Policy Clarification Memo

Data Sharing Between Continuums of Care and Member Counties for Care Coordination

To:	California Behavioral Health Departments, Continuums of Care and other interested parties
From:	California Mental Health Services Authority
Date:	August 24, 2026
Subject:	Data Sharing Between Continuums of Care and Counties for Care Coordination

This memorandum has been prepared in partnership with outside counsel for general informational purposes only. It does not constitute legal advice and should not be relied upon as such. The legal authorities discussed below are subject to change, and their application depends on the specific facts and circumstances of each organization. Readers should consult qualified legal counsel for advice specific to their circumstances.

I. EXECUTIVE SUMMARY

This memorandum provides guidance in connection with care coordination between Department of Housing and Urban Development ("HUD") recognized Continuums of Care (each a "CoC") that organize housing services and California Mental Health Services Authority ("CalMHSA") county behavioral health agencies (each a "county").

Specifically, this memorandum addresses CalMHSA's position on two questions arising from that coordination effort: (1) Whether CoCs may disclose self-reported and client-level information, including housing and health information, to counties to coordinate care without obtaining the client's separate, specific consent; and (2) Whether counties may disclose information to CoCs to coordinate care without obtaining the client's consent, where such information is limited to: (i) recent or updated housing-status data; and (ii) whether the client is eligible for county behavioral health services.

In short, a CoC may disclose information to a county for care coordination without separate, specific client consent under HUD rules, provided the disclosure is consistent with the applicable CoC's privacy notice.[1]

A county may in turn disclose updated housing-status data and behavioral health eligibility data to a CoC for the county's own treatment, care coordination, and case management without client consent under the Health Insurance Portability and Accountability Act ("HIPAA") treatment and health care operations permissions, provided the disclosure is consistent with the county's notice of privacy

[1] As discussed below, some may interpret language in the state's standardized authorization form as generating confusion about whether and to what extent housing information can be shared without additional consent. Planned modifications to the ASCMI Form are expected to clarify these questions to allow for continued sharing consistent with CalMHSA's position in this memorandum.

practices and the eligibility information do not include substance use disorder ("SUD") information subject to 42 C.F.R. Part 2 ("Part 2").

II. RELEVANT PARTIES

CalMHSA is an independent public entity and joint powers authority formed by California counties to develop, fund, and implement mental health services and education programs throughout the state. Counties collaborate through CalMHSA to deliver public health programs, clinical staffing, and electronic health record implementation.

CoCs are HUD-recognized regional bodies that coordinate homeless services.[2] Each CoC operates a Homeless Management Information System ("HMIS") for its geographic area. An HMIS is a local information system used by homelessness and housing organizations to collect and share client-level data, including self-reported health conditions, mental health diagnoses, and SUD treatment status.[3]

Counties are tasked with coordinating care across county behavioral health and homelessness services. This goal is advanced by the state's Medicaid program (Medi-Cal) transformation initiative, California Advancing and Innovating Medi-Cal ("CalAIM").[4] CalAIM funds housing-related community supports and care coordination services for Medi-Cal Members experiencing or at risk of homelessness.[5] Effective coordination requires a bidirectional flow of information between Medi-Cal partners, including counties and CoCs.[6]

III. RELEVANT LAWS

The information exchanged in care coordination between Counties and CoCs may include housing, health, and mental health information, and therefore implicates an overlapping set of federal and state privacy regimes governing the use and disclosure of that information. This section summarizes the principal frameworks that apply.

A. HUD HMIS Standards

HUD's privacy and security standards govern CoC disclosures of HMIS data such that

[2] 42 U.S.C. § 11360a (HMIS authority under the HEARTH Act); 24 C.F.R. § 578.3.

[3] 24 C.F.R. §§ 578.3, 578.7(b); U.S. Dep't of Hous. & Urban Dev., 2004 HMIS Data and Technical Standards; Final Notice, 69 Fed. Reg. 45888 at *45916–17 (describing client-level data elements collected and shared through an HMIS).

[4] Medi-Cal is overseen by the California Department of Health Care Services ("DHCS").

[5] Medi-Cal Members include individuals who are or will be enrolled in a managed care plan ("MCP") within Medi-Cal, individuals who are justice involved, and individuals not enrolled in managed care who receive behavioral health services. *See* Cal. Dep't of Health Care Servs., Data Sharing Authorization Guidance Toolkit: Medi-Cal Housing Support Services n.3 at 3 (Apr. 9, 2025) https://www.dhcs.ca.gov/wp-content/uploads/2025/10/DSAG-Medi-Cal-Housing-Services-Toolkit.pdf [hereinafter "Toolkit"].

[6] Medi-Cal Partners are persons or organizations that provide Medi-Cal reimbursable health and social services to Members and include county and other public agencies and the community-based housing organizations that deliver or coordinate CalAIM Housing Support Services. *Id.* n.1 at 3. Medi-Cal Partners include MCPs, behavioral health plans, health care providers, community-based organizations and providers, and county and other public agencies that provide services and manage care for Medi-Cal Members. *Id.*

data exchanges from CoCs to counties are subject to HUD requirements.[7] By contrast, HUD requirements do not apply to data exchanges from counties to CoCs because Counties are not HUD-funded entities.

HUD privacy and data security standards permit data exchanges that are sufficiently disclosed in the CoC's privacy notice, including disclosures to provide or coordinate services.[8] The CoC must obtain specific consent for any uses of data that are not properly disclosed.[9] An individual CoC may also impose consent requirements beyond what federal law mandates through its own policies and privacy notices, including by adding data minimization and consent requirements.[10]

B. HIPAA

Counties operate as health care providers or health plans. Accordingly, counties are HIPAA covered entities, and the individually identifiable health information they maintain in that capacity constitutes protected health information ("PHI") subject to HIPAA's Privacy Rule.[11]

By contrast, CoCs and their participating housing organizations are generally not HIPAA covered entities or business associates, though covered entity status is an entity-specific determination to be confirmed for each organization. As a result, the self-reported health and personal information that CoCs collect and hold in HMIS is generally not PHI under HIPAA, and HIPAA does not restrict disclosures of such information.

HIPAA generally permits covered entities to use or disclose PHI to third parties for the covered entity's own treatment, payment, and health care operations ("TPO") without the individual's authorization.[12] Subject to certain conditions, disclosures for the *recipient's* treatment activities are permitted where the recipient is a health care provider,[13] and for the recipient's health care operations where the recipient is a covered entity.[14] "Treatment" includes the provision, coordination, or management of health care and related services by one or more health care providers, including coordination or management by a health care provider with a third party

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[7] 24 C.F.R. § 578.3.

[8] 69 Fed. Reg. 45888 at *45930 (noting that a covered homeless organization ("CHO") "may infer consent for all uses and disclosures specified in the [privacy] notice and for uses and disclosures determined by the CHO to be compatible with those specified in the notice"); *see also id.* at *45929-30 (noting that "[c]onsent of the individual for data collection may be inferred from the circumstances of the collection" and providing exemplar notice language and notice requirements). A CoC is considered a CHO where it records, uses, or processes protected personal information ("PPI") on homeless clients for an HMIS. *Id.* at *45928.

[9] *Id.* at *45930.

[10] *Id.* (noting that a CHO may, in its privacy notice, commit itself to additional privacy protections consistent with HMIS requirements and listing example additional requirements).

[11] 45 C.F.R. § 160.103 (defining "covered entity"); Toolkit, *supr*a note 5, at 8 (treating county behavioral health agencies as covered entities).

[12] 45 C.F.R. §§ 164.506(a), (c)(1).

[13] *Id.* § 164.506(c)(2).

[14] *Id.* § 164.506(c)(4).

(including non-provider third parties), consultation between providers, and referrals.[15] "Health care operations" includes "case management and care coordination," as well as population-based activities to improve health and related quality-improvement functions, to the extent those activities relate to the covered entity's covered functions.[16]

Disclosures from a HIPAA covered entity to a third party that is part of the individual's broader health treatment plan or is participating in the coordination of care for the individual but who is not itself a covered health care provider are subject to the "minimum necessary" standard, which limits the disclosure to the minimum amount of PHI reasonably necessary to accomplish the care coordination purpose.[17] Additionally, any use or disclosure of PHI (including for treatment or health care operations) must be consistent with the covered entity's notice of privacy practices.[18]

C. 42 C.F.R. Part 2

Part 2 protects records that identify a person as having a substance use disorder when those records are obtained by a Part 2 provider or program.[19] The regulation's restrictions attach to the record based on its origin rather than the current holder's status: they apply to any record that (i) would identify a patient as having or having had a substance use disorder and (ii) contains SUD information obtained by a federally assisted Part 2 program.[20] Those restrictions follow the record downstream if the Part 2 program informs the recipient of such restrictions (as it is required to do under the regulation).

A county, or a specific agency or unit within the county, may be subject to Part 2 if it qualifies as a Part 2 provider or program, i.e., if it (i) receives federal assistance and (ii) holds itself out

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[15] *Id.* § 164.501 (definition of treatment includes coordination or management of health care "by a health care provider with a third party"); *see also* U.S. Dep't of Health & Human Servs., Off. for Civ. Rts., FAQ 3008, https://www.hhs.gov/hipaa/for-professionals/faq/3008/does-hipaa-permit-health-care-providers-share-phi-individual-mental-illness-third-party-not-health-care-provider-continuity-care-purposes/index.html [hereinafter "HHS FAQ 3008"] (contemplating disclosures from health care providers to certain social service entities that are not health care providers in furtherance of an individual's treatment).

[16] 45 C.F.R. §§ 164.506(a), (c)(1), 164.501 (definition of "health care operations" includes "case management and care coordination").

[17] *Id.* § 164.502(b) (minimum necessary standard). This interpretation is consistent with a draft proposed rule under the previous administration that intended to clarify that the proposed data sharing is authorized under the current regulatory framework. *See* U.S. Dep't of Health & Hum. Servs., Proposed Modifications to the HIPAA Privacy Rule To Support, and Remove Barriers to, Coordinated Care and Individual Engagement; Proposed Rule, 86 Fed. Reg. 6446 at *6475-76 (noting that some commenters to the proposed rule did not believe a change in the regulation was needed to address disclosures to third parties such as social services agencies and community-based organizations through rulemaking and that they "correctly stated that covered health care providers already are permitted to make such disclosures").

[18] *See* U.S. Dep't of Health & Hum. Servs., Off. for Civ. Rts., Uses and Disclosures for Treatment, Payment, and Health Care Operations, https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/disclosures-treatment-payment-health-care-operations/index.html [hereinafter "HHS TPO Guidance"]; *see also* 45 C.F.R. § 164.520(b) (describing requirements for notice of privacy practices).

[19] *See* 42 C.F.R. § 2.2.

[20] *Id.* § 2.12(a)(1).

as providing, and actually provides, SUD diagnosis, treatment, or referral for treatment.[21] In practice, a county may operate multiple agencies, and often only an identified unit or agency within the county – rather than the county as a whole – will be designated as a Part 2 program. A Part 2 "program" includes "[a]n identified unit within a general medical facility that holds itself out as providing, and provides, SUD diagnosis, treatment, or referral for treatment," as well as medical personnel or other staff in a general medical facility whose primary function is the provision of such services and who are identified as such providers.[22] Accordingly, a county may treat only one of its agencies (e.g., a specialized substance use disorder services agency) as a Part 2 program, while the county's other agencies are not Part 2 programs.

In any event, a county or an agency within a county need not itself be a Part 2 program for data to be subject to Part 2. Section 2.12(d) extends Part 2's restrictions on the use and disclosure of SUD information to any person who receives a record from a Part 2 program, covered entity, business associate, intermediary, or other lawful holder, and who is notified of the prohibition on redisclosure through the statement required by Section 2.32. Accordingly, if a county obtains behavioral health eligibility information from a Part 2 program, that information may retain its Part 2 protection in the county's possession, even though the county is not itself a Part 2 program. However, SUD information that a county generates independently, or that the individual self-reports, is not Part 2 data.[23]

Part 2 does not permit disclosure for treatment or care coordination purposes without the patient's written consent.[24] Under the 2024 Part 2 final rule, however, an individual may now provide a single consent (a "TPO consent") authorizing all current and future uses and disclosures of SUD records for treatment, payment, and health care operations, including care coordination.[25] Once a HIPAA covered entity or business associate receives Part 2 records pursuant to a TPO consent, it may redisclose them in accordance with the HIPAA Privacy Rule without additional authorization, except for uses and disclosures in proceedings against the individual.[26]

D. AB 133

AB 133, codified at California Welfare and Institutions Code section 14184.102(j), permits Medi-Cal partners to disclose personally identifiable information ("PII") among one another without individual consent, provided the disclosure helps implement applicable CalAIM components and is consistent with federal law.

AB 133 limits the application of certain California consent laws, including those governing SUD records, HIV/AIDS information, medical information under the Confidentiality of Medical Information Act, and mental health information under the Lanterman-Petris-Short ("LPS") Act,

[21] *See* 42 C.F.R. § 2.11 (defining "Part 2 program").

[22] *See id.* (defining "program").

[23] 42 C.F.R. § 2.12(d)(2)(ii)(C), (e).

[24] 42 U.S.C. § 290dd-2(b)(1).

[25] 42 C.F.R. § 2.33(a)(2).

[26] *Id.* § 2.33(b).

such that such information may be shared to coordinate care under CalAIM even where those state laws would otherwise require consent.[27] AB 133 does not, however, override federal requirements such as HIPAA and Part 2.[28]

E. AB 210

AB 210, codified at California Welfare and Institutions Code section 18999.8, authorizes California counties to form homeless adult and family multidisciplinary personnel teams ("MDTs") to better coordinate care.[29] The law permits MDTs to exchange otherwise confidential information to facilitate the expedited identification, assessment, and linkage of homeless adults and families to housing and supportive services, and counties[30] must establish policies and procedures that govern this information sharing. Like AB 133, AB 210 does not supersede federal laws or regulations such as HIPAA and Part 2.[31]

IV. ANALYSIS

A. A CoC May Disclose Information to a County Without Separate Consent, Provided That Such Disclosure is for Care Coordination Purposes and Consistent with the CoC's Privacy Notice.

A CoC may disclose self-reported and client-level information to a county without separate, specific consent, for care coordination where such sharing is consistent with the CoC's privacy notice. This conclusion rests on three grounds: (1) CoCs and their participating housing organizations are generally not HIPAA covered entities,[32] so the information they hold is not PHI under HIPAA; (2) federal HUD rules permit disclosures described in a CoC's privacy notice without individual consent; and (3) California law independently authorizes certain information sharing for the coordination of homeless services, to the extent consistent with federal law.

(1) HIPAA Does Not Restrict Disclosures by CoCs or Their Participating Organizations.

CoCs and the housing organizations that participate in them are generally not HIPAA covered entities or business associates.[33] The self-reported health and personal information they collect and maintain in the HMIS is therefore not PHI, and HIPAA does

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[27] Cal. Welf. & Inst. Code § 14184.102(j).

[28] *Id.*

[29] An MDT is a team of two or more persons who are trained in the identification and treatment of homeless adults and families, and who are qualified to provide a broad range of services related to homelessness. Cal. Welf. & Inst. Code § 18999.8(b)(2). MDTs may include: mental health and substance abuse services personnel, medical personnel, social services workers, and housing or homeless agencies that provide social, health, mental health, substance abuse, or probation services. *Id.* § 18999.8(b)(3).

[30] *Id.* §§ 18999.8(b)(2), (c)(1).

[31] *Id.; see* Toolkit, *supra* note 5, at 11.

[32] Covered entity status is an entity-specific determination that should be made by each CoC.

[33] *See* 45 C.F.R. § 160.103 (defining "covered entity" and "business associate"); Toolkit, *supra* note 5, at 17, 24.

not restrict its disclosure.[34] Health information that a CoC or housing organization receives from a covered entity likewise ceases to be PHI in its hands and is no longer subject to HIPAA.

(2) HUD Rules Permit Disclosures Described in the CoC's Privacy Notice.

HUD rules do not require CoCs to obtain additional consent for the uses or disclosures of information that are specified in the CoC's privacy notice (and for those determined to be compatible with the notice), because consent for such uses and disclosures may be inferred.[35] Accordingly, where the CoC's privacy notice describes data sharing with health and behavioral health partners for purposes of coordinating care – or describes activities that can be fairly understood to encompass such sharing – the CoC may share such data with the county without obtaining the individual's separate, specific consent.[36] However, because each individual CoC has the ability to impose further sharing restrictions beyond the HUD rules, including heightened consent requirements, each relevant CoC's privacy notice and any local consent policy will be the operative constraint on disclosures from CoCs to counties.

The Authorization to Share Confidential Member Information release form administered by DHCS (the "ASCMI Form") may affect how a CoC's disclosure permissions and consent obligations are understood in practice.[37] The ASCMI Form is a standardized tool that CoCs can use to obtain an individual's (e.g., Member's) consent to share information between Care Partners in order to support care coordination.[38] Included in the ASCMI Form is an opt-in checkbox through which an individual may consent to the sharing of "housing-related personal information," including housing status, history, and supports.[39] The intent of this checkbox is to facilitate broader sharing of this information where a specific CoC's privacy notice does not already allow it. The stated purpose of the ASCMI Form is to promote and standardize rather

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[34] 45 C.F.R. § 160.103 (protected health information is individually identifiable health information held by a covered entity or business associate); *see* Toolkit, *supra* note 5, at 15.

[35] ASCMI Form, *supra* note 37, at § 2.12.

[36] *See* 69 Fed. Reg. 45888 at *45930; Toolkit, *supra* note 5, at 15.

[37] *See* CalAIM ASCMI Initiative, *supra* note 38 (providing that the ASCMI initiative "is a statewide effort to promote and standardize the exchange of Clients' sensitive information . . . among Care Partners such as providers, health plans, county agencies, and social services organizations" and that "[t]he ASCMI Form is a standardized tool designed to overcome persistent barriers that limit broad and secure access to sensitive information"); *see also* Cal. Dep't of Health Care Servs., Authorization to Share Confidential Member Information Frequently Asked Questions: Care Partners (Jul. 1, 2026) https://www.dhcs.ca.gov/calaim-transforming-medi-cal/authorization-to-share-confidential-member-information [hereinafter "Care Partner FAQs"].

[38] *Id*. § 164.506(c)(1) (covered entity may use or disclose PHI for its own treatment, payment, or health care operations); *see id*. § 160.103 (a recipient of a treatment, payment, or health-care-operations disclosure is not thereby a business associate). The relationship-based condition that applies when one covered entity discloses PHI for another covered entity's health care operations is not implicated here, because the disclosure rests on the County's own activity rather than the CoC's. *See id*. § 164.506(c)(4) (relationship condition governing disclosures for another covered entity's health care operations).

[39] *See* 42 C.F.R. § 2.12(a)(1) (describing records subject to restrictions on use and disclosure).

than restrict the exchange of information for care coordination.[40]

The ASCMI FAQs directed at Care Partners (including employees at community organizations and homeless service providers who administer the ASCMI Form) explain that "[t]he Form is intended to obtain consent for data sharing when required by federal or state law,"[41] that "generally, no individual consent is needed to disclose housing status from HMIS, as long as such data sharing is permissible in the Continuum of Care (CoC) Notices of Privacy Practices (NPPs)," and that "[i]f housing information is originating from a CoC's HMIS, and the CoC NPP does not expressly permit data sharing for the purposes of care coordination, the ASCMI Form can be used by a CoC to capture the necessary Client consent."[42] The Care Partner FAQs further confirm that the ASCMI Form does not restrict otherwise-permissible sharing, providing that "[r]egardless of whether a Client signs the Form, Care Partners may continue to share some physical health, behavioral health, and social services information for purposes permitted under [HIPAA], including treatment, payment, and health care operations"[43] and that the ASCMI Form covers only "housing information that originates from a [COC] and [where the] purpose of the disclosure is not authorized in the CoC's NPP."[44]

(3) California Law Provides Additional Authority for Information Sharing.

Two California statutes provide independent authority for certain data sharing activities without consent. First, where the data sharing occurs within the delivery of CalAIM services, AB 133 permits Medi-Cal partners to exchange PII – including health and mental health data – for care coordination without individual authorization, to the extent consistent with federal law.[45] Second, AB 210 permits MDTs of participating agencies to exchange information in order to facilitate the expedited identification, assessment, and linkage of homeless adults and families to housing and supportive services within the county.

B. A County May Disclose Information to a CoC Without Patient Authorization, Provided That Such Disclosure is for the County's Care Coordination Purposes, Consistent with the County's Notice of Privacy Practices, and Does Not Include Substance Use Disorder Records Governed by Part 2.

A county may disclose both behavioral health eligibility and recent or updated housing status data to a CoC for care coordination without the individual's separate, specific consent, provided that such disclosures are consistent with the county's notice of privacy practices and

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[40] *See id.* § 2.13(c) (restricting sharing an identified patient's presence at a facility publicly identified as providing only SUD diagnosis, treatment, or referral for treatment).

[41] Care Partner FAQs, *supra* note 40, at #11.

[42] *Id.* at #4.

[43] *Id.* at #11.

[44] *Id.* at #41.

[45] Cal. Welf. & Inst. Code § 14184.102(j); Toolkit, *supra* note 5, at 10–11.

do not contain substance use disorder records governed by Part 2. The county is a HIPAA covered entity, so the information it maintains in that capacity is PHI and HIPAA governs any data shared with the CoC.[46] The analysis therefore turns on HIPAA's permission to use and disclose PHI for treatment, payment, and health care operations.

As discussed above, HIPAA permits a covered entity to use or disclose PHI for the covered entity's own treatment, payment, and health care operations without the individual's authorization, even where the recipient is not a health care provider.[47] A county's coordination of a Member's behavioral health and housing needs falls within "treatment" where the county is providing or coordinating the Member's health care or related services, and within "health care operations" where the county acts in its health plan or administrative capacity, including for population-based activities relating to improving health or reducing health care costs, and for individual case management and care coordination.[48]

Where a data share can be grounded in the county's *own* treatment and health care operations, the HIPAA Privacy Rule permits the county to share PHI with any recipient consistent with that purpose, including a CoC that is not itself a covered entity or business associate.[49] HHS guidance confirms that these permissions reach disclosures to social service agencies such as CoCs. Specifically, HHS instructs that a covered entity may disclose the minimum necessary PHI, including mental health information, about a patient needing mental health supportive housing, to social service agencies such as housing providers who arrange such services without the individual's authorization, where the covered entity believes the disclosure is a necessary component of, or may further, the individual's health or mental health care.[50] HIPAA treats mental health information the same as other PHI for these purposes, with the exception of psychotherapy notes.[51] In all cases, the data share from the county to the CoC must be consistent with the county's notice of privacy practices.[52]

(1) Recent or Updated Housing Information

Recent or updated housing information, such as current address, housing status, or move-in information, that a county maintains in its covered entity capacity is PHI, but in most cases it is not subject to any heightened federal or California confidentiality regime: ordinarily it is neither SUD information protected by Part 2 nor mental health

[46] 45 C.F.R. §§ 160.103, 164.502(a)(3).

[47] *Id.* §§ 164.506(a), (c)(1).

[48] *Id.* § 164.501 (defining "treatment" and "health care operations").

[49] 42 U.S.C. § 290dd-2; 42 C.F.R. §§ 2.31, 2.33; Cal. Welf. & Inst. Code § 14184.102(j); *see supr*a Section III(C).

[50] HHS FAQ 3008, *supra* note 15; HHS TPO Guidance, *supra* note 18.

[51] U.S. Dep't of Health & Human Servs., Off. for Civ. Rts., HIPAA Privacy Rule and Sharing Information Related to Mental Health, https://www.hhs.gov/sites/default/files/hipaa-privacy-rule-and-sharing-info-related-to-mental-health.pdf; *see* 45 C.F.R. §§ 164.501, 164.508(a)(2).

[52] *See* 45 C.F.R. § 164.520(b).

treatment information protected by the LPS Act.[53] Disclosing such information to the CoC to help arrange or sustain the individual's housing is a core care coordination activity within the county's treatment and health care operations, and HHS's supportive housing example is directly on point. The disclosure is therefore generally permitted under the TPO permission, and independently under AB 133, without the individual's consent.

Housing information may be subject to Part 2 in certain circumstances. Part 2 reaches not only records that expressly document SUD diagnosis or treatment, but also records that would identify an individual as having a substance use disorder indirectly, including by reference to publicly available information or through verification by another person.[54] Where the housing information originates from, or reflects the individual's residence at, a Part 2 program providing SUD services (e.g., residential SUD treatment housing or recovery housing operated as part of a Part 2 program), the fact of the individual's placement there may itself reveal that the individual has an SUD, even if the record does not otherwise describe SUD treatment.[55] In those circumstances, the housing record held by the county may be protected by Part 2, and the county should confirm the source and nature of the housing before disclosing it to a CoC and, where Part 2 applies, obtain a Part 2-compliant consent.[56]

Because HIPAA permits these disclosures only in furtherance of the covered entity's own treatment or health care operations, the county should confirm and document that the disclosure to a CoC serves the county's treatment or care coordination for that individual, ideally through a written agreement limiting the CoC's use of the housing information it receives. And because the CoC is not a health care provider, HIPAA's minimum-necessary standard applies, so the county must disclose only the information reasonably necessary to accomplish the coordination purpose.

(2) Eligibility for County Behavioral Health Services

For the same reasons, behavioral health eligibility information is also PHI that a county may disclose to a CoC for care coordination under the TPO permission. HHS's guidance addresses the referral of a homeless patient to a housing provider where doing so may reveal that the basis for the individual's eligibility relates to mental health, and confirms that the disclosure may be made without authorization where it supports the individual's care.[57]

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[53] *See* 42 C.F.R. § 2.12(e)(3) (describing information to which Part 2 restrictions are applicable); Cal. Welf. & Inst. Code § 5328(a) (describing LPS-protected mental health information).

[54] *See* 42 C.F.R. § 2.12(a)(1) (describing records subject to restrictions on use and disclosure).

[55] *See id*. § 2.13(c) (restricting sharing an identified patient's presence at a facility publicly identified as providing only SUD diagnosis, treatment, or referral for treatment).

[56] *See id.* § 2.12(d)(1) (providing that Part 2's restrictions on the use and disclosure of SUD information "applies to any person who obtains the record from a part 2 program, covered entity, business associate, intermediary, or other lawful holder, regardless of the status of the person obtaining the record").

[57] HHS FAQ 3008, *supra* note 15 (addressing referral of a homeless patient to a housing provider where the disclosure may reveal a mental-health basis for eligibility).

As with housing information, the county may consider confirming and documenting that the disclosure serves the county's own treatment or care coordination for that individual, such as by linking the individual to housing or supportive services connected to a behavioral health treatment plan rather than serving general reporting or administrative purposes, including through a written agreement limiting the CoC's use of the information. The minimum-necessary standard applies here as well, because the CoC is not a health care provider.

Behavioral health eligibility information is more likely than housing information to implicate Part 2. Where eligibility information reflects SUD records obtained from a Part 2 program, or otherwise identifies the individual as having an SUD – whether directly or by reference to publicly available information or verification, such as where eligibility is premised on or derived from a referral to or from a Part 2 program – Part 2 generally requires the individual's written consent (or a qualifying TPO consent) even where HIPAA would permit the disclosure. Counties should therefore confirm whether the source of any eligibility information is a Part 2 program and, if so, obtain a Part 2-compliant consent before disclosing it to a CoC.[58]

IV. KEY TAKEAWAYS

A CoC may share information with a county for care coordination without separate, specific individual consent under HUD rules, provided that the CoC's privacy notice accounts for such disclosures and does not require additional consent for such disclosures. Because that notice is the operative constraint on the data sharing, a threshold step is confirming that each CoC's privacy notice describes the contemplated data sharing activity and does not otherwise require consent.

A county may in turn share minimum necessary updated housing information and behavioral health eligibility to a CoC for care coordination related to the county's treatment or health care operations without authorization under HIPAA's treatment and health care operations-related permissions. Each county's notice of privacy practices therefore needs to describe the contemplated data sharing activity. Expressly limiting (e.g., via a written agreement) the CoC's ability to use such information only for purposes in furtherance of the county's goals (e.g., improving reporting, data accuracy and service delivery) may also be useful, because such limitations underscore that the disclosure is made for the county's own treatment or health care operations, and by extension is permitted by HIPAA.

Further, the individual's written consent is required where the eligibility information identifies the individual as having a substance use disorder and originated from a Part 2 program, unless a qualifying TPO consent permits redisclosure under the 2024 Part 2 final rule. Confirming that the source of any behavioral health eligibility information is not a Part 2 program – or, where it is, that the individual has provided a Part 2-compliant consent permitting the disclosure – is therefore an important step before making any such disclosure.

[58] 42 U.S.C. § 290dd-2; 42 C.F.R. §§ 2.31, 2.33; Cal. Welf. & Inst. Code § 14184.102(j); *see supra* Section III(C).