



## The Impact of 42 CFR Part 2 on Care Coordination by Health Plans for Members with Substance Use Disorders

### Overview

States have increasingly turned to Medicaid managed care organizations (MCO) to provide coordinated, integrated care in a cost-effective manner for people with Medicaid coverage, including people with special needs. Medicaid MCOs have developed care coordination programs under which they assess their members' needs, identify treatment gaps, engage members, develop individualized care plans, and coordinate care delivery.

These programs include initiatives to coordinate and facilitate access to care and social services for Medicaid beneficiaries with substance use disorders (SUD).<sup>1</sup> However, in many cases plans seeking to coordinate care for members with SUD have experienced challenges to coordination arising from regulations that predate current models of care. These barriers lead to worse health outcomes, higher costs to Medicaid programs, and frustrate efforts to integrate behavioral and physical health for people experiencing SUD.

In 2011, almost 12 percent of adult Medicaid beneficiaries were estimated to have an SUD.<sup>2</sup> For individuals newly eligible for Medicaid, the percentage was higher: about 15 percent.<sup>3</sup> These individuals have complex health care needs that often include co-occurring mental and physical health diagnoses.

People with SUD may have physical health conditions directly attributable to their addiction, including liver disease and pancreatitis.<sup>4</sup> In some instances, an SUD is related to a physical health condition with associated chronic pain that has been treated with opioid pain relievers. For these individuals, their pain must continue to be managed while addressing their addiction.

In fact, those suffering from SUD are some of the highest utilizers of health care services among Medicaid beneficiaries. For example, individuals with untreated alcohol use disorders use twice as much health care and cost twice as much as those with treated alcohol use disorders.<sup>5</sup> About 12.5 percent of all emergency department visits across payers are due to mental health or substance abuse treatment needs.<sup>6</sup>

Care coordination initiatives involving Medicaid beneficiaries with SUDs have had remarkable success.<sup>7</sup> However, appropriate care coordination of Medicaid beneficiaries with SUDs who are enrolled in managed care requires the exchange of patient health information among physical and behavioral health providers and with the beneficiary's MCO. Physical health providers (e.g., a PCP who is treating an individual for chronic pain) need to know about the SUD diagnoses of



their patients and whether they are receiving treatment for the SUD. SUD treatment programs need information about the physical health status of their clients and the care they are receiving. All of these providers must also be able to share information with their patients' mental health providers. To facilitate whole-person care and coordinate care across all providers, MCOs must know which of their members have SUDs, whether those members are receiving SUD treatment, and know their physical and behavioral health needs.

When individuals with both physical and behavioral health conditions are subject to a fragmented system of care with little or no coordination across providers, the result is poorer quality and higher costs.<sup>8</sup> Poor coordination of care increases health care spending because it leads to preventable hospitalizations and duplicative tests.<sup>9</sup>

Today, in large part due to the federal rules protecting confidentiality of substance abuse records, 42 CFR Part 2 (Part 2), SUD treatment programs often operate in silos, and the integration of SUD services with mental and physical health care is impeded. Exchange of information about patients receiving SUD treatment in substance abuse treatment programs defined in regulation as "federally assisted" is subject to Part 2 and cannot be shared without patients' explicit consent, even for care coordination purposes.

The requirements for disclosure under Part 2 are far more stringent than the requirements under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule<sup>10</sup> for the disclosure of other types of sensitive, protected health information, including information about mental health treatment<sup>11</sup> and SUD treatment provided outside of Part 2 programs. The HIPAA Privacy Rule permits disclosure of protected health information (PHI) without patient consent for limited purposes related to payment, treatment and health care operations, which by definition includes care coordination.

The Association for Community Affiliated Plans (ACAP) is an association of 60 nonprofit and community-based Safety Net Health Plans located in 24 states. ACAP's member plans provide coverage to over 15 million individuals enrolled in Medicaid, the Children's Health Insurance Program (CHIP), Medicare Special Needs Plans for dually-eligible individuals, and Qualified Health Plans through the Marketplaces. Nationally, ACAP plans serve roughly one-third of all Medicaid managed care enrollees, including around one-third of all enrollees in the Medicaid-Medicare financial alignment demonstrations. ACAP plans are members of their communities, partnering with states to improve the health and well-being of their members who rely upon publicly funded programs.

In 2013, ACAP received a grant from The Foundation to Promote Open Society in collaboration with the Open Society Institute (OSI) to support the Reducing Prescription Drug Abuse Collaborative. Since 2014, Safety Net Health Plans participating in the Collaborative have designed and implemented evidence-based quality improvement projects to reduce prescription drug abuse in the Medicaid population. To address the high rates of opioid misuse and abuse



among beneficiaries, many of these programs targeted opioid utilization and incorporated strategies to promote safe and effective pain management which were documented in a toolkit.<sup>12</sup> As an extension of this grant, ACAP is also facilitating a collaborative on the integration of behavioral and physical health services. These efforts have highlighted the challenges Part 2 presents for plans trying to address the physical, mental, and substance use disorder needs of their members.

ACAP strongly supports protections for the privacy and security of patient health information. However, as this paper will discuss, 42 CFR Part 2, which was promulgated over 40 years ago when Medicaid managed care and care coordination barely existed and prior to the enactment of HIPAA, imposes restrictions on the disclosure of SUD information which interfere with care coordination between Medicaid beneficiaries' health plans and health care providers. The HIPAA Privacy Rule, which permits disclosure without consent for the purpose of care coordination of other sensitive protected health information, includes safeguards to protect the privacy of individuals receiving treatment in Part 2 programs.

### **42 CFR Part 2**

In the early 1970s, in response to a series of incidents in which law enforcement officials sought to obtain patient records from drug treatment programs, Congress passed a statute<sup>13</sup> guaranteeing the confidentiality of information for persons receiving substance abuse treatment services from federally assisted programs. Under the statute, a federally assisted substance abuse program generally may only release identifiable information related to substance abuse diagnosis or treatment services with the patient's express consent.

The Substance Abuse and Mental Health Services Administration (SAMHSA) in the U.S. Department of Health and Human Service promulgated 42 CFR Part 2, which implemented the statute, in 1975. Part 2 protects the confidentiality of substance abuse records of any person who has applied for or been given a diagnosis of or treatment for alcohol or drug abuse at a "federally assisted alcohol or drug abuse program."<sup>14</sup> An alcohol or drug abuse program is considered to be "federally assisted" if it receives federal funds in any form (including Medicaid, Medicare, and grant funds), operates under federal authorization (including authorization to conduct methadone maintenance treatment or dispense controlled substances), or has tax-exempt status.<sup>15</sup> An "alcohol or drug abuse program" is defined as an individual or entity, or an entity within a general medical facility, that holds itself out as providing, and provides, alcohol or drug abuse diagnosis, treatment or referral for treatment, or medical staff in a general medical facility whose primary function is the provision of alcohol or drug abuse services and who are identified as such.<sup>16</sup>

An SUD provider or program must hold itself out as providing substance use diagnosis, treatment, or referrals in order to be subject to Part 2. Thus, a primary care practice or community health center that, for example, administers Screening, Brief Intervention, and



Referral to Treatment (SBIRT) to its patients, but does not advertise that it is a drug treatment program, would not be bound by the Part 2 disclosure requirements even if the provider receives federal assistance in the form of Medicaid reimbursement.<sup>17</sup>

The general rule is that a Part 2 program may not disclose patient information unless the patient has consented, the program has a qualified service organization agreement (QSOA) with the entity to which it is disclosing the information, or some other exception (e.g., a medical emergency) applies. A qualified service organization (QSO) is a person or organization that “provides services to a program, such as data processing, bill collecting, dosage preparation, laboratory analyses, or legal, medical, accounting, or other professional services, or services to prevent or treat child abuse or neglect, including training on nutrition and child care and individual and group therapy,” and with which the Part 2 program has entered into a QSOA.<sup>18</sup> SAMHSA has indicated it is considering expanding the functions of a QSO to include care coordination.<sup>19</sup>

Patient consent must be obtained by Part 2 programs before the providers can submit claims<sup>20</sup> to health insurance companies, including Safety Net Health Plans. Once an insurer receives the claim, the information is protected and generally may not be redisclosed, even for the purposes of care coordination,<sup>21</sup> unless the patient has consented to the further disclosure to specified recipients.<sup>22</sup> In that case, health plans may redisclose the SUD-related treatment information, but only to the specified providers. The information must be accompanied by a written statement that specifies that the information disclosed is protected by federal law and that the recipient may not disclose the information to any other party unless permitted by the regulation.<sup>23</sup>

Because Part 2 requires individual consent in almost every instance of disclosure, it can pose a substantial impediment to the timely sharing of information, frustrating the efforts of health plans and providers to effectively manage and coordinate care.

Moreover, amending Part 2 to expand the function of a QSO to include care coordination would not address the need for integrated care coordination on a programmatic system-wide basis because managed care entities would be required to negotiate a QSOA with every substance use disorder provider from which they seek information about their members and would still not be able to redisclose that information to other QSOs or other providers, such as the patient’s primary care physician, for the purposes of coordinating care without consent. It should be noted that while obtaining information on members via a QSOA may not allow the insurer to share the information to coordinate care amongst a member’s providers, an insurer would still have interest in knowing this information for reasons such as care management.

### **How Safety Net Health Plans Meet the Part 2 Requirement for Patient Consent**

Safety Net Health Plans coordinating care for their members with SUD are confronted by the Part 2 requirement for patient consent. This requirement makes it very difficult for plans to





effectively coordinate care for a member with SUD, and at a broader level frustrates the efforts of Safety Net Health Plan efforts to break down the traditional silos between physical and behavioral health.

Safety Net Health Plans' experience has been that most members receiving SUD treatment want and expect their health care providers to share their health information, and that few object to signing a consent for disclosure when asked. However, in many cases, members are not being given the opportunity by their SUD providers to authorize release of their information to their other providers. SUD providers are often small and have limited time and resources. Accordingly, they may be resistant to educating members on the consent when there is no additional reimbursement for the effort.<sup>24</sup>

Inland Empire Health Plan (IEHP), a Medicaid and Medicare plan that operates in Riverside and San Bernardino counties in California, educates providers on the importance of obtaining this consent. IEHP uses its leverage as a payer to require Part 2 providers to seek members' consent to release their information to their PCP at the initial visit and to submit a Web Based Treatment Plan or Coordination of Care Report following the visit. If the provider attests electronically that the member has signed the consent, the treatment plan is automatically dropped in a secure Web-based mailbox for the member's PCP through IEHP's provider portal. To make this coordination of care routine, IEHP pays an enhanced rate for the initial visit and the submission of the Treatment Plan or Coordination of Care Report to the IEHP Behavioral Health Care Management Team following the initial visit.

The attestation of obtaining the member's consent is called out on the form. Over the past six years, IEHP behavioral health providers have obtained the release about 80% of the time. Should the behavioral health provider not attest that a client has provided consent, which prevents a PCP from accessing the treatment report, an IEHP care manager is able to follow up to find out whether the member objected to consenting or was not asked by the provider; in IEHP's experience, members rarely object to consenting. IEHP is hoping to further improve its consent rate through outreach efforts.

It should be noted that IEHP has a built-in advantage when providing care for people who are dually eligible for Medicare and Medicaid: all behavioral health benefits are carved in, including SUD care. Accordingly, as a claims-payer, IEHP knows which of its members receive SUD treatment—and which providers serve them.

In contrast, when SUD benefits are carved out, the health plan is not directly responsible for substance use services as part of the benefit package. This creates unique challenges for integration efforts because the health plan lacks information about which members are receiving services from Part 2 programs and therefore does not know which providers to approach to obtain patient consents.



This is an issue in Maryland, which transitioned from a carve-in to a carve-out model for substance use disorder services in January 2015. To facilitate MCOs receiving behavioral health information, the State requires its behavioral health administrative services organization (ASO),<sup>25</sup> which is now responsible for administering SUD benefits, to make efforts to share this information with the state's eight Medicaid MCOs. The ASO is permitted under the HIPAA Privacy Rule and state law to share mental health information extracted from claims with MCOs. However, under Part 2, the ASO must obtain a patient consent before transmitting SUD claim information to the beneficiary's MCO. As of September 2015, the ASO had experienced only moderate success in enlisting SUD providers to return client consents; consents were not obtained for nearly 4 in 10 individuals in treatment. Specifically, the report notes that 61.6 percent on the individuals had signed consents, while 21 percent of SUD providers had not asked their clients to sign the consent form.<sup>26</sup>

L.A. Care Health Plan devised a workaround to this problem by creating a universal consent form and asking providers to present it to members where they receive substance use disorder services.

The form was developed jointly by a coalition of representatives from county behavioral health systems, hospitals, primary care, Part 2 providers, and L.A. Care and its partner health plans in Los Angeles County. As required by 42 CFR §2.31, the universal consent form identifies each authorized recipient of the Part 2 data, including L.A. Care. By enlisting the cooperation of Part 2 programs to secure client consents to share information, L.A. Care will have the opportunity to learn which of its members are receiving SUD treatment, receive information about that treatment, and exchange the information with the members' other providers for the purpose of coordination of whole person care. Los Angeles County has not implemented the universal consent form, but expects to do so soon as the form is in its final stage of approval by all entities.

Although L.A. Care has little leverage or ability to incent SUD providers to secure consents since they do not know which of their members receive treatment services, they are counting on persuading SUD providers in Los Angeles County that it is in their best interest to participate in a community-wide effort to encourage clients to sign the universal consent form.

### **The HIPAA Privacy Rule Adequately Protects Part 2 Information Disclosed for Care Coordination Purposes**

Part 2 is regarded by advocates as an important protection for individuals with SUD, encouraging them to seek treatment without fearing that by doing so their privacy will be compromised. Consumer advocates have expressed legitimate concerns that sharing of alcohol and drug patient information can lead to stigma and discrimination that can have both criminal and civil consequences, including loss of child custody, loss of employment, and loss of housing.<sup>27</sup> However, this fails to recognize the stigma that can also be associated with treating



SUD treatment differently than other acute and chronic conditions—and that actual patient harm can arise as a result of uncoordinated care.

The privacy of individuals with SUD can be protected while ensuring they still receive integrated services. The confidentiality of sensitive protected health information, including mental health information, is protected under federal law by the HIPAA Privacy Rule. The HIPAA Privacy Rule, promulgated in 2001 and amended in 2002 and 2013, permits protected health information, including most mental health information, to be disclosed by covered entities without patient consent in a limited way for purposes of payment, treatment, and health care operations.<sup>28</sup> Covered entities include health plans, health care providers, and health care clearinghouses.<sup>29</sup> “Health care operations” is defined as including, among other things, “case management and care coordination.”<sup>30</sup> Thus, under the HIPAA Privacy Rule, sensitive health information that is not subject to another federal authority (such as Part 2) can be disclosed without patient consent to the patient’s health plan and health care providers for care coordination purposes.

Part 2 was essential prior to the enactment of HIPAA because no other federal laws in the 1970s protected the confidentiality of health information. Today and for the last 14 years, however, the HIPAA Privacy Rule establishes strong protections for sensitive, protected health information. HIPAA Privacy Rule restrictions that allow the disclosure of patient information without patient consent for care coordination purposes prevent sensitive health information, including SUD information, from being shared inappropriately by health plans.

SAMHSA has acknowledged that the Part 2 regulations do not fit today’s health care system and has been developing proposed amendments to Part 2.<sup>31</sup> At the beginning of its rulemaking process, SAMHSA held a listening session with the public to provide interested parties with the opportunity to share their views on Part 2.<sup>32</sup> SAMHSA noted that significant changes have occurred within the U.S. health care system since the regulations were issued, including “new models of integrated care that are built on a foundation of information sharing to support coordination of patient care and a new focus on performance measurement within the health care system.” SAMHSA also pointed out that Part 2 does not take into account “the impact on coordination of care” of its consent requirements.<sup>33</sup> However, SAMHSA has yet to publish proposed regulatory changes.

## **Conclusion**

The federal requirement for patient consent for disclosure of Part 2 information has prevented Safety Net Health Plans from accessing the information they need about members who have SUD, from sharing that information when they receive it with the members’ health care providers, and from coordinating care for their members who need it most.

Health plans have invested considerable time and resources working with their communities and Part 2 programs to obtain member consents. However, even when the health plan is the payer, it



cannot assure that consents will be obtained from every member who is willing to have their SUD information shared with their health plan and health care providers. The outcome is that vulnerable Medicaid beneficiaries with serious behavioral and physical health issues are deprived of care coordination that could dramatically improve their health and the quality of their health care as well as reduce unnecessary utilization. This is clearly inconsistent with the health and welfare of the beneficiary and the goal of value-based care.

The privacy of members who live with an SUD is of paramount importance. At the same time, the protections afforded under HIPAA are more than sufficient to protect these individuals' privacy.

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<sup>1</sup> Centers for Medicare and Medicaid Services Integrated Care Resource Center. Technical Assistance Brief: Coverage and Delivery of Adult Substance Abuse Services in Medicaid Managed Care (April 2014).

<sup>2</sup> Substance Abuse and Mental Health Services Administration. Behavioral Health Treatment Needs Assessment Toolkit for States. HHS Publication No. SMA13-4757. Rockville, MD: Substance Abuse and Mental Health Services Administration (2013).

<sup>3</sup> Centers for Medicare and Medicaid Services. CMCS Informational Bulletin: Delivery Opportunities for Individuals with Substance Use Disorder (October 2014).

<sup>4</sup> Bouchery, E, R Harwood, R Malsberger, E Caffery, J Nysenbaum, and K Hourihan. Medicaid Substance Abuse Treatment Spending: Findings Report. U.S. Department of Health and Human Services Office of Disability, Aging and Long-Term Care Policy (September 2012).

<sup>5</sup> Holder, H.D. Cost Benefits of Substance Abuse Treatment: An Overview of Results from Alcohol and Drug Abuse. J. Mental Health Policy Econ. (March 1998).

<sup>6</sup> Owens L et al. Mental Health and Substance Abuse-Related Emergency Department Visits among Adults. Agency for Healthcare Research and Quality (2007).

<sup>7</sup> Examples include medical homes for persons with substance abuse issues and case management. Centers for Medicare & Medicaid Services. CMCS Informational Bulletin. Reducing Non-Urgent Use of Emergency Departments and Improving Appropriate Care in Appropriate Settings (January 2014).

<sup>8</sup> Centers for Medicare and Medicaid Services Integrated Care Resource Center. Technical Assistance Brief: State Options for Integrating Physical and Behavioral Health Care (October 2011).

<sup>9</sup> Families USA. The Promise of Care Coordination: Transforming Health Care Delivery (April 2013).

<sup>10</sup> "The HIPAA Privacy Rule" is the term commonly used to refer to the group of federal regulations at 45 CFR Part 160 and Subparts A and E of 42 CFR Part 164 that implement HIPAA.

<sup>11</sup> The only type of mental health record disclosure for which patient consent is required is psychotherapy notes. 45 CFR §164.508(a)(2).

<sup>12</sup> Association of Community Affiliated Plans. Strategies to Reduce Prescription Drug Abuse: Lessons Learned from the ACAP SUD Collaborative (April 2015).

<sup>13</sup> 42 USC §290dd-2.

<sup>14</sup> 42 CFR §2.3(a).

<sup>15</sup> 42 CFR §2.12(b).

<sup>16</sup> 42 CFR §2.11.

<sup>17</sup> SAMHSA. Frequently Asked Questions Applying the Substance Abuse Confidentiality Regulations – 42 CFR Part 2 (Revised) (2011). FAQs #10 and #11.

<sup>18</sup> 42 CFR §2.11.

<sup>19</sup> 79 Fed. Reg. 26929, 26931 (May 12, 2014).

<sup>20</sup> SAMHSA. Frequently Asked Questions Applying the Substance Abuse Confidentiality Regulations to Health Information Exchange (HIE) (2010). Answer to Question #5.

<sup>21</sup> 79 Fed. Reg. 26929, 26931 (May 12, 2014).

<sup>22</sup> 42 CFR §2.32.





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<sup>23</sup> Ibid.

<sup>24</sup> Robert Wood Johnson Foundation (prepared by Manatt, Phelps & Phillips). Integrating Physical and Behavioral Health – Strategies for Overcoming Legal Barriers to Health Information Exchange (January 2014).

<sup>25</sup> The Maryland behavioral health administrative services organization provides utilization management, claims payment, and data collection and management services for the Maryland Department of Health and Mental Hygiene, but does not bear financial risk for the cost of covered services. Centers for Medicare and Medicaid Services Medicaid Managed Care Information Resource Center. Technical Assistance Brief: Coverage and Delivery of Adult Substance Abuse Services in Medicaid Managed Care (May 2014).

<sup>26</sup> Report by Daryl Plevy, Deputy Director of Operations, Behavioral Health Administration, Maryland Department of Health and Mental Hygiene, to the Maryland Medicaid Advisory Committee, September 24, 2015.

<sup>27</sup> SAMHSA. Behavioral Health IT Summer Webinar Series: 42 CFR Part 2: Myths & Scenarios (joint presentation by SAMHSA and the Legal Action Center (2014).

<sup>28</sup> 45 CFR §164.506.

<sup>29</sup> 42 CFR §160.103.

<sup>30</sup> 45 CFR §164.501.

<sup>31</sup> 79 Fed. Reg. 26929, 26930 (May 12, 2014).

<sup>32</sup> Ibid.

<sup>33</sup> Ibid.