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August 14, 2015

Secretary Sylvia Burwell
U.S. Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Burwell:

As states move toward full integration of behavioral and physical health care, the State of Oregon supports further review and evaluation of the Confidentiality of Alcohol and Drug Abuse Patient Records Regulations (hereinafter, "42 C.F.R. Part 2" or the "Part 2 regulations") by the Substance Abuse and Mental Health Services Administration, the Office of Civil Rights, and the Office of the National Coordinator for Health Information Technology. Oregon agrees that there continues to be a need for confidentiality protections that encourage patients to seek substance abuse treatment without fear of compromising their privacy; however, the Part 2 regulations do not support Oregon's vision of health system transformation. Improvements can be made by evaluating and reviewing:

- Disclosure and redisclosure requirements and restrictions;
- The restrictive nature of 42 C.F.R. Part 2 consent form requirements; and
- The role of a Qualified Service Organization (QSO) and uses of a QSO agreement.

The State of Oregon has started to transform its healthcare delivery system to achieve the Triple Aim of better care, better health, and lower costs and information exchange is critical to fulfilling our vision. Oregon's Coordinated Care Organizations (CCOs) function as the single point of accountability for health quality and outcomes in the population they serve and are responsible for integrating care for their clients, including substance use screening, intervention and treatment. This new model of care delivery is built on a foundation of information sharing to support coordination and integration of patient care, the development of an electronic infrastructure to manage and exchange patient data, and a new focus on performance measurement. It is necessary to facilitate the exchange of patient personal health information, including substance use treatment, to improve care coordination across different provider types and to achieve the goals of better care and health for populations served by CCOs.

The Oregon Health Authority has been working closely with providers and CCOs to define the challenges and barriers to information sharing. Though OHA is invested in finding solutions to facilitate information sharing, we also acknowledge that there are limitations due to the challenges posed by Part 2 regulations. We highlight below some of the most important issues that have arisen for providers and CCOs.

Despite state law that encourages information sharing within the CCO network for the purposes of treatment, health care operations, payment and health oversight, many CCOs and providers limit the extent of mental health and substance abuse treatment information that is shared for care coordination purposes because of the concern that Part 2 regulations prohibit the exchange of these records. Several CCOs and providers have approached the Oregon Health Authority seeking clarification of Part 2 regulations, but we are unable to provide legal guidance on the matter due to the concern that the state may face civil liability if guidance is interpreted incorrectly resulting in improper sharing of personal health information.

Under Part 2 regulations, substance use information may not be shared with health care entities without consent for purposes of care coordination and population health management. This creates a tension with the CCO mandate to freely share information to coordinate and integrate care across provider types, including physical health care, dental care, mental health care and substance use treatment. For individuals suffering from substance use disorders, it is difficult to develop comprehensive care plans if there are barriers to sharing addictions history, treatment and diagnoses information.

Having to include the name or title of the individual or organization to which disclosure should be made is a challenge for CCOs, which have large and constantly evolving numbers of providers and entities that provide care to clients. It is difficult and costly to update consent forms when a new provider joins a network. Oregon supports the proposal to allow the consent to include a more general description of the individuals, organizations, or health care entities to which disclosure is to be made.

When information is exchanged, CCOs are unable to redisclose other health-related information received from a Part 2 program that does not identify an individual as a substance abuser. This additional health-related information may be of assistance to providers treating an individual concurrently, especially for those suffering from substance abuse and mental health and/or physical health conditions.

Substance abuse treatment providers may share protected information without client consent with qualified service organizations (QSOs) with written QSO Agreements (QSOA). Though a QSO is defined as an entity that provides services to a Part 2 program, CCOs are unclear if they properly serve in the role of a QSO and can share information among organizations within their network without consent. Additionally, it is unclear if providers, acting as agents of the CCO under QSOAs may share protected

information with the CCO and the CCOs Health Information Organization without obtaining individual consent. The proposed SAMHSA solution to expand the QSO definition and to allow QSOAs to be executed between an entity that stores Part 2 information and a service provider does not fully meet the needs of Oregon's CCOs. Oregon hopes that the Part 2 regulations will also include an exception that permits providers that are participating in an organized care network like a CCO to share information with one another and allow the Part 2 program to share information with other providers within the network.

Part 2 regulations require several changes to ensure that it does not continue to stand as a barrier to the exchange of substance abuse treatment information and integrated delivery of behavioral and physical health care. In addition to the challenges highlighted above, Part 2 regulations also restrict the flow of information in other areas. Emergency services, prescription drug monitoring programs and researchers/evaluators could benefit from the disclosure of Part 2 data to further improve patient experience, care coordination, and the ability of states to evaluate health system performance. We hope that these comments will be helpful in identifying a solution that protects patient privacy, yet allow for improved care integration and coordination across providers.

In recognition of this important issue, Senate Joint Memorial 4, as approved by the 78th Oregon Legislative Assembly, calls Congress to action to develop a fix that will be helpful to states moving forward with new models of care delivery (attached).

Thank you for your attention to this matter.

Sincerely,

A handwritten signature in cursive script, appearing to read "Lynne Saxton", with a long horizontal flourish extending to the right.

Lynne Saxton
Director