NAACOS
National Association of ACOs

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Washington, DC – Bradenton, FL

The National Association of ACOs (NAACOS) genuinely appreciates the opportunity to comment on SAMHSA's consideration of revising the "Confidentiality of Alcohol and Drug Abuse Patient Records" regulation (42 CFR Part 2).

NAACOS is an organization of over 100 Pioneer and MSSP (Medicare Shared Savings Program) ACOs, including the most experienced ACOS, or those from the original April and July 2012 classes. NAACOS is member led and member driven. In principle, NAACOS believes easier and more streamlined access of their physicians to patient alcohol and drug abuse claims and data will benefit the patient with little risk of improper disclosure. If the patient does not approve of this disclosure then making available de-identified but service specific claims and records should be implemented so that ACOs can properly account for these expenditures and use the dataset to develop and improve clinical management programs.

Concerning 42 CFR Part 2 we should note first our members we well recognize and respect the importance and necessity of patient privacy particularly related to alcohol and drug abuse diagnoses. As stated in the regulation's introduction we understand why "records of the identity, diagnosis, prognosis, treatment of any patient which are maintained in connection with the performance of any drug abuse prevention function . . . be confidential" (Section 290eee-3 (a)) and that "the content of any record . . . be disclosed in accordance with the prior written consent of the patient" ((b) (1)).

As the Federal Register announcement for the June 11th public listening session noted confidentiality of alcohol and drug abuse patient records however "make it difficult for . . . new organizations including health information exchange organizations (HIEs), Accountable Care Organizations (ACOs), and others to share substance abuse treatment records" due to the difficulty and expense of implementing the functionality and work flow changes necessary to comply with current regulations" and as a result "patients are prevented from fully participating in integrated care efforts even if they are willing to provide consent."

With respect to affording patients with an alcohol or drug abuse diagnoses full participation in an ACO and enabling an ACO to fully coordinate that patient's care please allow us to comment on patient consent and provide a brief note regarding re-disclosure.

First, it's our belief that alcohol and drug abuse issues do not carry the stigma that they once did. Second, since patients were assigned or attributed to an ACO because a preponderance of their past care was provided by an ACO physician, the ACO likely already has related treatment data in their electronic medical records. Regardless, ACO program rules allow patients to opt out of (CMS) sharing claims data with their assigned ACO. That is a patient with an alcohol or drug abuse diagnosis (or for that matter any other diagnosis) already has the ability to keep its claims data private or unavailable to their ACO provider. (An ACO patient can also keep alcohol or drug abuse treatment data private since they are not obligated to seek treatment from their assigned ACO provider.)

These points aside, the current confidentiality regulation presents several problems. First, as the Federal Register notes the regulation has not been undated since 1987, that is it takes no account for, provides no guidance on, electronic medical records. It's our understanding for a patient to provide an ACO consent it must identify every member of the ACO and any and all ancillary providers in the ACO's network including HIEs. This is impractical if not unrealistic as well as burdensome and has the effect of neither allowing the patient with an alcohol or drug abuse diagnosis to participate fully in an ACO nor allowing the ACO to fully coordinate the patient's care. For these reasons we believe the patient be given the option to electronically consent to have its alcohol or drug abuse records shared with any or all those in an ACO network that has a treatment relationship with the patient. In order for this option to be allowed we recognize the regulation would likely have to provide a definition of an ACO, HIE and others in the care coordination network, for example, post-acute services including home health.

If the federal government is unwilling to reform patient consent for the purposes of an ACO's ability to provide adequate care coordination we would recommend related claims data be provided ACOs as de-identified. This would at least allow ACOs to create better patient population profiles, enable ACOs to develop more effective programming and allow them to better manage costs or increase their accountability for costs.

The Federal Register's discussion of “re-disclosure” (c) first notes “currently most notes EHRs don't support data segmentation” and then states SAMHSA is considering a “prohibition on re-disclosure [that] only applies to information that would identify an individual as a substance abuser, and allows other health-related information shared by the Part 2 program to be re-disclosed, if legally permissible.” Our first read of this text (c) is these statements are conflicted, i.e., how is patient participation and/or ACO care coordination improved if re-disclosure prohibits making known the patient's alcohol or drug abuse diagnoses. Our second read is SAMHSA is proposing the patient be de-identified but that their “related information”, i.e., information related to their alcohol or drug abuse, be conveyed or re-disclosed. If the latter interpretation is correct, we would be supportive.

Thank you again for allowing NAACOS to make comment on 42 CFR Part 2. We would welcome any additional or subsequent opportunity to discuss possible revisions after SAMHSA reviews all public comments provided.

Warm regards,

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National Association of ACOs