Key Questions	Consent to share information needed?
		covered by Part 2?	originally held by a Part 2 provider. As a result, **no Part 2 consent is required.**
AB 133	Yes	» Is the information being shared for the purposes of delivering services under CalAIM (e.g., Community Supports)?	**No.** AB 133 permits the sharing of data among Medi-Cal partners for purposes of implementing CalAIM without individual authorization, and as a result **no consent is required** under California state law.

Diagram for In Reach and Embedded Care Management Model Under Care Coordination for Housing Scenario



Reentry Care Plan

In-Reach/Embedded Pre-Release Care Management Model

The Pre-Release Care Manager must complete a final reentry care plan, documented in Nico's medical record, which includes release plans related to physical health, mental health, substance use, housing needs, other health-related social needs, functional needs, strengths, and support resources. The final reentry care plan and supporting medical records will be shared with the Post-Release ECM Lead Care Manager and assigned MCP within one business day of release, as well as with community-based providers (e.g., specialty BH providers) as needed.

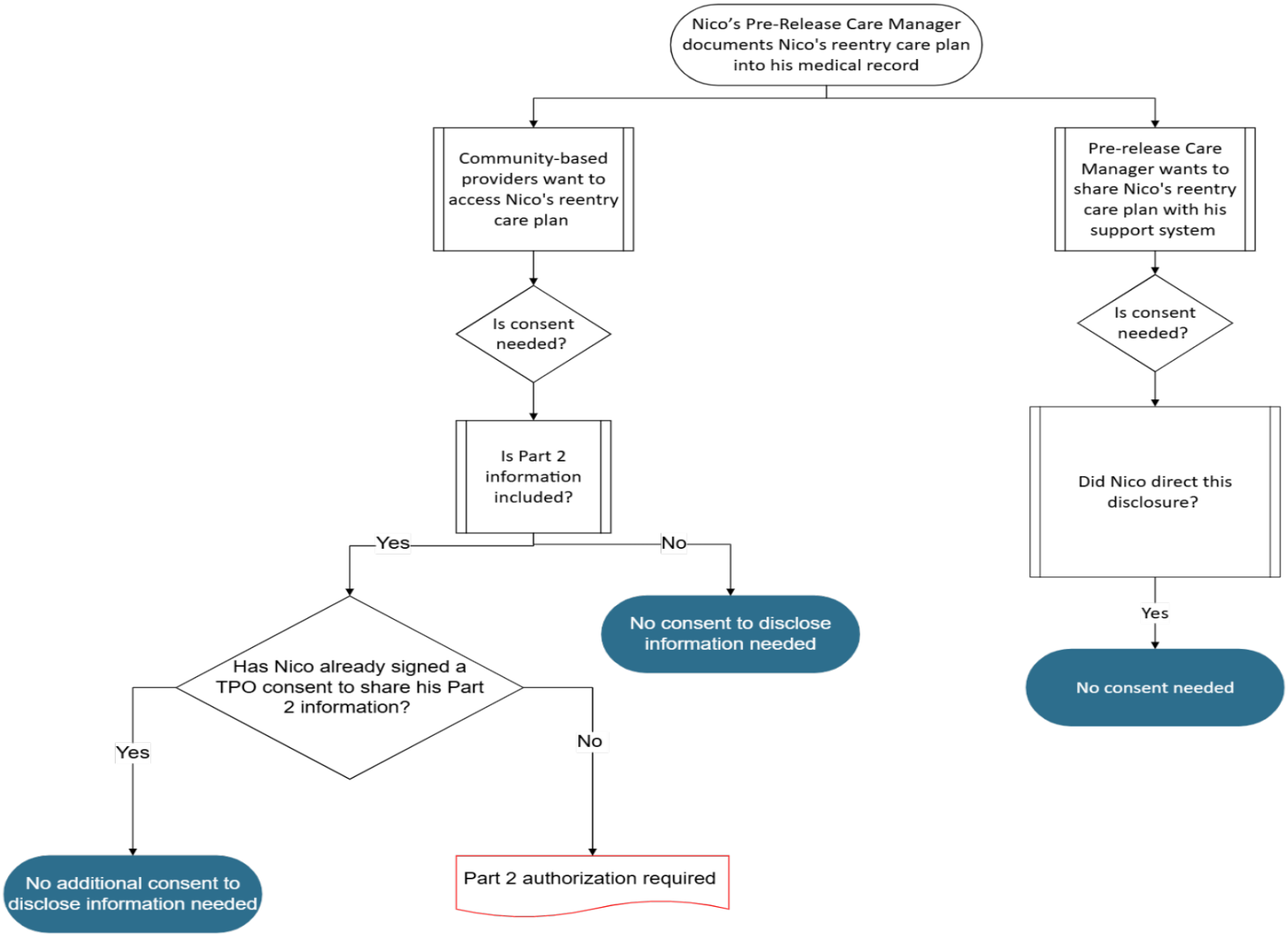
The Pre-Release Care Manager also shares the final reentry care plan with Nico and identified members of Nico's designated support system (e.g., family members) that Nico previously authorized to receive information.

Law/Regulation	Applicable?	Key Questions	Consent to share information needed?
HIPAA	Yes	» Is the embedded Pre-Release Care Manager a covered entity under HIPAA? » Is the In-Reach Pre-Release Care Manager a covered entity under HIPAA? » Are the community-based providers covered entities under HIPAA? » Are the desired disclosures for purposes of treatment or health care operations (e.g.,	**No.** The Pre-Release Care Manager, Post-Release ECM Lead Care Manager, assigned MCP, and community-based providers are all covered entities under HIPAA, exchanging data for purposes of treatment and care coordination. **HIPAA permits such disclosures without individual authorization.** Nico has asked that his reentry care plan and any supportive clinical data be shared with his designated support system, so no written authorization is necessary. HIPAA permits covered entities to share information that is directly

Law/Regulation	Applicable?	Key Questions	Consent to share information needed?
		care coordination)? » Has Nico been part of discussions regarding the sharing of his re-entry care plan with members of his designated support system, either by asking that it be shared, or verbally agreeing that it can be shared?	relevant to the involvement of a spouse, family members, friends, or other persons identified by a patient, in the patient's care.
42 C.F.R. Part 2	It depends	» Is any Part 2 information included in the re-entry care plan? » If there is Part 2 information included in the re-entry care plan, has a prior consent to disclose Part 2 information for future purposes of treatment and care coordination been signed?	**It depends.** If information originally held by a Part 2 provider is included in the reentry care plan, then whether consent is required to share it with community-based providers **depends on whether Nico has previously signed a TPO Part 2 consent**, which is a consent to all future disclosures for purposes of treatment, payment, and care coordination (as opposed to a provider- or purpose-specific, time-limited consent). Part 2 allows covered entity recipients of Part 2 information to use and disclose it for purposes of

Law/Regulation	Applicable?	Key Questions	Consent to share information needed?
			treatment, payment, and care coordination, and to redisclose it, in accordance with HIPAA, without additional consent. Please see for "How to Determine Whether an Individual or Entity is a Part 2 Provider," discussion of the Part 2 consent process.
AB 133	Yes	» Is the information being shared for the purposes of delivering services under CalAIM (e.g., Community Supports)?	**No.** AB 133 permits the sharing of data among Medi-Cal partners for purposes of implementing CalAIM without individual authorization, and as a result **no consent is required** under California law.

Diagram for In-Reach and Embedded Pre-Release Care Management Model Under Reentry Care Plan Scenario



Warm Handoff

Embedded Pre-Release Care Management Model[36]

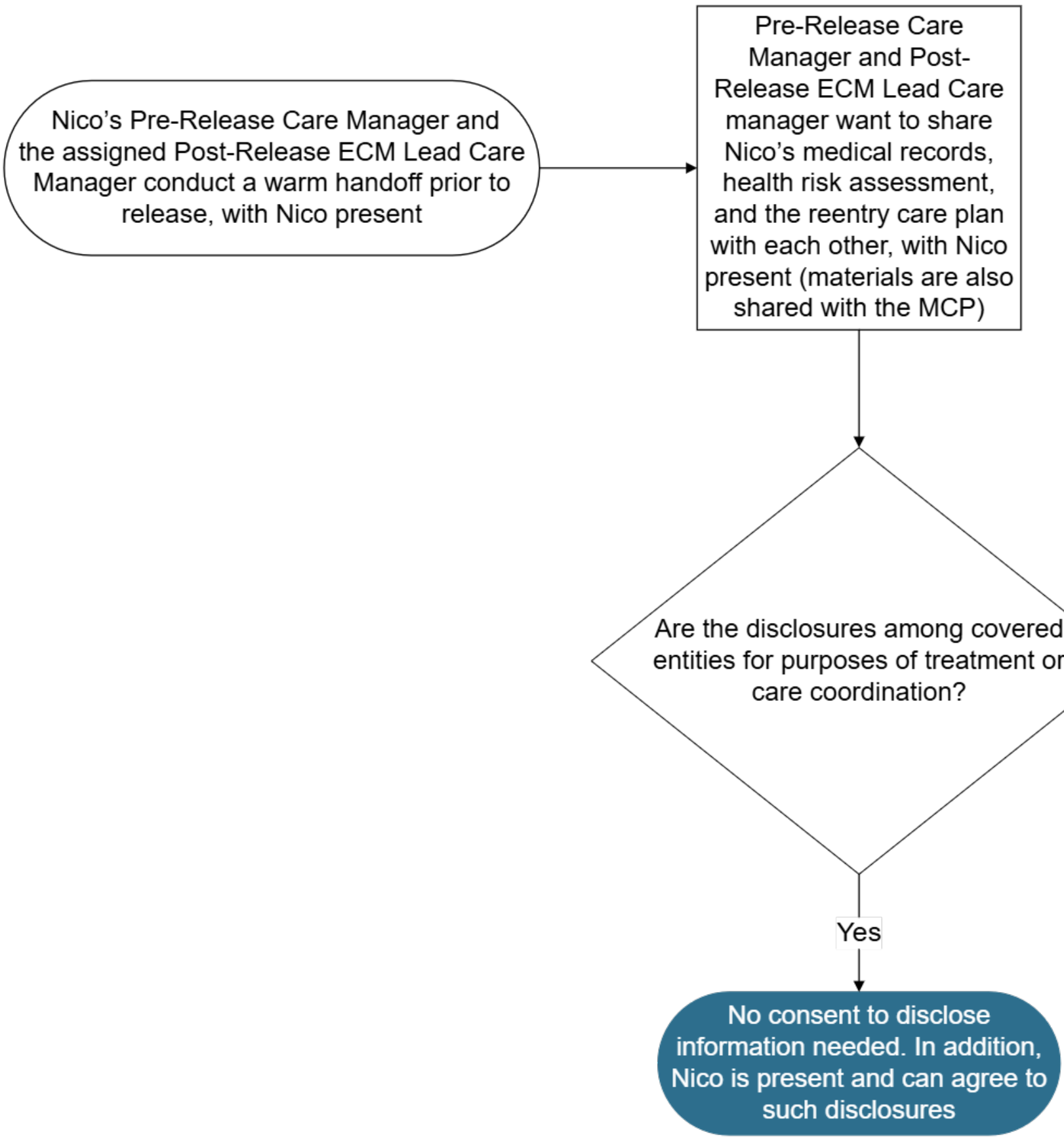
Because the correctional facility is using an embedded care management model, the Pre-Release Care Manager and the assigned Post-Release ECM Lead Care Manager are required to conduct a warm handoff prior to release, with Nico present. A warm handoff is the first step in establishing a trusted relationship between Nico and his community-based care manager to ensure seamless service delivery and coordination. The Pre-Release Care Manager schedules a warm handoff appointment to introduce the Post Release ECM Lead Care Manager, assigned by Nico's MCP, to Nico and to review and update (as needed) the correctional facility medical records, the HRA, and the reentry care plan. Nico has already signed a Part 2 consent form that enables his Pre-Release Care Manager to share SUD information originally held by his prior treating providers that may be contained in his HRA or reentry care plan.

Law/Regulation	Applicable?	Key Questions to Ask	Consent to share information needed?
HIPAA	Yes	» Is the Pre-Release Care Manager a covered entity under HIPAA? » Is the Post-Release ECM Lead Care Manager a covered entity under HIPAA? » Are the desired disclosures for purposes of treatment or care coordination?	**No.** The Pre-Release Care Manager and the Post-Release ECM Lead Care Manager are both covered entities under HIPAA and the disclosures are for purposes of treatment and care-coordination. HIPAA permits such disclosures without individual authorization.
42 C.F.R. Part 2	Yes	» Is any Part 2 information included in the re-entry care plan?	**No.** For purposes of this scenario, Nico has already signed a Part 2 TPO consent to future disclosures of his SUD

[36] Under the In-Reach care management model, Nico's In-Reach Pre-Release Care Manager is the same person as his Post-Release ECM provider and will provide Nico's services once he re-enters the community. Thus, a warm handoff under the In-Reach care management model is not needed.

		» If there is Part 2 information included in the re-entry care plan, has a prior consent to disclose Part 2 information for purposes of future treatment, payment and care coordination been signed?	information for purposes of treatment, payment, and care coordination. As a result, **no additional Part 2 consent is necessary.** Please see Part 2 FAQs for more information.
AB 133	Yes	» Is the information being shared for the purposes of delivering services under CalAIM (e.g., Community Supports)?	**No.** AB 133 permits the sharing of data among Medi-Cal partners for purposes of implementing CalAIM without individual authorization, so **no consent is required** under California state law.

Diagram for In-Reach and Embedded Pre-Release Care Management Model Under Warm Handoff Scenario



Toolkit Scenario: Additional Reentry Initiative-Related Clinical Services

Treatment for SUD (also referred to as medication-assisted treatment or MAT)

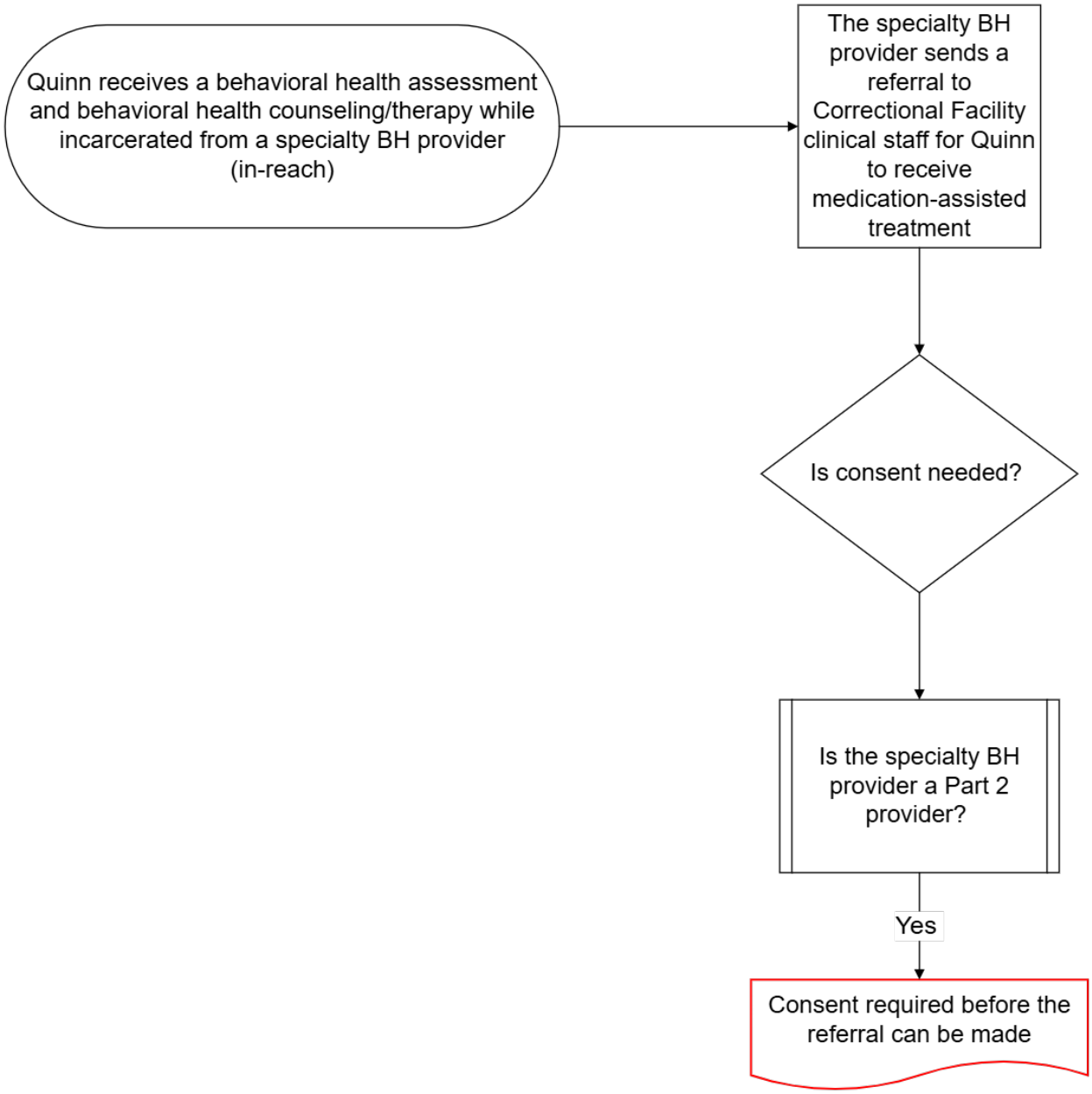
In-Reach Pre-Release Care Management Model

Quinn receives a behavioral health assessment and behavioral health counseling/therapy while incarcerated from an In-Reach County BH Provider (i.e., clinical consultant), who is a Part 2 provider. The In-Reach Specialty BH provider submits a referral and shares medical documentation, including diagnoses, recommended treatment, and relevant clinical information, with the correctional facility clinical staff so that the correctional facility can prescribe medications for SUD. The correctional facility prescribing staff receives this recommendation with associated clinical information and prescribes as appropriate to Quinn. Additionally, Quinn receives cognitive behavioral therapy (CBT) from the correctional facility provider. The correctional facility CBT provider receives clinical information from the Pre-Release Care Manager to inform the counseling services provided to Quinn. The correctional facility CBT provider shares pertinent clinical information back to the In-Reach specialty behavioral health provider so they can adjust medications as needed.

Law/Regulation	Applicable?	Key Questions	Consent to share information needed?
HIPAA	Yes	» Is the correctional facility clinical staff a covered entity under HIPAA? » Is the In-Reach Specialty BH Provider a covered entity under HIPAA? » Are the desired disclosures for purposes of	**No.** The In-Reach County BH Provider, correctional facility clinical staff, and correctional facility CBT provider are all HIPAA-covered entities, and the disclosures are for purposes of treatment and care coordination. HIPAA permits disclosures for these purposes without individual authorization, **so no consent is needed.**

Law/Regulation	Applicable?	Key Questions	Consent to share information needed?
		treatment or care coordination?	
42 C.F.R. Part 2	Yes	» Is the embedded or In-Reach Specialty Provider a Part 2 provider?	**Yes.** Because the In-Reach Specialty BH Provider in this scenario is a Part 2 provider, **Quinn's consent will be required before these records** can be shared with the correctional facility. Please find additional information on Part 2 here.
AB 133	Yes	» Is the information being shared for the purposes of delivering services under CalAIM (e.g., Community Supports)?	**No.** AB 133 permits the sharing of data among Medi-Cal partners for purposes of implementing CalAIM without individual authorization, so **no consent is required** under California law.

Diagram for In-Reach Pre-Release Care Management Model Under Medications for SUD (also referred to as medication-assisted treatment or MAT) Scenario



Community Health Worker Services

Embedded or In-Reach Pre-Release Care Management Model

Nico's Pre-Release Care Manager (either an embedded care manager or an In-Reach care manager who will continue to serve Nico as his Post-Release ECM Lead Care Manager) works at a facility that leverages CHWs with lived experience to provide pre-release CHW services as part of the Reentry Initiative. The Pre-Release Care Manager identifies that Nico could benefit from CHW services related to education and navigation during their sessions together and through Nico's Health Risk Assessment.

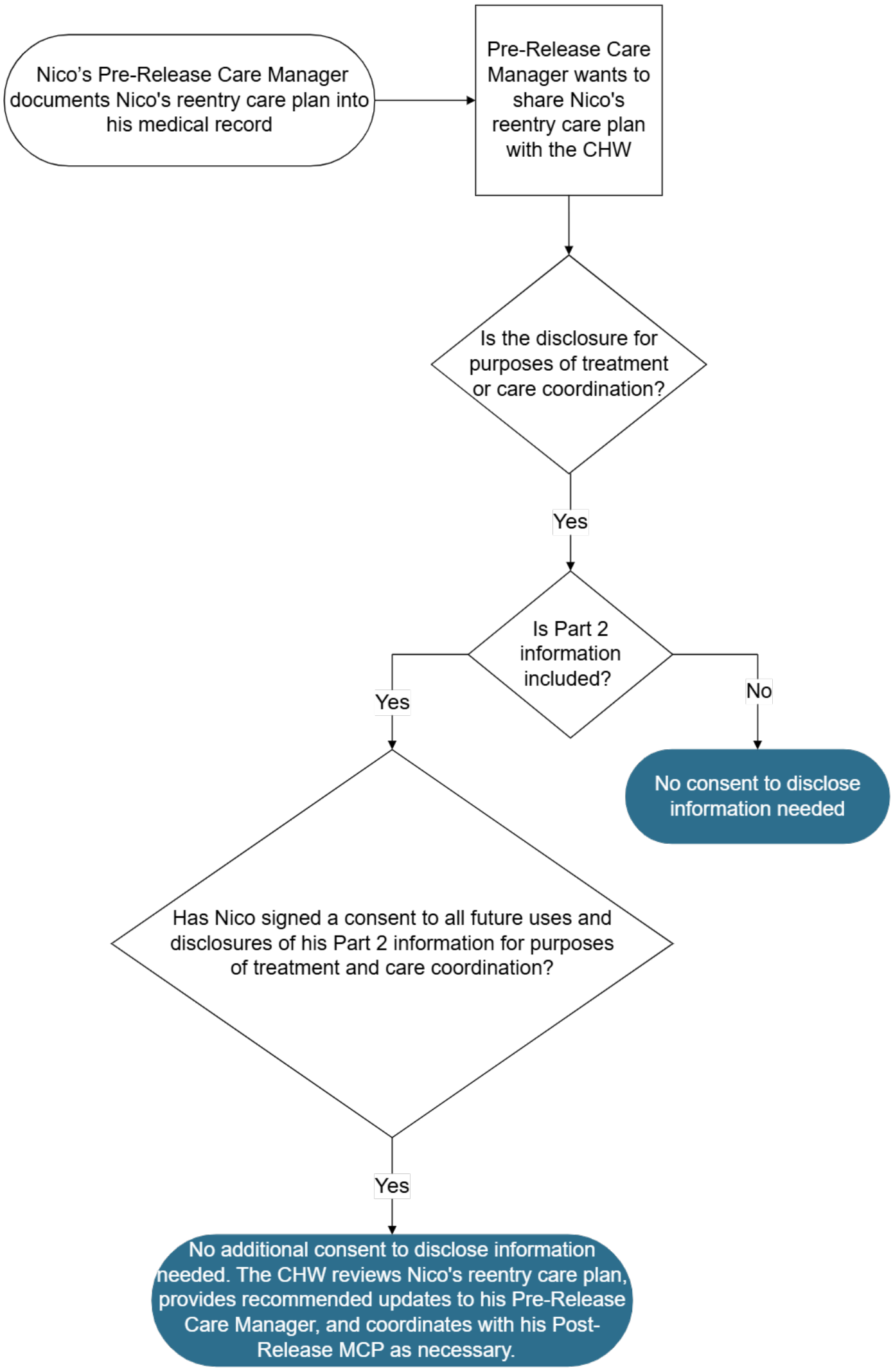
The CHW receives information from the Pre-Release Care Manager about Nico's reentry care plan. The CHW meets with Nico via telehealth, facilitated by the correctional facility, and during their conversation learns that Nico is worried about drug activity in his planned release housing. The CHW provider recommends that the Pre-Release Care Manager update the reentry care plan to change the plan for Nico's release housing/location, as well as update his follow-up appointments to be closer to his planned release location. The Pre-Release Care Manager works with Nico's assigned post-release MCP to connect him to a new housing situation.

Nico previously signed a consent form that allows for future disclosures of his Part 2 information to other covered entities, such as CHWs, for purposes of his treatment and care coordination.

Law/Regulation	Applicable?	Key Questions	Consent to share information needed?
HIPAA	Yes	» Is the Community Health Worker a covered entity under HIPAA? » Is the Pre-Release Care Manager a covered entity under HIPAA? » Is the Post-Release ECM Lead Care Manager a	**No.** The CHW, Pre-Release Care Manager, and Post-Release ECM Lead Care Manager are all HIPAA-covered entities, and the disclosures are for purposes of Nico's treatment and care coordination. HIPAA permits disclosures for these purposes without individual authorization, so **no consent is necessary.**

Law/Regulation	Applicable?	Key Questions	Consent to share information needed?
		covered entity under HIPAA? » Are the desired disclosures for purposes of treatment or care coordination?	
42 C.F.R. Part 2	Yes	» Is anyone seeking to disclose or obtain information that is covered by Part 2? » Has Nico previously signed a TPO Part 2 consent?	**No.** Although Nico's reentry care plan may contain Part 2 information, for purposes of this scenario, Nico has already signed a Part 2 TPO consent that authorizes future disclosures for purposes of treatment, payment, and healthcare operations. As a result, **no additional Part 2 consent is necessary.**
AB 133	Yes	» Is the information being shared for the purposes of delivering services under CalAIM (e.g., Community Supports)?	**No.** AB 133 permits the sharing of data among Medi-Cal partners for purposes of implementing CalAIM without individual authorization, so **no consent is required** under California law.

Diagram for Embedded and In-Reach Model Under Community Health Worker Services Scenario



DME Upon Release

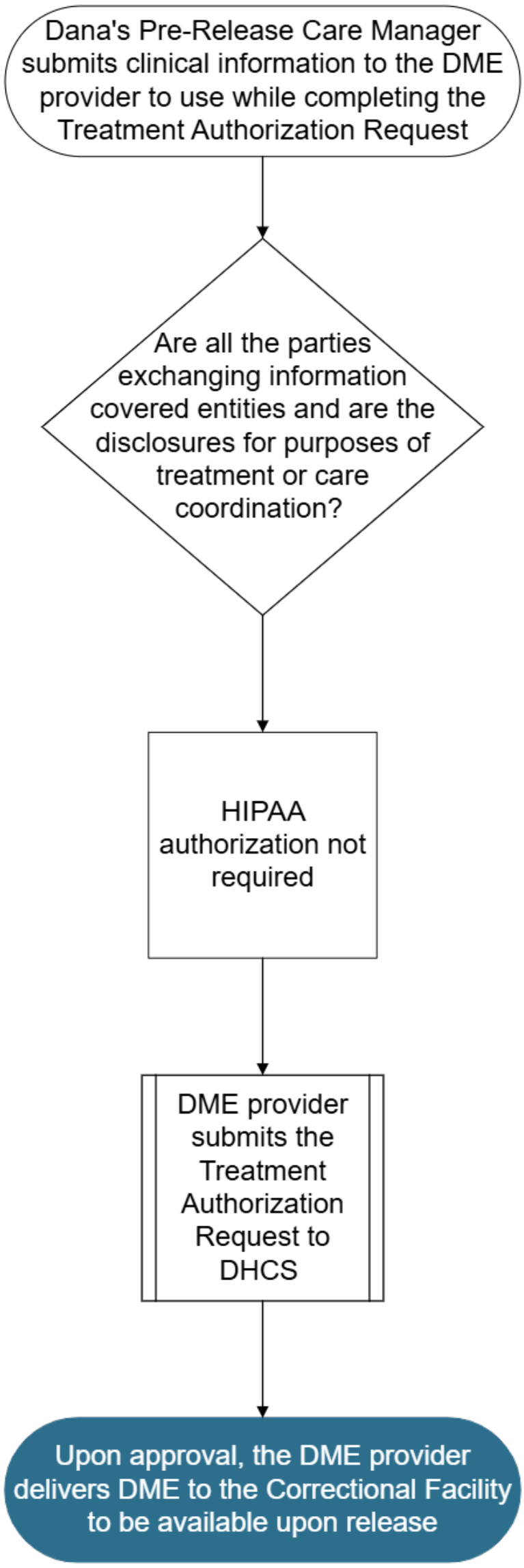
In-Reach/Embedded Pre-Release Care Management Model

Dana, who was identified as having mobility impairments by her care manager, received an evaluation by a contracted physical therapist clinical consultant, who recommended a walker for Dana. The Pre-Release Care Manager coordinates with the correctional facility prescribing staff to obtain a prescription for the recommended walker with appropriate clinical documentation. The Pre-Release Care Manager submits the prescription to the DME provider and works with the correctional facility clinical staff and clinical consultants to gather and submit any needed clinical information for the Treatment Authorization Request (TAR) to the DME provider to ensure the walker will be available to Dana upon release. The DME provider submits the TAR to DHCS.

Law/Regulation	Applicable?	Key Questions	Consent to share information needed?
HIPAA	Yes	» Are the correctional facility clinical staff covered entities under HIPAA? » Is the clinical consultant a covered entity under HIPAA? » Is the Pre-Release Care Manager, whether embedded or In-Reach, a covered entity under HIPAA? » Is the DME provider a covered entity under HIPAA? » Are the desired disclosures for	**No.** The correctional facility clinical staff, the Pre-Release Care Manager, clinical consultant, DME provider, and DHCS are all HIPAA covered entities, and the disclosures are for purposes of treatment and care coordination. HIPAA allows disclosures for these purposes without individual authorization, **so no consent is necessary.**

		purposes of treatment or care coordination?	
42 C.F.R. Part 2	No	» Is anyone seeking to disclose, obtain or share information covered by Part 2?	**No.** There are no Part 2 providers in this scenario, and no Part 2 SUD information is being shared. As a result, **no Part 2 consent is required**.
AB 133	Yes	» Is the information being shared for the purposes of delivering services under CalAIM (e.g., Community Supports)?	**No.** AB 133 permits the sharing of data among Medi-Cal partners for purposes of implementing CalAIM without individual authorization, so **no consent is required** under California law.

Diagram for In-Reach and Embedded Care Management Model Under DME Scenario[37]



[37] DME provider to use while completing the Treatment Authorization Request for DHCS FFS program.

APPENDIX A: GLOSSARY OF TERMS

Most of these terms originate from the Policy and Operational Guide for Planning and Implementing the CalAIM Reentry Initiative,[38] except where noted otherwise:

1. **1115 Demonstration Waiver:** A waiver approved by the Centers for Medicare & Medicaid Services that, among other things, allows DHCS to partner with state agencies, providers, counties, and CBOs to offer a targeted set of Medicaid services to Medi-Cal-eligible youth and adults in state prisons, county jails, and youth correctional facilities for up to 90 days prior to release.

2. **Behavioral Health Link:** Behavioral health links were created under state law AB 133 in 2021 to implement a process requiring correctional facilities to facilitate referrals to county SMHS, DMC, the DMC-ODS, and/or Medi-Cal MCPs for incarcerated members who received behavioral health services while incarcerated to allow for the continuation of behavioral health treatment. These referrals are called behavioral health links.

   Behavioral health links seek to ensure continuity of treatment for individuals who receive behavioral health services while they were incarcerated and who wish to continue to receive these services from SMHS, DMC, and/or DMC-ODS in the community. Behavioral health links are also for individuals who receive medication treatment for SUD, including through the MCP provider network. Correctional facilities and County Behavioral Health Agencies will work in partnership to facilitate professional-to professional clinical handoffs to post-release providers and share information with the member's health plan (e.g., county MHP, DMC/DMC-ODS counties, and MCPs as needed) or the provider who will prescribe the medication for SUD.

3. **Care Manager Warm Handoff:** In cases where different care managers provide pre- and post-release care management services (i.e., if the correctional facility leverages an embedded care management model or if the individual will be released into a county in which their In-Reach prerelease care manager does not operate), the two care managers must conduct a warm handoff with the individual prior to release. The warm handoff is the first step in establishing a

[38] CA Department of Health Care Services, "Policy and Operational Guide for Planning and Implementing the CalAIM Justice-Involved Initiative" (October 20, 2023), *available at*: https://www.dhcs.ca.gov/provgovpart/pharmacy/Documents/CalAIM-JI-Policy-and-Operations-Guide-FINAL-October-2023-updated.pdf.

trusted relationship between the individual and the new care manager to ensure seamless service delivery and coordination.

4. **Community-Based Organization:** a public or private non-profit organization with a 501(c)(3) status or a fiscally sponsored entity of a 501(c)(3) non-profit organization[39]

5. **Community-Based Providers**: Providers who provide care in the community. These may include, but are not limited to, Post-Release ECM Lead Care Manager, Managed Care Plans, and Specialty Behavioral Health Providers.

6. **Community Health Workers:** May include individuals known by a variety of job titles, including promotors, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals. Community health worker services are preventive health services to prevent disease, disability, and other health conditions or their progression; to prolong life; and promote physical and mental health and well-being.[40]

7. **Community Supports:** Services that help address members' health-related social needs, help them live healthier lives, and avoid higher, costlier levels of care. These include:

8. **Correctional Facilities**: State prisons, county jails, and county youth correctional facilities.

9. **Correctional Facility Clinical Staff:** A clinical provider employed or directly contracted by the correctional facility to provide health care services (physical and behavioral health) in the correctional facility.

10. **County Welfare Department (CWD):** Another term for a county social services department. In the context of reentry, the department often serves as the designated entity to facilitate enrollment of inmates and youth in health insurance affordability programs on or before their release date.

[39] CA Department of Health Care Services, "Community-Based Organizations and Local Health Jurisdictions Enrollment" (December 2023), *available at*: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/news/32589.
[40] CA Department of Health Care Services, "Community Health Workers," *available at*: https://www.dhcs.ca.gov/community-health-workers#:~:text=%E2%80%8B%E2%80%8B%E2%80%8B%E2%80%8B%E2%80%8B,%E2%80%8BCommunity%20Health%20Workers%E2%80%8B&text=CHW%20services%20are%20preventive%20health,mental%20health%20and%20well%2Dbeing.

11. **Designated Support System**: Family members or guardians of the Medi-Cal individual.

12. **Drug Med-Cal Organized Delivery System:** A voluntary pilot program that offers California counties the opportunity to expand access to high-quality care for Medi-Cal members with an SUD. The goal of the system is to demonstrate how organized SUD care improves beneficiary health outcomes, while decreasing system-wide health care costs. Counties that choose to participate are required to provide access to a full continuum of SUD benefits modeled after the American Society of Addiction Medicine Criteria.[41]

13. **DME Providers:** A clinician (physician, nurse practitioner, clinical nurse specialist, or physician assistants) prescribing DME.[42]

14. **Enhanced Care Management:** A statewide Medi-Cal benefit available to select members with complex needs. Enrolled members receive comprehensive care management from a single lead care manager who coordinates all their health and health-related care, including physical, mental, and dental care, and social services.[43] ECM services break down the traditional walls of health care, extending beyond hospitals and health care settings into communities are provided to meet the Members where they are.

15. **ECM Lead Care Manager:** A member's designated care manager for ECM, who works for the ECM Provider. The Lead Care Manager operates as part of the member's care team and is responsible for coordinating all aspects of ECM and referrals for any Community Supports. To the extent a member has other care managers, the Lead Care Manager will be responsible for coordinating with those individuals and/or entities to ensure a seamless experience for the member and non-duplication of services.

16. **ECM Provider:** A Provider of ECM. ECM Providers are community-based entities with experience and expertise providing intensive, in-person care management services to individuals in one or more of the Populations of Focus for ECM.

17. **Embedded Care Management Model:** A model through which embedded care managers (i.e., care managers employed by or contracted with the correctional

[41] CA Department of Health Care Services, "Drug Medi-Cal Overview," *available at*: https://www.dhcs.ca.gov/services/adp/Pages/default.aspx.
[42] CA Department of Health Care Services, "Durable Medical Equipment in Medi-Medi Plans," June 2023, *available at*: MMP DME Provider Factsheet (ca.gov).
[43] CA Department of Health Care Services, "Medi-Cal Transformation: Enhanced Care Management," *available at*: https://www.dhcs.ca.gov/CalAIM/Documents/CalAIM-ECM-a11y.pdf.

facility) deliver pre-release care management services to individuals eligible for pre-release services.

18. **Health and Social Service Information:** Information gathered by a medical provider or community organization that may include personal demographics; housing information; employment and financial needs; and/or receipt of or eligibility for social services.[44]

19. **In-Reach Care Management Model:** A model through which community-based care management providers deliver pre-release care management for individuals eligible for pre-release services, either in person or via telehealth.

20. **In-Reach Providers:** Providers can include but are not limited to clinical consultants and In-Reach Specialty BH Providers.

21. **Reentry Initiative Individual:** An individual who is currently or was formerly incarcerated within the past twelve months.

22. **Medications for SUD:** These include medications to treat opioid use disorder or medications to treat alcohol use disorder, including the important use of medication as a stand-alone treatment without the prerequisite use of psychosocial services, when clinically indicated.

23. **Mental Health Plans:** Health plans run through county behavioral health departments which are responsible for the delivery of care for patients with specialty mental health issues that result in impairment in functioning, and for emergency and in-patient behavioral health services for all Medi-Cal beneficiaries.[45]

24. **Managed Care Plan (MCP):** Medi-Cal contracts for health care services through established networks of organized systems of care, which emphasize primary and preventive care. MCPs are a cost-effective use of health care resources that improve health care access and assure quality of care.

[44] California Health Care Foundation, "Consent-to-Share: California's Opportunity to Modernize Cross-Sector Data Sharing," October 2023, *available at*: https://www.chcf.org/wp-content/uploads/2023/10/ConsentToShareCACrossSectorDataSharing.pdf.
[45] California Health Care Foundation, "Medi-Cal and Behavioral Health Services," February 2019, *available at*: https://www.chcf.org/wp-content/uploads/2019/02/MediCalExplainedBehavioralHealth.pdf.

25. **MCP JI Liaison:** An individual or a team (i.e., a live person not an automated hotline) who will be available to support correctional facilities, Pre-Release Care Manager, and/or ECM providers as needed.

26. **Protected Health Information:** Individually identifiable health information held or maintained by a covered entity or its business associates acting for the covered entity, that is transmitted or maintained in any form or medium (including the individually identifiable health information of non-U.S. citizens). This includes identifiable demographic and other information relating to the past, present, or future physical or mental health or condition of an individual, or the provision or payment of health care to an individual that is created or received by a health care provider, health plan, employer, or health care clearinghouse.[46]

27. **Pre-Release Care Manager:** The person who will act as the primary point of contact to ensure whole-person reentry services are provided as outlined by the CalAIM JI policy. The care manager will work, as appropriate, with other providers, including correctional facility providers, Post-Release ECM Providers (if different than the prerelease care manager), County Behavioral Health Agency providers, and community-based resources.

28. **Prior Treating Providers:** Providers who treated Medi-Cal individuals prior to their incarceration.

29. **Post-Release ECM Lead Care Manager:** The person who will act as the primary point of contact after reentry once the member is enrolled in an MCP and at any point during the post-release period enrollment gap when the member is still in the FFS delivery system. If this provider is different from the Pre-Release Care Manager, they should have a warm handoff of the member, ideally at least two weeks prior to release.

30. **Reentry Care Plan:** Pre-Release Care Managers must develop a person-centered reentry care plan for all individuals receiving pre-release care management.

31. **Medi-Cal Specialty Mental Health Services:** A group of Medi-Cal mental health services covered under county mental health plans that are available to children, youth, and adults with a diagnosed or suspected mental health disorder that causes significant impairment or has reasonable probability of causing significant deterioration in an important area of life functioning. These services may include crisis counseling, individual/group/family therapy, medication management,

[46] National Institutes of Health, "What Health Information is Protected by the Privacy Rule?" *available at*: https://privacyruleandresearch.nih.gov/pr_07.asp.

targeted case management, psychological testing, psychiatric inpatient hospitalization, and recovery services.[47]

[47] CA Department of Health Care Services, "Medi-Cal Specialty Mental Health Services," *available at*: https://www.dhcs.ca.gov/services/Pages/Medi-cal_SMHS.aspx.