

Medicaid Managed Care for Members with Mental Health Conditions and/or Substance Use Disorders:

Strategies Used by Medicaid Managed Care Organizations to Promote Effective Information Sharing

DECEMBER 2016

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EXECUTIVE SUMMARY

Anthem's affiliated health plans and other Medicaid managed care organizations (MCOs) across the country are focused on integrating the delivery of physical health, mental health, and substance use disorder care and services for Medicaid members. In support of these efforts, MCOs often find themselves determining how best to facilitate the secure, confidential sharing of sensitive health information among physical health, mental health and substance use disorder providers. Without this integration, individuals with mental health and substance use disorders (MH/SUD) will continue to receive care in a fragmented system that addresses only part of an individual's needs and leads to poorer patient outcomes.

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In order to safely and confidentially share information, MCOs face a range of potential obstacles including a complex set of laws and regulations that govern the exchange of MH/SUD health information, confusion among providers, shortcomings in the MH/SUD information technology (IT) infrastructure, and cumbersome consent procedures. Each of these elements was designed to enable individuals with MH/SUD to determine when and how their information should be shared. However, the complexity of the laws and regulations can hamper individuals' ability to effectively determine who will see their records and when. In the face of these challenges, Anthem's affiliated plans and other MCOs are working with states and providers to promote effective, confidential information sharing through the following strategies:

- **Engaging Federal and State Policymakers:** MCOs are working to engage state and federal legislators and regulators about how to share information in the current health care environment and the value of that information sharing when appropriately done. When a patient consents to sharing critical medical and treatment records in a secure fashion, treating providers and MCOs can work to coordinate and improve care. Federal and state policy makers have a role in supporting this information exchange.
- **Educating Providers:** MCOs are providing educational materials and technical support to providers on how to treat sensitive personal MH/SUD data and regarding their legal obligations when it comes to data sharing. These efforts include dispelling some of the myths about federal health information privacy rules and ensuring providers understand the particular laws and regulations that apply to the sharing of SUD data.
- **Promoting Effective Consent Procedures:** MCOs are assisting providers in establishing procedures for securing consent from Medicaid members to share their data, relying on a combination of technical assistance, education, and even financial incentives. In some instances, MCOs use their own care management staff to supplement providers' efforts to secure consent from members.
- **Strengthening the IT Infrastructure for Integration:** In partnership with states and providers, MCOs are supporting investment in and adoption of a more robust IT infrastructure for MH/SUD care and services as well as care coordination. They are seeking to promote greater interoperability of physical health and MH/SUD data and encouraging the creation of more sophisticated electronic health records (EHRs) that allow for the "segmentation" of sensitive SUD information.

INFORMATION SHARING IS CRITICAL FOR HIGH QUALITY, INTEGRATED CARE FOR MEDICAID MEMBERS

Medicaid programs across the country are increasingly focused on integrating the delivery of physical health, pharmacy, and MH/SUD care and services, reflecting the growing recognition that the traditional “siloeed” approach to care has not served patients well and has prevented a holistic approach to supporting individuals. One of the biggest challenges that MCOs face is finding ways to facilitate the sharing of patient information among MH/SUD and physical health providers. If a physical health provider is unable to see the medical history, lab results, medication lists or treatment plans of a MH/SUD provider – and vice versa – it can result in poorly coordinated care, conflicting advice, interrupted treatment regimens, or medication errors.¹ All of these factors can put individuals with MH/SUD at risk for sub-optimal care.

Although it is clear that the exchange of information is critical to integrated care, providers confront an array of technological and legal barriers – both real and perceived – that make it challenging to do so.² Moreover, individuals with MH/SUD needs often have a heightened concern about sharing personally sensitive health information. They worry that physical health providers will treat them differently due to their MH/SUD or that it will be used against them by an employer, law enforcement or public welfare agency, making it critical that information sharing be done with their informed consent.³

This issue brief reviews the legal and regulatory landscape governing the exchange of sensitive patient information and identifies the strategies being employed by MCOs to improve information sharing and protect patient privacy.

Current State of MH/SUD Information Sharing

- **Adoption of EHRs Is Low Among MH/SUD Organizations.** A 2012 survey of MH/SUD organizations determined that while 65 percent of respondents reported using some type of electronic health record (EHR) in at least some sites, only 21 percent were “all electronic” (i.e., using an EHR in place of paper charts at all sites).⁴
- **MH/SUD Providers Excluded from Meaningful Use Incentives.** CMS provides incentives to health care providers who meet minimum standards for using EHRs and for exchanging patients’ clinical data between health care providers, insurers, and patients. However, MH/SUD providers have generally been excluded from these meaningful use incentives. Consequently, only 11 percent could use their systems in a way that would allow them to meet federal EHR incentive program requirements.⁵
- **HIEs Frequently Not Exchanging MH/SUD Data.** In a national study, almost 40 percent of surveyed Health Information Exchange (HIE) initiatives excluded the exchange of sensitive health data that is subject to current federal restrictions that require written patient consent, including 17 percent that reported they also were refraining from exchanging sensitive health data not subject to these same restrictions (e.g., data on reproductive health, HIV status).⁶

ENGAGING STATE AND FEDERAL POLICYMAKERS

MCOs and the providers with whom they work face both federal and state legal requirements aimed at protecting the confidentiality of sensitive patient information pertaining to MH/SUD care and services. The current requirements were intended to address patient privacy concerns, but these requirements can be complex, confusing, and represent a barrier to effective information sharing between MH/SUD and physical health providers, particularly for patients with SUDs.⁷ These barriers can place individuals at risk of poor quality, fragmented care and/or can result in duplicative or unsafe prescribing that can put them at risk of overdose or death.

Of particular concern is that federal regulations – often referred to as the “Part 2” regulations – make it challenging for providers to receive information on the treatment that their patients are receiving for SUDs. The regulations can prevent individuals with SUDs from fully participating in new integrated care delivery models, such as health homes or accountable care organizations, thus

contributing to fragmented care and impairing access to care and services. The Obama Administration has proposed an update to these rules, but, it is not clear that the update will fully resolve the issues that the rules pose for consumers and providers.

The major laws and regulations that govern when and how providers can share sensitive patient information pertaining to MH/SUD conditions and treatment are described in detail below and summarized in Table 1.

Table 1: Summary of Privacy Laws and Regulations and Challenges

Law/Regulation	What It Does	Issue/Concern	Impact	Strategy to Address
HIPAA	<ul style="list-style-type: none"> Regulates use/disclosure of patient information. Permits providers to use and disclose health care information without patient’s authorization for purposes of treatment, payment, or “health care operations” “Health care operations” includes activities such as care management, care coordination, and quality improvement activities Regulates disclosure of identifiable patient information from “alcohol and drug abuse treatment programs” that are “federally assisted” 	<ul style="list-style-type: none"> Not well understood by some providers—limits sharing of information Does not preempt other more stringent state or federal laws 	<ul style="list-style-type: none"> Can limit how much information is shared between treating providers and with caregivers, when appropriate 	<ul style="list-style-type: none"> Educating and Assisting Providers Strengthening IT Infrastructure for Integration
42 CFR Part 2	<ul style="list-style-type: none"> Patient identifiable information from a federally assisted Part 2 program or facility can only be disclosed with patient’s written consent Broad interpretation of which programs are federally assisted Regulation also includes any provider that receive information from a federally assisted Part 2 program 	<ul style="list-style-type: none"> Not well understood by providers—broad interpretation of “federally assisted” limits sharing of information No HIPAA-exception for treatment, payment, or health care operations 	<ul style="list-style-type: none"> Makes it difficult for patients to determine how and when their information can be shared Limits sharing of patient information between treating providers, posing patient safety risk (e.g., medication overdose) Limits ability to offer integrated MH/SUD and physical health treatment, care management or care coordination, leading to poor patient outcomes 	<ul style="list-style-type: none"> Educating Federal and State Policymakers Educating and Assisting Providers Promoting Effective Consent Procedures Strengthening IT Infrastructure for Integration
State Health Information Privacy Laws	<ul style="list-style-type: none"> Varies from state to state, often includes different rules for certain providers or distinct rules for certain sensitive health information 	<ul style="list-style-type: none"> More restrictive than HIPAA 	<ul style="list-style-type: none"> Causes confusion among providers and MCOs as well as patients 	<ul style="list-style-type: none"> Educating Federal and State Policymakers Educating and Assisting Providers Promoting Effective Consent Procedures

Health Insurance Portability and Accountability Act (HIPAA)

Although often cited as a barrier, HIPAA, in most instances, does not preclude MH/SUD or other providers from exchanging information in the service of their patients. In general, HIPAA prohibits “covered entities,” such as health care providers and plans, from using or disclosing a patient’s protected health information without written authorization.⁸ However, the law also includes broad exceptions that allow providers to use and disclose information without a patient’s authorization for the purposes of treatment, payment or “health care operations.”⁹ “Health care operations” is a term that encompasses a broad array of activities critical to the integration of physical and MH/SUD care and services, including care management, care coordination, and quality-improvement activities such as clinical guidelines development or outcomes evaluation.¹⁰

Unlike other federal and state privacy laws described below, HIPAA applies the same standards to all protected health information; it generally does not distinguish between MH/SUD and physical health data.¹¹ However, HIPAA does not pre-empt other more stringent federal or state laws.¹²

Federal Substance Use Disorder Rules (“Part 2” Regulations)

In contrast to HIPAA, federal SUD confidentiality rules can create significant legal obstacles for providers that need information about their patients.¹³ Federal regulations at 42 C.F.R. Part 2, often referred to as the “Part 2 Regulations,” place stringent restrictions on providers and plans sharing information on SUDs. Dating back to the 1970s and established in response to law enforcement officials seeking access to SUD program information, the regulations were adopted before the advent of personal computers and EHRs and before the strong press for integration of physical and MH/SUD care and services.¹⁴ In February of 2016, the Obama Administration proposed modifying these rules, but they are likely to remain an impediment to effective information sharing even if the changes under consideration are adopted.

Part 2 regulates the disclosure of identifiable patient information from “alcohol and drug abuse treatment programs” that are “federally assisted.” The definition of “federally assisted” is very broad – encompassing providers that receive any federal funds or tax benefits, such as tax-exempt status, as well as those licensed by a federal agency. As a result, the great majority of specialized substance abuse treatment programs are subject to the provisions of the Part 2 Regulations.¹⁵ Further, any providers that receive information from a Part 2 program must also comply with Part 2 rules if they plan to disclose that information. This means that general medical professionals who provide a mix of SUD and other health care services – and so are not considered to be Part 2 providers – still must abide by the Part 2 regulations if they receive information from a Part 2 program and need to disclose it to someone else for treatment or other purposes.¹⁶

Under Part 2, any patient identifiable information from a Part-2 covered program or facility may be disclosed only with the patient’s written consent.¹⁷ The regulations impose a number of specific requirements on the content and nature of the consent. For example, consent forms must identify the specific provider or individual entity authorized to receive the disclosed information; “blanket” consent approaches are not allowed. As a result, individuals cannot sign a general consent allowing all of their treating providers to receive information on their SUD and treatment.¹⁸ (As explained below, this ban on use of a blanket approach to consent forms may change under a new version of the Part 2 regulations proposed by the Administration in February 2016.) Also, any disclosure of Part 2-protected information must be accompanied by a warning that highlights the specially protected nature of the records being shared.¹⁹ Unlike HIPAA, Part 2 does not provide a broad exception for treatment, payment or health care operations, or for quality improvement or care management activities.²⁰ This means that providers who want to provide Part 2 information in support of MH/SUD improvement or integration efforts must have a distinct process for securing patient consent.²¹

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Proposed Modifications to the Part 2 Regulations

In February 2016, the Substance Abuse and Mental Health Services Administration (SAMHSA) published a Proposed Rule that would modify the Part 2 regulations to better facilitate the electronic exchange of SUD information in support of integrated care delivery models.²² The Proposed Rule is intended to ensure that individuals with SUDs are able to participate in new integrated care delivery models, like health homes and accountable care organizations, while ensuring that their privacy concerns are addressed. The Proposed Rule proposes to allow a “blanket” approach to consent in which a broad general consent form identifies an entity, like a health information exchange organization or research institution, or generally designates providers who have a treating relationship with the provider as authorized recipients of their protected health information. However, the Proposed Rule would also maintain the requirement that written patient consent be obtained prior to disclosing any patient identifiable information from a Part 2-covered program or facility, thereby maintaining many of the barriers currently in place for health insurers and others to confidentially share information that could impact patient safety.

State Health Information Privacy Laws

Similar to HIPAA, Part 2 does not pre-empt state privacy laws that are more stringent than the Part 2 regulations. While the specifics of these laws vary from state to state, some states, such as California, Massachusetts and New York, have enacted rules that, for instance, apply to particular types of providers or establish more robust protections for specific types of sensitive health information. In some instances, the laws are designed to increase patients’ access to their own records beyond what is required by HIPAA. For example, Minnesota requires that patients have access to psychotherapy notes, even if kept in a separate file, and that they be able to view and release them.²³ More often, though, state health information privacy laws extend or expand the federal legal framework to additional classes of providers or activities. This patchwork of state and federal law has the potential to increase provider confusion about what is allowable.

Anthem’s affiliated health plans are working to educate federal and state legislators and regulators about the challenges with these laws and regulations and how changes can be made to assist MCOs and treating providers in exchanging critical patient data with the consent of individual patients. For example, MCOs have advocated to update the current 42 CFR Part 2 regulation to align it more closely with the consent requirements in the HIPAA privacy rules, allowing the exchange of protected health information between health care providers and health plans for the purposes of “treatment, payment, and health care operations.”²⁴ This alignment would ensure health plans can more easily provide a complete record of patient information to a treating provider in order to prevent overdose or death from multiple opioid prescriptions, for instance.

As Table 1 shows, the complex legal and regulatory framework governing the sharing of information, particularly information related to SUDs, is one major challenge to effective information sharing, but not the only one. There is also widespread confusion regarding the federal laws and regulations, gaps in the health IT available to MH/SUD providers, and the need to secure consent from patients who are concerned about the sharing of sensitive information. These are discussed in the next sections.

EDUCATING PROVIDERS ABOUT THE REQUIREMENTS FOR INFORMATION SHARING

While there are real and notable restrictions on sharing some kinds of MH/SUD data, a related challenge faced by MCOs is that in light of the complex laws and regulations, providers tend to operate conservatively, opting not to share MH/SUD data even when it is legally permissible and consistent with the best interests of Medicaid members and other patients to do so.

To reduce confusion regarding the legal requirements for information sharing, MCOs can work with states to educate and equip providers with tools and training materials – such as Frequently Asked Questions or ongoing technical assistance – regarding when and how they can share MH/SUD information. Table 2 offers an example of the kind of information that

MCOs can share with providers to help dispel some of the myths surrounding the sharing of MH/SUD information. MCOs routinely send informational bulletins and other alerts to providers on clinical developments, billing issues and a range of other topics, and can readily disseminate information regarding the rules and best practices for sharing MH/SUD data.

Table 2: Common Misconceptions Regarding Federal Information Sharing Laws

Misconception	Federal Requirement
HIPAA requires patient authorization for disclosures for treatment purposes.	Patient authorization is not required for treatment purposes.
A HIPAA provider is precluded from disclosing information to another provider for treatment purposes unless the receiving provider has a pre-existing relationship with the patient.	No pre-existing relationship is required to receive information for treatment purposes. (A prior relationship is required to receive information for quality improvement purposes.)
HIPAA's restriction on the disclosure of psychotherapy notes applies to all notes of counseling sessions that are part of the patient's medical record.	A clinician's notes are considered psychotherapy notes only if they are maintained separately from the patient's medical record.
The Part 2 regulations restrict the disclosure of all substance abuse treatment information.	The Part 2 regulations apply only to specialized substance abuse providers, not general medical providers who deliver substance abuse services. (However, a medical provider who receives information from a specialized substance use disorder must protect the received information in accordance with Part 2 regulations.)
A consent for the release of Part 2 protected information must be a separate document and cannot be combined with any other type of patient consent.	A Part 2 consent can be combined with another patient consent form if the form contains all required elements under the Part 2 regulations.

Table adapted from a Robert Wood Johnson Foundation Issue Brief on legal barriers to health information exchange. Belfort, R., Bernstein, W., Ingargiola, S. "Integrating Physical and Behavioral Health: Strategies for Overcoming Legal Barriers to Health Information Exchange." Robert Wood Johnson Foundation. January 2014.

PROMOTING EFFECTIVE CONSENT PROCEDURES

As discussed above, the process of gathering consent is governed by an array of federal and state laws with particularly stringent standards imposed on consent procedures for SUD information. Fortunately, individuals typically will provide consent if they understand how and why their MH/SUD information is being shared to improve care and are assured of the privacy and security measures in place to protect the confidentiality of their information. For example, when the Colorado Regional Health Information Exchange undertook a series of community forums on information sharing, it found that consumers were quite worried about employers, physical health providers and others finding out about sensitive MH/SUD information, but nearly all still supported information sharing when needed for purposes of improving care.²⁵ The Office of the National Coordinator for Health IT found nearly identical results in a 2012/2013 survey of consumers.²⁶

As MCOs work with providers to gather consent from patients, they confront the reality that many MH/SUD providers are not necessarily eager to adopt new consent management processes.²⁷ It can be time-consuming to educate patients about their rights, secure signatures on consent forms, and monitor whether consent has been secured, and it often requires changes

to practice workflows and staffing to implement these new processes. In contrast to hospitals or other institutional providers, small independent MH/SUD providers may lack the resources, both human and financial, to dedicate specialized personnel to the process of securing consents. Furthermore, providers at all levels may be reluctant to dedicate significant resources to obtaining patient consent if there is no immediate clinical benefit to be realized as a result of doing so.²⁸

Attitudes toward the Privacy and Security of Medical Information

A survey conducted by the Office of the National Coordinator for Health IT in 2012 and 2013 reflects the prevalence of patient apprehension regarding the privacy and security of their medical information, finding that 75 percent of respondents had concerns about the privacy of their medical record.²⁹ However, the same survey found that more than 90 percent of respondents would not withhold information from a health care provider over privacy worries, and that a large majority still support the use of EHRs and health information exchange.

In the face of these challenges, Anthem's affiliated plans and other MCOs are working with providers and states to strengthen and simplify the consent process, particularly for the sharing of Part 2 information, through a variety of means.

- **Providing financial incentives to providers to pursue consent.** Since it is resource-intensive to gather consent forms, MCOs sometimes offer financial incentives to providers to undertake this work. For example, one Medicaid managed care plan in California provides an enhanced rate for a beneficiary's initial visit if the SUD provider creates a treatment plan and secures the patient's consent to share it with the primary care provider.³⁰
- **Using care managers to monitor and secure consent.** Some MCOs are looking to their care managers to assist in securing consent from members, particularly those with MH/SUD and complex care management needs. As they speak with members about upcoming visits, care managers can leverage those existing relationships to check whether the member has signed a consent form and, if not, explain to them the clinical benefit of doing so and how to go about it.
- **Working with states and other partners to establish a standardized consent form.** In some instances, MCOs have worked with providers and other plans to craft universal consent forms that can be used by all SUD providers in the community. For example, MCOs in Los Angeles worked with the county government, hospitals, and primary care providers to establish a universal consent form that identifies each authorized recipient of Part 2 data.³¹ The county has not yet implemented the new form, but is expected to do so shortly. New York also developed a streamlined consent form for use by providers and patients.

New York's Streamlined Consent Process

In 2012 and 2013, New York developed a relatively easy-to-use consent process for providers and patients, including a standard consent form for use with patients, which covers all information shared by physical health and MH/SUD providers – including mental health, SUD and HIV-related records. The form, which was carefully crafted to comply with federal and state regulatory requirements, has reduced provider confusion and concerns regarding how best to comply with the legal requirements for patient consent to share their information.³²

STRENGTHENING THE IT INFRASTRUCTURE FOR INTEGRATION

Even though it is widely recognized that effective information exchange is critical to integrated care, there remain significant gaps in the health IT available to support it.³³ MH/SUD providers generally are ineligible to receive the federal incentive payments available under the Health Information and Clinical Technology Act to physical health providers and facilities for meaningful use of EHRs. In combination with limited access to capital and technological sophistication, this leaves many MH/SUD providers without the ability to purchase and maintain high-functioning EHR systems.³⁴ Moreover, EHR systems rarely are designed to support the integration of care – they often fail to include data fields needed by physical health providers to document and address MH/SUD and vice-versa.³⁵ Finally, most health IT systems still lack the ability to easily segment sensitive MH/SUD data subject to the Part 2 regulations.³⁶ In light of these shortcomings, many MH/SUD providers are reluctant to make major investments in EHRs and other health IT tools.³⁷ These limitations make it difficult for MH/SUD providers to participate in integrated care arrangements that may provide more coordinated and holistic care for their patients.

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In partnership with states, providers, IT vendors, consumer advocates, and the federal government, MCOs can help to support the investment in and adoption of an IT infrastructure that is sufficiently sophisticated and robust to support the exchange of MH/SUD data. To ensure that MH/SUD providers are able to purchase EHR systems that have been customized to meet their unique needs, the federal government may ultimately need to provide them with EHR adoption and use incentives similar to those made available through the Meaningful Use incentive program. For now, though, MCOs can work with state and provider partners to promote greater interoperability of physical and MH/SUD data and to encourage the creation of more sophisticated EHRs that allow for the “segmentation” of sensitive SUD information.

CONCLUSION

The ability of physical health and MH/SUD providers to share patient data is necessary to fully realize the benefits of integrated care.³⁸ Without effective information sharing, individuals with MH conditions and SUDs will continue to receive care in a fragmented system that only addresses part of an individual’s needs. To facilitate this effective information sharing:

- Patients must be assured that their MH/SUD information is being shared with their consent and only to the extent needed to deliver better care.
- Both MH/SUD and physical health providers require EHRs that allow them to record, use and share information on all kinds of conditions.
- Providers and MCOs must feel confident that their consent procedures are consistent with federal and state laws and regulations and in the best interest of the member.

Fortunately, there is much that MCOs can continue doing to help address these challenges. This includes educating providers about the real versus perceived barriers to sharing information; supporting providers in developing and implementing effective procedures to gather consent from members; and working with states, beneficiary advocates and others to encourage creation of health IT that fully supports integration.

This paper is one of several issue briefs focused on integrating care for physical health and mental health and substance use disorders; the others are available at <http://antheppublicpolicyinstitute.com>. The Anthem Public Policy Institute gratefully acknowledges the support of Manatt in the research and writing of this paper.

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About the Anthem Public Policy Institute

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