

# SHARING BEHAVIORAL HEALTH INFORMATION IN MASSACHUSETTS: OBSTACLES AND POTENTIAL SOLUTIONS

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## EXECUTIVE SUMMARY

Due in part to the stigma that is sometimes associated with behavioral health care, information relating to mental health or substance use disorder treatment is given greater protection under both federal and Massachusetts law than most other types of health records. The benefit of such protection is that it helps keep potentially sensitive information private, and therefore may encourage patients to seek treatment. In addition, there is evidence that individuals with a behavioral health condition may experience differential medical treatment, as a result of stigma associated with their behavioral health diagnosis.<sup>1</sup> The greater protection of behavioral health care information may help mitigate this issue, but these laws may also limit the ability of providers to share information regarding patients who are jointly under their care, thereby impeding care coordination and possibly worsening health outcomes. These obstacles to information sharing are at odds with the growing array of behavioral health integration initiatives that are designed to encourage behavioral and physical health providers to work collaboratively to provide better care to patients.

With that as context, this report provides a review of the primary Massachusetts<sup>2</sup> and federal privacy laws relevant to the exchange of information among physical and behavioral health providers and an assessment of technological and operational challenges faced by providers seeking to integrate care through enhanced data exchange. This analysis yielded the following conclusions:

1. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy rule does not create substantial barriers to information exchange among physical and behavioral health providers for routine treatment, care management, and quality improvement purposes.
2. The main legal barriers to data exchange arise under the federal regulations governing substance use disorder treatment programs—42 C.F.R. Part 2—and Massachusetts laws governing mental health information.<sup>3</sup> The Part 2 rules require patient consent for most disclosures for treatment purposes, and the Massachusetts mental health laws could be interpreted as imposing a similar limitation.
3. In addition to legal barriers, primary obstacles to information sharing include variable adoption of electronic health records across behavioral health providers, the absence of true interoperability between the electronic health record systems maintained by different providers, and the failure of electronic health systems to segregate records subject to heightened privacy restrictions.

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1 See D. Lawrence and S. Kisely, “Inequalities in Healthcare Provision for People with Severe Mental Illness,” *Journal of Psychopharmacology* (2010, November) 24(4\_supplement), 61–68.

2 Our review of Massachusetts privacy laws and regulations was limited to those laws and regulations covering general health, mental health, and substance use information. We did not perform a comprehensive review of all state health information privacy laws and regulations.

3 See, e.g., Mass. Gen. Laws ch. 112, §§ 129A, 135A; 104 Mass. Code Regs. 27.17, 28.09; 251 Mass. Code Regs. 1.11; 258 Mass. Code Regs. 22.04; 262 Mass. Code Regs. 8.02.

4. The impact of the current regulatory obstacles could be mitigated to some degree if (a) Massachusetts provided clarifying guidance on the interpretation of ambiguous mental health regulations, (b) providers adopted procedures for exchanging data, such as a “consent-to-access” model, that align with existing legal restrictions and (c) the government promoted beneficial technological developments, such as more widespread electronic health record acquisition, stricter interoperability standards, and enhanced data segmentation capabilities.
  
5. More effective behavioral health information exchange among all of a patient's treating providers will require changes to current laws and regulations. Key changes could include revisions to the Part 2 regulations to simplify the patient consent process and broader treatment exceptions under Massachusetts mental health information laws.

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## INTRODUCTION

Behavioral health providers and clinicians delivering physical health services have historically operated in separate silos. In this segregated treatment model, psychiatrists, psychologists, and social workers often do not regularly communicate with the primary care practitioners serving common patients in order to coordinate care. Similarly, substance use disorder providers do not routinely discuss the interplay between addiction and their patients' medical conditions with other health care professionals treating their patients.

There is a growing recognition that this siloed treatment model must change. The Institute of Medicine has highlighted the need for better care coordination among behavioral and physical health providers,<sup>4</sup> and providers in both the behavioral health and physical health fields of practice now feel strongly that high-quality care requires care integration and coordination.<sup>5</sup> Patients suffering from severe mental illness and addiction often have complex medical problems that cannot be properly addressed in isolation from their behavioral health needs. Moreover, there is increasing recognition that integration of behavioral and physical health care can result in higher-quality and lower-cost care.<sup>6</sup> An important part of a more integrated care delivery model supported by greater information sharing is the careful consideration of a patient's desire for confidentiality and privacy, as well as continued efforts to diminish stigma associated with behavioral health conditions.

In response, the Commonwealth has demonstrated strong interest in supporting care delivery and payment approaches that facilitate behavioral health integration. Chapter 224 of the Acts of 2012 established a Behavioral Health Integration Task Force charged with addressing a range of issues related to this topic, including identifying the best approaches to ensuring integrated care delivery, evaluating how existing reimbursement methods may need to be modified to support integration of care, and considering the range of privacy factors necessary for the development of integrated and interoperable health records.<sup>7</sup> That task force released a detailed set of recommendations addressing those issues in 2013. In addition, the state's Health Policy Commission (HPC) is in the process of implementing Accountable Care Organization (ACO) and Patient Centered Medical Home (PCMH) certification programs that incorporate specific criteria intended to foster behavioral health integration.<sup>8</sup>

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4 The Institute of Medicine of the National Academies, "Improving the Quality of Health Care for Mental and Substance Abuse Conditions" (2006), available at <http://www.ncbi.nlm.nih.gov/books/NBK19830/>.

5 See, e.g., The National Alliance of Mental Illness, "A Family Guide: Integrating Mental Health and Pediatric Primary Care" (2011), available at [http://www.integration.samhsa.gov/integrated-care-models/FG-Integrating\\_12.22.pdf](http://www.integration.samhsa.gov/integrated-care-models/FG-Integrating_12.22.pdf); and Chris Collins et al., "Evolving Models of Behavioral Health Integration in Primary Care" (2010), available at <http://www.milbank.org/uploads/documents/10430EvolvingCare/EvolvingCare.pdf>.

6 For example, in a recent proposed rule SAMHSA observed: "Improving the quality of substance use disorder care depends on effective collaboration of mental health, substance use disorder, general health care, and other service providers in coordinating patient care." 81 Fed. Reg. 6988, 7001 (Feb. 9, 2016).

7 Behavioral Health Integration Task Force, "Report to the Legislature and Health Policy Commission" (2013), available at <http://cliniciansunited.org/wp-content/uploads/2013/10/Behavioral-Health-Integration-Task-Force-Final-Report-and-Recommendations-July2013.pdf>.

8 For more information, see <http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/certification-programs/>.

Finally, leaders of the state's Medicaid program, MassHealth, have identified behavioral health integration as one of the key priorities for the MassHealth program as they develop Medicaid ACO models.<sup>9</sup> To enable implementation of these efforts, policymakers and practitioners are increasingly recognizing that timely and efficient information sharing between behavioral and physical health providers is essential.

Despite this pressing need, the development of information-sharing arrangements between physical and behavioral health providers in Massachusetts has been proceeding at a relatively slow pace.<sup>10</sup> In attempting to explain the halting progress toward robust data exchange, providers frequently point to the barriers created by health information privacy laws. This report is intended to:

- Evaluate the extent to which Massachusetts and federal privacy laws serve as obstacles to the exchange of information among physical and behavioral health providers;
- Assess and summarize some of the technological and operational challenges faced by providers seeking to integrate care through enhanced data exchange;
- Identify potential operational strategies for minimizing the restrictive impact of existing privacy laws on information-sharing initiatives; and
- Propose ways in which existing laws could be clarified or amended to better facilitate data exchange without unduly compromising patient privacy.

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## FEDERAL LAW

### HIPAA

HIPAA establishes a framework under which covered entities—providers, health plans and health care clearinghouses—may share health-related information that identifies an individual, referred to as “protected health information.” Although HIPAA requires covered entities to obtain a patient’s signed authorization for certain types of disclosures, with one limited caveat noted below, HIPAA contains a broad exception that permits covered entities to share protected health information with another provider for purposes of treating a patient.<sup>11</sup> Moreover, HIPAA allows covered entities to disclose information for “health care operations” so long as only the minimum necessary information is disclosed and both parties have a relationship with the patient.<sup>12</sup> “Health care operations” include quality improvement and case management, among other activities.<sup>13</sup> Information may also be exchanged without patient authorization for payment purposes, which

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9 See Executive Office of Health and Human Services, “Public Stakeholder Session: Creating a Sustainable MassHealth Program” (2015), available at <http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/masshealth-innovations/150406.pdf>.

10 See Margaret Houy and Michael Bailit, “Barriers to Behavioral and Physical Health Integration in Massachusetts” (June 11, 2015), available at <http://bluecrossfoundation.org/publication/barriers-behavioral-and-physical-health-integration-massachusetts>.

11 45 C.F.R. § 164.506.

12 45 C.F.R. § 164.506; see also 42 C.F.R. § 164.502(b).

13 45 C.F.R. § 164.501.

includes billing and collecting payment from health plans. As a result, the routine exchange of information among providers to facilitate the integration of physical and behavioral health care is not restricted by HIPAA.

For example, if a primary care physician seeks to share a patient's treatment history with the patient's social worker in order to assist the social worker in providing mental health services to the patient, the primary care physician may do so in compliance with HIPAA even if the patient has not authorized that information sharing. Likewise, a behavioral health provider—without obtaining the patient's authorization—can share treatment information with a patient's health plan care manager to assist the care manager in connecting the patient with other needed services so long as the care manager has an established relationship with the patient.

HIPAA does impose one special limitation on mental health providers. Generally, a covered entity must obtain a patient's authorization in order to disclose psychotherapy notes, even if the disclosure is made to another health care provider for treatment purposes.<sup>14</sup> However, psychotherapy notes are defined narrowly under the HIPAA privacy rule. They consist of notes that (a) are prepared by a mental health professional, (b) document or analyze the contents of a counseling conversation, and (c) are maintained separately from the rest of the patient's medical record. Psychotherapy notes do not include prescription records or summaries of diagnoses, treatment plans, or symptoms.<sup>15</sup> For two reasons, the HIPAA limitation on the exchange of psychotherapy notes is unlikely to have a material impact on initiatives for sharing physical and behavioral health data. First, many institutional mental health providers do not maintain psychotherapy notes because they require their practitioners to incorporate all information about patient care in a single patient chart maintained by the institution. Institutional providers are often reluctant to allow their clinicians to maintain notes in a separate location outside the institution's medical chart because they fear that important information will be lost if the clinician leaves the institution. If the notes are not kept separately from the rest of the medical record, they do not qualify as psychotherapy notes under HIPAA. Second and more important, providers typically do not seek to exchange psychotherapy notes or believe that sharing such notes is necessary to effectively integrate care. Rather,

#### INFORMATION COVERED BY HIPAA

HIPAA applies to "protected health information" (PHI), which is defined as all "individually identifiable health information" other than limited categories of excluded information, such as employment records or education records covered by the Family Educational Rights and Privacy Act. In order for information to be considered individually identifiable health information, it must:

- Be created or received by a health care provider, health plan, employer, or health care clearinghouse;
- Relate to the health status or health care provided to that individual; and
- Identify the individual, by itself or in conjunction with any publicly available information.

For example, a record created by or sent to any provider indicating that John Smith was treated by Physician X would be considered PHI regardless of whether it was part of the physician's medical record, was included in a claim sent to an insurer, or mentioned in an email. Even if John Smith's name was not used, the record could still be considered PHI if it contained other identifying information such as an address or a social security number. The record would be PHI even if it contained no details about John Smith's diagnosis or treatment.

<sup>14</sup> 45 C.F.R. § 164.508(a)(2).

<sup>15</sup> 45 C.F.R. § 164.501.

sharing of other relevant information—such as summaries of treatment plans or diagnoses, and prescription records, which are not considered psychotherapy notes and can be shared under HIPAA without patient consent—can serve to adequately coordinate care.

## 42 CFR PART 2

While HIPAA grants providers a great deal of flexibility to share patient information for treatment and other clinically related purposes, the federal Confidentiality of Alcohol and Drug Abuse Patient Records regulations (42 C.F.R. Part 2) impose significantly stricter restrictions. But before considering these limitations, it is important to understand the particular class of providers subject to the Part 2 rules.

Unlike HIPAA, which applies to all health care providers, Part 2 governs only “federally assisted alcohol and drug abuse treatment programs.” Thus, in order to be subject to Part 2, a provider must meet two tests:

- **Program:** To be considered an alcohol or drug abuse treatment “program,” an individual or entity must “hold[ ] itself out as providing, and provide[ ], alcohol or drug abuse diagnosis, treatment or referral for treatment.”<sup>16</sup> This generally means that a clinic, residential setting, or inpatient facility specially licensed to provide substance use disorder treatment, or any other organization that publicly describes itself as a substance use disorder treatment provider is a “program.” In contrast, a typical medical practice or a general hospital is not a “program” even if it provides substance use diagnosis or treatment services on a periodic basis.<sup>17</sup> For example, a general hospital that provides detoxification services through its emergency room would not be a program so long as it does not promote its provision of these services.
- **Federally assisted:** Most individuals or entities that meet the definition of a “program” are considered “federally assisted” because of the broad definition of this term. Federal assistance includes:
  - The receipt of any federal funds;
  - Tax-exempt status; or,
  - The maintenance of a license issued by a federal agency, such as certification by Medicare or registration to dispense controlled substances.<sup>18</sup>

A small number of “programs” may not meet the test for federal assistance. For example, a private, for-profit substance use disorder residential program that does not accept payment from Medicare, Medicaid, or any other government program and does not dispense controlled substances may fall outside the scope of Part 2.

Part 2, in contrast to HIPAA, does not allow providers that operate federally assisted programs to share Part 2 information without patient consent for purposes of non-emergency treatment, payment, or health care operations. Instead, Part 2 requires such programs to obtain the patient’s

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<sup>16</sup> 42 C.F.R. § 2.11.

<sup>17</sup> A specialized substance use disorder treatment unit that operates within a general medical facility would generally constitute a “program.”

<sup>18</sup> 42 C.F.R. § 2.12(b).



consent for these types of information sharing. However, patient consent is not required to provide treatment in a medical emergency, which is defined under Part 2 as a situation under which “medical personnel . . . have a need for information about a patient for the purpose of treating a condition which poses an immediate threat to the health of any individual and which requires immediate medical intervention.”<sup>19</sup>

A patient’s consent must be in writing and signed by the patient or his or her personal representative. The consent form must include a general description of the program or person making the disclosure, the purpose of the disclosure, and the kind of information being disclosed. Importantly, the consent form must also list “[t]he name or title of the individual or the name of

the organization to which disclosure is to be made.”<sup>20</sup> The Substance Abuse and Mental Health Services Administration (SAMHSA) has interpreted this provision to mean that the consent form cannot reference a class of providers—such as all providers who treat the patient—and, instead, must specifically list each provider authorized to receive patient information. SAMHSA has further indicated that the list of potential recipients must be included within the text of the consent form itself or on a printed attachment to that form. That means that if a consent form indicates that information may be shared with all providers who are listed at a particular Web address, this form violates the Part 2 rules because the names of the providers are not listed on the form itself.<sup>21</sup> However, a Part 2 consent form does not have to specify all individual practitioners employed by or associated with a practice or a facility. For example, a consent form stating that information may be shared with Hospital X would allow a substance use disorder clinic to share information with all practitioners providing services at Hospital X.

SAMHSA’s interpretation presents significant challenges to implementing community-wide or multi-provider data exchange. For example, a new patient visiting a substance use disorder program may need treatment in the future for a number of physical ailments. That patient may not yet know which physical health providers are going to be providing that treatment, but the patient may nonetheless want the substance use disorder program to communicate with any of those providers as the need arises. The patient, though, cannot sign a consent form allowing all of those treating providers to access the patient’s information from the Part 2 program. Instead, every time the patient visits a new provider, the patient must sign a new consent form allowing that provider to access the patient’s Part 2 data. This process can be cumbersome. In practice, many

#### IS PATIENT CONSENT REQUIRED?

Purpose of Disclosure	HIPAA	Part 2*
Emergency treatment	No	No
Non-emergency treatment	No	Yes
Billing insurers	No	Yes
Care management	No	Yes
Quality improvement	No	Yes

\* Part 2 permits a federally assisted program to disclose information to a “qualified service organization” assisting the program in carrying out certain functions such as billing or quality reviews. A qualified service organization is similar to a business associate under HIPAA and must sign a “qualified service organization agreement” with the program. However, the qualified service organization may not disclose information to any other party without patient consent.

<sup>19</sup> 42 C.F.R. § 2.51.

<sup>20</sup> 42 C.F.R. § 2.31(a).

<sup>21</sup> SAMHSA, “Applying the Substance Abuse Confidentiality Regulations, Q16” (Apr. 28, 2015), available at <http://www.samhsa.gov/about-us/who-we-are/laws/confidentiality-regulations-faqs>; and SAMHSA, “Applying the Substance Abuse Confidentiality Regulations to Health Information Exchange, Q18,” available at <http://archive.samhsa.gov/healthPrivacy/docs/EHR-FAQs.pdf>.

patients will fail to sign these multiple forms, thereby preventing their physical health providers from understanding their concurrent substance use disorder treatment.

Further complicating the compliance challenge is the fact that, while the Part 2 rules apply only to federally assisted alcohol and drug abuse treatment programs, the rules' restrictions extend to the re-disclosure of information received by any provider from a Part 2 program pursuant to the patient's consent. Indeed, every time a Part 2 program shares a patient's condition and treatment plan with another entity in accordance with the patient's consent, the program that is sharing information must provide a written warning notice to the recipient. That notice must contain standard language indicating that the data is protected by Part 2 and that the recipient may re-disclose the information to a third party only in accordance with the Part 2 rules.<sup>22</sup> As a result, providers ostensibly not subject to Part 2 may maintain some records whose disclosure is governed by Part 2 limitations. Distinguishing this Part 2 information from the remainder of the provider's records may be extremely difficult, especially in an automated electronic data exchange environment. For example, in a paper-based world, if a primary care physician receives information about a patient from a Part 2 program, the physician may keep the Part 2 information in a separate file that is not shared with other providers as part of the patient's medical record. In contrast, in an electronic world, all of the primary care physician's records may be uploaded into an electronic health record, and if the electronic health record has no means of distinguishing the Part 2 information from other data, the Part 2 information may be inadvertently disclosed to another provider when the primary care physician engages in an electronic exchange of patient records.

SAMHSA has recently recommended changes to the Part 2 rules, but SAMHSA's proposal as it currently stands does not appear to resolve these challenges. In a proposed rule issued on February 9, 2016, SAMHSA states that "an entity that facilitates the exchange of health information" should be allowed to share substance use disorder information with providers who provide treatment to the patient even if the consent form only contains a "general designation" of the recipients.<sup>23</sup> In other words, a patient could sign a form that says that substance use disorder information may be shared with "all of my current and future treating providers that participate in the Massachusetts Health Information Highway (Mass Hlway)."

However, SAMHSA also proposes stricter requirements relating to a Part 2 consent form. One new requirement is that a consent form would have to include "an explicit description of the substance use disorder information that may be disclosed" and that writing "all of my records" would be unacceptable. While SAMHSA has not provided an in-depth explanation of this proposed change, it could be interpreted to require that a patient would have to execute a new consent form every time a patient sought to share a different category of information. Under this interpretation, if a patient wanted to share his or her substance use disorder medication information with providers participating in the Mass Hlway, the patient would have to execute one consent form, but if the patient later wanted to share his or her treatment plan, a separate consent form would have to be executed. This could effectively mean that patients would have to continuously sign consent forms in order to share their information and therefore could cause Part 2 programs to

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<sup>22</sup> 42 C.F.R. § 2.32; see also 42 C.F.R. § 2.12(d)(2)(iii).

<sup>23</sup> 81 Fed. Reg. 6988 (Feb. 9, 2016).

decline to share information rather than take on the burden of obtaining these multiple consents. SAMHSA also proposes that the consent form must list the names of all Part 2 programs that are sharing information, a requirement that may also pose implementation challenges.

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## MASSACHUSETTS LAW

### GENERAL HEALTH RECORDS

Massachusetts does not have a detailed, comprehensive health privacy statute akin to HIPAA. Instead, the state has a patchwork of laws and regulations that address how different types of providers may share different types of health information. The statutory provisions that apply generally to all health records state broadly that such records are confidential but provide little detail regarding the circumstances under which those records may be disclosed. For example, patients have a right “to confidentiality of all records and communications to the extent provided by law.”<sup>24</sup> Clinics must “maintain and use patient records in a manner that protects the confidentiality of the information contained therein.”<sup>25</sup> Given the fact that these laws do not expressly prohibit providers from sharing information for purposes of treatment, payment, or health care operations, Massachusetts officials interpret them as allowing providers to share information so long as they do so in compliance with HIPAA.<sup>26</sup>

Other state statutes, however, apply clearer standards to the disclosure of specific categories of sensitive health information. For example, Massachusetts requires providers to obtain the patient’s written consent prior to disclosing HIV test results<sup>27</sup> or genetic test results.<sup>28</sup> Some of the most detailed legal provisions relate to the sharing of behavioral health information. These provisions are described below.

### MENTAL HEALTH INFORMATION

Massachusetts law goes beyond HIPAA in restricting the disclosure of mental health information for treatment, payment, and health care operations. One set of state rules applies to mental health practitioners:

- **Psychologists:** The statute governing the practice of psychology prohibits psychologists from disclosing patient information absent patient consent except in limited circumstances. There is no exception for disclosures for treatment.<sup>29</sup> The statute does, however, authorize the Board of Registration of Psychologists to set out other exceptions by issuing regulations. And the

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24 Mass. Gen. Laws ch. 111, § 70E(b).

25 105 Mass. Code Regs. 140.302(D).

26 See, e.g., Massachusetts Executive Office of Health and Human Services, “Health Information Technology Council Meeting” (Dec. 7, 2015) (noting that Massachusetts allows most health information to be exchanged without patient consent via fax, mail, or phone so long as it is done in compliance with HIPAA), available at <http://www.mass.gov/eohhs/docs/eohhs/masshway/20151207hitcouncilpresentation.pdf>.

27 Mass. Gen. Laws ch. 111, § 70F.

28 Mass. Gen. Laws ch. 111, § 70G.

29 Mass. Gen. Laws ch. 112, § 129A.

Board's regulations do allow psychologists to share patient information "to another appropriate professional as part of a professional consultation which is designed to enhance the services provided to a client or clients..." Psychologists must "use their best efforts to safeguard the client's privacy by not disclosing the client's name or other identifying demographic information, or any other information by which the client might be identified by the consultant, unless such information is, in the psychologist's judgment, necessary for the consultation to be successful."<sup>30</sup> The above language suggests that the consultation exception is a narrow one—enabling providers to share information with professional colleagues (such as psychiatrists, social workers or other psychologists) for purposes of informing their own care approach and practices—but would not cover broad access to a psychologist's records by all of a patient's treating providers. For example, a psychologist looking for advice on how to encourage a bipolar patient to adhere to the psychologist's treatment plan would be able to consult with another professional regarding the facts of the case. But it is not clear that a psychologist could share patient-identifying information with the patient's internist to enable the internist to deliver better primary care, because this scenario does not fall into the traditional definition of a "consultation" by the psychologist.

- **Social workers:** Massachusetts law generally allows social workers to disclose information only with the "express, written consent" of the patient; there is no statutory exception permitting disclosure for treatment purposes absent some type of patient consent.<sup>31</sup> Regulations allow social workers to disclose patient information to an employee, agent, supervisor, or licensed, professional colleague if (a) the client has been informed of the disclosure in advance and has not objected to it, (b) the recipient "is responsible for ensuring the adequacy and/or continuity of professional services for that client" and the disclosure relates to that responsibility, (c) the disclosure is limited to what is reasonably necessary, and (d) the recipient is required to keep the information confidential.<sup>32</sup>
- **Allied mental health professionals:** Allied mental health professionals include mental health counselors, marriage and family therapists, rehabilitation counselors, and educational psychologists. The statute governing these professionals allows them to disclose patient information only "where a client agrees to a waiver." As is the case with psychologists and social workers, the statute does not allow disclosures for all treatment-related purposes.<sup>33</sup> The allied mental health regulation, like the psychologist regulation, allows these professionals to disclose patient information to another professional "as part of a consultation which is designed to enhance the services provided" as long as the professional uses her or his best efforts not to disclose the "client's name or other identifying demographic information, or any other information by which the client might be identified by the consultant."<sup>34</sup>
- **Psychiatrists:** There are no statutory or regulatory provisions that are specifically applicable to health information maintained by psychiatrists. As a result, psychiatrists in private practice can share mental health information with other providers without obtaining patient consent

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<sup>30</sup> 251 Mass. Code Regs. 1.11(1).

<sup>31</sup> Mass. Gen. Laws ch. 112, § 135A.

<sup>32</sup> 258 Mass. Code Regs. 22.04(1).

<sup>33</sup> Mass. Gen. Laws ch. 112, § 172.

<sup>34</sup> 262 Mass. Code Regs. 8.02(3).

so long as they do so for purposes of treatment, payment, or health care operations and the information does not consist of psychotherapy notes.<sup>35</sup>

Different rules apply to mental health facilities and programs. As is the case with psychologists, social workers, and allied mental health professionals, mental health facilities cannot share patient information unless a specific exception applies. These facilities may disclose patient information “upon receipt of written authorization from the patient or the patient’s legally authorized representative”—if the authorization meets HIPAA requirements.<sup>36</sup> That means that the authorization must, among other things, describe the information to be disclosed “in a specific and meaningful fashion,” identify the disclosing party and the recipient (either by name or by a class), describe the purpose of the disclosure, and include an expiration date.<sup>37</sup> In addition, mental health facilities may disclose patient information without patient consent if the state has determined that disclosure would be in the best interest of the patient, that the disclosure is permitted under HIPAA, and that it is not practical to obtain the patient’s written authorization. Examples of when, under state regulations, it is in the “best interest” of a patient to disclose information include cases where any of the following is true: (a) the patient is being transferred from one facility to another; (b) there is a medical or psychiatric emergency; (c) the information is sent to a facility currently caring for the patient and “the disclosure is necessary for the safe and appropriate treatment and discharge of the patient”; or (d) “if the patient has provided consent for a particular treatment or service, to those persons involved in such treatment or service.”<sup>38</sup> But even in cases where it is in the best interest of the patient, exchange is only permitted if it is “not possible or practicable” to obtain the written authorization of the patient. The same framework applies to community-based programs providing mental health services.<sup>39</sup> These rules are ambiguous in two respects. First, there may be uncertainty as to when it is “not possible or practicable” to obtain the patient’s authorization. Second, it is unclear whether these rules apply to the services of a professional provided within a mental health facility or if the records of such services are governed by the profession-specific laws discussed above.

Where mental health services are provided to a patient covered by MassHealth, the Massachusetts Medicaid program, disclosures may be subject to further restrictions. MassHealth regulations mandate that psychiatric hospitals, psychiatric day treatment programs, and mental health center services obtain a patient’s signed authorization whenever they disclose the patient’s information; there are no exceptions listed in the regulations.<sup>40</sup> Similarly, MassHealth regulations allow psychologists to release medical information only if the disclosure is *required* by law or if the information is being shared with employees or consultants of the Massachusetts Division of Medical Assistance or the federal Department of Health and Human Services (HHS).<sup>41</sup> These MassHealth restrictions appear to override the otherwise applicable privacy laws.

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<sup>35</sup> Psychiatrists who practice in licensed mental health facilities arguably are subject to a different set of rules, as discussed below.

<sup>36</sup> 104 Mass. Code Regs. 27.17(9)(b).

<sup>37</sup> 45 C.F.R. § 164.508(c).

<sup>38</sup> 104 Mass. Code Regs. 27.17(9)(c), (d).

<sup>39</sup> 104 Mass. Code Regs. 28.09(4)(b), (c), (d).

<sup>40</sup> 130 Mass. Code Regs. 417.437(B), 425.423(B), 429.436(B).

<sup>41</sup> 130 Mass. Code Regs. 411.413(B).

Certain mental health practitioners who counsel patients regarding sexual assault or domestic violence may disclose information arising out of such counseling only with the victim’s prior written consent. This restriction applies to sexual assault counselors working at rape crisis centers and domestic violence victims’ counselors working for a domestic violence victims’ program.<sup>42</sup>

**DISCLOSURE FOR TREATMENT PURPOSES BY MENTAL HEALTH PROVIDERS UNDER MASSACHUSETTS LAW**

<b>Provider Type</b>	<b>May the provider disclose patient information without patient consent for treatment purposes in non-emergency situations?</b>
Psychologists	Only if (a) information is shared with another professional pursuant to a consultation and (b) the psychologist undertakes best efforts to safeguard the patient’s identity, unless identifiable information is necessary for the consultation to be successful. But psychologists may not share if treating a MassHealth patient.
Allied mental health professionals (mental health counselors, marriage and family therapists, rehabilitation counselors, educational psychologists)	Only if (a) information is shared with another professional pursuant to a consultation and (b) the professional undertakes best efforts to safeguard the patient’s identity.
Social workers	Only if (a) the patient has been informed of the disclosure and has not objected, (b) the recipient is responsible for ensuring the adequacy and/or continuity of professional services to the patient, (c) the disclosure is limited to what is reasonably necessary, and (d) the recipient is required to keep the information confidential.
Psychiatrists	Yes.
Mental health facilities and community-based programs	Only if it is not practical to obtain the patient’s consent and doing so is in the “best interest” of the patient. But mental health facilities may not share if treating a MassHealth patient.
Sexual assault counselors and domestic violence victims counselors	No.

The net result of all these rules is that Massachusetts mental health providers will typically need to ensure that a patient has provided written consent before sharing mental health information with other providers. This is the case because:

- The rules governing psychologists, social workers, and allied mental health professionals significantly limit when these practitioners may exchange patient information without consent.
- The rules applicable to mental health facilities and programs are more flexible in that they allow these facilities and programs to exchange patient information in certain circumstances where it is in the “best interest” of the patient, but these providers still must make an effort to obtain consent or determine that obtaining consent is not practical.
- When the patient is on Medicaid or the practitioner works at a rape crisis center or domestic violence victims’ program, the “best interest” exception is not available.

<sup>42</sup> Mass. Gen. Laws ch. 233, §§ 20J, 20K.

Compliance with consent requirements is complicated by the fact that some of the regulations require the written consent to comply with the HIPAA authorization form standards. As a result, it may be simplest for providers to always use a HIPAA-compliant authorization form, even though that is not always required by Massachusetts law. A list of the required elements of a HIPAA authorization form, and a comparison of these elements with those required for a Part 2 consent, are presented below.

#### AUTHORIZATION FORM REQUIREMENTS: HIPAA VS. PART 2

Element	HIPAA*	Part 2**
<b>Identity of disclosing party(ies)</b>	Identifying a “class of persons” is sufficient.	Similar to HIPAA. May be identified by name or through a “general designation.” Proposed rule would end “general designation” option.
<b>Identity of recipient(s)</b>	Identifying a “class of persons” is sufficient.	More stringent than HIPAA. Must be identified by name. Proposed rule would allow a “general designation” if exchange occurred through a health information exchange and if shared only with treating providers.
<b>Name of patient</b>	Required.	Required.
<b>Description of information</b>	Information being disclosed must be identified in a “specific and meaningful fashion.”	How much and what kind of information being disclosed must be identified. Proposed rule would require an “explicit description” of the information being disclosed.
<b>Purpose of disclosure</b>	Required.	Required.
<b>Expiration date</b>	Expiration date must relate to the individual or the purpose of the disclosure.	Expiration date cannot be longer than necessary to serve the purpose of the disclosure.
<b>Patient signature</b>	Required.	Required.
<b>Disclosures</b>	Form must inform the patient that (a) he/she has a right to revoke; (b) treatment/eligibility cannot depend on authorization; and (c) information may be re-disclosed and will be no longer protected.	Form must inform the patient that it is subject to revocation at any time. Proposed rule would require form to indicate that patient may receive a list of entities that received the patient’s Part 2 information.

\* 45 C.F.R. § 164.508(c).

\*\* 42 C.F.R. § 2.31(a).

One helpful consent management consideration is that, unlike the version of the Part 2 rules that are currently in effect, the HIPAA authorization requirements (and, by extension, the Massachusetts mental health provider rules) do allow the authorization form to list a class of recipients and do not require the form to list the specific name of every information recipient. Thus, although providers will generally need to make sure the patient has consented to the sharing of his or her mental health information, a form that allows the sharing of mental health information with all

entities that provide treatment to a patient could comply with Massachusetts and federal law. This means that the barriers to exchanging mental health information through a health information exchange, such as the Mass Hlway—a conduit through which providers can exchange patient information electronically (discussed in more detail below)—are lower than the barriers to exchanging information subject to Part 2.

## **SUBSTANCE USE DISORDER INFORMATION**

The Massachusetts Department of Public Health regulations require state-licensed substance use disorder treatment programs to comply with the requirements of Part 2 if applicable.<sup>43</sup>

To the extent there are private drug rehabilitation facilities and programs in Massachusetts that are not “federally assisted” and therefore fall beyond the reach of Part 2, a state statute requires these facilities to comply with Part 2 requirements. Moreover, the state’s public health law dictates that the form of consent for drug rehabilitation programs “shall state the name of the person or organization to whom the disclosure is to be made, the specific type of information to be disclosed, and the purpose or need for such disclosure.”<sup>44</sup> It is worth noting that if SAMHSA follows through on its proposal to eliminate, under certain circumstances, the requirement to name all information recipients in the consent form, it appears that this public health law provision would have the effect of keeping that requirement in place for Massachusetts providers.

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## **TECHNOLOGICAL BARRIERS TO SHARING BEHAVIORAL HEALTH INFORMATION**

Privacy laws are not the only barriers to the sharing of behavioral health information among providers. There are technological obstacles to electronic data exchange that also impede the integration of physical and behavioral health care.

## **LACK OF ELECTRONIC HEALTH RECORDS SYSTEMS**

Behavioral health providers are less likely than hospitals or physical medicine practices to use electronic health record (EHR) systems. Behavioral health organizations, on average, spend half as much money on information technology as general health care providers.<sup>45</sup> A 2012 study found that only two percent of psychiatric hospitals responding to an earlier survey had an EHR system.<sup>46</sup> While adoption of EHRs has increased in the last few years, behavioral health providers in Massachusetts still lag behind their physical medicine counterparts. A 2014 survey found that 55 percent of Massachusetts’s behavioral health providers had EHRs, compared with 96

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<sup>43</sup> 105 Mass. Code Regs. 164.084.

<sup>44</sup> Mass. Gen. Laws ch. 111E, § 18(a).

<sup>45</sup> Office of the National Coordinator for Information Technology, Behavioral Health and Health IT (Sept. 26, 2013), available at [https://www.healthit.gov/sites/default/files/bhandhit\\_issue\\_brief.pdf](https://www.healthit.gov/sites/default/files/bhandhit_issue_brief.pdf).

<sup>46</sup> Larry Wolf et al., “Hospitals Ineligible for Federal Meaningful-Use Incentives Have Dismally Low Rates of Adoption of Electronic Health Records,” *Health Affairs* (Mar. 2012), available at <http://content.healthaffairs.org/content/31/3/505.long>.



percent of primary care providers.<sup>47</sup> Providers that lack EHRs are more likely to rely on faxes and other less efficient or secure paper-based methods for sharing health information. Although the state's health information exchange, the Mass HIway, does enable providers to participate in the exchange via webmail if they do not have an EHR system, it will likely be difficult for providers to obtain the full benefits of the electronic exchange of information if they lack EHRs, since webmail users cannot send and receive large volumes of information and can participate only on an ad-hoc basis.<sup>48</sup>

The lower rate of EHR adoption within the behavioral health community may stem, in part, from the view that behavioral health records are more sensitive than physical health records and therefore should be less widely shared. But the EHR adoption gap also results from the fact that the Medicare and Medicaid EHR incentive programs enacted under the Health Information Technology for Economic and Clinical Health (HITECH) Act, under which hospitals receive financial incentives to adopt EHRs, does not apply to psychiatric facilities.<sup>49</sup> Likewise, while psychiatrists and psychiatric nurse practitioners are eligible for the Medicare and Medicaid EHR incentives, other types of mental health practitioners, such as psychologists, social workers, and family therapists, are not.<sup>50</sup> Without a funding source to pay the costs of EHR adoption, many behavioral health providers have been unable to do so.

## LACK OF INTEROPERABILITY

Even behavioral health providers that have adopted an EHR system may face difficulties in electronically exchanging patient information with other providers. In order to make full use of the data exchange potential of their EHRs, the respective providers' EHR systems must be interoperable; the systems must be able to share information with one another even if they are designed by different EHR vendors. However, many EHR systems do not readily interface with other EHR platforms, making the electronic exchange of patient information difficult.

Interoperability obstacles reflect an unintended policy failure of the federal EHR incentive program. In order to fit within exceptions to federal fraud and abuse laws designed to promote EHR adoption, physician EHR systems subsidized by hospitals have to be interoperable.<sup>51</sup> Yet interoperability is defined narrowly in the relevant regulations; the result is that subsidized EHRs do not truly have to seamlessly interface with EHRs designed by other vendors in order to be subsidized.

The HITECH "meaningful use" rules compound the problem. Providers eligible for the incentive program earn payments—and avoid financial penalties—by demonstrating "meaningful use" of their EHR systems through achieving various metrics. Currently, those metrics focus on issues

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47 Massachusetts eHealth Institute, "MeHI Connected Communities Overview," available at <http://mehi.masstech.org/sites/mehi/files/documents/Presentations/Webinars/Connected%20Communities%20Overview%20HIT%20Week%2010.01.15.pdf>.

48 Massachusetts Health Information HIway, "Mass HIway Connection Options," available at <http://www.masshiway.net/HPP/Services/ConnectionMethods/index.htm>.

49 42 C.F.R. §§ 495.100, 495.304(a); see also 42 C.F.R. §412.23(a).

50 42 C.F.R. §§ 495.100, 495.304(a)(1), (b).

51 42 C.F.R. §§ 411.357(w), 1001.952(y). The relevant fraud and abuse laws are the physician self-referral law, commonly known as the Stark law, and the anti-kickback statute. The Stark law prohibits certain financial relationships between hospitals and physicians who make referrals to those hospitals. The EHR exception allows hospitals to subsidize EHR systems of referring physicians in some circumstances without violating the Stark law. Similarly, the anti-kickback statute prohibits entities from offering or conveying remuneration in order to obtain a referral paid for by a federal health care program. Hospitals and practitioners could be viewed as violating this law in cases where the hospital helps pay for the referring practitioner's EHR. The EHR "safe harbor" to the anti-kickback statute is designed to protect this activity.

such as patient access to information and electronic prescribing, not the routine sharing of clinical records among different treating providers. For 2015 through 2017, eligible providers must show they are engaging in “Health Information Exchange,” but this only requires the provider to make available a summary-of-care record to another provider in 10 percent of the cases where the first provider refers or transfers a patient to another provider.<sup>52</sup> The “meaningful use” requirements that are set to go into effect in 2018 require providers to deliver summary-of-care records in 50 percent of such cases, but providers may never be subject to this rule. The acting administrator of the Centers for Medicare and Medicaid Services (CMS) recently announced that 2016 may be the last year of the EHR incentive program and that the Merit-Based Incentive Payment System (MIPS) established under the Medicare Access & CHIP Reauthorization Act of 2015 may replace the EHR incentive payment system.<sup>53</sup> Even if the “Health Information Exchange” requirement does survive, under the current iteration of the rule providers could demonstrate “Health Information Exchange” by incorporating summary-of-care documents received into their EHRs and by engaging in clinical information reconciliation, instead of providing summary-of-care records themselves.<sup>54</sup> Moreover, since behavioral health providers generally are not eligible to participate in the Medicare and Medicaid EHR incentive programs and therefore are not subject to the meaningful use requirements that are part of those programs, this rule will only encourage physical health providers to share information with behavioral health providers, not vice versa.

Difficulties in sharing information may also result from active “information blocking.” According to the Office of the National Coordinator for Health Information Technology (ONC), “[i]nformation blocking occurs when persons or entities knowingly and unreasonably interfere with the exchange or use of electronic health information.”<sup>55</sup> Some EHR vendors and providers have been accused of engaging in information blocking as a means of maintaining profits. For example, an EHR vendor may impose fees on the sharing of information with providers who use other EHR products in order to encourage the widespread adoption of its products. Providers may also engage in information blocking to keep in place referral patterns or to prevent information sharing that could lead to an unwelcome reduction in services. Privacy laws are often used as an excuse for information blocking. Given the stricter privacy laws in the behavioral health realm, certain behavioral health providers may cite these privacy laws as a reason for not engaging in health information exchange when they are actually refraining from such exchange for strategic, rather than privacy, reasons.

Mass Hlway may ameliorate some of these problems, but it is unlikely to fully resolve the technological barriers to data exchange. Under a provision of Massachusetts’ health information technology statute that goes into effect on January 1, 2017, “[a]ll providers in the Commonwealth shall implement fully interoperable electronic health records systems that connect to the

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<sup>52</sup> 42 C.F.R. § 495.22(e)(5).

<sup>53</sup> See Henry Powderly, “Andy Slavitt Puts Meaningful Use on Ice,” *Healthcare IT News* (Jan. 13, 2016), available at [http://www.healthcareitnews.com/news/andy-slavitt-puts-meaningful-use-ice-read-his-jp-morgan-speech-transcript?mkt\\_tok=3RkMMJWWfF9wsRonuq%2FPcO%2FhmjTEU5z16u4qW660i4kz2EFye%2BLIHETpdcMTcBhN7%2FYDBceEJhQyQJxPr3MLtINwNlqRhPrCg%3D%3D](http://www.healthcareitnews.com/news/andy-slavitt-puts-meaningful-use-ice-read-his-jp-morgan-speech-transcript?mkt_tok=3RkMMJWWfF9wsRonuq%2FPcO%2FhmjTEU5z16u4qW660i4kz2EFye%2BLIHETpdcMTcBhN7%2FYDBceEJhQyQJxPr3MLtINwNlqRhPrCg%3D%3D).

<sup>54</sup> 42 C.F.R. § 495.24(d)(7).

<sup>55</sup> The Office of the National Coordinator for Health Information Technology, “Report of Health Information Blocking” (Apr. 2015), available at [https://www.healthit.gov/sites/default/files/reports/info\\_blocking\\_040915.pdf](https://www.healthit.gov/sites/default/files/reports/info_blocking_040915.pdf). In 2015, Congress required eligible providers in the Medicare EHR incentive program to demonstrate that they are not engaging in information blocking in order to be considered a meaningful user. See Medicare Access and CHIP Reauthorization Act of 2015, § 106(b)(2).

statewide health information exchange.”<sup>56</sup> In theory, this means that all providers in the state will have technology that enables them to electronically share health information with every other provider in the state within one year. In reality, though, providers can get waivers of this requirement for good cause, and some behavioral health providers may continue to fail to connect to the Mass Hlway.<sup>57</sup> Moreover, providers lacking an EHR system that connects with the Mass Hlway may choose instead to connect via webmail. This approach may prevent these behavioral health providers from fully participating in information exchange.

## **DIFFICULTY IN SEGMENTING SENSITIVE INFORMATION**

Health information technology also generally fails to simplify compliance with the more stringent legal requirements imposed on the disclosure of sensitive health information. For example, as noted earlier, a consent form that fails to state the name of every data recipient is not valid under the federal Part 2 rules. In contrast, a consent that references a class of providers can satisfy Massachusetts rules, which generally follow the HIPAA requirements for the content of patient authorizations. Moreover, while the Mass Hlway law allows providers to exchange information only about patients who have chosen to opt in to the exchange,<sup>58</sup> there are no specific requirements as to what must be in the Mass Hlway consent form, and the Massachusetts Information Technology Council has informed providers that they may choose to use a separate consent form or incorporate a Mass Hlway consent into other consent forms.<sup>59</sup>

Thus, a more easily obtained consent form that refers broadly to “all treating providers” could be used for exchanging physical and mental health information if substance use disorder treatment information subject to Part 2 could be filtered or segregated from the physical and mental health records. Unfortunately, EHR systems generally do not provide a simple mechanism for such data segmentation. Lacking an ability to separate the information subject to a stricter consent requirement, many providers are left with the choice of either withholding all of their records or obtaining a limited provider-specific consent in all cases.<sup>60</sup>

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## **POTENTIAL SOLUTIONS WITHIN THE CURRENT REGULATORY ENVIRONMENT**

While, as discussed below, regulatory change at the federal and state levels is likely necessary to fully achieve the goal of physical and behavioral health data exchange, there are steps that policy makers and the Massachusetts provider community can take to promote such exchange under

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<sup>56</sup> Mass. Gen. Laws ch. 118I, § 7.

<sup>57</sup> Mass. Gen. Laws ch. 118I, § 8.

<sup>58</sup> Mass. Gen. Laws ch. 118I, §§ 11, 13.

<sup>59</sup> The Massachusetts Health Information Highway, “About Mass Hlway Consent,” available at <http://www.masshiway.net/HPP/Resources/ConsentforMassHlway/index.htm>.

<sup>60</sup> A similar problem arises regarding services obtained by minors based on their own informed consent, rather than the informed consent of the minor’s parent or guardian. These “minor consent services” are subject to different consent rules than other services provided to minors, but EHR systems do not distinguish between these two categories.

the current regulatory schemes. These solutions involve both clarification of existing laws and regulations by government officials as well as creative operational approaches by providers.

## CLARIFICATION OF EXISTING LAWS AND REGULATIONS

The myriad Massachusetts laws governing mental health information are open to differing interpretations. In a multi-provider exchange, the most conservative interpretations are likely to govern. The state could assist providers by issuing guidance that focuses on what information-sharing practices are allowed under state law. In particular, state clarification of the following provisions could help promote information exchange:

- **Consultation exception:** It seems likely that many, if not most, psychologists and allied mental health professionals currently interpret the consultation exception as applicable only to traditional consults in which the disclosing professional is seeking another practitioner's opinion about a clinical matter relating to the disclosing professional's treatment of the patient. The state could clarify that the term "consultation" may be construed more broadly to apply to all types of care coordination and joint treatment being carried out by multiple providers serving the patient.
- **Best interest exception:** State law allows mental health facilities and community programs to disclose patient information to another provider if "not possible or practicable" to obtain consent and if disclosure is in the "best interest" of the patient. The state could provide guidance giving providers substantial leeway in determining whether it is possible or practicable to obtain consent. For example, state guidance could indicate that the standard is met if the patient is not physically present when a provider seeks access to records for purposes of informing treatment of the patient.
- **Facilities vs. professionals:** The rules that cover professionals clearly apply when a professional such as a psychologist treats a patient in his or her own private office. But if the psychologist is providing care in a state-licensed mental health facility, it is unclear whether the rules for psychologists or those for mental health facilities apply. State guidance indicating that the more flexible facility rules apply would eliminate this ambiguity.
- **Content of consent form:** Some Massachusetts mental health regulations indicate that consent can be obtained using a HIPAA-compliant authorization form. Massachusetts regulators could clarify that a HIPAA-compliant authorization form is always sufficient for the exchange of mental health information.

In addition to clarification regarding the consent form rules, providers, Mass Hlway, and state government officials could work together to develop a model consent form that could be used for the exchange of all categories of sensitive health information, including mental health information subject to heightened protections under state law and Part 2 information. Mass Hlway has so far left it up to providers to determine the specifics of a consent form. However, both Part 2 and Massachusetts regulations have specific requirements as to what must appear on a consent form that is used to exchange behavioral health information, meaning that behavioral health providers must ensure their consents meet standards that are not applicable to most other medical providers. A standardized consent form that is also recognized by Mass Hlway could help give behav-

ioral health providers confidence that they are exchanging information in compliance with both state and federal law.

## **OPERATIONAL SOLUTIONS**

As discussed above, one of the most substantial barriers to the exchange of substance use disorder treatment information is the Part 2 requirement that the patient consent form specifically list each individual or organization that will have access to Part 2 information. This requirement is extremely difficult to satisfy if consent is obtained at the point of disclosure by the Part 2 program. However, obtaining consent at the point of access simplifies compliance. Under a “consent-to-access” model, the non-Part 2 provider that is seeking Part 2 data, rather than the disclosing Part 2 program, obtains consent from the patient. The advantage of this model is that it better aligns with the Part 2 rules, which allow a broader description of data disclosers than data recipients. While the Part 2 rules require the names of all information recipients to be listed on the consent form, the parties disclosing data can be identified by a “general designation.” This means that a consent obtained by a primary care physician participating in an exchange such as the Mass Hlway could describe the disclosing providers as “all substance use disorder providers in Massachusetts.” At the same time, the consent could simply list the primary care provider as the recipient of the information. Each accessing provider could obtain a similar consent. As new Part 2 providers join the exchange, the consent would permit disclosure of their records to the primary care physician.

The consent-to-access model offers two ancillary benefits. First, providers seeking to access information for their own purposes may be more motivated to obtain patient consent than disclosing providers whose efforts will benefit others. Second, in accordance with SAMHSA guidance, a Part 2 program may upload its records to a centralized health information organization (HIO) without patient consent under a qualified service organization agreement. If Part 2 information is uploaded in this manner, it can be made available by the HIO to hospital emergency rooms in a medical emergency without patient consent.

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## **POTENTIAL CHANGES TO LAWS AND REGULATIONS**

### **REVISIONS TO THE PART 2 RULES**

The greatest obstacles to efficient data exchange created by SAMHSA's interpretation of 42 C.F.R Part 2 are not dictated by federal statute. The Public Health Service Act, which incorporates language from two 1970s laws related to alcohol and drug abuse treatment and upon which the Part 2 rules are based, requires only that a patient's consent be obtained prior to exchanging alcohol and drug abuse records.<sup>61</sup> The law is silent on the form of consent and defers to regulators as to potential exceptions. Thus, SAMHSA has the statutory flexibility to revise the Part 2 regula-

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<sup>61</sup> 42 U.S.C. § 290dd-2(b)(1).

tions and its related guidance to give providers more flexibility to exchange Part 2 information, SAMHSA's issuance of the proposed rule confirms this interpretation.

In its proposed rule, SAMHSA recognizes the importance of allowing substance abuse disorder patients to participate in behavioral health integration efforts, and it is recommending a change in the consent form requirements with the goal of fostering such efforts. By allowing a patient in a Part 2 program to sign a form stating that information will be shared with "all of my treating providers participating in Mass Hlway," SAMHSA is proposing a change that, by itself, could make it easier for patients to share their information without abandoning the basic privacy framework of Part 2 that requires informed consent.

However, as discussed above, other proposed changes may have the effect of requiring Part 2 programs to obtain consent from a patient on multiple occasions and therefore could inhibit behavioral health integration. SAMHSA will need to work with patient advocates, providers, and health information exchanges to try to determine which elements of its proposal are safeguards that ensure that a patient's consent is actually informed, and which are administrative barriers to information sharing that have little practical effect in promoting patient choice.

## **REVISIONS TO MASSACHUSETTS BEHAVIORAL HEALTH LAWS AND REGULATIONS**

If state regulators do not believe they have legal authority to clarify Massachusetts behavioral health privacy regulations in the manner recommended above, amendments to state laws and regulations could promote integration among behavioral and physical health providers. Potential amendments are discussed below.

First, the Massachusetts Department of Mental Health could convene a panel of providers, patient advocates, and other community stakeholders to assist the department in evaluating whether it should revise the regulations that permit providers to share mental health information when it is in the "best interest" of the patient.<sup>62</sup> Those regulations allow providers to share information only if the provider has determined that obtaining patient consent is not practical. A diverse panel reflecting different perspectives could help weigh the benefits and risks of eliminating the current requirement to make a determination regarding the impracticality of obtaining consent.

Second, the MassHealth regulations that establish a stricter privacy standard for MassHealth patients could be revised to defer to other applicable state and federal privacy laws.<sup>63</sup> As long as information is being used to advance legitimate purposes of the MassHealth program, such as treatment, it is unclear why information about MassHealth beneficiaries should be subject to greater restrictions than information about patients covered by other payers.

Third, the legislature could amend the statutes governing allied mental health professionals and social workers.<sup>64</sup> While the psychologist statute allows regulators to issue rules as to when patient information can be shared, the laws that pertain to allied mental health professionals and social workers do not grant such flexibility to regulators.

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62 104 Mass. Code Regs. 27.17(9)(c), (d), 28.09(4)(b), (c), (d).

63 130 Mass. Code Regs. 411.413(B), 417.437(B), 425.423(B), 429.436(B).

64 Mass. Gen. Laws ch. 112, §§ 135A, 172.

Fourth, the legislature could amend the state public health law provision that dictates that the form of consent for drug rehabilitation programs “shall state the name of the person or organization to whom the disclosure is to be made, the specific type of information to be disclosed, and the purpose or need for such disclosure.”<sup>65</sup> This law is a recitation of a current requirement under 42 C.F.R. Part 2. However, if SAMHSA adopts its proposal to amend this requirement, the Massachusetts statute would have the effect of continuing to demand compliance with a federal rule that has been withdrawn.

## **ELECTRONIC HEALTH RECORD SYSTEM DEVELOPMENT AND INTEROPERABILITY STANDARDS**

The federal government may have gone as far as it is willing to go in regard to investment in EHR systems. HITECH and its implementing regulations left out many classes of behavioral health providers from the EHR incentive programs, and it appears unlikely that there will be additional federal funding for behavioral health EHR adoption in the near future. Likewise, the latest meaningful use standards have already been promulgated, and it is unclear whether the federal government will adopt more stringent standards for interoperability (although a recent federal law does require HHS to develop metrics to determine if “widespread” interoperability has been achieved by the end of 2018).<sup>66</sup>

However, there may be a role for states to play in regard to these issues. While funding EHR adoption for all behavioral health providers in the state may be too expensive, Massachusetts could target such funding to particular behavioral health providers or classes of such providers that would benefit from information exchange, particularly where there is evidence of a robust integration or care coordination model in effect. States could also play a role in setting interoperability standards. While Massachusetts alone may not have the market power (or the desire) to establish an interoperability framework, a coalition of states could help develop such standards to the extent that the federal standards are inadequate. In addition, Massachusetts could follow Connecticut in adopting a law that prohibits information blocking; Congress has also adopted a similar law.<sup>67</sup>

## **DATA SEGMENTATION STANDARDS AND GUIDANCE**

As more sensitive health information, such as behavioral health data, is incorporated into electronic records, it is critical that EHR systems have the ability to flag sensitive information and segregate it from other health information that is not subject to heightened privacy requirements. Unfortunately, EHR systems often lack the ability to do so. The inability to segment sensitive health information encourages providers to keep such information outside health information exchanges and continue the paper-based system of exchanging such information. This is an inefficient result that prevents patients from obtaining the potential quality-of-care benefits that come from electronic sharing of information.

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<sup>65</sup> Mass. Gen. Laws ch. 111E, § 18(a).

<sup>66</sup> Medicare Access and CHIP Reauthorization Act of 2015, § 106(b)(1).

<sup>67</sup> Conn. Pub. Acts 15-146, §20(c); Medicare Access and CHIP Reauthorization Act of 2015, § 106(b)(2).

ONC is currently addressing these issues. In 2012, it launched the Data Segmentation for Privacy (DS4P) initiative, which aimed to develop technical solutions for segmenting health information subject to heightened privacy rules.<sup>68</sup> Under that initiative, a DS4P standard has been developed under which summary-of-care documents sent from Part 2 providers are flagged (using metadata tagging at the document level) to indicate that the information being provided is subject to Part 2. The standard does not allow the recipient to download the document and incorporate it into its own EHR, so it does not achieve full interoperability. The standard has been adopted by Health Level 7 International (HL7), the international health standards body.<sup>69</sup> Moreover, in March 2015, ONC proposed that certified EHR technology incorporate the DS4P standard.<sup>70</sup>

While the ONC proposal would assist in the sharing of Part 2 information if finalized, it is only a first step in facilitating the sharing of behavioral health information, and additional federal regulatory standards are needed to achieve sufficient data segmentation for the sharing of sensitive health information. Massachusetts and other state governments would assist in these efforts by issuing guidance that clearly defines the health information subject to heightened consent rules under state law and the form of consent needed to exchange such information. Moreover, if states initiate discussions with EHR developers regarding the privacy requirements of their own state laws, states can help shape these data segmentation initiatives to ensure that all forms of sensitive health information can be exchanged electronically.

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## CONCLUSION

The efforts of providers to share information to facilitate behavioral health integration are in tension with multiple federal and Massachusetts laws that were developed in an era that pre-dates electronic information exchange and robust care coordination. These laws can make it difficult for providers to share records even when patients want their health care professionals to have greater access to their information. But the laws also reflect the reality that behavioral health care treatment may still carry greater stigma than other types of health care and that greater privacy protections in this area may therefore be necessary. Working with the behavioral health community, Massachusetts policymakers can take steps to further promote the sharing of behavioral health information by clarifying, and in some cases revising, state laws and regulations as well as by fostering interoperability and data segmentation initiatives. Nevertheless, given the need to continually balance patient privacy with integration efforts, addressing challenges in this area is likely to require ongoing engagement and continued discussion among all stakeholders.

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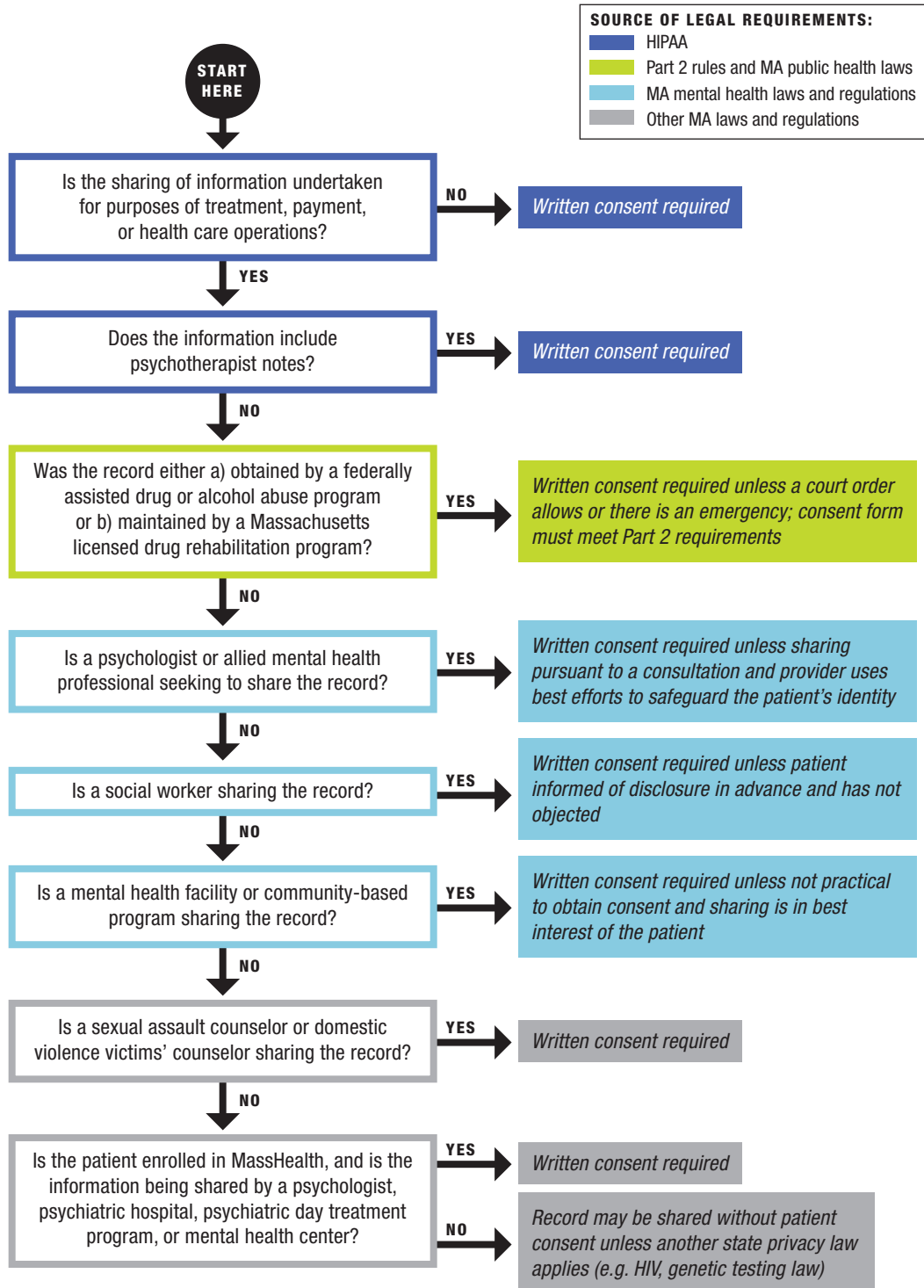
68 80 Fed. Reg. 16804, 16840 (Mar. 30, 2015).

69 Health Level Seven International, "Project Summary for HL7 Data Segmentation for Privacy (DS4P) Implementation Guide," available at <http://www.hl7.org/special/committees/projman/searchableprojectindex.cfm?action=edit&ProjectNumber=1006>.

70 80 Fed. Reg. 16804, 16841-42 (Mar. 30, 2015).



# APPENDIX: EXCHANGING BEHAVIORAL HEALTH MEDICAL RECORDS IN THE COURSE OF TREATING PATIENTS



Note: This chart is designed to provide an overview of requirements and exceptions; additional rules may be found in the text of the relevant laws and regulations.



**FOUNDATION**  
MASSACHUSETTS

manatt