

Care Coordination Issues under the LPS Act (W&I Code §5328 *et. seq.*)

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Jessica E. Pentland has served as a Deputy County Counsel for Santa Clara County since 2013 with a focus on conservatorships established under the Lanterman-Petris-Short Act (LPS Act). She has litigated numerous bench trials and several jury trials involving the issue of an individual's ability to provide for their own basic needs for food, clothing, and shelter. Ms. Pentland has presented on LPS related issues throughout the State of California and provided educational training for attorneys, paralegals, and social workers. She is a member of Santa Clara County's Mental Health Coalition, Financial Abuse Specialist Taskforce, and the Elder Abuse Taskforce.

Objective of Talk

- Subject: Care coordination involving *mental* and physical health data (not substance use)
- HIPAA (Health Insurance Portability and Accountability Act) defines purposes of data exchange as Treatment, Payment and Operations. The Privacy Rule applies uniformly to all protected health information, not providing extra protections for mental health information.
- CMIA (Confidentiality of Medical Information Act) has similar categories
- LPS (Lanterman Petris Short) Act (W&I code 5328) does not recognize the operations category.
- Review four types of data exchange, challenges and solutions
 - Joint service activities
 - State/Federal reporting
 - Case management
 - Evaluation

PREVALENCE OF MENTAL HEALTH DISORDERS

Prevalence

Fact: 43.8 million adults experience mental illness in a given year.



1 in 5 adults in America experience a mental illness.



Nearly 1 in 25 (10 million) adults in America live with a serious mental illness.



One-half of all chronic mental illness begins by the age of 14; three-quarters by the age of 24.

Source: National Alliance for Mental Illness (NAMI), Infographic 2016. Statistics from National Institute of Mental Health, Department of Justice, SAMSHA, and American Journal of Psychology. Available at: <http://www.nami.org/Learn-More/Mental-Health-By-the-Numbers>

Prevalence

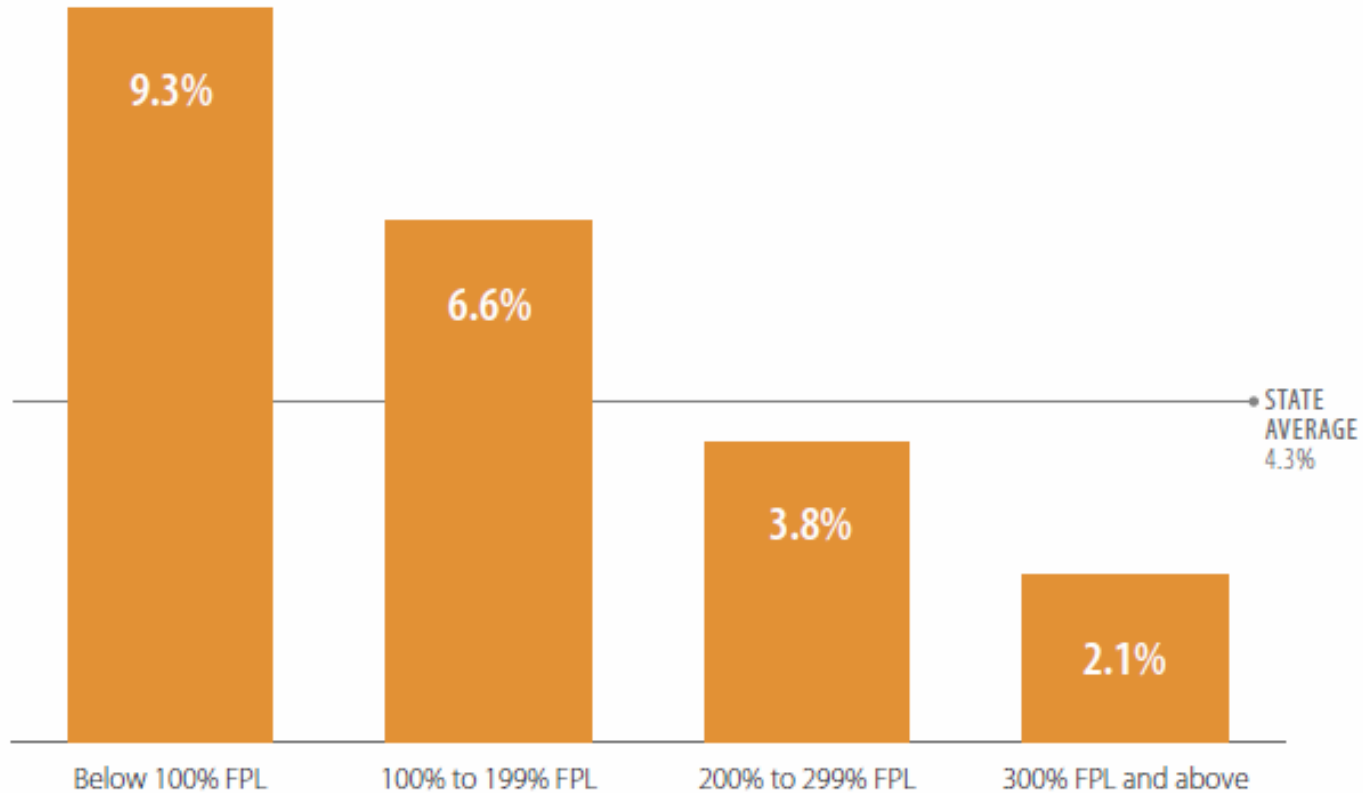
- **Half of all people will meet criteria for a behavioral health diagnosis at some point in their lives. (Mild-Moderate-Severe)**
- Approximately 1 in 5 adults in the U.S.—43.8 million, or 18.5%—experiences mental illness in a given year.¹
- Approximately 1 in 25 adults in the U.S.—10 million, or 4.2%—experiences a serious mental illness in a given year that substantially interferes with or limits one or more major life activities.
- Approximately 1 in 5 youth aged 13–18 (21.4%) experiences a severe mental disorder at some point during their life. For children aged 8–15, the estimate is 13%.

From NAMI Website, Citations to studies available at:

<http://www.nami.org/Learn-More/Mental-Health-By-the-Numbers>

Adults with Serious Mental Illness by

PERCENTAGE OF ADULT POPULATION



Notes: Serious mental illness (SMI) is a categorization for adults age 18 and older. See page 4 for full definitions of mental illness categorizations. FPL is federal poverty level; 100% of FPL was defined in 2009 as an annual income of \$10,830 for an individual and \$22,050 for a family of four.

Source: HSRI, TAC, and Charles Holzer, *California Mental Health Prevalence Estimates* (Sacramento, CA: Department of Health Care Services), accessed January 31, 2013, www.dhcs.ca.gov.

OVERVIEW OF THE LAWS

Health Insurance Portability and Accountability Act (HIPAA)

- Passed in 1996. Major amendment in 2009.
- Requires national standards for electronic healthcare transactions and national identifiers for provider, health insurance plans and employers.
- Includes HIPAA rules for privacy and security, now the principal rules on the topic.
- Allows the sharing of information without authorizations for
 - Treatment
 - Payment and
 - Operations.

TPO

- ***Treatment*** means provision, coordination or management of health care and related services among healthcare providers by a health care provider with a third party consultation among healthcare providers regarding a patient or the referral of a patient from one provider to another.
- ***Payment*** encompasses the activities of healthcare providers to obtain payment for services and of a healthplan to obtain premiums. Includes determining eligibility or coverage, risk adjustments, billing and collection, reviewing healthcare services for medical necessity, coverage, etc., *and* utilization review activities.

TPO - 2

- ***Healthcare operations*** are certain administrative, financial, legal and quality improvement activities of a covered entity necessary to run its business and to support treatment and payment. These activities, as listed in 45 CFR 164.501, include
 - conducting quality assessment and improvement activities,
 - population-based activities related to improving health or reducing healthcare costs and
 - case management and care coordination.

Confidentiality of Medical Information Act (CMIA)

- Passed in 1981.
- Under CMIA, healthcare providers and employers must obtain written patient authorization prior to disclosure of identifiable information.
- Authorization is not required for disclosures related to
 - Diagnosis
 - Treatment
 - Billing
 - Emergency care
 - Licensing & accreditation
 - Utilization review and
 - Quality assurance activities.

Lanterman Petris Short Act (The Act)

- Enacted in 1967, 29 years before HIPAA envisioned electronic exchange of health information
- The LPS Act confidentiality provision applies to patients who are voluntarily or involuntarily treated in an institutional setting.
- The Act ended the indefinite, involuntary commitments of people with mental illnesses and ensured that those facing civil commitment have substantive due process rights.

CONTEXT OF THE LAWS

Intent and Background of Privacy and Confidentiality Laws - 1

- Patient's civil rights are central to all of these laws
- Stigma and discrimination are still challenges for many health conditions, especially mental health
- Stigma and discrimination based on certain conditions are also displayed by some health providers

Intent and Background of Privacy and Confidentiality Laws - 2

- HIPAA

- **Health Insurance Portability:** allows individuals to maintain their health insurance when losing or changing jobs
- **Electronic exchange of health information:** allowed or required parties to exchange data electronically for eligibility, claims, authorizations, etc.

Insight: Principal goals of the Act were the two above. The third below was included so that there would not be resistance to the first two.

- **Accountability:** ensures the security and confidentiality of patient information, including standards for electronic transmission of data
- California law takes precedence when more stringent

- CMIA

- Protects identifiable health information from unauthorized disclosures to third parties

Enactment of Privacy and Confidentiality Laws - 3

- The LPS Act was enacted to accomplish the following:
 - a) To end the inappropriate, indefinite, and involuntary commitment of mentally disordered persons, developmentally disabled persons, and persons impaired by chronic alcoholism, and to eliminate legal disabilities;
 - b) To provide prompt evaluation and treatment of persons with serious mental disorders or impaired by chronic alcoholism;
 - c) To guarantee and protect public safety;
 - d) To safeguard individual rights through judicial review;
 - e) To provide individualized treatment, supervision, and placement services by a conservatorship program for gravely disabled persons;
 - f) To encourage the full use of all existing agencies, professional personnel and public funds to accomplish these objectives and to prevent duplication of services and unnecessary expenditures;
 - g) To protect mentally disordered persons and developmentally disabled persons from criminal acts.

Intent and Background of Privacy and Confidentiality Laws - 4

Patient consent/authorization is not necessarily a barrier to data sharing and coordination

Alternative View: National Academy of Sciences, 2016

- State laws vary widely in terms of authorizing disclosure of mental health records without consent for treatment purposes
- Many state laws are more restrictive than HIPAA (or are so interpreted)
- These laws could stand in the way of coordinated treatment of persons with mental illness.

Source: Improving the Quality of Health Care for Mental Health and Substance-Use Conditions: Quality Chasm Series, Appendix B, Constraints on Sharing Mental Health and Substance-Use Treatment Information Imposed by Federal and State Medical Records Privacy Laws, Timothy Stoltzfus Jost, National Academy of Sciences, 2016.

Reality of Health Care Practice

- Workflow is critical
 - Valuable additional tools are not used because of time pressure
 - Providers look at the EHR and accept what is there
 - Requiring a consent is equivalent to destroying the information

CALIFORNIA MENTAL HEALTH CONTEXT AND STRUCTURE

The County Carve Out Today

Medi-Cal Managed Health Plans:

Have the responsibility to pay for and/or provide coverage.

County Departments of Behavioral Health:

Have the responsibility to pay for and/or provide coverage.

Medi-Cal & Medicare Benefit Package

Array of Health Services Plus, Mild, Moderate Behavioral Health Services

Specialty Mental Health Services (SMHS)

MILD

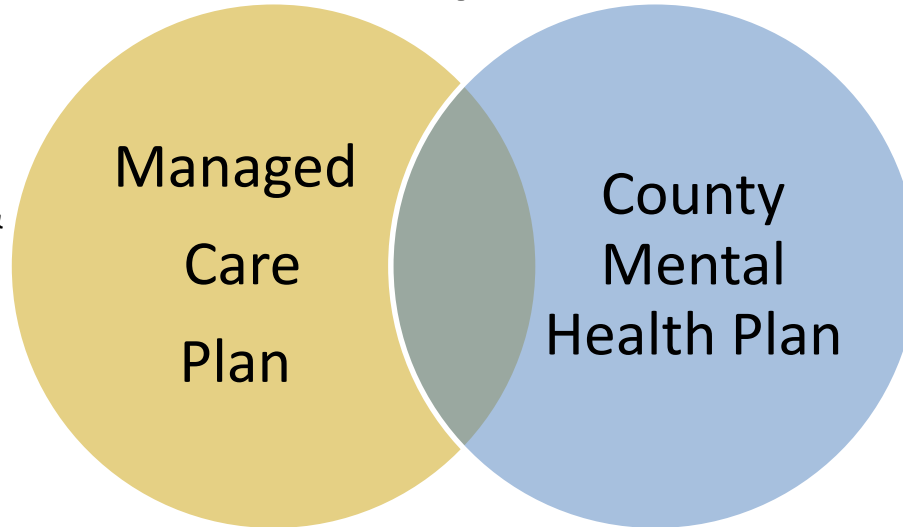
MODERATE

SEVERE

Managed Care & County Carve-Out Comparison

Managed Care Organization

- **Beneficiaries:**
 - Closed groups
 - Primary, Secondary & Tier I & II* Services
- **Financed:** Capitation
 - Average CA Medi-Cal Plan:
 - \$129-624 PMPM
 - \$1500 PMPY
- **Motivation:** Cost-savings
- **Risk:** Limited Medical-Risk
 - Contract-out higher risk services
 - Limit services
 - Stop-gap insurance for medical loss



Common Ground:

1. Improve quality of life over life-span through best practice, evidence-based practice defined by internal quality review and external quality review.
2. Manage medical necessity: provide the right care, at the right time, in the right setting.

County Mental Health Plan (MHP)

- **Beneficiaries:**
 - Anyone: Tier III*, SPMI & SUD who has Medi-Cal, Medicare & Medi-Medi or Dual Choice
 - Indigent/Uninsured
- **Financed:** FFS Medi-Cal & Medicare & tax revenue
 - Average is \$450 PMPM, should be \$900.
 - True cost of MH care
- **Motivation:** Cost-savings
- **Risk:** Full Medical Risk
- **Safety Net:** Prevention & Education
- **Supportive Services:** Housing, social services; address social determinants of health

* Tier 1 = Mild, Tier 2 = Moderate, Tier 3 = Severe

County's Role

- Manage a wide variety of services into a continuum of care for consumers
- Responsible for creating a network of providers, managing consumer utilization, and processing claims for reimbursement.
- “Safety Net” services, public education, and prevention activities.
- Substance use disorder services.
- Supportive services like housing and other rehabilitative services.
- MH Services in CA are paid for through specific tax initiatives.



Examples of County Services

- Authorize and pay for inpatient psychiatric hospitalizations
- Clinics throughout the county:
 - Psychiatry & Medication Management
 - Therapy (Individual, group, family – many modalities and services)
 - Case management services
- Crisis Stabilization Services:
 - Residential and stabilization units as an appropriate care destination during psychiatric crisis (instead of hospital emergency rooms).
- Mobile Teams:
 - Crisis response in the field, engagement teams to develop relationships with consumers and help them access services
- Children's Services: Full spectrum with specialty populations
 - Transitional Age Youth
 - Foster Children
- Peer Support Services: Club Houses
- Alcohol & Drug: Detox, Residential, Treatment, and Support
- Prevention, education, and early intervention programs



**COORDINATION AND THE LAW:
EXAMPLES OF CHALLENGES AND
SOLUTIONS**

Mental and Physical Health Care Coordination without Consent

- Treatment-based care coordination – always allowed if a provider is coordinating care.
- Operations-based care coordination – allowed if HIPAA and CMIA apply. Not allowed by LPS Act. (When the LPS Act was passed, few patients had treatment for mental illness and that treatment carried some stigma. Today, when 1 in 5 adults experience mental illness in one year and approximately 50% of adults have experienced mental illness [CDC, https://www.cdc.gov/mentalhealthsurveillance/fact_sheet.html], the stigma of mental illness is less a factor.)

Circumstance 1: Joint Service Efforts = Treatment

- Broad agreement that more information is beneficial for health outcomes, customer service, reduced costs.
- Whole person care projects
 - Solution 1. BH agency receives & aggregates data
 - Solution 2. All participants sign a consent
- Health information exchange
 - Solution 1. Regulations mean to allow inclusion of MH data for treatment without consent
 - Solution 2. Can ask patients to sign consent (culture vs regulation)

Circumstance 1: Joint Service Efforts = Treatment - 2

- Patient covered by LPS Act
 - Solution 1. Sharing of MH data for treatment without consent allowed
 - Solution 2. Obtain consent (common best practice and training versus regulation)

Circumstance 2: Case Management = Operations

- Patient **not** covered by LPS Act.
 - Provide data to HIE **without consent**
 - Solution 1. Allowed by regulation
 - Solution 2. Require consent (common best practice and training)
 - Provide data to health plan for case management **without consent**
 - Solution 1. Allowed by regulation
 - Solution 2. Require consent (common best practice and training)
 - WPC project **without consent**
 - Solution 1. If **grantee is BH entity, assembly of mental health data is allowed by regulation. If grantee is not BH entity, assembly of data is not allowed by regulation.**
 - Solution 2. Require consent (common best practice and training)

Circumstance 2: Case Management = Operations

- Patient **is** covered by LPS Act.
 - Provide data to HIE **without consent**
 - Solution 1. No by LPS Act
 - Solution 2. Require consent (common best practice and training)
 - Provide data to health plan for case management **without consent**
 - Solution 1. No by LPS Act
 - Solution 2. Require consent (common best practice and training)
 - WPC project **without consent**
 - Solution 1. If **grantee is BH entity**, ok. If **grantee not a BH entity**, no by LPS Act.
 - Solution 2. Require consent (common best practice and training)
 - Send LPS Act filing to court electronically: No.

Circumstance 3: State & Federal Reporting

- Health plan requests MH utilization data for its members for reporting purposes
 - Solution 1. Legal to provide for patients not covered by LPS Act. Otherwise, not.
 - Solution 2. Obtain consents.
- Other entity state/federal reporting
 - Same as above

Circumstance 4: Evaluation

- Continuous quality improvement
 - Without LPS Act patients. Allowed under operations.
 - With LPS Act patients. Not allowed.
- HIE analytics
 - Without LPS Act patients. Allowed under operations.
 - With LPS Act patients. Not allowed.
- SB82-funded programs to reduce recidivism
 - Solution 1. Consumer self-report
 - Solution 2. Use state database (as allowed)
 - Solution 3. Use data from court (partial only)

HEALTH PLAN CASE EXAMPLES OF CHALLENGES

LPS as barrier to care: Case 1

- Health plan member with history of cardiac complaint contacted health plan BH unit in crisis. Reported voices telling her to stab a relative in the house. Had previously stabbed another person.
- BH case manager contacted authorities and patient referred to psychiatric ER.
- When BH case manager attempted to follow-up with psychiatric ER, no information was provided.
- BH case manager sent letter to threatened relative. Additional research was required to determine patient's BH support needs, location of patient.

LPS as barrier to care: Case 2

- Health plan member with eating disorder & depression.
- Patient in general acute care facility due to medical complications. Stepped down to partial hospital program and discharged for non-compliance. Family member notified healthplan.
- Patient later put on 5150 hold for release within 72 hours. Case manager unable to obtain information from facility.
- Difficult to contact patient after discharge as housing unstable. Information was needed to get patient into outpatient services.

Updating the LPS Act

- The LPS Act predates HIPAA by 29 years.
- LPS Act did not contemplate electronic health records or the increasing public acceptance of mental illness.
- Technology now permits development of a reasonably comprehensive patient record.
- Is it reasonable to mask certain elements of patient treatment for patient privacy as this means treatment will not have advantage of a full medical record – treatments, medication, allergies, etc.?

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DISCUSSION