



Association for Behavioral
Health and Wellness

*Advancing benefits and services
in mental health, substance use
and behavior change.*

February 17, 2017

The Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services
5600 Fishers Lane, Room 13E89A
Rockville, MD 20857
Attn: Danielle Tarino

Dear Ms. Tarino:

The Association for Behavioral Health and Wellness (ABHW) appreciates the opportunity to submit comments on the supplemental notice of proposed rulemaking regarding 42 CFR Part 2 (SAMHSA-4162-20; RIN 0930-AA21).

ABHW is the national voice for companies that manage behavioral health and wellness services. ABHW member companies provide specialty services to treat mental health, substance use, and other behaviors that impact health. ABHW supports effective federal, state, and accrediting organization policies that ensure specialty behavioral health organizations (BHOs) can continue to increase quality, manage costs, and promote wellness for the nearly 170 million people served by our members.

ABHW favors the modernization of 42 CFR Part 2 (Part 2) and appreciates SAMHSA's efforts to take on that task. Below, please find ABHW's responses to the changes SAMHSA has proposed and on which it has sought comment.

Issue for Comment: Retain in regulation the notice found in § 2.32 regarding re-disclosure of Part 2 data but consider whether it would be appropriate to add an abbreviated notice and in which circumstances the shorter notice may be warranted.

The prohibition on re-disclosure in § 2.32 effectively prevents providers participating in a health information exchange (HIE), health home, accountable care organization (ACO), or care coordination entity (CCE) from disclosing substance use disorder treatment information among each other for treatment and care coordination purposes. We recommend allowing for the re-disclosure of substance use disorder treatment information by and among provider-members of the above mentioned integrated care settings with a direct treatment relationship for the purposes of health care treatment, payment, and operations (TPO). SAMHSA's clarification in the Final Rule that the prohibition on re-disclosure only applies to information that would identify an individual as a person with substance use disorder, and allows other health-related information to be re-disclosed is appreciated. However, it still does not accomplish the goal of coordinated care. SAMHSA itself recognizes the importance of care coordination to, "help achieve the goals of treatment and care", even referencing, "Research shows that care coordination increases efficiency and improves clinical outcomes and patient satisfaction with care."¹ The end result of these revisions would still be the presentation of a clinically incomplete record of a patient's treatment, since the substance use disorder information cannot be re-disclosed.

¹ <http://www.integration.samhsa.gov/workforce/care-coordination>

Health care providers and plans will still be working with incomplete data which still pose the same clinical risks, failure to coordinate care, and lack of an integrated approach. This results in less effective care, less reliable health records, and less coordination.

Regarding SAMHSA's consideration of adding an abbreviated notice, ABHW members believe the current notice is sufficient. Creating an additional notice could add a level of complexity from an operational perspective. A single abbreviated notice would only be beneficial if it can be used in all circumstances.

Issue for Comment: Further revise § 2.33 regarding disclosures permitted with written consent in order to define and limit the circumstances in which certain disclosures for the purposes of payment and health care operations can be made.

We recommend further revising this section to include "care coordination" as one of those such circumstances. ABHW believes an explicit definition of "care coordination" will alleviate confusion and align with SAMHSA's goals; this definition can indicate that the provision of care/treatment is not a component of care coordination for these purposes. The National Quality Forum defines care coordination as "a function that helps ensure that the patient's needs and preferences for health services and information sharing across people, functions, and sites are met over time. Coordination maximizes the value of services delivered to patients by facilitating beneficial, efficient, safe, and high-quality patient experiences and improved healthcare outcomes." When BHOs use the term "care coordination", we are referring to the facilitation of comprehensive patient care, "care coordination" goes beyond just navigating the system, to closely monitoring the treatment plan and connecting providers to one another. "Care coordination" or "case management" are not direct services ABHW members provide; but rather, they are the manner in which BHOs facilitate patient care. As a partner in coordinating care, our member companies connect patients to the appropriate services in a safe and effective manner. The Centers for Medicare and Medicaid Services (CMS) encourages care coordination across the health care continuum so all health care patients receive seamless and more effective care. A BHO's inability to participate in a conversation about the whole person presents a huge barrier to patients receiving the best possible care.

Issue for Comment: Further revise § 2.53 regarding disclosures related to audits and evaluations to expressly address further disclosures by contractors, subcontractors, and legal representatives for purposes of carrying out a Medicaid, Medicare, or Children's Health Insurance Program (CHIP) audit or evaluation.

ABHW does not hold a strong position for or against this proposal. While our member companies believe it could be helpful to specify that it is permissible to disclose this information to contractors and subcontractors, we do not believe further revision is necessary.

Issue for Comment: Additional purposes for which lawful holders should be able to disclose Part 2 patient identifying information.

As stated above, ABHW believes SAMHSA must expand its definition of "coordinated care." We support expanding the qualified service organization (QSO) definition to enable increased sharing of health information for care coordination purposes. Expanding the definition even further than including "population health management" will help achieve greater care coordination while respecting the goal of patient privacy. SAMHSA should not only add the definitions of peers and coordinated care, but broaden the concept of the QSO. ABHW believes it should include the development of an agreement that is not merely a two-party, one-way arrangement for the storage and use of data, but rather a multi-party agreement for the multi-directional sharing of information covered under Part 2. This agreement could establish a baseline of collective responsibilities for ensuring privacy of the disclosed information. ABHW believes this type of dynamic and disclosure of information would enable better care coordination and population health management. The ability to exchange information more freely through these agreements would enable organizations to provide more comprehensive, effective, coordinated care.

ABHW has concerns with the ability to share information with parents of a minor and believes SAMHSA should address the issues concerning minor patients and information to disclosure to parents. If states allow a minor to consent to treatment, information cannot be given to a parent unless the minor consents, even in the circumstance where the minor did not consent to treatment in the first place. This creates an unworkable framework for the exchange of health information and coordination of care and merits consideration for revision with the current proposal. In practice, parents receive billing information from their insurance carriers when a covered minor receives treatment without parental consent. Parents are unable to receive any protected information despite being the policyholder. By not addressing this issue, substance use disorder-related information of minors will continue to be withheld, resulting in less informed and less effective care. It also provides a misperception that health plans are withholding information from the family, when in reality the plan is trying to comply with an outdated and misguided regulation that does not reflect the realities of the current opioid treatment crisis and the need for effective disclosure and communication of information.

ABHW supports the increase of discretion given to providers to determine when a “bona fide emergency” exists. However, SAMHSA’s continued requirement of immediate documentation, in writing, by the Part 2 program specifying information related to the medical emergency does not address the already unworkable framework this requirement presents. We believe the requirement that a Part 2 program immediately document a disclosure pursuant to a medical emergency should be removed from the regulations. ABHW member organizations possess data and information from claims and utilization review activities that could, and should, be shared in order to prevent an emergency from occurring in the first place without undue burden.

ABHW believes it would be beneficial for SAMHSA to provide examples of emergency situations where a consent form is not needed to disclose information. For instance, is it an emergency when someone with present or past addiction to opiates visits a dentist for a procedure that will likely result in a prescription for opiates for the pain? BHOs could prevent potentially dangerous drug interactions; for example, persons engaged in medication assisted therapy who are also taking one or more of the following: antidepressants, sedatives, antihistamines, pain medications, or muscle relaxants. In circumstances such as these, in order to prevent a foreseeable emergency from occurring, disclosure would be necessary. We encourage SAMHSA to create a broader definition of “emergency”, to include urgently needed services to prevent a medical emergency.

Issue for Comment: Further subregulatory guidance that SAMHSA and other agencies could provide to help facilitate implementation of 42 CFR Part 2 in the current healthcare environment.

In the face of a growing opioid epidemic in this country, ABHW strongly believes that aligning Part 2 with the Health Insurance Portability and Accountability Act (HIPAA) for the purposes of TPO will promote safe, effective, coordinated care for persons with opioid addiction and other substance use disorders. All of the recent steps taken to address the opioid crisis will be moot without removing communication barriers and promoting care coordination in the same fashion as applies to every other medical condition under HIPAA.

SAMHSA encourages Part 2 programs to try to use HIPAA hybrid models when possible, but that creates great confusion around when that is acceptable. Harmonization with HIPAA would eliminate that confusion and ensure increased care coordination among treating providers and other entities which share health information for care coordination and integration purposes, improve patient care, and enhance privacy protections by making confidentiality restrictions more uniform across health care settings. This allows for the achievement of improved health outcomes through increased coordination of care for patients, while preserving the privacy rights of patients as provided for under HIPAA’s privacy rules. We strongly urge you to align Part 2 with HIPAA whenever possible in any future guidance on this issue.

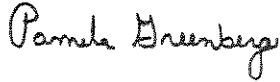
Additionally, ABHW members often face obstacles with outside organizations that do not accept that BHOs are a Part 2 program. Can you please clarify whether or not payers that are in possession of substance use disorder treatment information of their members and as managed care organizations that have a referral role are considered a Part 2 program?

Please also confirm that if a BHO contracts with a government program and separately contracts with a commercial health benefit plan, thus receiving both federal and private funds, the BHO is not required to comply with Part 2 for a consumer whose benefits are provided solely through a commercial health benefit plan.

Finally, if the BHO is required to comply with Part 2 for a consumer whose benefits are provided solely through a commercial health benefit plan because the BHO receives federal funds through a separate contract with a government program, is the BHO a “Program” or a “OSO” for the commercial health benefit plan?

We appreciate the opportunity to comment on SAMHSA’s proposals to further update Part 2 and thank you for your consideration of our recommendations. For your reference, we have attached our initial comments on the notice of proposed rulemaking (NPRM) for proposed revisions to 42 CFR Part 2 (Part 2). If you have any questions or would like to discuss any of these issues with ABHW, please contact Rebecca Klein at (202) 449-7660 or klein@abhw.org.

Sincerely,



Pamela Greenberg
President and CEO, ABHW

Attachment