

GUIDANCE ON HEALTH CARE INFORMATION SHARING

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BACKGROUND:

According to the 2006 National Association of State Mental Health Program Directors (NASMHPD) report, Morbidity and Mortality in People with Serious Mental Illness, on average persons with serious mental illness die 25 years earlier than those without serious mental illness. This alarming disparity signals the need to increase access to primary care services, in order to combat higher rates of hypertension, diabetes, obesity and cardiovascular disease, and promote healthy lifestyle choices such as increased physical activity, balanced diets, smoking cessation, and minimizing the side effects of psychotropic medication, including weight gain.

Routine health promotion activities, primary care screenings, monitoring, and treatment, and coordinated care management have been shown to be effective in improving health outcomes. Because people with serious mental illness frequently seek and obtain services from community-based behavioral health providers, it is increasingly important for these service providers to formulate partnerships with primary care services in order to foster integrated client-centered, recovery-focused approaches to service coordination and outreach. The goal would be to improve health outcomes and the quality of life for persons with serious mental illness.

With this end in mind in 2008, the Department of Public Welfare (DPW) partnered with the Center for Health Care Strategies (CHCS) in the *Rethinking Care Program* (RCP), a multi-state national effort to improve the quality and cost effectiveness of services to Medicaid beneficiaries with complex medical and behavioral needs. DPW will be launching two regional pilots that have engendered extensive collaboration with persons with serious mental illness, their stakeholders, county behavioral health agencies, their subcontracted behavioral and physical health plans, plus local participating primary care & behavioral health providers.

Key to coordinated services is information sharing. For example it is important for a physician to know the medications that a client is taking in order to avoid prescribing others that could result in serious or even fatal drug interactions. Physical and behavioral health entities that wish to share information must be aware of the federal and state laws and regulations that govern the sharing and confidentiality of personal health care information. Of equal importance is the ethical treatment of individuals around information sharing. It is acknowledged that legal opinions contained hereafter in this document do not address ethical components of information-sharing. Furthermore, the department respects the consumers' rights to control access to their medical/behavioral health information and agrees that individuals participating in these pilots have the right to determine, through use of consents to release information, which providers will have access to their medical/behavioral health information.

Accordingly, the following information is intended to serve as general guidance on the information sharing envisioned for these pilots as it relates to the applicable federal and state laws and regulations (HIPAA, the Mental Health Procedures Act, HIV, and Drug and Alcohol). It will inform the pilot design and implementation which will include innovative models of care, member outreach strategies and consent. Throughout the pilot implementation period these approaches will be tested, monitored, adjusted and evaluated by independent evaluators to assure compliance and assess health outcomes.

SUMMARY

General Rule

When disclosed for purposes of medical treatment, diagnosis or coordination of care, no written consents are required for disclosure of any medical information except information related to drug and alcohol treatment or to entities other than health care providers (and their agents) for HIV treatment.

Disclosure of drug and alcohol treatment information:

Pennsylvania Law: Disclosure of drug and alcohol treatment information from a drug and alcohol treatment provider to an MCO: With the patient’s consent, a “project” may disclose the patient’s drug and alcohol treatment information to a managed care organization (MCO) – but only to the very limited extent permitted by 4 Pa. Code § 255.5(b).¹ (These restrictions are set forth below.) It is important to note, however, that the restrictions set forth in 4 Pa. Code § 255.5(b) only apply to the disclosure of information from licensed treatment providers to MCOs and other third party payers, government officials, judges and probation and parole officers. The disclosure of information between licensed treatment providers and other entities is governed by less restrictive federal law.

Federal Law: Disclosure or redisclosure of drug and alcohol treatment information by the MCO to other entities: With the patient’s written consent, an MCO can share the patient’s drug and alcohol treatment information with another entity. For the consent to be valid, it must meet the requirements set forth in 42 CFR § 2.31. In addition, the MCO can share information without obtaining the patient’s consent as long as the information does not in any way identify the patient as someone seeking or receiving drug and alcohol treatment.

Disclosure of HIV treatment information:

HIV treatment information may be disclosed without consent for purposes of treatment, diagnosis (to health care providers and agents) or payment for treatment or diagnosis (to providers, agents and insurers). Disclosure between MCOs would appear to require a written consent.

We believe that the simple consent form we prepared satisfies all the requirements discussed above and that these are the relevant requirements.

¹ A “project” is defined as “The public or private organization responsible for the administration and delivery of drug or alcohol services, or both, through one or more facilities. A project is a component of an SCA drug and alcohol program.” See 28 Pa. Code § 701.1

QUESTIONS AND ANSWERS

1. HIPAA

Question: Does HIPAA permit a Physical Health managed care organization (PH/MCO) or Behavioral Health managed care organization (BH/MCO) to release identifying health information (other than protected drug/alcohol or HIV-related information) to a qualified service organization (“QSO”), to another PH/MCO or BH/MCO or to a provider without the patient’s written authorization?

Answer: Yes.

Discussion: Without question, HIPAA permits mutual release of identifying health information in these scenarios, if the purpose of release is for treatment, payment or health care operations (“TPO”). See 45 C.F.R. § 164.506. In the preamble text for the privacy regulations and related federal guideline, the federal Office of Civil Rights (“OCR”) specified that case management and care coordination are TPO activities, requiring no written authorization to release.

2. MENTAL HEALTH PROCEDURES ACT (50 P.S. § 7101 et seq.)

Question: Does the Mental Health Procedures Act (MHPA) permit a BH/MCO to disclose without consent to a PH/MCO records which are subject to the Act and its regulations that will enable the PH/MCO to determine what, if any, physical medical evaluation and treatment may be needed by the patient?

Answer: Yes.

Discussion: This is permissible because (1) applicable regulations expressly make nonconsensual disclosure for referral for treatment permissible, (2) because the “treatment” includes physical health as well as mental health treatment, and (3) the separation of BH/MCOs from PH/MCOs is arbitrary.

(1) Without consent, “relevant portions or summaries” of records created under the MHPA may be sent to “persons at other facilities...when the person is being referred to that facility and a summary or portion of the record is necessary to provide for continuity of proper care and treatment.” 55 Pa. Code §5100.32(a)(1). While the MHPA itself and its regulations at Ch. 5100 are directly applicable only to inpatient care and involuntary outpatient care, 50 P.S. §7103, the Ch. 5100 confidentiality regulations have been incorporated by reference into the licensing regulations for outpatient psychiatric clinics and partial hospitalization programs. See 55 Pa. Code §5200.41(c), 5210.56. Accordingly, they are applicable to all treatment at such facilities, whether voluntary or involuntary.

(2) That the treatment includes physical health as well as mental health is clear from Allen v. Montgomery Hospital, 696 A.2d 1175 (Pa. 1997), where the Court held the

qualified immunity provisions of the MHPA, 50 P.S. §7114, applicable to persons providing physical health as well as mental health treatment to persons hospitalized under the MHPA.

(3) In light of the holding in Allen, and the statutory language at 50 P.S. §7104 (“treatment shall include...other services that supplement [mental health] treatment”) and what is, for purposes of the MHPA, the arbitrary separation of BH/MCOs from PH/MCOs, there is neither any textual nor policy justification for requiring consent for the sharing of the records at issue.

3. DRUG AND ALCOHOL TREATMENT INFORMATION

Question 1: What information may be disclosed by drug and alcohol abuse treatment providers with the written consent of the patient?

Answer: Generally, the Federal drug and alcohol confidentiality regulations permit drug and alcohol treatment providers to disclose a patient’s drug and alcohol treatment information as long as the patient has signed a valid written consent form. *See* 42 CFR §2.31 and § 2.33. This includes the disclosure of information to government officials, MCOs and other third party payers.

The Commonwealth’s drug and alcohol confidentiality regulations, however, are much more restrictive. In Pennsylvania, a Department of Health regulation, 4 Pa. Code 255.5(b), governs the release of information between licensed drug and alcohol treatment providers and government officials, MCOs and other third party payers. Under 255.5(b) and its Interpretive Guidelines, with a patient’s consent, only the following five categories of information can be released to MCOs in order to obtain benefits for the patient:

- (1) Whether the patient is or is not in treatment.
- (2) The prognosis of the patient.
- (3) The nature of the project.
- (4) A brief description of the progress of the patient.
- (5) A short statement as to whether the patient has relapsed into drug or alcohol abuse and the frequency of such relapse.

Accordingly, even with the patient’s consent, a project cannot disclose key information such as the drug(s) used, the frequency and duration of drug use, withdrawal symptoms, prior substance abuse diagnoses, substance use and treatment history, psychiatric conditions, suicide risk, concurrent medical illnesses, prescribed medications, vital signs

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and laboratory test results to the relevant MCO in order to obtain benefits for that patient.

It is important to note that the restrictions in Section 255.5(b) do not apply to the disclosure of information between a drug and alcohol treatment provider and another treatment provider.

Question 2: Do the laws providing for the confidentiality of drug and alcohol treatment information permit a PH/MCO or BH/MCO to disclose drug and alcohol treatment information to other PH/MCOs or BH/MCOs or to providers without the written consent of the patient?

Answer: Depends.

Discussion: Disclosure of information that would identify the patient as someone seeking or receiving drug and alcohol treatment without the patient's written consent is generally prohibited. See 42 C.F.R. § 2.12, 71 P.S. § 1690.108, 4 Pa. Code § 255.5. Likewise, subsequent re-disclosure of information that would identify the patient as someone seeking or receiving drug and alcohol treatment, without the express written consent of the patient, is prohibited for all entities that receive the information from a drug and alcohol treatment provider. See 42 C.F.R. § 2.32. Disclosure of information that does not identify the patient as someone seeking or receiving drug and alcohol treatment, however, is governed by other, less restrictive, authorities, such as HIPAA.

Question 3: May MCOs disclose to other MCOs and providers drug and alcohol treatment information for purposes of treatment, diagnosis or management of treatment with the written consent of the patient?

Answer: Yes.

Discussion: Managed care organizations are not "projects" and thus are not subject to the restrictions on disclosure set forth in 4 Pa. Code § 255.5(b). Accordingly, if the patient signs a consent form that meets the requirements set forth in the federal regulations (42 C.F.R. §2.31), MCOs may disclose the patient's treatment information to other MCOs and to providers for purposes of treatment, diagnosis or management of treatment.

Question 4: What matters must be addressed in a written consent in order to be sufficient to authorize the release of drug and alcohol abuse treatment information?

Answer: Federal regulations (42 C.F.R. §2.31) require the following elements for a patient's consent form to be valid:

- (1) The specific name or general designation of the program or person permitted to make the disclosure.
- (2) The name or title of the individual or the name of the organization to which disclosure is to be made.

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- (3) The name of the patient.
- (4) The purpose of the disclosure.
- (5) How much and what kind of information is to be disclosed.
- (6) The signature of the patient and, when required for a patient who is a minor, the signature of a person authorized to give consent under Sec. 2.14; or, when required for a patient who is incompetent or deceased, the signature of a person authorized to sign under Sec. 2.15 in lieu of the patient.
- (7) The date on which the consent is signed.
- (8) A statement that the consent is subject to revocation at any time except to the extent that the program or person which is to make the disclosure has already acted in reliance on it. Acting in reliance includes the provision of treatment services in reliance on a valid consent to disclose information to a third party payer.
- (9) The date, event, or condition upon which the consent will expire if not revoked before. This date, event, or condition must insure that the consent will last no longer than reasonably necessary to serve the purpose for which it is given.

In addition, a Pennsylvania Department of Health regulation, 28 Pa. Code §711.43(d)(2) requires the dated signature of a witness. Finally, while the limitations of 4 Pa. Code §255.5(b) apply to disclosures by providers to MCOs and other third party payers, government officials, judges and probation and parole officers, there is no need to reference those limitations in a consent form.

Question 5: May a PH/MCO and a BH/MCO disclose drug and alcohol abuse treatment information to a Qualified Service Organization for the purpose of processing the information provided by the two MCOs together to identify persons who are severely mentally impaired?

Answer: No.

Discussion: Under the federal regulations, a drug and alcohol treatment provider can share a patient's treatment information with a Qualified Service Organization (QSO) without the patient's consent. (42 CFR § 2.12(c)(4)). A QSO is typically an entity that provides services, such as data processing or bill collecting, to the drug and alcohol treatment provider. (See 42 CFR § 2.11) Only a "program" can enter into a Qualified Service Organization Agreement (QSOA).² (See 42 CFR § 2.11 defining Qualified Service Organization as an entity that "provides services to a program" or has "entered into a written agreement with the program" (emphasis added)). An MCO cannot enter into a QSOA for the

² A "program" is defined as "(a) An individual or entity (other than a general medical care facility) who holds itself out as providing, and provides, alcohol or drug abuse diagnosis, treatment or referral for treatment; or (b) An identified unit within a general medical facility which holds itself out as providing, and provides, alcohol or drug abuse diagnosis, treatment or referral for treatment; or (c) Medical personnel or other staff in a general medical care facility whose primary function is the provision of alcohol or drug abuse diagnosis, treatment or referral for treatment and who are identified as such providers." See 42 C.F.R. § 2.11.

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purpose of sharing drug and alcohol treatment information because it is not a program. (See 42 CFR § 2.12(c)(4), noting that “the restrictions on disclosure in these regulations do not apply to communications *between a program and a qualified service organization of information needed by the organization to provide services to the program*” (emphasis added)).

Question 6: Can drug and alcohol treatment information obtained during an emergency room visit be shared?

Answer: Yes, but the patient’s written consent is required in most circumstances.

Discussion: Federal and state drug and alcohol confidentiality regulations in 42 C.F.R. Part 2 and 4 Pa. Code § 255.5 generally do not apply to emergency rooms. Most emergency rooms are neither “programs” covered by federal drug and alcohol confidentiality regulations nor “projects” covered by state regulations, even when they provide treatment associated with drug and alcohol abuse. See 42 C.F.R. § 2.12(e)(1), 28 Pa. Code § 701.1.

However, state statutory confidentiality requirements have a broader scope of applicability to a broader range of records and providers than those regulations. See 71 P.S. § 1690.108. The state statute requires the patient’s written consent to release information, except in an emergency where the patient’s life is in immediate jeopardy. Therefore, MCOs must obtain the patient’s written consent in most instances, even with respect to information the MCOs receive from emergency rooms.

HIV

Question 1: Do HIV confidentiality provisions permit an MCO to release identifying HIV-related information to a QSO without the client’s written authorization?

Answer: Arguably yes.

Discussion: 35 P.S. § 7607(a)(7) permits release to insurers for payment purposes. It arguably follows that for payment-related activities, the MCO may release HIV information to a QSO without written authorization. But if the QSO performs activities beyond the scope of payment-related activities—and perhaps creating an algorithm to identify high risk individuals is beyond that scope—then we can rely on other statutory provisions for release from MCO to QSO.

If we consider MCOS to be “agents” of health care providers, then MCOs might also fit under the exception in 35 P.S. § 7607(a)(4). That section permits agents to receive and use HIV-related information for medical care purposes. And if a QSO is itself an agent of the MCO (which it would be under HIPAA—as a business associate performing duties on behalf of the MCO), § 7607(a)(4) arguably covers the QSO as well.

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For those still not convinced that we do not need written authorization in this context, we can point to 40 P.S. § 991.2131, which allows disclosure to MCOs and their respective designees, etc. for purposes of utilization review, quality oversight and evaluation, patient care management. If we read the HIV confidentiality provisions to include QSOs in this scenario, then the two statutes do not conflict.

In the context of MCOs, insurer and provider³ co-exist and the division between them can be somewhat murky. Release of HIV information to MCOs clearly fits under the exception in 35 P.S. § 7607(a)(7) for insurers. That section permits release to insurers for payment purposes.

If we can reasonably consider MCOs as “agents” of health care providers (if not health care providers themselves), then MCOs may fit under the exception in 35 P.S. § 7607(a)(4). That section permits agents to receive and use HIV-related information for medical care purposes.

³ A health care provider includes agents of the provider. *See* 35 P.S. § 7603.