

June 25, 2014

Pamela Hyde
Administrator
Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services
1 Choke Cherry Road
Rockville, MD 20857

RE: Netsmart Comments to 42 CFR Part 2 Listening Session

Dear Administrator Hyde:

The SAMHSA Public Listening Session on the Confidentiality of Alcohol and Drug Abuse Patient Records held on June 11, 2014 provided a good forum for discussion of important issues related to 42 CFR Part 2 consent requirements.

I appreciate the opportunity to provide comments on this topic from the perspective of the largest provider of technology to behavioral health organizations. Netsmart serves more than 20,000 private behavioral health practices, 40 state-operated hospital systems, and approximately one third of all community mental health centers in the country, many of which offer substance use treatment services. We are also engaged in the creation of care coordination systems and the associated health information exchanges (HIEs) needed to connect behavioral health to physical health for some of the nation's largest health homes.

The confidentiality of substance use treatment records is important, but much has changed in the last 42 years – in fact, much has changed in the past four years. In this digital era, the act in its current form is threatening patient safety by forcing healthcare providers to work in proverbial silos.

Health homes, Accountable Care Organizations (ACOs) and HIEs will not succeed until behavioral health organizations are able to share data with their physical health care partners in care coordination programs. However, due to SAMHSA's interpretation of the privacy laws, behavioral health and substance use providers are all but eliminated from participating fully these entities.

HIE Example

For example, if an adult with Alzheimer's disease and diabetes consents to sharing his or her records on an HIE, they can receive the superior care that can be delivered by coordinating care and reducing the risk of medication interactions associated with their multiple medications. A second person, one with diabetes and a substance use issue who has part of his or her treatment provided by a substance use treatment provider, cannot consent to share their records on an HIE without enormous administrative burden on themselves and their provider. In fact, in most cases, this is impossible to do because of the current technologies in use in HIEs. As was indicated in the Listening Session, most HIEs currently refuse to accept substance use EHRs.

In essence, providers cannot effectively participate in HIEs because when a patient wishes to consent to the release of his or her records to an HIE, he or she must specifically identify every member of that HIE. The HIE members/providers change over time, and maintaining the list as well as updated consents for redisclosure is challenging, which diminishes the ability coordinate care. Current regulations restrict providers from being able to send their substance abuse data up to the HIE, but only query down the longitudinal record comprised of physical health providers. This model does not serve the larger continuum because emergency departments and other physical health providers do not have access to the critical patient data represented during their substance abuse or behavioral health treatment.

This unintended consequence is a result of SAMHSA's interpretation of "informed consent." On the surface, this appears to be discriminatory to a consumer with substance use issues and against the intent of Mental Health Parity and Affordable Care Act legislation.

We strongly urge HHS and SAMHSA to issue sub-regulatory guidance that allows a patient to identify "current and future providers in the HIE involved in my care" as an appropriate title under the "To Whom" requirement of a Part 2 consent.

ACO Impact

Similarly, the Accountable Care Workgroup of the Office of the National Coordinator for Health Information Technology (ONC) noted the same problem in the context of Medicare ACOs (also applicable to Medicaid ACOs) – the inability to share addiction and mental health EHRs because of HHS privacy interpretations. In fact, the CMS Center for Medicare and Medicaid Innovation (CMMI) acknowledges that in sharing Medicare claims data with Pioneer ACOs nationwide, it must redact all addiction medical records due to Part 2 consent requirements.

Consent Requirements

Netsmart strongly urges a new 42 CFR Part 2 regulation to allow consent forms to include more general descriptions of the individual, organization or health care entity to which disclosure is to be made. This important change would ease the multiple consent requirements discussed above, thereby facilitating the interchange of substance abuse treatment information across HIEs, Medicare ACOs, Medicaid Health Homes and state-based Coordinated Care Organizations (CCOs). In conjunction with this proposal, it is important to note that substance use EHRs would be covered under existing HIPAA privacy standards, which protect the confidentiality of sensitive medical information associated with stigmatized medical conditions including HIV/AIDS and Sexually Transmitted Disease (STDs).

Qualified Service Organizations

We also urge SAMHSA to issue a Part 2 regulation that expands the definition of qualified service organization (QSO) to explicitly include care coordination services, and to allow a QSO Agreement (QSOA) to be executed between an entity that stores Part 2 information (such as a payer or an ACO that is not itself a Part 2 program), and a service provider.

The ability to share information with appropriate but updated privacy safeguards is key to treatment and recovery for patients with substance use issues. It will also improve the quality and breadth of substance



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use treatment, mitigate the negative impact of co-occurring conditions and significantly enhance patient safety.

In addition, the timely, efficient sharing of authorized medical information via the fastest and most complete methods possible reduces risk of medication errors and increases the ability of emergency room clinicians to provide appropriate treatment in that setting.

The overwhelming feedback at the June 11 Listening Session was in favor of updating the rules. **Overall, we suggest a larger scale change: Exempt care coordination and population health management from Part 2 requirements to align with similar exemptions in HIPAA.**

Sincerely,

A handwritten signature in black ink that reads "Kevin Scalia".

Kevin Scalia
Executive Vice President
Netsmart